COUNCIL OF THE CITY OF PHILADELPHIA
COMMITTEE OF THE WHOLE

- - -

Room 400, City Hall
Philadelphia, Pennsylvania
Wednesday, April 20, 2011, 10:27 a.m.

- - -

RES. 110161 - Five-Year Plan
BILL 110135 - Capital Program 2012 through 2017
BILL 110136 - FY 2012 Capital Budget
BILL 110137 - FY 2012 Operating Budget
BILL 110138 - Wage Tax Bill

COMMITTEE MEMBERS PRESENT:

Anna C. Verna, Chair
Marian B. Tasco, Co-Chair
Jannie C. Blackwell
Blondell Reynolds-Brown
W. Wilson Goode, Jr.
Bill Green
James F. Kenney
Frank Rizzo
Maria Quiñones-Sanchez

- - -

4.20.11 COMM. OF THE WHOLE - BILL 110137

COUNCIL PRESIDENT VERNA: Good morning. This is a continued public hearing of the Committee of the Whole.

I would ask Mr. McPherson to please read the titles of the resolution and the bills.

MR. McPHERSON: This is a continuation of the hearing for:

Resolution 110161, the City's Five-Year Plan;

Bill No. 110135, the Capital Program for 2012 through 2017;

Bill No. 110136, the Capital Budget for 2012;

Bill No. 110137, the Operating Budget for Fiscal 2012;

And Bill No. 110138, the wage tax.

Today we're continuing testimony on Bill No. 110137, the Operating Budget for Fiscal 2012.

And the first department is Behavioral Health.

(Witness comes forward.)

4.20.11 COMM. OF THE WHOLE - BILL 110137

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

DR. EVANS: Okay. Good morning. I'm Dr. Arthur C. Evans, Jr., Commissioner for the Philadelphia Department of Behavioral and Intellectual Disability Services.

COUNCIL PRESIDENT VERNA: Please proceed.

DR. EVANS: Sure. Good morning, Council President Verna and members of Council. My name is Dr. Arthur C. Evans, Jr., Commissioner for the Philadelphia Department of Behavioral Health and Intellectual Disability Services, and I'm here to present testimony on our FY 2012 budget.

FY 2012 budget request totals $1.2 billion, and $14.2 million of that is in the City General Fund, $276 million is in the Grants Revenue Fund, and $919 million is in the Health Choices

4.20.11 COMM. OF THE WHOLE - BILL 110137

Behavioral Health Fund.

The DBH/IDS FY '12 budget will support 291 positions, 21 in the General Fund, and 270 in the Grants Revenue.

Of the $1.2 billion, $71 million, or 6 percent, is for Intellectual Disability and Early Intervention Services; and $1.1 billion, or 94 percent, is for Behavioral-Health Services.

Class 100 totals $23.3 million. Class 200 totals $1.1 billion, Class 300 totals $159,700, Class 400 totals $155,000, and Class 800 totals $1.3 million.

Effective March 1, 2011, the Department of Behavioral Health and Mental Retardation Services became the Department of Behavioral Health and Intellectual Disability Services.

The term "intellectual disability" is the current terminology for what's historically been known as "mental retardation." Objections to the

word "retarded" have been growing, and "intellectual disability" language is now commonly accepted by advocates, self-advocates, and professionals.

In 2009, U.S. Senator Barbara Mikulski introduced legislation that would bar the use of the word in government offices. This key legislation was enacted in October 2010 and is now federal law.

The mission of DBH/IDS is to support people in an environment of recovery, with a focus on prevention, wellness, and self-determination, to facilitate realizing goals, and attaining the highest possible quality of life.

We work with consumers, families, and providers to ensure that services are accessible, effective, appropriate, and of high quality. We are committed to developing a system of care that is data-driven, employs evidence-based practices, increases cultural competence, and eliminates health care

disparities. The goal of this integrated system of care is to attend to individual needs and preferences as well as to function in collaboration with a broad range of stakeholders.

The behavioral health component of the department coordinates the City's behavioral health-treatment system for a hundred thousand adults and children annually.

Intellectual Disability Services, or IDS, is a component of the department responsible for the development, coordination, and monitoring of services for 12,000 infants, toddlers, children, and adults with Intellectual Disability Services.

In FY '11, DBH/IDS has continued its efforts to address behavioral health and intellectual disability needs of Philadelphia citizens. Key activities supporting these efforts include:

1. Enhancement of community-

based recovery and resiliency supports, including the hiring of certified peer specialists, the engagement of the faith-based community, and the engagement of indigenous community helpers.

2. Sustaining supports to vulnerable underserved populations, including the continuation of assistance rendered to individuals who are homeless, persons leaving prison, the Southeast Asian community, and the LGBTQ community.

3. In the fall of 2010, IDS convened a strategic planning process to enhance its commitment to the employment of individuals with intellectual disabilities. The goal of this effort, known as "Employment First Philadelphia," is to increase the number of individuals employed in the community.

4. Decreasing behavioral health care disparities by promoting important community linkages through advisory groups and tasks forces focusing on underserved and underrepresented

communities. Examples include the Faith-Based Task Force and the LGBTQ Task Force.

And 5. The continuation of crisis intervention training to assist police officers in interacting with people impacted by serious behavioral health challenges. As of February 7, 2011, we have provided training for more than one thousand law enforcement officers, including 986 Philadelphia police officers, 19 Philadelphia Prison staff, and 15 SEPTA officers.

During FY '12, DBH/IDS will continue and expand its efforts to support the Administration's goal to improve the well-being of Philadelphians. Examples of our efforts include the following:

1. The reduction of out-of-state placements. The residential reduction initiative involves bringing youth back to their communities from out-of-state placements. Since 2009,

DBH/IDS has worked to reduce the number of out-of-state placements from 151 children to 28 children; that is a 81 percent decrease. These efforts have been undertaken in close collaboration with the Department of Human Services, the Family Court, the State's Office of Mental Health and Substance Abuse Services, and the State's Office of Children, Youth, and Families as well the School District of Philadelphia.

During FY '12, we will continue our efforts to minimize the use of out-of-state residential facilities and serve children and youth in their communities.

Secondly, securing federal grants. Over the course of the last year, DBH/IDS has secured a number of state and federal grants that will become fully operational during FY '12. These grants will bring millions of dollars into the City's behavioral health system. Examples include the following:

4.20.11 COMM. OF THE WHOLE - BILL 110137

The Access to Recovery Program, which is a four-year, $11 million grant from the Substance Abuse and Mental Health Services Administration that provides individuals who are uninsured or underinsured and who have alcohol- and other drug-related challenges access to clinical and recovery support services.

It is expected that the grant will provide supports to over 10,000 individuals over the next four-year period.

The Veterans Jail Diversion Project is a four-year, $576,000 grant from the Commonwealth, which will integrate veterans' issues into the crisis intervention training I mentioned earlier. This grant will also serve to divert 75 veterans into treatment through the Philadelphia Veterans Court.

And the Homeless Case-Management Program is a five-year, $1.7 million grant from SAMHSA to provide case-management support to 400

chronically homeless individuals seeking substance-abuse treatment.

These are just a few examples of the department's effort to garner additional resources for our behavioral health system.

3. Early intervention. The Infant Toddler Early Intervention Program continues to provide supports to an increasing number of children, ages birth to 3, with developmental delays and their families.

In collaboration with DHS, the Department of Public Health, the Office of Supportive Housing, the School District, and Elwyn, we have served 120 more children in FY '10.

The State Office of Child Development and Early Learning has identified Philadelphia as a leader in pioneering the use of the State-administered family survey, which has demonstrated success in improving outcomes for children receiving early-

intervention services.

4. Performance Improvement. The department has embarked on the development and implementation of provider profiles and performance indicators in our continuing efforts to improve clinical outcomes and reinforce our goals of recovery for adults and resilience for children who are users of behavioral health services.

By articulating and identifying programmatic targets for a variety of key clinical indicators, we believe service delivery and outcomes can be enhanced.

In the fall of 2010, DBH/IDS completed profiles and awarded performance payments to mental-health, inpatient acute hospitals, children's residential treatment facilities, and drug and alcohol residential rehabilitation programs that achieve certain performance goals.

During the upcoming year, we will continue to refine and add

additional measures as well as to expand this process to other services.

And 5. Evidence-based practice. The use of evidence-based and promising practices is being expanded to maximize the effectiveness of the behavioral health and intellectual disabilities services. Examples include the following:

Cognitive therapy. Cognitive therapy has voluminous empirical support as a highly effective treatment. In collaboration with the University of Pennsylvania, the department is infusing this practice throughout the service system.

Philadelphia's employment of cognitive therapy is expected to constitute one of the first large-scale implementations of an evidence-based psychotherapy in a public mental health system. To date, 140 therapists across 16 agencies have been equipped to practice this evidence-based practice.

Wellness recovery action plans is another evidence-based tool developed by Mary Ellen Copeland, which has proven to be highly effective in promoting personal recovery. These are self-directed and self-implemented tools that enable people to proactively manage their mental illness. To date, WRAP training has been provided to 120 personnel, with multiple contract agencies and 478 persons in recovery.

Trauma training is being initiated in response to research that shows that over 90 percent of people with mental health and/or addiction challenges have experienced at least one traumatic event in their lifetime. We know from local surveys administered last year that very few of our agencies are equipped to deal with the complex issues associated with trauma.

With that in mind, we have identified the clinical practices that have the greatest empirical support and

have engaged the creators of these practices to provide trauma training for 21 agencies and more than 120 clinical staff over the course of the next year.

And 6. Enhancing minority-, women-, and disabled-owned business participation. DBH/IDS continues to be committed to serving the Administration's goal of minority-, woman-, and disabled-owned businesses. It should be noted that the majority of the DBH/IDS are with not-for-profit providers and, therefore, cannot be officially classified as minority-, women-, or disabled-owned. DBH's efforts to date include the following:

First, continuing support of the Office of Economic Opportunity's efforts to build supplier diversity programs within the not-for-profit sector. These efforts have included the engagements of our not-for-profit agencies in an OEO-sponsored diversity forum to advance supplier diversity

policies. During FY '12, DBH/IDS will require all contract agencies to submit a supplier diversity plan.

Secondly, the department has surveyed the board composition of all of our nonprofit providers. Based on the most current information, 25 percent of all DBH/IDS nonprofit providers had more than 50 percent of their board consisting of minorities and/or females. The DBH/IDS will continue to update this information annually.

And then, thirdly, continued support of our minority, women, and disabled providers through community behavioral health. CBH contract providers with minority and female executive leadership account for 73 of our 208 contract providers. These 73 providers experience revenue increases of $9.6 million, or 5.4 percent, in Calendar Year 2009 to Calendar Year 2010.

DBH will continue to work closely with OEO to increase minority,

women, and disabled participation within our network.

And, finally, the current economic conditions at the state and federal levels continue to challenge efforts to provide essential services to individuals who are uninsured or underinsured. These challenges include continued job losses that impact the number of uninsured individuals seeking physical and behavioral health care.

While the proposed Governor's budget anticipates flat funding for most behavioral health and intellectual disability services, reductions in these funds have been sustained in each of the last few years and may continue in the future.

We appreciate Council's historical efforts to advocate for sustaining funding and are willing to partner with you in these ongoing efforts. We look forward to continuing with Council and other stakeholders to

advocate for resources to support our most vulnerable citizens.

Thank you.

COUNCIL PRESIDENT VERNA: Thank you very much.

Dr. Evans, you are requesting $919 million in FY 2012 for Health Choices Behavioral Health Program. Will you explain for the record, please, the funding source for these funds and the various per-month type of service fees that you receive.

DR. EVANS: I got the first part of the question; I didn't get quite the last part. You said something about fees? I'm not quite -- could you repeat that part? I'm sorry.

COUNCIL PRESIDENT VERNA: Certainly. Will you explain for the record the funding source for these funds and the various per-month, per-member --

DR. EVANS: Per-member, per-month.

COUNCIL PRESIDENT VERNA:

4.20.11 COMM. OF THE WHOLE - BILL 110137

Per-member, per month --

DR. EVANS: Okay, that's what I --

COUNCIL PRESIDENT VERNA: -- type of service fees that you receive.

DR. EVANS: Sure. The Health Choices Program is a contract that the City has with the State of Pennsylvania to provide all of the behavioral health-care services for individuals who have medical assistance who live in the City.

That -- the latest numbers are about 440,000 people in Philadelphia have medical assistance. The City is capitated for that entire population. And so, we get paid a per-member, per-month fee for each person who is Medicaid-eligible.

That -- the actual rates vary from a low of anywhere of $31 per member per month to as high as over $500, depending on the category of aid that the person is in. And so, people who are

more disabled, we get paid a higher rate for.

So the revenue that we generate and we're projecting to generate is based on the number of people that we have in each category of aid and the rate for that category.

And so, when we look at the projections of where we think Medicaid enrollment will be, what our per-member, per-month fee is, we're able to then determine what our revenue will be for the year.

COUNCIL PRESIDENT VERNA: Has your B Schedule for FY '12 been set?

DR. EVANS: Has been...?

COUNCIL PRESIDENT VERNA: Has been set?

DR. EVANS: For FY -- the Health Choices Program is on a calendar year, not a fiscal year.

And in the current fiscal year, which began January 1, the fees have been set through the end of December of this

year.

COUNCIL PRESIDENT VERNA: Do you estimate that your reserves will increase in 2012?

DR. EVANS: In 2012, they will most likely increase.

We have two types of contractual reserves. One is an equity reserve, which is 5 percent of our capitated revenue. And so, this year, that will be around $850 million we anticipate in terms of capitated revenue. And so, we will be required to have in reserve about 5 percent of that amount.

The other reserve account that we have to have, per the contract, is a risk and contingency reserve, and that's based on medical expenses for the year. And it's a range of between 45 and 60 days of medical expenses; a day is about $1.8 million. And so, our revenue would be between 45 to 60 days of 1.8.

COUNCIL PRESIDENT VERNA: In the event that the federal and state

governments reduce its funding support to the level that you are no longer covering your costs, what happens?

DR. EVANS: Well, at that point, the City can always get out of the Health Choices contract. We have a 120-day clause, and if we ever felt that we were in a position where we didn't have the -- have adequate funding, the City could always choose to get out of the contract.

However, the reason that the contract requires us to have reserves is in the event that in any given year, if we were to go over the revenue that we had, we would have reserves to cover that.

And so, our revenues again right now are $140 million? Or $160 million? So it would have to be a pretty catastrophic problem for us not to be able to cover any given year's medical expenses.

COUNCIL PRESIDENT VERNA: Thank

you, Doctor.

The Chair recognizes Councilman Goode.

COUNCILMAN GOODE: Thank you, Madam President.

COUNCIL PRESIDENT VERNA: Oh, I'm sorry. We have a number of Councilmembers that want to be recognized. So for the first go-around today, each Councilmember will be given five minutes.

COUNCILMAN GOODE: Thank you, Madam President.

Good morning, Dr. Evans.

DR. EVANS: Good morning, Councilman.

COUNCILMAN GOODE: What's the largest contract that you will award in Fiscal '12?

DR. EVANS: That would have been the CBH contract.

COUNCILMAN GOODE: And CBH holds that contract this year?

DR. EVANS: Yes.

COUNCILMAN GOODE: And it's a renewable contract?

DR. EVANS: Yes.

COUNCILMAN GOODE: And how many years has the firm held that contract?

DR. EVANS: Since the beginning of the contract with the Commonwealth.

If you are interested in the provider, you know, CBH is a City-created entity. If we are looking at for-profit providers, the largest contract would be with an organization --

COUNCILMAN GOODE: Or non --

DR. VANCE: -- called Kids and Family.

COUNCILMAN GOODE: Or nonprofit.

DR. EVANS: Or nonprofit. It would be -- if it's a City contract, it would be Resources for Human Development.

COUNCILMAN GOODE: Okay. And how much is that contract for?

DR. EVANS: A little over $6 million.

4.20.11 COMM. OF THE WHOLE - BILL 110137

COUNCILMAN GOODE: And how long has the firm held that contract?

DR. EVANS: It's a contract that includes a variety of different services. And over the years, they've done a variety of different service, residential service, other kinds of behavioral health services. So it's not one -- sort of one contract, per se.

COUNCILMAN GOODE: Is it a renewable contract?

DR. EVANS: It is a renewable contract, and they are nonprofit.

COUNCILMAN GOODE: And when's the last time it was bid?

DR. EVANS: That contract -- or those services have -- most of the services, I should say, that they have provided are not services that we bid out because they've been for-profit, not-for profit residential services --

COUNCILMAN GOODE: So they will be required to submit a supplier diversity plan?

DR. EVANS: They will be.

COUNCILMAN GOODE: Okay. Are they currently compliant with the City's living-wage-and-benefits standard?

DR. EVANS: They are.

COUNCILMAN GOODE: And they will --

DR. EVANS: I'm sorry?

COUNCILMAN GOODE: And they will continue to be required to be so?

DR. EVANS: That's correct.

COUNCILMAN GOODE: Okay. That's all I have.

Thank you, Madam President.

COUNCIL PRESIDENT VERNA: Thank you.

The Chair recognizes Councilman Green.

COUNCILMAN GREEN: Thank you, Madam Chair.

Good morning, Dr. Evans.

DR. EVANS: Good morning.

COUNCILMAN GREEN: First of all, I want to say really I want to

commend you and your department and your staff on tremendous testimony on the way you run your department.

The detail that is available with respect to specific outcomes in all of what you do, or almost all of what you do, it is, I think, a model that every single department should follow. There are metrics by which people can judge how successful they've been compared to goals. And you've been doing that for years.

And, you know, I think you are the model for outcome and program-based budgeting that we need to spread to the rest of city government.

So I just want to commend you on, you know, the work that you continue -- the good work that you and your staff continue to do in that regard.

DR. EVANS: Sure. Thank you so much.

COUNCILMAN GREEN: You testified about the department's

data-driven approach, the commitment of you and your team to using data to access performance and strive for continuous improvement. It's impressive.

I understand that DBH has a series of system metrics, both programmatic and financial, that it uses to assess the department's performance. What process did you use to develop these metrics?

DR. EVANS: Okay, thank you.

The process has evolved over several years. It's led by Dr. Kathy Bolton, who is in the audience, but we have a team of whom who work with her.

The primary purpose -- the primary way that we figure out what we want to look at is based on our system goals. You know, I talked a lot about recovery in my testimony. Our goal is to help as many people as possible get into long-term recovery, and that includes individuals who have serious mental illness or people who have addictions.

And so, the measures that we look at are derived from what we believe are good indicators of people making those kinds of gains.

We look at at least three levels, what we call three levels of analysis. We try to look at systems indicators that show our people at -- if we look at the system as a whole, our people moving towards recovery, are they sustaining the gains that they make in acute treatment, are they doing better.

The second level that we look at is at the program or provider level, and we do a variety of things at that level, including provider profiling so that we can determine who are the providers who are doing a good job and who are the providers who are not doing a good job in those areas.

And then we try to look at the individual level, at specific cohorts, and how they're doing. And so, we look at, for example, how are individuals who

are homeless in our system doing; or how are kids in residential treatment doing.

And so we try to look at all three of those levels to determine both how we're doing as a system in managing the system, but how are providers doing in terms of meeting those goals.

COUNCILMAN GREEN: And within that, how do you choose the performance metric to determine whether or not a child is being successful or a provider is being successful -- or is it -- you've looked at data and outcomes over years in terms of what has worked, and then you're driving providers towards using that practice, and then, you know, measuring the outcome of, you know --

DR. EVANS: Sure.

COUNCILMAN GREEN: You know what I mean? Like --

DR. EVANS: Yeah, sure.

COUNCILMAN GREEN: Like how do you --

DR. EVANS: Well --

COUNCILMAN GREEN: How do you choose what the measure is --

DR. EVANS: Okay.

COUNCILMAN GREEN: -- is really the question.

DR. EVANS: Sure. The --

COUNCILMAN GREEN: The process of that.

DR. EVANS: That's both empirically determined and theoretically determined.

So we -- for example, to get concrete, one of the things that we think is really important -- when we look at the literature and when we look at our own data, one of the things that we know that happens in the system is that people tend to use the most acute parts of the system, and there are a cohort of people that use those systems over and over.

So if you look at our recidivism rate, our recidivism rate and inpatient psychiatric hospitalizations is about 15 percent. We think that that

number should be at around 10 percent. And despite a lot of things that we've done, we've not been able to drive that number down appreciably.

So one of the things we start to look at are things that we think are correlates of performance that would get that number down.

So one of the things that we know is that providers who make sure that individuals are connected to the next level of care tend to have lower recidivism rates. And so, that's one of the things we now track.

(Timer bell rings.)

DR. EVANS: We also know that providers who make sure that they do a good job of discharge planning are also going to have lower recidivism rates.

And so, once we've identified sort of the problem area in our department or in the system, we then try to go back and look at what are the things we think or correlates of that and

begin to measure those and then to tie performance to those indicators that we think are related to the outcome that we're trying to get.

COUNCILMAN GREEN: Thank you, Doctor. I have more questions but my time is up.

DR. EVANS: Sure.

COUNCILMAN GREEN: Thank you.

COUNCIL PRESIDENT VERNA: The Chair recognizes Councilwoman Blackwell.

COUNCILWOMAN BLACKWELL: Thank you, Madam President.

We have so many issues. I won't ask any now. I will say thank you to Mr. Evans. If I have any questions about anything in the City, I call him; he always comes up with a answer.

But we thank you for your commitment to our city and for all you do, and thank you for personally for answering all of my questions about government.

(Laughter.)

4.20.11 COMM. OF THE WHOLE - BILL 110137

DR. EVANS: You're certainly welcome, although I don't know how good a job I do, but I appreciate the sentiment.

COUNCILWOMAN BLACKWELL: Thank you.

Thank you, Madam President Madam President.

COUNCIL PRESIDENT VERNA: You're welcome.

The Chair recognizes Councilwoman Sanchez.

COUNCILWOMAN SANCHEZ: Good morning. Thank you.

Thank you, Dr. Evans.

DR. EVANS: Good morning.

COUNCILWOMAN SANCHEZ: This is going to sound like a parade of everybody's congratulating Dr. Evans. But in my case, I do want to echo -- I inherited some challenging situations in my district, and I want to thank you and your department for always being there to work through the challenges of how -- what do we do with folks in recovery and

how do we make sure they get integrated back into their own neighborhoods and that they get service. So I greatly want to say that I appreciate your willingness to work with me through all of those, from prevention point to our recovery house situation.

Last year, when we talked, we talked about figuring out ways in how we get our stakeholders, our providers to work better with us and their clients in the neighborhoods, and one of the things that I had requested from the department was, could we get our providers to be more engaged in providing house visits or home visits, particularly in places that we understand recovery houses and recovery support is provided in neighborhoods.

Can you update me on that?

DR. EVANS: Sure. The issue that you brought up was that there are a number of recovery houses around the City that don't necessarily do a good job, and

the thing that we pointed out last year was that of the 200 -- we estimate there are over 200 recovery houses in the City -- about 20 of those are funded by the department and we have direct control over and oversight.

For those 20 that we do provide direct oversight over, you know, we don't get complaints; they are viewed as good neighbors and so forth.

The issue you raise are the others that we don't have under our control and how do we get those providers to really adhere to the standards that we have for the other providers. And one of the things you suggested was whether our providers who provide service and have clients who live in those recovery houses could do more to try to encourage those not-so-good recovery houses to do better the.

I got the issue, right?

COUNCILWOMAN SANCHEZ: Mm-hmm.

DR. EVANS: So there've been a

number of things that we have tried to do to increase our footprint within the recovery house world. So one of the things -- and I think we mentioned this last year -- is that even though there are providers who we have really no control over, we've asked them to voluntarily adhere to our standards.

And so, we've had -- initially we got 35 providers to do that. And so, those providers are adhering to the same standards as the providers that we directly fund.

In terms of providers doing site visits, we didn't go to the point of requiring them to do that, but we have encouraged providers to do that. And I think that that has helped because I think more providers have voluntarily stepped up to adopt our standards because of that.

The thing that has happened in the last year that I think has been -- that will really make a big impact is

that we received a federal grant that allows us to fund additional recovery houses. We won't be able to give them a grant, but if a person needs a recovery house, we can give them a voucher and they can attend the recovery house. Obviously, all of those providers now have to, if they want to have that source of income, will have to adhere to our standards.

So I think that it is, you know, realistic that we will easily, in the next year, again, increase our footprint in terms of the number of providers who are adhering to those standards. Already we have at least five or six that have taken on our standards because of that. And we're just starting; we're only a couple of months into the grant.

COUNCILWOMAN SANCHEZ: What's value of the voucher? What is -- how is that going to work?

DR. EVANS: It's $31 a day.

4.20.11 COMM. OF THE WHOLE - BILL 110137

COUNCILWOMAN SANCHEZ: It's $31 a day.

DR. EVANS: Right.

COUNCILWOMAN SANCHEZ: Okay. So someone will be able to pay...

In addition to this oversight, because now you have a voucher and people get involved, or hopefully will get more involved, is there anything else that you think we need to be doing in terms of how we communicate with our community, that we should be doing?

DR. EVANS: Well, I think if -- and I do appreciate your work and willingness to work with us around some of these issues. I would say two things.

One is if there are providers who are problematic, for whatever reason, to call our office. And, again, even though we don't have the authority to make providers do things, we do have some influence.

(Timer bell rings.)

DR. EVANS: And so, we have no

problem in stepping into those situations.

The other thing is that on a national level, there is a move to create national standards for recovery houses and create actually a network of recovery houses so that there will be some peer review of what people are doing. We are encouraging, and, in fact, there's some organizing in Philadelphia to do that.

We think that that will help because it will create essentially a peer group of people who are really trying to do the right thing and to be neighbors. And so, if there are recovery houses in your community that you think could benefit from that, we could certainly connect them to that group.

COUNCILWOMAN SANCHEZ: Yeah. I mean, one of the results of all the attention that has been paid is that the good guys have stepped up, and at least, in Frankford and West Kensington, they have started a coalition that's being

more aggressive on the ground in terms of cleanups and showing and demonstrating to the community that they're better members. So we've seen that immediately.

DR. EVANS: Good.

COUNCILWOMAN SANCHEZ: And that's good and that's a result of our town halls, our annual town halls, and I look forward to next year having even more progress.

DR. EVANS: Sure.

COUNCILWOMAN SANCHEZ: 'Cause I can now see it.

DR. EVANS: Good.

COUNCILWOMAN SANCHEZ: You know, and when we call them, they're there, and they're really helping us with our parks --

DR. EVANS: Good.

COUNCILWOMAN SANCHEZ: -- and just showing neighbors in the neighborhood that they want to be there.

DR. EVANS: Good.

COUNCILWOMAN SANCHEZ: So I

want to thank you for that. Thank you.

DR. EVANS: Good. Thank you.

COUNCILWOMAN SANCHEZ: Thank you, Madam Chair.

COUNCIL PRESIDENT VERNA: Thank you.

The Chair recognizes Councilwoman Tasco.

COUNCILWOMAN TASCO: Good morning.

DR. EVANS: Good morning.

COUNCILWOMAN TASCO: And thank you for the good job that you all are doing there.

Under -- and this question may have been asked; I've been distracted.

DR. EVANS: Okay.

COUNCILWOMAN TASCO: Under Governor Corbett's budget, significant cuts have been proposed, the State education funding. If cuts are shifted from State education funding and State behavioral health funding, what areas are mostly likely to be impacted by

reductions?

DR. EVANS: I do a lot of thinking about that every night, Councilwoman.

I think that it is most likely that the State will cut where they have cut before, and that is the State-only dollars. The Medicaid dollars and the Medicaid program is a cost-sharing program. So for every dollar that the -- roughly every dollar the State puts in, they get a dollar back from the federal government.

COUNCILWOMAN TASCO: Mm-hmm.

DR. EVANS: So it doesn't make a lot of sense to make deep cuts into the funding of Medicaid because of the leverage that the State uses to bring in additional federal dollars.

So that means that the most likely place are the grants that we give to providers to cover the uninsured and in what we call the BHSI, Behavioral Health Special Initiative, program, which

has received consistent cuts over the last several years. That is a program that is a hundred percent State-funded. It is for the uninsured.

It is the -- the irony is that as the economy gets worse, that's where we have the greatest need, because more people lose their jobs, they don't have health insurance. And we depend on that funding to serve those individuals.

So it's most likely to be in the area of BHSI or community grants that we pay our providers to cover the uninsured in our community mental health centers.

COUNCILWOMAN TASCO: You talked about the providers, not all of them being a part of the organization. If someone decides to become a provider of services, where do they get their funding from; is it through Medicaid?

DR. EVANS: It is through Medicaid. So the primary way that new providers come into our system is through

the CBH network.

COUNCILWOMAN TASCO: Mm-hmm.

DR. EVANS: And so, if a provider meets the criteria, we credential the provider; they would be then be paid on a fee-for-services basis for the services that they provide.

COUNCILWOMAN TASCO: But otherwise, they're dealing directly with what department with the State?

DR. EVANS: They would be dealing with either other private providers if they are seeking public funds. And if they are in Philadelphia, they would receive those through my department, through one of the funding streams that we manage and control.

COUNCILWOMAN TASCO: We talked about the reserves, and when we started CBH years ago and we knew that we had to set up the reserve account, has there ever been any effort to remove those reserves from you to --

DR. EVANS: No.

4.20.11 COMM. OF THE WHOLE - BILL 110137

COUNCILWOMAN TASCO: -- for you to redirect them?

DR. EVANS: No. One of the things that the State has done is to change the reserve requirements.

So when I took this job, the reserve requirements were between 60 and 90 days of paid claims, and I mentioned earlier that our paid claims were about $1.8 million a day.

COUNCILWOMAN TASCO: Mm-hmm.

COUNCIL PRESIDENT VERNA: So, you know, do the math. Roughly 1.8 times 90 would have been the maximum amount that we could have had in reserve.

Over the years, the State has sort of played with that as a way of getting dollars back into the State coffers. And so, they've pushed that number down. And so, today our reserve requirements are between 45 and 60 days of paid claims.

COUNCILWOMAN TASCO: Mm-hmm.

DR. EVANS: And so, but they

wouldn't -- the reason that they wouldn't the reserve requirements is that if for whatever reason the City decided to get out of the business, we would need reserves to pay for claims and to pay for services that may have been provided as we were trying to bring the program down.

COUNCILWOMAN TASCO: Mm-hmm. Okay.

Thank you, Madam President.

COUNCIL PRESIDENT VERNA: The Chair recognizes Councilwoman Brown.

COUNCILWOMAN BROWN: Thank you, Madam President.

Good morning.

DR. EVANS: Good morning.

COUNCILWOMAN BROWN: Let me underscore the accolades expressed by my colleagues. I agree 2,000 percent.

DR. EVANS: Thank you.

COUNCILWOMAN BROWN: You've mentioned a number of constituencies. I'm particularly interested in the infant, toddler early-intervention

program. What type of intervention strategies or services are delivered to children with developmental delays?

DR. EVANS: Sure. So the early-intervention program is a program that tries to identify developmental delays in kids early on and tries to intervene.

And so, depending on what the delay is, there are therapies, there are interventions that are made. So sometimes kids may have speech problems or are not developing their speech or maybe have hearing difficulties or maybe it's a visual difficulty.

So what happens is, after the kids are assessed, screened and assessed, a plan is put together. And then, based on the kinds of developmental problems that they have, there will be either speech pathologists or some other professional that will work with the child to try to ameliorate those problems.

COUNCILWOMAN BROWN: Any special focus or emphasis on children with developmental delays as a result of lead poisoning?

DR. EVANS: Not lead poisoning per se, but I would imagine that if a child has a delay as a result of lead performing, they would be picked up in that screening process; and, again, they would get the same kinds of interventions as other kids would whose delays may be caused for some other reason.

COUNCILWOMAN BROWN: Mm-hmm. Is there any categorizing of the reasons why young people may have a developmental delay? Like do you put in a box all of those children who have a developmental delay because of lead poisoning, and they get a certain type of treatment problem?

DR. EVANS: I don't think so, but the person who would know that agrees with me, no. No, no, there's not.

I think at that age, what we're -- you know, whether it's a

congenital problem or genetic or whatever, the issue is, you know, what is the delay, and then how do we then intervene and treat that.

COUNCILWOMAN BROWN: Sure.

DR. EVANS: But we don't then go back and try to find out the etiology of the delay and that kind of thing necessarily.

COUNCILWOMAN BROWN: Okay, all right. I'll have a separate sidebar around this whole lead opining issue.

DR. EVANS: Sure.

COUNCILWOMAN BROWN: 'Cause we're going to look at that very, very closely soon.

Are diagnosis of developmental delays among African-American children equal to their proportion of the population?

DR. EVANS: That, I don't know that number. I do know the number and I don't know if --

(Addressing colleague.) Kathy,

do you know the number? Do you know if the proportion diagnostically is equal across racial groups?

(Kathy's response is off-mic and, therefore, inaudible to stenographer.)

DR. EVANS: Okay. So she said that she believes there are more male children.

I think that socioeconomic status does affect delays. And so, to the extent that you have disproportionate numbers of people with color in the lower socioeconomic status, you would expect them to find greater delays in some of those populations.

COUNCILWOMAN BROWN: Could we have that data --

DR. EVANS: Sure.

COUNCILWOMAN BROWN: -- forwarded to the Chair?

DR. EVANS: Sure, absolutely.

COUNCILWOMAN BROWN: A lot of concern was raised last year around

out-of-state placements.

DR. EVANS: Mm-hmm.

COUNCILWOMAN BROWN: And we see here that that's dropped significantly from 151 to 28 children last year.

So under what circumstances now are children placed in facilities outside the state?

DR. EVANS: Yeah. Well, we're very proud of the fact that we are serving children in Philadelphia in the community, and it is only the rare instance now that we will have to use a facility out-of-state.

The only time that that happens is -- right now is if there is a service that is not provided within Pennsylvania or the five-county area, that -- where we can send a child.

So it tends to be, for example, residential programs for children who might be -- who might have a core occurring intellectual disability and mental health problem.

COUNCILWOMAN BROWN: Mm-hmm.

DR. EVANS: So it's those kind of really specialized programs that we may not have a program for in the City --

COUNCILWOMAN BROWN: Citywide.

DR. EVANS: Or citywide.

COUNCILWOMAN BROWN: So what systemic changes did you make to make it clear that in-state placements are the priority?

DR. EVANS: Okay. So a couple of things. One is, as you know, the Blue Ribbon Commission that you were a co-chair of, one of the things that was identified was that we serve too many children in residential settings outside of the State, which makes it very difficult to do family work, it makes the transition back to the community very difficult.

We had kids who were doing quite well in Texas for two or three years and would come back to the City and not do so well.

4.20.11 COMM. OF THE WHOLE - BILL 110137

(Timer bell rings.)

DR. EVANS: And so, there were several things, starting with the Blue Ribbon Commission.

Secondly, when Commissioner Ambrose came on, one of things we agreed to, because most of those kids are involved in the DHS system, we agreed that we would begin shutting off residential programs that were out-of-state and forcing people to do -- to find alternatives.

And then, thirdly, and I think, very importantly, I think Nancy Lucas, Kenny Selonka (sp?) at CBH, I think, did a really fantastic job of looking at alternatives, 'cause this doesn't work unless you have community-based alternatives.

COUNCILWOMAN BROWN: Mm-hmm.

DR. EVANS: And so, there are a couple of things that happened. One is that we expanded the use of things like family functional therapy, evidence-based

practices that kids could access within the City.

And then the other thing that I think has made a huge difference is that we created an assertive outreach team, an assertive after-care team so that as kids were coming out of residential or being diverted out of residential, we had basically case managers that made sure that those kids got connected to local services and that those services were working.

So we didn't just refer kids to local community services; we made sure that those services were working for kids and that they were having access.

COUNCILWOMAN BROWN: Before the referral.

DR. EVANS: That's right.

COUNCILWOMAN BROWN: Okay. Thank you. I'll circle back my next chance.

Thank you, Madam President.

COUNCIL PRESIDENT VERNA: Thank

you.

The Chair recognizes Councilman Green.

COUNCILMAN GREEN: Thank you, Madam Chair.

The Five-Year Plan highlighted, and you had testified about, DHS's new pay-for-performance, approach which is designed to enhance service delivery and client outcomes. And you and your team were kind enough to brief my office on this initiative.

And I wondered if you could, for the record, describe how DBH's provider profile and pay-for-performance model works. The current model uses incentive payments to reward high-performing providers.

How does the department plan to address low-performing providers either in terms of helping them to improve services or end their contracts?

DR. EVANS: Sure.

COUNCILMAN GREEN: And before

you answer that question, if you could just describe to us how you came up with this plan and, you know, how it's worked for you so far.

DR. EVANS: Sure.

COUNCILMAN GREEN: And just for the record what it is.

DR. EVANS: Sure. So as we were discussing a little while earlier, one of our major concerns is the -- what we think is the excessive recidivism rate for people leaving acute in-patient hospitalization.

And so, we identified that as one of our primary goals is to reduce that because we think it's better care for people, and it's certainly more efficient and effective care to make sure that people are sustaining the gains that they make in in-inpatient post-discharge.

So for our -- for the paid-for-performance, I think it was a combination of two things that happened. One, at the State level, the State was

encouraging counties to move to pay-for-performance. And then, secondly, we had these issues where we wanted to make an impact, and for as much as we have spent a tremendous amount of time and energy and training and all those kinds of things, we know that the most powerful incentive that we can use is money.

And so, we really wanted to tie resources to increased performance to shape provider behavior.

So that's sort of the background as to how we got there.

COUNCILMAN GREEN: Did you do any kind of return-on-investment analysis in determining what the appropriate amount of pay-per-performance is, because if they achieve that, it was going to save even more than you were giving as the incentive?

DR. EVANS: Sure, yes. It's a great question. And the answer to that is -- I'll give you an example of the benefit.

So we spent for the entire pay-for-performance project last year about $3 million. And if you look at the levels of care that we use that on, that's about 3 percent of what we spent on those levels of care. So $3 million pay-for-performance.

We did another analysis that looked at recidivism over a three-and-a-half year period, and we stratified the population in different groups. And so, there was one group that had four to nine readmissions over a three-and-a-half year period.

We calculated that if we were to reduce the number of episodes in the people that had four to nine by just one episode, it would save the system about $18 million.

So if you look at the impact, the potential impact, that this can have, it's more than -- do the math -- six times potentially just for that one cohort. So the cost benefit is pretty

large.

COUNCILMAN GREEN: Are there additional service areas where you think you might be able to expand this model, and are you looking at that?

DR. EVANS: Yes, we are.

Our goal is to have a pay-for-performance strategy for each type of service in our system. Last year, we did three: We did inpatient hospitalization, we did residential drug treatment, and we did residential children's services.

This year, we're doing BHRS, we're doing targeted case-management. We're also going to be doing some incentives for outpatient providers.

Our goal is that by 2013, our entire system will have some kind of pay-for-performance. Next year I think if you added -- did it by revenue, we would probably be up to about 75 percent of our service system.

COUNCILMAN GREEN: Thank you.

4.20.11 COMM. OF THE WHOLE - BILL 110137

You testified about some of your diversionary -- working with the courts on -- mental health courts and providing the resources for treatment instead of prison, and I know that program has just begun.

But are you or anybody else in the system going to measure outcomes in terms of recidivism for, you know, on the criminal side in addition to outcomes sort of on your treatment area of mental health?

DR. EVANS: Mm-hmm. Yeah, we're early on right now, so it's kind of hard to do that now.

(Timer bell rings.)

DR. EVANS: For any of these kinds of programs that we do, we will do some kind of analysis.

And so we do one of two things: Either we do it by ongoing data collection and looking at the numbers, as I mentioned earlier; or we'll do a small study to look at that. So we've done

that with a variety of services, and we'll be doing that with this one.

COUNCILMAN GREEN: Thank you. My time's up. I just have a few more questions, so I'll come back one more time.

COUNCIL PRESIDENT VERNA: Thank you.

The Chair recognizes Councilwoman Brown.

COUNCILWOMAN BROWN: Persons with disabilities, how has the business community responded to the work you're doing in that area?

DR. EVANS: Well, I think -- I think two things. One is that when we talk about people with severe mental illness, for example, we've put a lot of emphasis on recovery, on normalizing, helping people to have a more normal kind of life. A lot of emphasis on what in the field is called "community inclusion," and I'll just give you an example.

4.20.11 COMM. OF THE WHOLE - BILL 110137

When the State hospitals were closed -- and I think this happened really around the country -- people were deinstitutionalized, they were taken out of large state hospitals and brought back to communities, but the reality is that people were what we call "institutionalized within the community." They're not really a part of the community; they live in segregated living situations, they're not really interacting.

And, frankly, the way we had structured our treatment system, we really contributed to that to some extent.

Over the last several years, we've made a concerted effort to look at how do we help people become a part of the community and not just live in the community.

COUNCILWOMAN BROWN: Mm-hmm.

DR. EVANS: And so, we've -- with one program in particular, where

people were going to those programs literally for years, day after day, brought to the program by a -- by medical transportation, taken home at the end of the day, sort of in that pattern for literally ten, fifteen years, we radically changed those programs so that those programs were focused on recovery, they were focused on people obtaining jobs, getting an education, we taught people how to use public transportation.

And the -- sort of the short story here is that not only did we improve outcomes, for example, we -- for people who went through those programs, we saw a 33 percent decrease in crisis visits, and we saw -- half of those visits would have converted to inpatient hospitalization.

So we know from a system standpoint that it's been very effective in both saving resources but also in improving people's clinical care.

COUNCILWOMAN BROWN: Sure.

DR. EVANS: But the real, I think, important part is that it really has improved people's quality of life. A number of people have gotten jobs, they've gone back to school. I think we've tried to model the importance of hiring people who are in recovery who have disabilities.

And so, we have a number of people within our department who are people who have had psychiatric disabilities or who are in recovery from drug addiction.

COUNCILWOMAN BROWN: Okay.

DR. EVANS: And so, I think we're getting there, but we have a long way to go to really get the larger business community to really embrace that.

COUNCILWOMAN BROWN: Mm-hmm. So have you had a chance, then, to explore strategically how you penetrate that community in a real strategic way?

DR. EVANS: I heard a really

interesting presentation a few weeks ago in Washington of a group that has done just that, and it was led by people who are in recovery themselves, who were business people themselves, and they had done some really interesting things in terms of engaging the business community.

So I think there's some lessons learned out there that we want to tap into.

COUNCILWOMAN BROWN: Okay, sure.

DR. EVANS: But, you know, getting -- you know, breaking through the stigma around having behavioral health problems is a big challenge. So if you can help us with that, we'd appreciate it.

COUNCILWOMAN BROWN: It's a huge hurdle.

DR. EVANS: Yes.

COUNCILWOMAN BROWN: Will Philadelphia have a face with the national effort to standardize best

practices for recovery agencies?

DR. EVANS: Yes. We are actively involved in that. And, in fact, Philadelphia and Pennsylvania was one of the first actually --

(Addressing colleague.) Was it Philadelphia or was it Pennsylvania that first started trying to organize the recovery houses?

UNIDENTIFIED SPEAKER: Well, Pennsylvania (inaudible.)

DR. EVANS: Pennsylvania? Okay. So it was at the state level. So there were providing from around the State that were trying to do that, and our staff are going to be actively involved in that effort.

COUNCILWOMAN BROWN: Okay. It's a -- national best practices or standards is long overdue.

DR. EVANS: Yes, yes.

COUNCILWOMAN BROWN: My last question. Last year, you discussed the process of monitoring providers for those

who were deemed inefficient, mostly resulting from duplicative inspectors and overlap of duties.

What steps has the department taken to create efficiencies in that way?

DR. EVANS: I am pleased to report that we've, I think, come a long way from last year. We now have what we're calling "an integrated monitoring team." The issue has been historically, because of the categorical nature of funding --

(Timer bell rings.)

DR. EVANS: -- each category of funding had a different monitoring process.

So if it was Medicaid dollars, we had one group of funding; if it was State Block Grant dollars, it was another group of people.

COUNCILWOMAN BROWN: Mm-hmm.

DR. EVANS: And so, a provider literally would have five, six different people coming out, all from my

department, sometimes saying different things.

COUNCILWOMAN BROWN: Mm-hmm.

DR. EVANS: And so, what we've moved to do is to put all of those people on one team.

COUNCILWOMAN BROWN: Yes.

DR. EVANS: We have started that process; we started that process back in February as one team. And we're working to reduce the amount of time and the effort at doing this. And so, it's -- you know, it's rough.

COUNCILWOMAN BROWN: And different.

DR. EVANS: It's -- well, I think it's -- I mean, we're in the early stages, and I think it's very difficult when you have so many different views.

But I have to give the staff a lot of credit. I think people understand why it's really important.

COUNCILWOMAN BROWN: Sure.

DR. EVANS: And I think

providers really appreciate it. They get one visit; it's a big visit.

COUNCILWOMAN BROWN: Sure.

DR. EVANS: But they have it out of the way after the one visit.

COUNCILWOMAN BROWN: Just one quick story I'll close with.

Decades ago, I worked for the Youth Services Coordinating Office during Mayor Rizzo's administrating in the Evaluation Unit, evaluating programs receiving City dollars, providing services to kids, and that was an issue then.

DR. EVANS: Then, that's right. We've been dealing with issue for a long time in the field so we're --

COUNCILWOMAN BROWN: There's been some progress.

DR. EVANS: Yeah, there's definitely been progress, absolutely.

COUNCILWOMAN BROWN: Thank you for your testimony.

DR. EVANS: Okay, thank you.

COUNCILWOMAN BROWN: Thank you Madam President.

COUNCIL PRESIDENT VERNA: You're welcome.

The Chair recognizes Councilman Green.

COUNCILMAN GREEN: Thank you, Madam Chair.

Dr. Evans, you testified a little bit about crisis intervention teams and CIT training, first responders. Does that relate to the intercept program at all --

DR. EVANS: It does.

COUNCILMAN GREEN: -- which you talked to CJAB about?

DR. EVANS: Sure.

COUNCILMAN GREEN: Could you explain that?

DR. EVANS: Sure. So the intercept model basically is a model that was developed by Dr. Patty Griffith, who actually works with us, and another psychologist.

And basically what they did was, because of the high overlap of people who have mental illness who find themselves in the criminal justice system, they wanted to create a framework that would guide how people could intervene.

And so, basically, the intercept model is, you try to intercept people at various points in the criminal justice, starting with police officers who come into contact with people, the initial hearings that people have through people being incarcerated, all the way through reentry. And at each one of those points, there are a set of interventions that you try to implement.

So what we've done, I think the City, over a number of years, I think, has quite successfully created interventions at each one of those steps. One of the last, frankly, that we needed to do was sort of the first two intercepts, which was law enforcement and

the initial arraignment portion.

But that program has been enormously successful, we think. Commissioner Ramsey and I -- Commissioner Ramsey supports the program; in fact, he personally comes to the graduation of those officers who have gone through the training. So he and I do that graduation ceremony together, which, I think, reflects his commitment to this issue.

And he believes -- I'm not putting words in his mouth -- but he has said that he thinks it's really important for officers to be able to spot and understand when someone's having a mental health problem versus someone who's just being belligerent or non-cooperative and be able to intervene effectively.

COUNCILMAN GREEN: Is that program going to move into the Police Academy as part of the initial training of officers?

DR. EVANS: No, the -- we already do some mental health training

for officers within the Police Academy. What this is, is a much more extensive -- it's a one-week long process.

We have a variety of people that come in during that week. And it's geared for officers who've already had enough of an experience that they can actually integrate the training into what they do.

COUNCILMAN GREEN: Is the intercept model something that is applied to juveniles also or in the juvenile justice system?

DR. EVANS: It is. It's -- we primarily thought about it more in terms of the adult criminal justice system here.

With juveniles, we work a little differently in thinking about Family Court and the Youth Study Center and those kind of things. So we don't quite have the same kind of process that we have for adults.

COUNCILMAN GREEN: We've

developed and we're developing and I think we're going to develop broader diversionary programs not just related to mental health but, you know, substance abuse and other things, sentencing people to almost community service and other things that are -- you know, trying to prevent people from going to jail, diverting them into useful things, get your GED within this, your records expunged, et cetera.

I wonder if there's a model that you're aware of from around the country that we can -- an intercept-type model that we can apply in schools or in other places to help people identify problems that would allow social services to be applied when necessary before things get out of control and children end up in the juvenile justice system.

I don't know if you know of anything, but you have a great staff, and if they see something like that, I'd be very interested in it.

DR. EVANS: Sure. We can look at it.

I mean, I've actually spent a little time looking at that literature because of the school-violence issues that have come up.

And there are a number of interventions that people have developed: school climate kinds of interventions; family interventions; interventions directed at individuals, whether those are individuals who are at risk or more universal kinds of applications.

So there are a number of things that are out there that we can -- and, in fact, some of those things we're already using in the system.

COUNCILMAN GREEN: If your staff would be kind enough to forward what you think is relevant, I'd appreciate it.

DR. EVANS: Sure.

COUNCILMAN GREEN: Thank you.

Thank you, Madam Chair.

4.20.11 COMM. OF THE WHOLE - BILL 110137

COUNCIL PRESIDENT VERNA:

You're welcome.

Are there any other questions from members of the committee?

(No further questions.)

COUNCIL PRESIDENT VERNA:

Seeing none, Doctor, thank you very much.

DR. EVANS: Thank you. And congratulations on your retirement.

COUNCIL PRESIDENT VERNA: Thank you.

DR. EVANS: I appreciate you being here. And best wishes.

COUNCIL PRESIDENT VERNA: Thank you so much.

Our next department...

MR. McPHERSON: Is the Health Department.

(Witnesses come forward.)

COUNCIL PRESIDENT VERNA: Good morning, Doctor. Welcome.

DR. SCHWARZ: Good morning, Council President.

COUNCIL PRESIDENT VERNA: And

thank you for all the wonderful work that you do.

Please identify yourself for the record and proceed with your testimony.

DR. SCHWARZ: Yes, ma'am. Good morning, Council President Verna and members of Council. I'm Donald Schwarz, Health Commissioner for the City of Philadelphia.

With me today is Carmen Lemmo, Deputy Mayor for Finance and Administration; and Carla Hill, the Director of our Division of Human Resources.

Thank you for the opportunity to present the Department of Public Health's Operating Budget request for Fiscal Year 2012.

The department's Fiscal Year '12 budget requests almost $356 million. The breakdown by class of these funds is shown in my testimony, and I won't go through in detail, but I'm happy to

answer questions.

Of the total Fiscal Year '12 Budget request, about $110 million is in the General Fund, a little over a hundred million is in the Grants Fund, and $145 million is in the Acute Care Hospital Assessment Fund. Of the total budget, $39 million is the net amount supported by City tax dollars.

The Fiscal Year '12 General Fund Budget represents a decrease of $3. 3 million from Fiscal Year '11 estimated obligations. Fiscal Year '12 Budget will support 1,021 full-time positions -- 731 in the General Fund, 280 in the Grants Fund, and 10 in the Acute Care Hospital Fund.

The budget will continue to support services basic to the Department of Public Health's ability to carry out its core mission to protect and promote the health of all Philadelphians and provide a safety net for those most at risk.

4.20.11 COMM. OF THE WHOLE - BILL 110137

In keeping with the department's mission, our overall objectives are to prevent disease and promote health by increasing access to health care and providing quality primary care and traditional public health services for our residents and assuring safe and healthy environmental conditions for those who live in or visit the City.

I will provide an overview of a number of my divisions and what's been going on based on questions that Council has asked in the past or sent to us this year.

The City's eight health centers provided about 350,000 patient visits in Fiscal Year 2010, including comprehensive, primary care, prenatal care, dental care, family planning, podiatry, and specialty care to a little over 90,000 patients. This represents service to nearly one quarter of the City's uninsured population.

The average waiting time for an

appointment for an adult patient has increased from 56 days for an initial appointment system-wide in March 2010 to 66 days in March 2011.

We believe this delay reflects the increase in demand for our services in the face of staffing levels that have not been able to increase because of the hiring process and budget constraints, which I'm also happy to discuss.

For a return visit, waiting times having gone from 6 days to 27 days. For pediatric patients, the waiting times have gone down, though, from 3 days from an initial visit in March of 2010 to one day in March 2011. For return visits, those times have remained at two days.

We continue to provide care several evenings each week. At our busiest centers, we provide Saturday hours. We offer patients who first request an appointment at a center with a very long waiting time the chance to be seen at a center where there's a shorter

waiting time. And in order to ensure that those with an immediate need can always get in, we offer same-day, walk-in service to those who arrive for a visit.

Of note, we have very low rates of emergency-room use awning our patients, according to insurance companies and hospitals in town.

First-party collection of a modest fee was implemented in all eight health centers in the third quarter of Fiscal Year '10. In Fiscal Year '10, $150,000 was collected. Collections for the first five months of Fiscal Year '11 are more than $200,000, and we estimate that we will ultimately bring in about a half a million dollars.

This year, our health centers were recertified as federally-qualified lookalikes, which is a five-year designation and, I think, a major accomplishment because it means that the centers met new, more stringent federal certification requirements and a much

more complex application.

The health centers continue to work diligently to provide excellent care for all those who present, including the uninsured, into improved health insurance coverage where possible. A few achievements:

Approximately 70 percent of all pediatric visits are now made by insured patients. This represents an increase from 66 percent in Fiscal Year '09 and about 52 percent in 2008.

In Fiscal Year '10, benefits counselors enrolled 3243 patients in insurance plans, including Medicaid and CHIP.

We expanded the indigent fee drug program, utilizing 16 Americore workers to complete applications. Over 16,000 applications were completed, and free medications were provided to over 4500 health center patients between August of 2009 and 2010.

The Pfizer Sharing the Care

Program provided free medication valued at more than $3 million to over 17,000 patients.

And the AZ & Me Prescription Savings Program from AstraZenica provided 3700 free prescriptions to more 1326 patients. I should point out that for each of these patients, we have to complete an application, including income verification, so the work for our staff is considerable. But, as you can see from our budgeting, it has paid off both in terms of more prescriptions for our patients and less cost to the City.

Through pursuing every opportunity to improve our collection from insurance companies while utilizing all programs to cover expenses for the uninsured, our unreimbursed obligations for ambulatory health services for Fiscal Year '12 are estimated at just $14 million. For the last three years, unreimbursed obligations for ambulatory health were $14,400,000 in 2011,

$17 million in 2010, and more than $19 million in 2009. This represents a reduction of 28 percent in public tax dollars used, while the number of visits increased by more than 8 percent.

Our Get Healthy Philly program, which we discussed in this Council last year as simply a glimmer, has been implemented during the last year.

Implementation of our recovery-funded tobacco and obesity prevention programs, with $26 million over two years, began in March of 2010. So we've just completed our first year of operations.

Through Get Healthy Philly, we're changing the environment to make it easier for people to engage in health behaviors. Among the many accomplishments to date, we have joined with the Department of Recreation to launch the USDA Supper program in 40 of the 98 Recreation Center after-school sites, providing nutrition meals to

thousands of low-income children. The Supper program offers healthy, age-appropriate meals, including fruit and vegetables, dairy products, and lean meats. This program replaces a program that provided just snacks to a much smaller group of children.

We've worked with the School District to begin the Campaign for Healthier Schools in 200 public schools. Through these activities, school wellness councils have been created that will incorporate physical activity into the school day and eliminate junk foods from classrooms, fundraisers, and school stores. To date, over a hundred schools submitted plans that detail their objectives and approaches for improving student health.

We've worked directly with the School District to deliver free breakfast to children's classrooms in schools eligible to participate in the federal school lunch programs. Ninety-one

breakfast carts were purchased and are now being used to bring food to classrooms in 60 schools. With this change, 18 percent more children are now eating breakfast in our schools. We know that having breakfast makes a significant difference to children's ability to learn and achieve.

We've launched multi-media campaigns to decrease consumption of sugar-sweetened beverages, and increase the proportion of those who smoke, who try to quit, with assistance. Hopefully, everyone has seen our campaign.

We've launched the first-ever nicotine patch giveaway in Philadelphia, in partnership with the State of Pennsylvania Free Quit Line, 1-800-quit-now. Five thousand Philadelphians called for free counseling and free one-month supplies of nicotine patches. Usually only two to three Philadelphians call the quit line. During the campaign up, to 900 people called in a single day.

We've mapped so-called "food deserts" in Philadelphia for the first time ever. These are areas where people have poor access to fresh produce. From these maps, we have recruited nearly 500 corner stores into our new Healthy Corner Store Initiative. Ten have received the first mini grants for conversions that enable them to sell more fresh produce, low-fat dairy products, and lean meats. Again, stores are targeted in communities with poor access to fresh foods.

We've sponsored the first four of ten new farmers markets and helped farmers markets get equipped to be able to accept SNAP, or food stamp benefits, in areas with poor access. The City provided extra benefits to those receiving SNAP if they purchased fresh produce at neighborhood farmers markets. With this program, the use of SNAP benefits at farm markets more than doubled last year.

Through a partnership with

local foundations and nonprofit organizations, the department led an effort to draw down federal TANF benefits to supplement WIC funding for low-income women and children to purchase fresh fruits and vegetables at farmers markets. This increased the farmers market voucher benefit from $20 to $80 for WIC participants. As a result, nearly $1.3 million in WIC benefits were used at farmers markets during 2010.

With unanimous City Council support, fines for merchants that sell tobacco products illegally to our youth were increased. We've conducted 7,000 retailer youth compliance checks, and we provide merchant youth sales prevention education to all violators.

We're delighted to report that the City health insurance benefit plan for non-represented and exempt staff now offers coverage for the first time for free smoking-cessation medications. Vending machines, as, hopefully, people

have noticed in City Hall and today on this floor -- there are about 250 overall in the City -- are now giving healthier drink choices. Our recreation centers are becoming smoke-free by banning smoking on their entire grounds.

Environmental Health Services. The Environmental Health Services Division implemented a performance management system for food service inspections to reduce the time interval between inspections. The time interval is now at between 12 and 13 months for lower-risk establishments, and our goal is 12 months, and at four months for high-risk establishments, which is our goal.

Environmental Health also implemented an inspection program for the City's menu-labeling law to ensure that chain restaurants with menu boards have calories listed and other nutritional information available.

The Division of Disease Control

and the AIDS Activities Coordinating Office. As I hope all of you have heard, rates of sexually-transmitted infection among our youth are too high. In the past few weeks, we've launched a campaign to promote the use of condoms among young people who are engaging in sexual behaviors.

I should point out that just yesterday, the Centers for Disease Control identified an epidemic of sexually-transmitted diseases in youth in the northeastern part of this country. We got there first. Their recommendations have already been implemented in Philadelphia.

Our campaign is modeled after successful efforts in Washington and New York. Through this campaign, we hope to encourage our young people to delay the onset of their sexual activities, while promoting safer sexual practices among those who are sexually experienced. At the same time, we're partnering with

faith-based organizations and the School District and health-care providers to reach out to those at particular high risk of HIV disease, both to educate them and to encourage them to get tested for HIV.

Our Medical Examiner's Office. The department continued our successful work from the past two years to improve our system of using information about those who have died to change our public systems to help people stay alive.

This year, we began the first-ever HIV mortality review to learn from cases where individuals have died with HIV disease, and restarted our maternal mortality review.

At the same time, we've significantly reduced the time for State-mandated review of child deaths involving abuse and neglect to exceed the State's standards.

Through the use of our homeless death reviews, which were initiated in

2009, we've worked with the Office of Supportive Housing, The Department of Behavioral Health, and provider agencies to reduce the number of those who are homeless who died in the past year.

Electronic health records. The department, in concert with the Philadelphia Prison System, is establishing an innovative electronic health record that will support the integration of health services. As required by the federal high-tech law, the electronic record will enhance our provider's ability to access and share complete and accurate information, improving the coordination of care, improving the safety of care particularly with regard to prescription-writing, streamlining the provision of care, and improving health outcome for patients.

We also will use electronic health record information to help review the quality of our care and help formulate public policy and to monitor

and improve population health.

Our Office of Human Resources. The department has worked hard to improve our hiring efficiency and fill our vacancies, while identifying those workers who are not performing well. Through these efforts, we have kept up with the high rates of retirement among our aging workforce, have identified and recruited into many hard-to-fill job titles, and have improved our pipeline for qualified applicants for our civil service positions, particularly those who are from typically disadvantaged groups.

The department's workforce is 68.4 percent minority and 71.6 percent women.

Professional staff are 64.8 percent female and 64.3 percent minority.

Of staff classified as administrative or official, 56.8 percent are minority individuals, and 52.3 percent are women.

The Department of Public

4.20.11 COMM. OF THE WHOLE - BILL 110137

received a 96 percent overall rating for its health and safety program, as evaluated by the Office of Risk Management. We retained and educated the highest numbers of employees in recent years -- 950 out of 1,083, consistent with our goal -- in various and safety health topics.

I've read the President of District Council 47, Cathy Scott's, written testimony from the public hearing on budget and am happy to answer questions regarding this.

In terms of minority- and women-owned business contracting information, the department is committed to contracting with minority-, disabled-, and women-owned businesses and supporting the Mayor's goal of 25 percent M/W/DSBE participation in City contracting for these entities.

We are happy to report that the Department of Public Health has surpassed that goal for Fiscal Year '11. My

testimony reads, we are currently at 49.1 percent minority participation for our for-profit contracts. That calculation is based on numbers that have been reported to the Office of Economic Opportunity.

In the goal of transparency, we have added all contracting dollars that come through the Department of Public Health, both Procurement contracts and contracts that are professional service contracts, and reduced that rate to 33.3 percent, which still exceeds our goal, but we believe that it's a more accurate reflection of all City dollars used in for-profit contracting. I'm happy to talk more about that.

Our three largest for-profit contractors are: eClinical Works, LLC; General Health Care Resources, Inc., and Caremark, LLC (Procare/CVS), for a total amount of $10 million, of which $8.11 million, or 80.1 percent went to minority contracts this year.

eClinical Works, a minority vendor, is implementing the electronic health record for our health centers. General Health Care Resources primarily provides staffing for pharmaceutical services at our health centers and nursing services at Riverview. The staff working under this contract is 90 percent minority and all female. For Fiscal Year '11 this contract $1.1 million.

Caremark, LLC, or Procare/CVS, is used for pharmaceutical and drug services people with HIV. For Fiscal Year 2011, this contract award is over $1.1 million. And I have a summary of these for Council to assist in question and answer.

Our three largest nonprofit contractors are Fairmount Long-Term Care, the Public health Management Corporation, and the Health Federation of Philadelphia. Fairmount Long-Term Care is the contractor responsible for the operation of the Philadelphia Nursing

Home. The Fairmount Long-Term Care board is 80 percent minority and 20 percent women. The labor force is 85 percent minority and 78 percent women.

The dollars not used to support salaries, utilities, and other fixed costs are $10.6 million. Of that, 23 percent goes to vendors certified as M/W/DSBE, and we are working with Fairmount Long-Term Care to try to improve that number.

PHMC's board is one-third female and one-third minority, and its workforce is 60.7 percent minority and three-quarters female. Health Federation has a board that's 55 percent minority and 64 percent female. Approximately 90 percent of Health Federation contract dollars go to staff. This staff is about 61 percent minority and 74 percent women.

We are proud of the work we have done this year to improve public health in Philadelphia. I think we've made important progress in important

areas. We look forward to continuing this work next year.

As members of Council know, we still await a final bigot from the State, and until we have that, we remain concerned about what our final Fiscal Year 2012 funding will look like.

If the State budget stays as presented by the Governor, then I feel confident that our progress will continue, and I look forward to reporting to you next year at this time on that progress.

Thank you for the opportunity to present testimony today. I'm happy to answer questions.

COUNCIL PRESIDENT VERNA: Thank you, Doctor.

As of December, we're told that you had 72 vacancies in your department.

DR. SCHWARZ: That is the number that is recorded in the budget, yes.

COUNCIL PRESIDENT VERNA: Yes.

Were you able to fill any of those vacancies?

DR. SCHWARZ: Yes, ma'am.

COUNCIL PRESIDENT VERNA: And can you give us a little more information --

DR. SCHWARZ: I can.

COUNCIL PRESIDENT VERNA: -- A, on the vacancies, what types of positions they were, who you've been able to hire.

DR. SCHWARZ: I'm happy to do so.

COUNCIL PRESIDENT VERNA: Thank you.

DR. SCHWARZ: So first, let me clarify. As you know from City budgets, the number of positions listed is not necessarily the number of positions funded. That gives departments flexibility in times of change.

So a good example of that, I think, is pharmacists. The Department of Public Health has eight pharmacists listed in our budget, and eight

pharmacists is the number that we needed before we took away over-the-counter medications as part of our budget reductions during the recession and before we brought in all of the new vendor -- opportunities for free medications that I mentioned in my testimony.

With that, we no longer need eight pharmacists at all of our health centers, but we have eight in the budget. And the reason is that should any of those programs go away and demand increase during the year, we have the flexibility to hire pharmacists.

At the moment, there are 20 pharmacists on the City's list, so we believe that we could hire pharmacists if we need to, and we're working on that issue actively.

But that speaks to the issue of what is the number of funded versus unfunded positions for the department. So we have 72 positions in the budget.

We had 659 in the increment run that you saw people hired.

If we look at funded positions, the actual number of funded positions for the Health Department is not the 731 in the budget but, rather, 710 based on average salaries for workers and the average salaries of vacant classes. That means that we have 21 unfunded positions in the department, or actually 51 vacancies.

Fifty-one real vacancies translates to about 7.2 percent of our workforce. I should point out that in the health-care sector in the City of Philadelphia, the average for hospital HR folks is about 5 percent. Given the Civil Service system in Philadelphia and the difficulty of hiring, we believe that the extra 2.2 percent is reasonable.

So I actually believe norming our HR services, based on performance management, that we are actually on target for a system that provides health

care services in Philadelphia.

But you asked specifically about vacancies, and I'm happy to go through that in detail with you.

So, I don't know how it would be easiest for you to hear it. I can present you with the information. There are a lot of vacancies, and I have information on each one, and I believe that Council received a report on our vacancies, or I can go through specific ones of interest.

What would be best?

COUNCIL PRESIDENT VERNA: I don't recall seeing that.

Do any of the Councilmembers have that list?

Can you just give us the title of the positions that are vacant, please?

DR. SCHWARZ: Okay. We have:

One administrative services supervisor position.

One clerical supervisor II position.

Seven clerk typist I positions.

Five community health registered nurses.

Two community care coordinators.

One health services analyst director.

One social work services trainee, which we're using to replace, as in the budget, a social worker II.

Three medical assistants.

One medical clerk.

Would you like me to continue?

COUNCIL PRESIDENT VERNA: Yes, mm-hmm.

DR. SCHWARZ: Three pharmaceutical technicians.

Six pharmacists at the time of the increment run, but I've talked about pharmacists.

One pharmacy manager; that position is currently filled.

Public health administration analyst, which replaces a health services

administrator II.

One vacant position for a physician.

One vacant position for a public health dental hygienist.

One vacant position for a radiographer.

Two positions for a medical technologist.

That's in our health centers.

I move on to the Division of Maternal, Child and Family Health.

We have one position that's vacant for the director of Maternal, Child and Family Health.

One for a semiskilled laborer, with lead as a specialty.

One for an abatement worker.

One for a sanitarian.

One for a budget analyst II, which replaces a field investigator.

One for a laborer.

In the Public Health Nursing Home, we have one position for a

registered nurse supervisor.

In Environmental Protection Services, we have one electronic technician. We have one graduate environmental engineer, one clerk typist I, one semiskilled laborer, and one sanitarian.

In the area of Administration and Support Services: One public administration analyst, one secretary, one public relations officer, one account clerk, one industrial hygienist, one automotive driver, two custodial workers, one HVAC mechanic I, one HVAC mechanic II.

In the Medical Examiner's Office, one deputy medical examiner position is open, one forensic investigator I, one forensic investigator supervisor, and one municipal guard.

In the Division of Disease Control: Three management trainees; one public administration analyst; one physician; two clerk-typists I's, which

replace clerk-typists IIs; and one licensed practical nurse.

COUNCIL PRESIDENT VERNA: Thank you.

DR. SCHWARZ: You're welcome.

COUNCIL PRESIDENT VERNA: Doctor, how many physicians do we have for the clinics?

DR. SCHWARZ: Yes, ma'am.

COUNCIL PRESIDENT VERNA: And are they all part-time? Are some of them full-time? Have we hired any recently? Have those doctors been given waivers?

I'd just like to...

DR. SCHWARZ: Yes, ma'am.

COUNCIL PRESIDENT VERNA: ... get around that issue, if I may.

DR. SCHWARZ: Okay. I'm sorry to have to go through papers. But as you know, there's a lot of detail.

COUNCIL PRESIDENT VERNA: Take your time.

DR. SCHWARZ: Thank you.

So we have a total of three in

the -- should I do it by division or overall for the department? Do you want it just in the health centers?

COUNCIL PRESIDENT VERNA: Yes, in the health centers.

DR. SCHWARZ: Just in the health centers, yes, ma'am.

We have 3 full-time and 91 part-time physicians. Of those, 48 are in civil service, and 40 are on contract. And six of them are both.

COUNCIL PRESIDENT VERNA: I'm sorry. You said three full-time...

DR. SCHWARZ: Three full-time, 91 --

COUNCIL PRESIDENT VERNA: And 91 part-time.

DR. SCHWARZ: -- part-time, correct. And 48 of them are in civil service, 40 of them are on contract.

COUNCIL PRESIDENT VERNA: Are there -- all 48 are part-time?

DR. SCHWARZ: They are -- uh, no. Of the 48, three of them are

full-time.

COUNCIL PRESIDENT VERNA: Okay. Is that the full-time complement that we need?

DR. SCHWARZ: We need more physicians. We recruit constantly for physicians.

In general, the competition in Philadelphia for hiring physicians is pretty fierce. So, for instance, Miss Scott mentioned in her testimony that one of the incentives we should use is loan repayment.

We currently have about --

COUNCIL PRESIDENT VERNA: We should use...? I'm sorry.

DR. SCHWARZ: Loan repayment.

So the federal government provides the opportunity for physicians, nurses, and other personnel who work in areas with poor access to care. Particularly in federally qualified health centers, the government offers repayment of student loans because the

loan burden for health care professionals is often quite large.

COUNCIL PRESIDENT VERNA: That's wonderful.

DR. SCHWARZ: It is wonderful.

We have about six people, I believe, now who are taking advantage of that program, but we have 90 positions that have been approved by the federal government to offer loan repayment.

We advertise widely, we advertise on the federal website, and so forth.

The problem is, we compete with the other federally qualified health centers in town and other centers that are based in low-income, high-need areas. So the competition is large. And we're competing nationally with anyone who wants to go anywhere for loan repayment in practice a low-income community.

So I think our efforts are substantial. We're looking for people who will be successful with us, who will

come, like the job, and stay. It's difficult to find physicians who would like to work under the conditions we have, which are very high-volume practice. We have a lot of scrutiny on quality. We work very hard to keep people out of the emergency room; and as a result, we have a large number of people who walk into our centers because, on a given day, they're sick and they want care, and you've seen other waiting times.

That's not the most desirable set of conditions. And as a result, the people who succeed in our health centers generally are fairly mission-driven. They really want to serve people who need care and don't have other sources for care.

So I'm proud of the workforce we have, but it is a struggle to maintain that workforce.

COUNCILMAN RIZZO: Madam President?

4.20.11 COMM. OF THE WHOLE - BILL 110137

COUNCIL PRESIDENT VERNA: The Chair recognizes Councilman Rizzo for a point of information.

COUNCILMAN RIZZO: Doctor, I'm trying to keep track of this, but could you just get right to the number? How many doctors work without any benefits at all?

DR. SCHWARZ: The majority of our doctors work on the -- of the physicians who are contract physicians, the majority do not get benefits through their work with the City. Most of them are part-time, many of them work in other places, and many of them rely on their spouses.

And of the physicians who work in the City, being hourly employees, they receive pension benefits; they don't receive other benefits.

COUNCILMAN RIZZO: So why would some doctors work for 40 hours a week and not get benefits?

DR. SCHWARZ: They generally

don't work for 40 hours a week.

COUNCILMAN RIZZO: They don't?

DR. SCHWARZ: They are part-time folks. Many of them historically have had other practice areas, and we've been able to get their time to come and work in the City part-time.

COUNCILMAN RIZZO: So there's no doctors who work 40 hours, like a full schedule.

DR. SCHWARZ: We have a few doctors who are full-time docs.

COUNCILMAN RIZZO: And they get benefits.

DR. SCHWARZ: They do, but their salary, their actual take-home pay on a weekly basis, is substantially less in order to cover the benefit costs.

COUNCILMAN RIZZO: Okay.

DR. SCHWARZ: And generally folks, particularly if they have a spouse or someone else who can provide health insurance, would prefer to get higher

take-home pay from the City.

And we do that by doing essentially a dollar-for dollar match. If you don't get benefits, we build it into your cost.

COUNCILMAN RIZZO: I'll wait for my turn to come back around.

Thanks, Madam Chair.

COUNCIL PRESIDENT VERNA: Thank you.

Doctor, you mention in your testimony that the average waiting time for an initial visit is 66 days.

DR. SCHWARZ: That is correct, on average.

COUNCIL PRESIDENT VERNA: However, however, the waiting time in District 10 Health Center is, we're told, 244 days.

DR. SCHWARZ: 238.

COUNCIL PRESIDENT VERNA: You know, I think we went through this last year too.

DR. SCHWARZ: Yes, ma'am.

4.20.11 COMM. OF THE WHOLE - BILL 110137

COUNCIL PRESIDENT VERNA: Can you give us an explanation as to why that is and what could possibly be done to reduce the waiting time?

DR. SCHWARZ: Yes, ma'am.

So waiting time -- I should point out that waiting time is for adults, not for children. It's not the waiting time for family planning services, dental services, which are much shorter. So it is an outlier, it is for adults.

We know that the Northeast, particularly the lower Northeast, has been growing quickly, particularly with folks who are new immigrants to Philadelphia and are uninsured. And we know that that area of the City was particularly hit hard during the recession.

So demand for our services has gone up disproportionately in that area, but it's always been high. When I first got here, as you know, demand for our

services there was high and our waiting times were long.

So we have, with various budgets, tried over time to increase the number of folks who are working in the health centers. And each time, we diligently put it in, the recession, and we've cut back no less than the number that we've had, but we've had an issue.

What we've done in this year is tried very hard to at least fill the complement of staff at Health Center 10, so they have all the people that they can. But, again, remember, Health Center 10, because it's got such a long waiting time, it's very hard working conditions; people work very hard at Health Center 10.

They work hard at all of our health centers, 'cause we have waiting times at all of them, but they particularly very hard at Health Center 10. The volume is overwhelming.

So it's not easy to hire people

to do it. We don't have huge amounts of space. The health centers were built generally in the '50s and '60s, as you know, and we've expanded too the space that we have. We've opened on Saturdays, we've opened in the evening.

So coming up with the best solution, as Council has heard, I believe, is another health center. I think we need another health center in the lower Northeast.

The challenge is finding the capital and the property to build that health center. The first step in this was to create a mechanism that was the Health Center Authority for the City -- and I appreciate Council's support on that -- to allow us, at least for one health center, to try to identify a property and the support needed. And we're working actively on that.

But I think with a waiting time like this, the answer is not going to be, given the constraints on the space, that

we're going to staff up and fix this. I think the answer is that the demand is increasing, that it's going to continue to increase, we're not able to keep up; we need another health center in the Northeast.

COUNCIL PRESIDENT VERNA: Thank you.

Doctor, you also mention on page 2 of your testimony the initiatives that have been undertaken to reduce the City's unreimbursed obligations for ambulatory health services and have reduced this cost by over $5 million from your Fiscal 2009 level.

The revenue estimates for payments for patient care in the Five-Year Plan are a consistent $7.4 million for Fiscal 2011 through 2016. Why are the revenue estimates not increasing each year?

DR. SCHWARZ: The issue here is one that relates to how we are reimbursed as federally qualified, look-alike health

centers; and that is, we get an enhanced rate for Medicaid payment. And the timing issues with how we're paid determines ultimately how much money comes in.

So I've talked about as best I can actual and compared it to the budgeted amount to give you a sense that -- and the comparison was done to give Council a sense that the revenue estimates are conservative. Based on reality and what we've achieved in the past, we have been able, through appropriate and adequate billing, to reduce the dependence on the General Fund slightly.

COUNCIL PRESIDENT VERNA: Oh, my. Everybody wants to ask questions. I just want one more minute.

In your testimony that we received from District Council 47, Catherine Scott indicated that the district health centers would be more efficient and more cost-effective with

the use of additional certified registered nurse practitioners and physician assistants to aid physicians in providing health services.

What is your position on that issue?

DR. SCHWARZ: I agree with her.

COUNCIL PRESIDENT VERNA: Well, now that she agrees and you agree, where do we go from here?

DR. SCHWARZ: Okay. So three years ago, we were far behind the market in the salaries for nurse practitioners, physicians, and physician assistants.

The department's solution on physicians has been to contract physician positions. It gives us flexibility. It also is the case that many physicians actually don't want to work for the City, be that as it may.

For nurse practicers, we were way behind market rates. So we worked very diligently with the Civil Service Commission and the Office of Human

Resources for the City to increase the salary for nurse practitioners, and we've increased the hiring of nurse practitioners. We hope to continue to do that.

The problem is that in this health care market, as quickly as we increase salaries, the market readjusts, and it's very hard through civil service to keep up with market rates.

So it is our intention to hire more nurse practicers. At the moment, the chief, most attractive criterion for a nurse practitioner to come to the City is the other nurse practitioners working with us. So nurse practitioners working in an environment like ours, which has primarily had physicians as leaders and practitioners, they're a little leery about coming in to our workforce. So we have to convince them to do, which we're trying actively to do.

On physician assistants, we have not yet been able to do the work we

need to while doing everything else to hire folks to increase the salaries for physician assistants.

But that is on our list for this year, and we will increase the salary -- we will go back with the Office of Human Relations to the Civil Service Commission and attempt to increase salaries for physician assistants so that we can get again begin to hire them into the City.

Miss Scott mentioned a number of about 60-some thousand dollars for a salary in the City for a physician assistant. And based on that, she thinks it's a real bargain. It is a real bargain at that rate.

Unfortunately, the market rate for a physician assistant in Philadelphia is about $94,000, so...

COUNCIL PRESIDENT VERNA: Okay. And what is it for the nurse practitioner?

DR. SCHWARZ: Very similar.

4.20.11 COMM. OF THE WHOLE - BILL 110137

COUNCIL PRESIDENT VERNA: 60?

DR. SCHWARZ: Our rate now is at about 83,000.

COUNCIL PRESIDENT VERNA: 83?

DR. SCHWARZ: That's not market rate; we've still below market, but we're at least in a competitive range.

COUNCIL PRESIDENT VERNA: I'm sorry. Was that civil service or under contract?

DR. SCHWARZ: That's civil service.

COUNCIL PRESIDENT VERNA: Civil service?

DR. SCHWARZ: And our civil service rates, if they're hourly rates, not annual salary, but hourly rates for part-time people, our civil service rates and our contract rates are the same. We've done a lot of work to keep them the same.

COUNCIL PRESIDENT VERNA: Do we have an existing civil service list?

DR. SCHWARZ: We do. For nurse

practitioners, we do.

COUNCIL PRESIDENT VERNA: And nobody?

DR. SCHWARZ: No, we are -- there are four people on the list. We've been hiring off the list.

COUNCIL PRESIDENT VERNA: Very well.

I'm sorry to my colleagues. I know that you've all been waiting.

Councilman Goode.

COUNCILMAN GOODE: Thank you, Madam President.

Good afternoon, Dr. Schwarz.

DR. SCHWARZ: Good afternoon, Councilman.

COUNCILMAN GOODE: My first few questions are related to your capacity as Deputy Mayor.

DR. SCHWARZ: Yes, sir.

COUNCILMAN GOODE: Will all Fiscal Year '12 contracts under your control as Deputy Mayor contain provisions related to the living-wage-

and- benefits standard?

DR. SCHWARZ: I don't know the answer to that because that depends on people who are above me in the hierarchy. I'm not the decision-maker.

COUNCILMAN GOODE: You're not the decision-maker on what?

DR. SCHWARZ: I'm not the decision-maker on the terms in the contracts related to that. They're a part of the general provisions for contracts. So it's its the Law Department who makes that decision.

COUNCILMAN GOODE: Would you like all of the contracts under your control to contain provisions related to living-wage-and-benefits standard?

DR. SCHWARZ: So the more difficult answer to the question is, I believe in a living wage. The challenge is the amount that it will cost the City and what that will do to the budget over time.

So what we've tried to do is to

increase as best we can over time the proportion of contracted workforces who are earning a living wage. And I believe we need to continue to push in that direction.

The challenge is the budget constraints, particularly the constraints we've had over the last few years and the ones that I anticipate with --

COUNCILMAN GOODE: Have any firms requested waivers for Fiscal Year '12 or Fiscal Year '11?

DR. SCHWARZ: For-profit firms?

COUNCILMAN GOODE: Yes. Or nonprofit firms.

DR. SCHWARZ: I'm not aware of any.

COUNCILMAN GOODE: So no one has asked for a waiver.

DR. SCHWARZ: Not that I know of.

COUNCILMAN GOODE: So no one needs to receive a waiver then.

DR. SCHWARZ: If it's in the

general provisions, that would be correct.

COUNCILMAN GOODE: Okay. What is the largest contract that you will award in Fiscal Year '12, for-profit and nonprofit?

DR. SCHWARZ: In Fiscal Year '12. Yes, sir.

The largest contract awarded for '12 is the contract that --

COUNCILMAN GOODE: That will be awarded in Fiscal Year '12.

DR. SCHWARZ: -- will be awarded is the contract for Fairmount Long-Term Care.

COUNCILMAN GOODE: Okay. And they currently hold that contract?

DR. SCHWARZ: That is correct.

COUNCILMAN GOODE: And for what amount?

DR. SCHWARZ: Current or for '12?

COUNCILMAN GOODE: Either.

DR. SCHWARZ: For '12, it's

4.20.11 COMM. OF THE WHOLE - BILL 110137

$39,010,860.

COUNCILMAN GOODE: And it's a renewable contract.

DR. SCHWARZ: That is correct.

COUNCILMAN GOODE: And how long have they held the contract?

DR. SCHWARZ: Eleven years.

COUNCILMAN GOODE: And when's the last time you bid the contract or an RFP?

DR. SCHWARZ: It's a nonprofit, so it actually hasn't been bid in a while, since the beginning.

COUNCILMAN GOODE: Okay. Is that firm in compliance with the City's living-wage-and-benefits standard?

DR. SCHWARZ: It is, yes.

COUNCILMAN GOODE: Okay. Will that firm be required to have a supplier diversity plan and do they have it?

DR. SCHWARZ: They already have one, and we've worked with them on that. As is in my testimony, they've done pretty well. I can also give you a

summary of that for them for at least Fiscal Year '11.

COUNCILMAN GOODE: Okay.

DR. SCHWARZ: Would you like it?

COUNCILMAN GOODE: Yes.

DR. SCHWARZ: Okay.

COUNCILMAN GOODE: And the other contract, the other largest contract?

DR. SCHWARZ: The for-profit contract?

COUNCILMAN GOODE: Mm-hmm.

DR. SCHWARZ: Yes, sir. The largest for-profit contract is for CVS Caremark. It is for $1.121840 million in '12.

COUNCILMAN GOODE: And that's a renewable contract?

DR. SCHWARZ: It is.

COUNCILMAN GOODE: And for how long has that firm held the contract?

DR. SCHWARZ: Ten years.

COUNCILMAN GOODE: And are they

in compliance with the City's living-wage-and-benefits standard?

DR. SCHWARZ: They are, sir.

COUNCILMAN GOODE: Okay. And do they have a supplier diversity plan?

DR. SCHWARZ: We believe that since -- there aren't very many opportunities for them with us to do so, but we are in active conversation with them about that.

COUNCILMAN GOODE: The last question.

DR. SCHWARZ: Yes, sir.

COUNCILMAN GOODE: For Fiscal Year '11, your participation rate is 49 percent.

DR. SCHWARZ: I want to be sure you heard. I corrected it in my testimony not because the number's wrong. Based on -- as you know and we've talked about over time, how you calculate that number matters. And the question of the, do we count all of the contracts which go through Procurement but use health

dollars.

Having listened to you last year, you were very clear that you wanted all contract dollars for the department. So that number, using all contract dollars, is 33.3 percent.

COUNCILMAN GOODE: Okay. And you have a contract with eClinical Works, LLC?

DR. SCHWARZ: It's a new contract, a capital contract that we just signed, yes.

(Timer bell rings.)

COUNCILMAN GOODE: And the question is: When was that contract awarded? And what was your participation rate without that contract?

DR. SCHWARZ: What was the participation rate without the contract?

COUNCILMAN GOODE: First, when was that contract awarded?

DR. SCHWARZ: Okay.

COUNCILMAN GOODE: And then, what was the participation rate without

that contract?

DR. SCHWARZ: Okay. It was awarded the last week in March, and it was awarded, I believe, with best efforts. And the reason for that was that at the time that that RFP went out --

COUNCILMAN GOODE: The question is: If you subtract that contact from the other contracts, what would be your participation rate without that one contract?

DR. SCHWARZ: Understood. Much lower. It's, I think, probably somewhere around 1 percent.

COUNCILMAN GOODE: .8 percent?

DR. SCHWARZ: It's larger than .8.

COUNCILMAN GOODE: Okay. So it's about 1 percent without that contract.

DR. SCHWARZ: Correct.

COUNCILMAN GOODE: Okay. Thank you, Madam Chair.

4.20.11 COMM. OF THE WHOLE - BILL 110137

(Councilwoman Tasco now chairing this hearing.)

COUNCILWOMAN TASCO: The Chair recognizes Councilman Green.

COUNCILMAN GREEN: Thank you, Madam Chair.

Good afternoon, Dr. Schwarz.

DR. SCHWARZ: Good afternoon, Councilman.

COUNCILMAN GREEN: I have said this to you in the past and I'm also -- and I said it to Dr. Evans. I'm very impressed with your staff and your team in the various meetings and briefings we've had over the past year.

I do have a few questions for you, most of which I'm going to have to submit in writing, and I apologize for that, because I'm late for a meeting I had at 12 o'clock.

But just the general question I have for your department is: We just saw what I think is extraordinarily impressive testimony from DBH and the

attendant PowerPoint, which has specific performance metrics basically related to everything they do.

Do you think it is possible for you to present a budget like that to us next year?

DR. SCHWARZ: The answer is yes and no, and I apologize for equivocating.

So we are fortunate that the Centers for Disease Control, using dollars from health reform, has funded in large health departments in the country performance-management specialists. So we have hired a performance-management specialist, and it is our intention for all of our infrastructure areas -- Human Resources, fiscal IT and so forth -- to do that.

We believe it's going to take probably another year to get all of the rest of the areas of the Health Department onboard.

But what we did for this year's budget -- because I read your article in

the Inquirer -- is that we have output measures and cost-per-output. And where we have benchmarks, we have benchmarks for every division. So we believe that's a first step.

COUNCILMAN GREEN: It's a great first step.

DR. SCHWARZ: And we need to work from there.

The difference between Behavioral Health and Health is the diversity of the departments. Remember that Behavioral Health principally a series of insurance companies, and things are paid either for a program or for a service that's defined by a federal code. So the numerator and denominator can be defined easily because it's not so easy in Public Health to define a unit of service, unfortunately. So we're working on it.

COUNCILMAN GREEN: One of the things I'd be really interested in, if you could take a look at it as a

department, is -- and maybe you've done this -- how much would you estimate the existence of our eight health centers saves the hospitals and emergency room walk-ins and things like that?

And -- well, do you know the answer to that question?

DR. SCHWARZ: I don't know the answer. I --

COUNCILMAN GREEN: I mean, you cited a statistic that basically said, We know that the people who come to see us don't go to emergency rooms --

DR. SCHWARZ: Correct.

COUNCILMAN GREEN: -- as much as other people who are --

DR. SCHWARZ: Correct.

COUNCILMAN GREEN: -- in similarly-situated circumstances --

DR. SCHWARZ: That is correct.

COUNCILMAN GREEN: -- economically and in neighborhoods.

And I think it would be very useful for us to have a study of the

value we are giving the hospitals and medical community themselves.

As you say, you are having trouble getting physicians. That may be something to present people who pay no taxes for their real estate and other things to the City of Philadelphia to maybe cause them to want to provide the physicians that we need to reduce waiting times and other things that would have a further benefit on them.

That's just one small idea I have out of your testimony. I have a lot of questions for you.

DR. SCHWARZ: Sure.

COUNCILMAN GREEN: But I will submit them in writing.

DR. SCHWARZ: Thank you.

COUNCILMAN GREEN: And I'm assuming I'll be satisfied. If not, we can do a callback.

DR. SCHWARZ: Sure.

COUNCILMAN GREEN: Thank you very much.

DR. SCHWARZ: Thank you.

COUNCILMAN GREEN: I apologize.

DR. SCHWARZ: Not at all.

COUNCILWOMAN TASCO: The Chair recognizes Councilwoman Brown.

COUNCILWOMAN BROWN: Thank you, Madam President.

Good morning, afternoon?

DR. SCHWARZ: Good afternoon.

COUNCILWOMAN BROWN: Good day.

DR. SCHWARZ: Good day.

COUNCILWOMAN BROWN: And thank you for your testimony.

Of course, I pay close attention also to the line of questioning of my colleague Councilman Goode, and I wanted to thank you for the detail on page 5, which for sure is a great improvement from last year in terms of preparation, and we appreciate that.

What I would ask to dig even deeper, looking at next year, for those large -- for those organizations or agencies, nonprofit or profit, will you

stipulate the composition of staff, specifically minority and women.

DR. SCHWARZ: Yes, ma'am.

COUNCILWOMAN BROWN: My ask is that you dig even deeper.

And the next question will, be for example, with PHMC, 60 percent are minority, 75 percent are female. The next question, to dig deeper, a step lower is: Of that, what percent are in positions of leadership and responsibility, and what percent are line staff?

DR. SCHWARZ: For for-profit and nonprofit?

COUNCILWOMAN BROWN: Yes, uh-huh.

And I appreciate the information regarding the board 'cause I've been trying to get that for years.

DR. SCHWARZ: Yes, ma'am.

COUNCILWOMAN BROWN: But we now need to dig even deeper for that type of information for City agencies getting --

receiving City support, period.

Of all those that you've mentioned, there was no indication as to whether they are all local. Are they?

DR. SCHWARZ: No. For-profit and nonprofit?

COUNCILWOMAN BROWN: Yes.

DR. SCHWARZ: They are not.

COUNCILWOMAN BROWN: Oh, okay, 'cause that's helpful to us as well. We're interested in keeping Philadelphians working.

DR. SCHWARZ: Yes. We are too.

COUNCILWOMAN BROWN: Okay. So thank you for that.

DR. SCHWARZ: Yes, ma'am.

COUNCILWOMAN BROWN: With regards to the schools and the details you gave around schools that are participating in ensuring that our young people are having healthy lunches --

DR. SCHWARZ: Yes.

COUNCILWOMAN BROWN: That number seems to be growing. What are the

continuing hurdles or impediments for schools to just sign on and just get it done?

DR. SCHWARZ: I don't think there's been an impediment in will; I think it's a question of size.

COUNCILWOMAN BROWN: Okay.

DR. SCHWARZ: You have a big district.

COUNCILWOMAN BROWN: Okay.

DR. SCHWARZ: One of the things that we've worked with the district on is ideas. So for schools that are in communities that might not be used to eating the average American diet, as we might call it --

COUNCILWOMAN BROWN: Mm-hmm.

DR. SCHWARZ: -- or the new American diet that we want them to have --

COUNCILWOMAN BROWN: Yes.

DR. SCHWARZ: -- what are culturally appropriate foods, and how can they be prepared or contracted, and what

do kids wants to eat.

For the program we've done in rec centers --

COUNCILWOMAN BROWN: Yes.

DR. SCHWARZ: We were fortunate to be able to ask to ask the kids for the Supper program what they'd like to eat.

COUNCILWOMAN BROWN: That's helpful information, isn't it?

DR. SCHWARZ: We gave them what they like, and they're eating it, which has actually, despite the fact that we're feeding more children, the amount of wastage has gone down.

COUNCILWOMAN BROWN: The amount of what?

DR. SCHWARZ: The amount of wastage.

COUNCILWOMAN BROWN: Oh.

DR. SCHWARZ: The amount of stuff that's thrown out, unopened has gone down dramatically. So we're feeding many more kids, we're feeding them more, and the amount they're leaving behind is

down because they're getting what they want to eat.

So it's been clear with the School District that that's an important piece of this, within their budget constraint.

COUNCILWOMAN BROWN: Mm-hmm.

DR. SCHWARZ: And that doesn't happen for the whole district overnight. So you can't just say everybody has to do it this way.

The school Wellness Councils have helped us so.

COUNCILWOMAN BROWN: Okay.

DR. SCHWARZ: So there are parents and staff and others in the school, on the ground who are helping make those decisions, and we're excited to have them. There are 200 who have signed up. A hundred are in full-fledged action so far.

COUNCILWOMAN BROWN: Mm-hmm.

DR. SCHWARZ: So we're -- we think we're well on the way.

4.20.11 COMM. OF THE WHOLE - BILL 110137

COUNCILWOMAN BROWN: I agree 2,000 percent. I'm very excited about all of you're doing in that way, and I'd be remiss not to say thank you for the huge partnership we've enjoyed --

DR. SCHWARZ: We appreciate it.

COUNCILWOMAN BROWN: -- around the roll-out of the menu-labeling.

DR. SCHWARZ: Yes.

COUNCILWOMAN BROWN: So that there was one task that your office delivered on in terms of mapping high blood pressure and diabetes, and now you're mapping food deserts.

DR. SCHWARZ: Yes, ma'am.

COUNCILWOMAN BROWN: Have you broken that down by Councilmatic Districts because that becomes very informative for District Councilmembers --

DR. SCHWARZ: Yes, ma'am.

COUNCILWOMAN BROWN: -- who then may look to look for economic development opportunities where there may

be a growing -- you know, continuing needs for supermarkets.

DR. SCHWARZ: We have done that, yes.

COUNCILWOMAN BROWN: Okay. Could you forward that to the Chair, please.

DR. SCHWARZ: Yes.

COUNCILWOMAN BROWN: I posed a few questions --

(Timer bell rings.)

COUNCILWOMAN BROWN: Oh, my. Okay, thank you, Madam President.

COUNCIL PRESIDENT VERNA: Thank you.

The Chair recognizes Councilwoman Tasco.

COUNCILWOMAN TASCO: I'll be brief.

Good morning -- well, good afternoon.

DR. SCHWARZ: Good day.

COUNCILWOMAN TASCO: Good day, Dr. Schwarz and staff. Good to have you

here. And thank you so much for all f the work that you're doing, good work.

According to recent studies and an April 15th story in the Philadelphia Tribune, most new HIV infections are clustered in areas of the City with limited access to HIV-prevention services, including Germantown, North Philadelphia, Southwest Philadelphia.

President Obama national AIDES strategy calls for allocating resources to the area of the country and city most affected by HIV/AIDS.

How does the City plan to address the geographic clustering of infections, and will new resources be dedicated to the most highly affected areas of Philadelphia?

DR. SCHWARZ: I appreciate the question. I'm actually going to call up the head of the AIDS Activity Coordinating Office from the Health Department to give you more detail on that.

4.20.11 COMM. OF THE WHOLE - BILL 110137

COUNCILWOMAN TASCO: Mm-hmm, okay.

(Witness comes forward.)

MS. BAKER: Good morning.

COUNCILWOMAN TASCO: Good morning. How are you.?

DR. SCHWARZ: You have to identify yourself.

MS. BAKER: I'm Jane Baker. I'm the Director of the AIDS Activity Coordinating Office.

And in response to your question, we currently have a new ECHIP Grant that was put out through the City --

COUNCILWOMAN TASCO: A new what?

MS. BAKER: An ECHIP Grant, for enhanced comprehensive HIV program planning. So we're looking at those things for areas that are underserved.

And we're doing geo special mapping to look at these areas so that we can target, you know, those communities

and put services there.

COUNCILWOMAN TASCO: Would you -- are you -- do you know if you have resources or programs or offices in those areas where they could -- where the HIV patients could go to provide those services? Do you have providers in those areas? I guess --

MS. BAKER: Yes.

COUNCILWOMAN TASCO: -- is the question.

MS. BAKER: Yes, mm-hmm. But for some services, we will redirect providers to those areas that are underserved.

COUNCILWOMAN TASCO: Okay. Would the providers be from that area, or would they be in other areas but to provide services in those areas?

MS. BAKER: Preferably in those areas.

COUNCILWOMAN TASCO: Okay, all right. Don't go away.

The Tribune story also

highlighted the issue of wait lists for houses where people are living with HIV/AIDS. How does the City plan to deal with this housing crisis, given that we know that housing is a part of HIV prevention and treatment?

And how does Philadelphia's HIV/AIDS housing program and wait list compare to cities of comparable size?

MS. BAKER: I guess I would start by saying there's always more demand than there is resources available to serve that, but we do actively look at that, and we do keep a waiting list at ACO for our services.

DR. SCHWARZ: So I will help only because Ms. Baker needs reading glasses, and I don't have them for her, and she got up quickly. So I apologize let me fill in, and she'll add as we go, but I'd like to answer your question today, okay?

Okay. So we currently have -- as of March 2011, there were 165 people

on the waiting list for what's called "HOPWA," which is Housing Opportunities for People with HIV/AIDS.

COUNCILWOMAN TASCO: Mm-hmm.

DR. SCHWARZ: And that's down from 197 the year, before so we're making progress on that list.

Of those people, none of the people, the 165 people, on the current list consider themselves, or considered themselves homeless. So they're living somewhere, they need different housing. We try to work down the waiting list with housing opportunities.

We receive money from the federal government to provide that, and a little bit money from the State.

Concerning to us is that federal dollars for this support and State dollars for this support look like they're being reduced.

(Timer bell rings.)

COUNCILWOMAN TASCO: Mm-hmm.

DR. SCHWARZ: So we're worried

about being able to keep up even as we are at the moment.

We agree that housing opportunities would be important. We also know, with my other hat on, that there are very long waiting lists for housing in general in Philadelphia, including for people with disabilities and people with serious illness.

COUNCILWOMAN TASCO: Mm-hmm.

DR. SCHWARZ: So we prioritize those folks who are in shelter and homeless or those folks who have a medical need that can't be met otherwise urgently and/or homeless and in shelter.

COUNCILWOMAN TASCO: We get your message. Thank you very much. We'll come back.

MS. BAKER: Thank you.

DR. SCHWARZ: Okay.

COUNCIL PRESIDENT VERNA: The Chair recognizes Councilwoman Blackwell.

COUNCILWOMAN BLACKWELL: Thank you, Madam President.

I am glad that Councilwoman Tasco brought up those issues. We had been asked about AIDS and obviously asked about people, homeless people during this budget crisis and what happens.

I want to likewise say, Madam President, this is the day we have all good departments who work hard and do a good job for us, and we likewise want to say that to Dr. Schwarz and his department and certainly say that albeit we ask a lot of questions, and I continue to contact him, even before this meeting, on various issues, so we look forward to continuing to work with him, and we thank him for the work that he and his department does.

DR. SCHWARZ: Okay.

COUNCILWOMAN BLACKWELL: Thank you.

COUNCILWOMAN TASCO: A point of information.

We don't wait until budget time to ask questions of these departments; we

stay in contact with these departments all the time. So, you know, the questions are just a matter of formality for the record, but they provide us with information.

COUNCIL PRESIDENT VERNA: And they're always very responsive.

COUNCILWOMAN TASCO: Responsive and through hearings we've had an various issues. So it's not that we lack interest; it's just that they've been so helpful.

COUNCIL PRESIDENT VERNA: Right.

COUNCILWOMAN TASCO: So thank you.

DR. SCHWARZ: Thank you.

COUNCIL PRESIDENT VERNA: I don't believe Councilman Rizzo is here but his light had been on.

Do you have any further questions, Councilwoman?

COUNCILWOMAN TASCO: Yeah, I just had a couple.

Based on the current State

cuts, 72,000 will be cut from consumer education for ACO for AIDS education programs. How will this cut the City's ability to implement a local initiative that is consistent with President Obama's national AIDS strategy?

DR. SCHWARZ: I appreciate you asking that question. We obviously are worried as well about State cuts.

COUNCILWOMAN TASCO: Mm-hmm.

DR. SCHWARZ: The 72,000, I will say -- and let me be transparent. That's a small cut compared to the larger cut that was included in the Human Services Development Fund.

COUNCILWOMAN TASCO: Mm-hmm.

DR. SCHWARZ: So there's about a million dollars in cuts to ACO that happened through the State cut of the Human Services Development Fund.

COUNCILWOMAN TASCO: Mm-hmm.

DR. SCHWARZ: We are looking now to see what we can do with federal dollars. And if -- while the federal

government is changing some of its policy on housing, they seem to be, through the President's initiative, increasing funding opportunities particularly for prevention.

So we're hopeful that we will actually be able to move some of our work among programs. And as you heard from Ms. Baker, we're also reassessing in terms of our service network where we're providing service.

COUNCILWOMAN TASCO: Mm-hmm.

DR. SCHWARZ: So both of those will need to go on in the next year.

COUNCILWOMAN TASCO: All right. So I'm sure we'll be working together and you'll be talking about what you plan to do.

DR. SCHWARZ: Absolutely.

COUNCILWOMAN TASCO: Let me just ask this final question about the Governor's budget and the cuts that have been proposed for education. If they shift it from education to health, how do

you think it's going to impact on you?

DR. SCHWARZ: Well, one, we're hopeful that it won't shift to health. I think the biggest concern for us is around Medicaid.

COUNCILWOMAN TASCO: Mm-hmm.

DR. SCHWARZ: And where that is particularly pertinent is that we have been protected to date in the State budget process because when health care reform was passed, it included a provision which said that states had to maintain their effort for Medicaid, which meant that they could not cut the eligibility of people on Medicaid.

We are very worried that, through compromises that will happen because of the debt ceiling discussion, there will be a relaxation on that issue.

If that happens and states are permitted to cut eligibility, then our Medicaid reimbursement will likely go down. That is a big issue for the health centers.

And it is -- I can answer a little bit about Behavioral Health, if that would help as well, but I can tell with this, my Health Department had to say that whatever the impact is on the health centers, Medicaid cuts would be very bad for the health of people in Philadelphia, not just the health of our health centers.

COUNCILWOMAN TASCO: Mm-hmm.

DR. SCHWARZ: Demand for our services, I think, would go up, and our resources would be less. But the bigger issue is, there are probably a lot of people who will be cut off Medicaid if eligibility can be cut have, who will have nowhere to go, or will go nowhere.

We know that the largest line items in the State budget relate to education, but the second largest relate to Medicaid. It's almost one in five State dollars go to pay for Medicaid.

COUNCILWOMAN TASCO: Mm-hmm.

DR. SCHWARZ: So if the federal

government allows the State to cut Medicaid, I'm very worried about what will happen in Philadelphia.

COUNCILWOMAN TASCO: I have one other question to ask you. You talked about the increase in the serviced of the health centers for I guess maternal care?

DR. SCHWARZ: Yes, ma'am.

COUNCILWOMAN TASCO: Is that because we've lost so many -- so many hospitals have closed, providing those --

DR. SCHWARZ: Well, we've also provided prenatal care and postpartum care, and we have maintained that. We actually do that in partnership with the hospitals, the existing hospitals, so that we can facilitate entry to those hospitals for delivery and people have prenatal records that are available at the time of delivery.

COUNCILWOMAN TASCO: Mm-hmm.

DR. SCHWARZ: So we've not cut back on prenatal care.

COUNCILWOMAN TASCO: No, no.

I'm saying, have you -- you've increased it --

DR. SCHWARZ: We have increased it --

COUNCILWOMAN TASCO: Increased it because some of the hospitals have closed?

DR. SCHWARZ: A little bit, a little bit.

What has happened is, much of the change has been absorbed by other hospitals. And what we're seeing actually is, women are going outside the county.

So the total number of births within the county appear, from preliminary information from a number of the hospitals, to be going down compared to what they were immediately on the closure of Northeastern and Chestnut Hill for delivery.

COUNCILWOMAN TASCO: Mm-hmm.

DR. SCHWARZ: And it looks like women are shifting to choose where they

can to go outside the county in larger numbers for care.

So it means that there are a larger network of hospitals that we have to worry about in terms of Philadelphia births, but at least it means that women are getting good delivery care.

(Timer bell rings.)

COUNCILWOMAN TASCO: Thank you very much.

Thank you, Madam President.

COUNCIL PRESIDENT VERNA: You're welcome.

The Chair recognizes Councilwoman Brown.

COUNCILWOMAN BROWN: Thank you, Madam President.

Okay, I asked Dr -- help me out. I'm having a memory lapse.

DR. SCHWARZ: Dr. Evans?

COUNCILWOMAN BROWN: Dr. Evans about lead-related matters. We do know that there are new federal regulations. How will that impact what the department

is already doing with its lead-related work?

DR. SCHWARZ: We're really worried about lead. We're really worried about lead because we have cuts in the State budget, which likely will impact the amount of money we have for lead abatement. And at the same time, it looks as though there will be cuts at the federal level.

COUNCILWOMAN BROWN: And you know that already, that there will be cuts in the State budget around that?

DR. SCHWARZ: Thus far. It depends on what happens with the final State budget, obviously.

COUNCILWOMAN BROWN: Okay.

DR. SCHWARZ: And those cuts are not huge compared to what we anticipate from the federal government.

COUNCILWOMAN BROWN: I see.

DR. SCHWARZ: We already have, as you know, a waiting list for abatement. It's not as bad as it's been

in past years, but there is a waiting list. And we're very worried about the proportionate cut that we could receive for abatement services.

So I would like to have better news on that. We're thinking very hard about what super-cleaning. Do you know about super-cleaning and how super-cleaning has been used in many homes, where there are paint chips and things like that, to clean up or to seal --

COUNCILWOMAN BROWN: Sure.

DR. SCHWARZ: -- without removing lead, which is the most expensive thing.

COUNCILWOMAN BROWN: Right.

DR. SCHWARZ: We've done that in the past; we're looking to see if we can do more of that. But I am very worried about what's going to happen in terms of lead-abatement availability.

COUNCILWOMAN BROWN: Do you have any idea how long that wait list is for families?

DR. SCHWARZ: I know the numbers on it. And waiting depends a little bit on where you live and who you are and how your lead level is and so forth.

COUNCILWOMAN BROWN: Okay.

DR. SCHWARZ: So I'm not going to say a particular number.

COUNCILWOMAN BROWN: All right.

DR. SCHWARZ: I can give you the numbers of cases that we're waiting on if you'd like.

COUNCILWOMAN BROWN: Okay. Well, that's well taken.

As I shared with Dr. Evans offline, we're going to go to look at that very closely --

DR. SCHWARZ: Great.

COUNCILWOMAN BROWN: -- and see what alternative actions or strategies we need to look at, given the new budget constraints we're confronted with.

DR. SCHWARZ: It would be exciting to do this in concert with other

northeastern and midwestern cities that are going to have the same issues with lead, because the federal cuts will not just affect us; it will affect us disproportionately because of the number of homes that we have with lead, but there will be other cities impacted as well.

COUNCILWOMAN BROWN: Oh, okay. All right, then. so we'll have subsequent discussions around that.

DR. SCHWARZ: Sure.

COUNCILWOMAN BROWN: In your testimony, you talked about how an appointment for an adult patient increased from five, six days to 6-6 days. What are the wait times at your busiest health centers?

DR. SCHWARZ: Okay. So the busiest health center is Health Center 10 in the lower Northeast, and the waiting time at Health Center 10 is 238 days. And that's for adult care only. And in fact, the particularly long waiting times

are in general for adult care.

The next longest is at Health Center 6, which is at Third and Girard. And the waiting time there is 70 days for adult care, for an initial visit, not for a return visit.

COUNCILWOMAN BROWN: And given the earlier discussion around vacancies, do those vacancies in any way impact these realities you've just stated?

DR. SCHWARZ: Vacancies will always impact it a bit. We have -- and I have Carla Hill here because of the exemplary work she's done this year with the department, trying to come up with both a plan and move on how do we fill vacancies more quickly.

We have meeting weekly with Ambulatory Health Services to go through every vacancy that they have and have a plan on every vacancy so we can fill it for Ambulatory Health.

We have made remarkable progress on nurses. So a year ago, we

had a shortage of nurses. I've been to each of the health centers throughout the year, and the cries I heard last year were, "We don't have enough nurses." This year, it's much better on nurses.

The challenge for us is, we have a lot of job class, and filling them all is a big deal. But it's clear that the nurse and the nursing hierarchy -- supervisors, health care coordinators -- are very high priority.

We also have a very high turnover rate.

COUNCILWOMAN BROWN: Oh.

DR. SCHWARZ: Nurses who come to work us see, in more cases than we'd like, come, see how hard they have to work, and decide they could earn the same money elsewhere.

COUNCILWOMAN BROWN: I see.

DR. SCHWARZ: So we don't have the best working conditions.

COUNCILWOMAN BROWN: Mm-hmm.

DR. SCHWARZ: We have a very

dedicated staff. They delivery really wonderful care, but they work very hard. And as a result, it's hard to retain nurses.

COUNCILWOMAN BROWN: Sure. That raises a real interesting opportunity if anyone had, you know, another staff person to oversee it.

We have Teach for America, where teachers have to sign up for X-period of time. And so, linkages with Temple School of Nursing or Penn School of Nursing for young men and women who are coming out, any relationship at all with those schools?

DR. SCHWARZ: We've had relationships to help with recruitment in the past. It's difficult in the City system, in part, because we have a lot of hurdles, and it's a long process.

COUNCILWOMAN BROWN: Okay.

DR. SCHWARZ: And generally, if you're a new grad, you want to get licensed and go to work.

COUNCILWOMAN BROWN: Mm-hmm.

DR. SCHWARZ: This past year, we did better than we have in getting people onboard. We're hoping that this continue year, we'll continue to do better, but it's challenging -- it's been a challenge in the civil service system to be able to respond in the current health-care market fast enough --

COUNCILWOMAN BROWN: I see.

DR. SCHWARZ: -- to get people into jobs.

COUNCILWOMAN BROWN: So given that reality, do you think -- would you say that you've made progress, looking at where you were?

DR. SCHWARZ: Well, we've stabilized things.

COUNCILWOMAN BROWN: Okay.

DR. SCHWARZ: And we have a plan. We've actually increased the number of people who were hired in the Health Department this year. We think that we'll actually potentially make a

real visible dent by the increment report next year, in December.

COUNCILWOMAN BROWN: Okay.

DR. SCHWARZ: So I hope we can prove to you what we've been able to do, and that is part of our performance-management work.

COUNCILWOMAN BROWN: Okay. A follow-up question regarding the campaign around condoms. Are the schools linked in any way, shape, or form to that campaign?

DR. SCHWARZ: The public schools?

COUNCILWOMAN BROWN: Yes.

DR. SCHWARZ: There are centers in the schools currently which make condoms available, and the nurses refer kids to outside providers in their neighborhood, who have condoms available at the moment.

We are working with the School District to figure out how we might do more. The issue is that any condom

availability has to go through the SRC. And, remember, the SRC is controlled by the State.

So we believe we'll probably get one chance to make a request, and we want to make sure that it's right and it's exactly what we need. So we've taken a little bit of time to make sure we get everything right.

COUNCILWOMAN BROWN: Oh, okay. I think I have one more here.

Last year... The question is around this notion of telemedicine; I think that was Councilman Jones who had a real interest in that.

DR. SCHWARZ: Yes.

COUNCILWOMAN BROWN: You testified before Council last year about this new methodology, I guess you call it. You indicated uncertainty regarding how your agency would be reimbursed for services rendered.

Have you gotten any clarity on this whole reimbursement issue?

DR. SCHWARZ: We're in Philadelphia because the distances aren't great, and we don't do specialty services primarily; we do primary-care services. It's not going to work very well.

Where we may have an improvement is for patients where a photograph -- like a photograph of the skin with a rash could go to a dermatologist. We're waiting to see if dermatologists can be paid for that and paid adequately.

COUNCILWOMAN BROWN: Mm-hmm.

DR. SCHWARZ: And if that's the case, then with our electronic health record, we actually will have very easy and seamless connections with patient approval and consent to do that kind of work.

COUNCILWOMAN BROWN: Now, talking about records across systems. Is the Eagles mobile eye --

DR. SCHWARZ: Unit?

COUNCILWOMAN BROWN: -- service

linked into the Philadelphia Health Department?

DR. SCHWARZ: Um --

COUNCILWOMAN BROWN: -- so that when they take exams of young people at schools in their mobile vehicle, it gets to that child's record?

DR. SCHWARZ: It doesn't.

COUNCILWOMAN BROWN: So there's no talking to each other yet?

DR. SCHWARZ: There isn't at the moment. Remember, we don't have an electronic record yet.

COUNCILWOMAN BROWN: Oh, okay. All right, then. That's fine.

Well, again, to underscore the good work you've done that's been stated by my colleagues, it comes clear in the testimony, and I can't speak for Wilson; he can speak for himself.

But I really do appreciate the detail given now around MBE/WBE participation.

DR. SCHWARZ: Thank you.

COUNCILWOMAN BROWN: And the progress that's been made compared to last year.

DR. SCHWARZ: Thank you for your advocacy.

COUNCILWOMAN BROWN: Thank you very much.

Thanks, Madam President.

COUNCIL PRESIDENT VERNA: You're welcome.

Any other questions from members of the Committee?

(No further questions.)

COUNCIL PRESIDENT VERNA: Seeing no one, this committee will stand in recess until 2:15.

Thank you again.

Thanks, Doctor.

(Lunch break taken.)

(Proceedings resume.)

* * *

(Councilwoman Tasco now chairing this hearing.)

4.20.11 COMM. OF THE WHOLE - BILL 110137

COUNCILWOMAN TASCO: Our next department is the Department of Human Services.

(Witnesses come forward.)

COUNCILWOMAN TASCO: Good afternoon. Would you state your name for the record and begin your testimony.

PANEL MEMBERS: Good afternoon. Anne Marie Ambrose, Commissioner of the Department of Human Services.

COUNCILWOMAN TASCO: How are you doing?

COMMISSIONER AMBROSE: Good. How are you?

COUNCILWOMAN TASCO: Good, thank you.

Go ahead.

COMMISSIONER AMBROSE: Good afternoon. I am Anne Marie Ambrose, Commissioner of the Department of Human Services.

Today I will present to you DHS's FY 2012 Operating Budget request and report on how our expenditures align

with our organizational goals to improve outcomes for children and youth, improve the public's understanding of DHS, increase our community presence, and improve operational efficiency.

In order to add more transparency to the City's finances, the Fiscal Year 2012 proposed budget is moving reimbursed costs and corresponding revenues for services provided by the Department of Human Services to the Grants Revenue Department.

DHS's FY '12 General Grants Fund budget request is for $671,688,176. This is $95,322,931 above the FY '11 estimated obligation level of $576,365,245.

This is not additional funding but is required as part of the transition of DHS's Operating Budget from the General Fund to the Grants Revenue Department. The General Fund City share is appropriated at a level of $111,934,770.

4.20.11 COMM. OF THE WHOLE - BILL 110137

We currently have 1740 employees; 73 percent are female, 7 percent are black, 16 percent are white, 4 percent are Latino, and 2 percent are categorized as "others." Approximately 95 employees are bilingual.

DHS continues to make significant improvements in providing safety, permanency, and well-being for children at risk of abuse, neglect, and delinquency. In recognition of DHS's progress, DHS was recently granted an unrestricted full license by the Department of Public Welfare for the first time since 2007.

Also, the Community Oversight Board (COB), an independent multi-disciplinary panel of experts convened by the Mayor, recently issued its 2011 report and noted DHS's steady progress toward implementing the 37 reforms recommended by the Child Welfare Advisory Board.

The COB's report of February

2011 noted that DHS reforms over the last three years has led to increased childhood safety and to improve fairness in the decision-making process for families. DHS is now working with the COB to create new recommendations regarding family well-being. We believe that making families and communities stronger in fellowship with other City and private agencies will improve outcomes for children.

DHS is also undertaking several strategies to enrich families and communities, including the clarification of its roles and responsibilities and those of contracted provider-agency staff, as mandated by the COB.

For example, we have streamlined the performance standards and aligned them with the targeted outcomes of safety, permanency, and well-being.

In addition, recently, DHS, with the support of Casey Family Programs, began an initiative we call

"Improving Outcomes for Children," a community approach to child welfare to create a single-case management model with distinct and well-defined roles for contractor provider agencies and DHS staff.

The core components include strengthening partnership for service delivery at the neighborhood level, modifying current case-management practices and accountability systems, clearly defining DHS and provider-staff roles, and creating stronger quality-assurance functions within DHS.

We will begin doing a series of focus groups in communities and stakeholder groups with the support of the William Penn Foundation to create a service delivery system that is more connected to the community.

DHS has employed several other strategies to improve outcomes for children and families and enhance the well-being of children served by DHS.

Examples include maintaining partnerships with stakeholders, expanding Performance-Based Contracting (PCB), utilizing evidence-based practices, ensuring that medical and educational needs of children are met, and older youth strategies.

DHS has vital partnership with all of its stakeholders, especially Family Court. Every day, DHS works to improve the lives of Philadelphia's children and to decrease placements and to increase permanency.

DHS has reduced placement by 24 percent from January of '08 to July of '10. DHS, in partnership with the Department of Behavioral Health, has reduced out-of-state placements by 77 percent during the same time period, ensuring that more children in placement are closer home and family connections.

While the overall increase in permanencies from 2008 to 2009 was 10 percent, adoptions increased by 42 percent from January 1st of 2008 to

December 31st of 2010. The number of permanently legal custodianships increased during that same period.

Since 2003, DHS has used performance-based contracting to improve outcomes for children. Performance-based contracting has changed foster care services by increasing permanency and stability expectation placed on provider agencies in exchanges for increasing the resources and flexibility given them to meet new expectations.

Contractual expectations measured under PBC include the agency's acceptance of DHS referrals, permanency outcomes, and stability of placements. PBC has resulted in the following accomplishments:

The rate of permanencies for foster and kinship care more than doubled, the instability rate deceased, and the percentage of youth returning to care within one year of permanency has decreased significantly.

4.20.11 COMM. OF THE WHOLE - BILL 110137

Over the course of 2010 and, 2011, PBC has been expanded to treatment foster care. Expansion to group homes, institutional, and out-of-school-time care contracts is currently in the planning and development phase.

DHS has made substantial efforts to work closely with families themselves to increase permanency for children and youth. To meet that goal DHS, is increasingly using Family Group Decision-Making to foster family involvement and interagency collaboration in developing permanency plans for children in foster care.

Family Finding is another major initiative that DHS has undertaken to help to identify and locate family members who may be able to serve as formal or informal resources for children and youth in DHS's care.

DHS has also initiated the Sankofa Project, an aggressive outreach program, to engage fathers who have

children in placement and who have previously been uninvolved.

In order to ensure that the complex medical needs of children served by DHS are being addressed, we have expanded the staff of the Center for Child and Family Well-Being. Dr. Cindy Christian, a nationally recognized child-abuse expert, is the medical director, who focuses on ensuring effective management of the medical needs of children on an individual and systemic level.

In addition, we have five nurses on staff and plan to hire one additional nurse to assist in assessing children's medical needs.

Under Community-Based Prevention Services, DHS is also working diligently to improve the educational outcomes for children in our care. Our Educational Support Center was launched in 2009 to improve educational outcomes for children and youth in the child

welfare system and to facilitate a collaborative approach between DHS and the School District of Philadelphia in addressing the educational and social needs of children and youth impacted by both systems.

The Educational Support Center received a total of 619 child-specific consultations from November of 2009 through December of 2010. The total number of consults resolved was 539, which represents a resolution rate of 96 percent.

Last year, I advised City Council that DHS was creating an older unit youth, Youth Permanency Unit, to manage planning and service delivery as well as to optimize their outcomes as they exit the child welfare system.

In our efforts to improve the likelihood of achieving permanency and better outcomes for older youth, DHS and the Family Court have started a Permanency Action Teaming. The PAT group

consists of external and internal child-welfare experts who meet to determine what, if anything, changes can be made to a youth's plan to improve the youth's likelihood of achieving permanency. Family Group Decision-Making and Family Finding are also utilized to assist the youth in making family connections.

We also have partnered with Amachi and CCC to provide employment and training opportunities for older youth. By referring our youth to the Achieving Independence Center, we envision reducing poverty by developing employment and educational opportunities for youth in transition to successful adults and self-sufficiency.

Under the Juvenile Justice Services, DHS is also focusing on ensuring that the needs and well-being of youth involved in the delinquent system are met in an effective matter. DHS is partnering in the Crossover Youth

Practice Model with Georgetown University and Casey Family Programs to build even stronger collaboration with Family Court, Juvenile Probation, JJS, and other child welfare stakeholders to improve outcomes for youth that are both dependent and delinquent.

One of the outcomes of this work has been increased access to prevention services for pre-delinquent and delinquent youth to prevent further involvement in the Juvenile Justice System and to support youth returning to the community from delinquent residential placements.

DHS is also assisting aging out delinquent youth with behavioral health diagnosis to obtain SSI benefits upon discharge from placement and, thus, a sustainable income.

The JJS Division hosted youth law enforcement forums at the Youth Study Center facilitated by the Pennsylvania Commission on Crime and Delinquencies,

Philadelphia Working Group on Disproportionate Minority Contact. This represents the first time forums of this nature have even been held within a secure detention facility. This unique program was designed to improve relations between minority youth and law enforcement. It was recently recognized as the 2011 recipient of the County Juvenile Detention Center's Best Practices Award in the Large County category.

Finally, the new Youth Study Center is under construction, with plans to move by the fall of 2012. The state-of-the-art facility will better meet the needs of the youth who are placed there.

DHS has also enhanced its internal and external accountability system and organizational efficiency as part of its efforts to improve outcomes for Philadelphia's most vulnerable children and youth.

4.20.11 COMM. OF THE WHOLE - BILL 110137

As I previously reported to you last year, in January of 2009, DHS created the Division of Performance Management and Accountability to support system improvement by monitoring, evaluating, and reporting out on the effectiveness of our services, internal and external.

PMA developed DHS's quality service review process in the fall of 2009, wherein a case is randomly selected for review after receiving information gather from extensive interviews with all parties connected to the case.

In June of 2010, DHS successfully conducted our first QSR, which focused on youth in group homes. QSR is focused on assessing DHS's performance in specific service areas and to identify systemic improvements for DHS and its partner agencies.

The QSR is a powerful tool focused on system reform and designed to stimulate action to improve practice and

results at all levels within DHS.

DHS developed an Ace 33 Child Fatality and Near Fatality Review team, which serves as a state model for effective interdisciplinary and interagency coordination in examining child vitalities and near-fatalities and for identifying and monitoring the implementation of recommendations to improve child Since its inception, 55 Act 33 review meetings have been.

DHS continues with its child stat process, wherein our Quality Improvement Unit randomly selects cases on a monthly basis to review in-depth performance of DHS management, supervisors, and frontline staff.

DHS has now started Provider Child Stat, expanding the child stat process to once a month for its performance-based contracting providers

In an effort to continue to enhance our provider monitoring functions, DHS has also instituted

quality visitation reviews starting at the end of November 2010. The QVRs are conducted by an independent agency under contract with DHS to access the quality of the visits made by provider agencies. Information gathered is used to target any needed improvement efforts.

DHS is committed to utilizing technology to improve operational efficiency. Examples of these efforts include implementing its electronic case management system, starting a Mobile Technology Unit in the Sex Abuse Unit to provide staff with BlackBerries and laptops.

DHS plans to extend the use of this technology throughout DHS's Intake and Investigation Units. This initiative will improve productivity and maximize time and efficiency by allowing social work service managers to receive and transmit information in realtime.

DHS continues to better manage its personnel and related costs, looking

to introduce overtime by acquiring the use of flex time for staff conducting business after hours.

DHS is currently looking at job functions to ensure that work is not being duplicated and to align job functions by area of responsibility in order to maximize efficiency and productivity.

Because of our successful efforts at reducing the number of children in the former child welfare system, our caseloads have been significantly reduced. DHS workers continue to do an excellent job of meeting our higher expectations for quality service delivery.

I am pleased to report that since we implemented monthly visits by DHS workers in July, we have received over 90 percent compliance rate.

DHS is committed to supporting the Administration goal of 25 percent minority-, women-, and disabled-owned

business participation in City contracting. DHS's FY '12 participation goal is 25 percent for profits.

We currently have 208 providers under contract, and 76 of them are nonprofit providers, and 24 percent are for-profit.

Our nonprofit providers are not OEO-certified. Based on our survey, 35 percent of the 208 nonprofit providers have boards that are primarily minority, women, or disabled status. The nonprofit staff are 54 percent minority and 41 percent women.

It is DHS's intention to work with OEO and continue our efforts in having our nonprofits and for-profit providers increase minority-, women-, and disabled-status participation through subcontracting students.

Should any Councilmember wish to engage in further discussion on any of these matters, my staff and I are happy to meet with Councilmembers at their

convenience.

COUNCILWOMAN TASCO: Yes, you are. Thank you very much.

Commissioner, the Administration is proposing to move all of your State and federal funding to the Grants Revenue Fund for Fiscal Year 2012. Can you explain why the General Fund revenue estimates for DHS show 22.7 and 43.1 million in Fiscal 2012 and 2013, respectively?

COMMISSIONER AMBROSE: I'm going to ask either Rebecca or Romana to introduce themselves and answer that question.

ROMANA: I'm Romana (indiscernible) the Deputy Commissioner for (indiscernible).

STENOGRAPHER: I didn't hear that.

COUNCILWOMAN TASCO: You have to speak into the microphone.

ROMANA: Sorry.

(Romana does not repeat her

introduction.)

MS. RHYNHART: Rebecca Rhynhart, Budget Director. Good afternoon.

The question regarded the 22 million in federal monies that show in Fiscal '12; is that correct?

COUNCILWOMAN TASCO: Mm-hmm.

MS. RHYNHART: Okay.

COUNCILWOMAN TASCO: And '13.

MS. RHYNHART: And '13, the 43 million in '13?

COUNCILWOMAN TASCO: Mm-hmm.

MS. RHYNHART: The reason for these payments being budgeted in '12 and '13 to -- into the General Fund are, they're late payments, so that those are reimbursements from the State and the feds that we are not anticipating getting in Fiscal '11.

COUNCILWOMAN TASCO: But you bill for them?

MS. RHYNHART: Yes. They will be billed for. And Romana could give

more information on the types of payments, but the four reimbursement gets delayed, and so, it's not going to be received by the City in Fiscal '11, and that's something that we've already -- in our last quarterly report, the Fiscal '11 fund balance of $13.5 million already took that into consideration, but that comes in later than the end of the fiscal year.

And then the Act 148 State payment, there's actually a significant lag in that payment. The Fiscal '09 payment was received at the very beginning of Fiscal '11, so that's why we haven't received the Fiscal '10 payment. So that's why we budgeted that we would receive that in Fiscal '13.

COUNCILWOMAN TASCO: When do you typically receive your federal and State grant awards?

ROMANA: So we receive the final allocation after the State budget has passed. So we get a tentative

allocation after the Governor's address. So this year, it was March 3rd, so we get a tentative allocation the following week, but we don't get a final allocation until the State budget passes.

So it's -- last year, the State budget passed, I think, sometime in mid-July. So we got a final allocation the end of July.

COUNCILWOMAN TASCO: Okay. What is the operational impact on your department if the State budget is not passed by June 30th?

ROMANA: If the State budget's not the passed by June 30th, the impact is -- it does affect some of our 250 contracted providers, our ability to kind of finalize what our allocation is for some of the services.

So we have to kind of -- for the 290 place -- for all the placements providers, we're confident that we can get those contracts and move funding forward. But for the 250 providers, for

some of our services, where we have to assess what our actual funding for those programs is, that is where we're -- where we struggle.

COMMISSIONER AMBROSE: Yeah. And I just want to add, when the State budget wasn't passed on time two years ago, it was a disasters for our private providers. And so, we've really been trying to advocate for a budget that's passed on time, because then we're delayed in our contracting.

And, thankfully, the Finance Department set up an emergency payment process, but private providers were very severely impacted by that delay.

COUNCILWOMAN TASCO: The issue is, if you move it to the Grants Revenue Fund and the State doesn't pass the budget, you can't spend the money from the Grants Revenue Fund. If you leave it in the General Fund, then you could honor your contracts.

MS. RHYNHART: Well, as you

know, we manage our cash on a consolidated basis. So the Grants Fund and the General Fund are together, in one pot of cash, in the consolidated cash account.

So even when the -- when DHS was in the General Fund, and it still is currently, it still creates -- it actually creates a very big problem for us cash-wise when the payments are late or when the State budget is late, because we're, in essence, fronting money from the General Fund to pay for the DHS providers.

So moving it to the Grants Fund will not impact our cash position, or it will still be the same amount of cash basis, because we commingled the cash. That's how we manage our cash; we commingle it.

But it's still -- either way, it will be an issue for us if the State doesn't pass its budget on time.

COUNCILWOMAN TASCO: Okay,

thank you.

The Chair recognizes Councilman Goode.

COUNCILMAN GOODE: Thank you, Madam Chair.

Good afternoon, Commissioner.

COMMISSIONER AMBROSE: Good afternoon.

COUNCILMAN GOODE: Can you tell me what's the largest for-profit contracts you will award in Fiscal '12?

COMMISSIONER AMBROSE: The largest for-profit for Fiscal '12 was VisionQuest.

COUNCILMAN GOODE: I said, what's the largest contract that you will award in Fiscal Year '12?

COMMISSIONER AMBROSE: That is, yes.

Oh, the largest -- that's the largest for-profit. Our largest nonprofit is PHMC.

COUNCILMAN GOODE: So the largest for-profit in the next fiscal

year.

COMMISSIONER AMBROSE: Correct.

COUNCILMAN GOODE: Okay, is VisionQuest.

COMMISSIONER AMBROSE: Correct.

COUNCILMAN GOODE: And that's for how much?

COMMISSIONER AMBROSE: For $19,427,051.

COUNCILMAN GOODE: And that's a renewable contract?

COMMISSIONER AMBROSE: Correct.

COUNCILMAN GOODE: And how long has the firm held that contract?

COMMISSIONER AMBROSE: It was contracted in '08 for '09.

COUNCILMAN GOODE: Okay. And is that firm a certified disadvantaged business?

COMMISSIONER AMBROSE: No, sir.

COUNCILMAN GOODE: Does the firm subcontract with disadvantaged businesses?

COMMISSIONER AMBROSE: Yes.

4.20.11 COMM. OF THE WHOLE - BILL 110137

COUNCILMAN GOODE: What was the D/B/E participation goal in the RFP?

COMMISSIONER AMBROSE: I don't know if it was addressed in the RFP of this contract. I don't have...

(Desirée Thomas comes forward.)

MS. THOMAS: Desirée Thomas, Deputy Commissioner for Community-Based Prevention Services.

When we did the RFPs in 2008, at that time, we were using the best-efforts standard that was established by OEO.

COUNCILMAN GOODE: And why was that standard established?

MS. THOMAS: That was the -- during that time, our practice was to follow the lead of at -- that time, it was MBEC.

COUNCILMAN GOODE: We went through this last year.

MS. THOMAS: No, that was last year, and we did not -- I guess in terms of us --

COUNCILMAN GOODE: We went through this last year.

MS. THOMAS: Yes.

COUNCILMAN GOODE: You were procuring the service.

COMMISSIONER AMBROSE: I agree. I acknowledge the responsibility last year. This was a contract; we didn't have an opportunity to re-contract this out. Next year --

COUNCILMAN GOODE: So the answer to the question is, you didn't identify the subcontracting opportunity, so you didn't put a goal if in the RFP.

COMMISSIONER AMBROSE: Correct.

COUNCILMAN GOODE: Okay. Thank you.

What was the goal in the contract?

COMMISSIONER AMBROSE: Best efforts.

COUNCILMAN GOODE: The goal in the contract was best efforts?

COMMISSIONER AMBROSE: In the

original RFP, it was best efforts.

COUNCILMAN GOODE: Best efforts. What was the goal in the contract?

COMMISSIONER AMBROSE: The same as was in the RFPs.

COUNCILMAN GOODE: The goal was best efforts.

COMMISSIONER AMBROSE: Correct.

COUNCILMAN GOODE: And what has been achieved?

COMMISSIONER AMBROSE: Their achievements have not been good on the subcontracting portion.

COUNCILMAN GOODE: I wonder why.

COMMISSIONER AMBROSE: But at our request, they've actually done a lot of movement back to Philadelphia. So at our request, they moved their community-based detention shelter that was based in Chester County to Philadelphia, and they now have a hundred new staff working in that shelter.

4.20.11 COMM. OF THE WHOLE - BILL 110137

COUNCILMAN GOODE: Okay. You know what my questions are, right?

COMMISSIONER AMBROSE: Yes.

COUNCILMAN GOODE: Okay. I'm asking about subcontracting opportunities. You didn't take the time to identify them for the RFP, so there was no goal in the RFP. You didn't take the time to identify them for the contract.

The issue is: What has been done since then to identify subcontracting opportunities?

COMMISSIONER AMBROSE: So they have two new subcontracting opportunities. For minority businesses, it's a total of $78,464. For women, it's a total $12,754. For con --

COUNCILMAN GOODE: So they have two new opportunities.

COMMISSIONER AMBROSE: Correct.

COUNCILMAN GOODE: Is that the extent of the opportunities that exist within the contract?

4.20.11 COMM. OF THE WHOLE - BILL 110137

COMMISSIONER AMBROSE: No. They have also -- for the new construction and build costs for the shelter that they relocated in Philadelphia, there's $250,000, and they're currently -- there's a potential spend with a letter of intent for $500,000 with United Bank to relocate some group homes in Philadelphia.

COUNCILMAN GOODE: Okay. What does that represent in terms of percentage of the total contract?

COMMISSIONER AMBROSE: I'll ask somebody to do some quick calculations, but it's not the 25 percent goal that we have. It's not meeting our goal.

COUNCILMAN GOODE: I'll wait.

ROMANA: So if it's about a million dollars out of a $20 million, would be 0.5 percent.

COUNCILMAN GOODE: It's 0.5 percent.

ROMANA: I mean -- yeah, that's about a million dollars' worth of --

COUNCILMAN GOODE: A half of 1 percent.

ROMANA: Yes.

COUNCILMAN GOODE: Okay. So what do you think is achievable under the contract in terms of subcontracting opportunities?

COMMISSIONER AMBROSE: In discussions with VisionQuest, they have met with us on a number of occasions. They have also attended OEO's sessions on increasing their participation rates.

COUNCILMAN GOODE: My question is: What's achievable in terms of percentages of contract dollars in terms of subcontracting opportunities? I mean, clearly 0.5 percent is ridiculous.

COMMISSIONER AMBROSE: Right. So most of their budget. Actually goes to paying staff salaries, and their staffing is primarily minority and women staff, and about --

COUNCILMAN GOODE: What percentage goes to staff salaries?

4.20.11 COMM. OF THE WHOLE - BILL 110137

COMMISSIONER AMBROSE: I can tell you that. Hold on one second.

Seventy percent. Their annual payroll is $11,700,000, and approximately $8,190,000 of that amount is paid to minorities and women.

COUNCILMAN GOODE: So 30 percent of the contract is not dedicated to staff salaries.

COMMISSIONER AMBROSE: Yes.

COUNCILMAN GOODE: It's about $6 million?

COMMISSIONER AMBROSE: Correct.

COUNCILMAN GOODE: And so, what portion of $6 million is available for subcontracting opportunities for businesses owned by minorities and women?

COMMISSIONER AMBROSE: So those are the discussions that we continue to engage in with VisionQuest. And they've also hired somebody who's a minority who lives in Philadelphia to help them work on those efforts.

COUNCILMAN GOODE: In other

words, you still don't know.

COMMISSIONER AMBROSE: Correct.

COUNCILMAN GOODE: Okay. Is the firm in compliance with the City's living-wage-and-benefits standard?

COMMISSIONER AMBROSE: They are.

COUNCILMAN GOODE: What's the largest nonprofit contract that you will award?

COMMISSIONER AMBROSE: It's PHMC.

COUNCILMAN GOODE: Okay. And how long have they had their contact?

COMMISSIONER AMBROSE: The same. The contract was issued in '08 for '09.

COUNCILMAN GOODE: And is the firm a certified disadvantaged business?

COMMISSIONER AMBROSE: No.

COUNCILMAN GOODE: Is there a supplier diversity plan?

COMMISSIONER AMBROSE: Yes.

COUNCILMAN GOODE: And what

have they achieved?

COMMISSIONER AMBROSE: They haven't achieved much in the areas of what they do, but their subcontracting is actually very good.

So, for instance, their diversity plan wasn't something that was particularly helpful, so we --

COUNCILMAN GOODE: I have their numbers right here. It says 6.34 percent.

ROMANA: I'm sorry. Could you please clarify that?

COUNCILMAN GOODE: I have their numbers right here. It says 6.34 percent.

I guess you're wondering where I got it from. The Health Commissioner.

ROMANA: Okay.

COUNCILMAN GOODE: So you didn't know it was 6.34 percent.

COMMISSIONER AMBROSE: I actually think it's lower for DHS. I think that might be its numbers for the

Health number.

COUNCILMAN GOODE: But you just said you thought their numbers were pretty good.

COMMISSIONER AMBROSE: Well, their numbers for subcontracting with minority firms are good.

COUNCILMAN GOODE: And what's the number?

COMMISSIONER AMBROSE: So for our out-of-school time, the composition of executive director -- 53 percent are minority, the board is 43 percent minority --

COUNCILMAN GOODE: That's not what I'm talking about; I'm talking about subcontracting opportunities. You clearly still don't get it.

Could Miss Dowd-Burton come to the table.

(Ms. Dowd-Burton comes forward.)

COUNCILMAN GOODE: Good afternoon.

4.20.11 COMM. OF THE WHOLE - BILL 110137

MS. DOWD-BURTON: Good afternoon, Councilman. My name is Angela Dowd-Burton, Executive Director of the Office of Economic Opportunity.

COUNCILMAN GOODE: Has OEO looked at -- going back to VisionQuest, has OEO looked at subcontracting opportunities for the VisionQuest contract?

MS. DOWD-BURTON: We have looked at some opportunities but really have not done an in-depth --

COUNCILMAN GOODE: So does OEO know what the subcontracting opportunities should be, and out of the $20 million, what percentage of contract dollars should be going to businesses owned by minorities and women?

MS. DOWD-BURTON: Not in detail at this time.

COUNCILMAN GOODE: OEO does not know?

MS. DOWD-BURTON: No.

COUNCILMAN GOODE: So it's a

$20 million contract, the RFP was put out with just best efforts, the contract was put out with just best efforts. The accomplishment so far has been one half of 1 percent, and we still don't know what opportunities exist within the contract.

MS. DOWD-BURTON: The contract went into place in 2008, and we will be working with, and have over the past year been working with, the Department of Human Services to analyze all of their contracts and to get their contract providers engaged in supplier diversity programs.

COUNCILMAN GOODE: Okay. Thank you.

Madam President, I'd like to bring DHS back too. Thank you.

COUNCIL PRESIDENT VERNA: Councilman, yes?

COUNCILMAN GOODE: I'm done. I'd like to bring them back when they have more information about that

particular contract and what opportunities exist within that contract, and I'm not prepared to vote on the budget particularly funding them until they get a bit better with what they need to do in terms of diversity.

COUNCIL PRESIDENT VERNA: Very well.

Councilwoman Blackwell.

COUNCILWOMAN BLACKWELL: Thank you very much, Madam President.

We were concerned about three issues. One certainly is the whole issue of truancy with students, and I understand that's at about the same levels as last year.

Would you give us some feedback on how you're handling that?

COMMISSIONER AMBROSE: Sure. I'll also invite Desirée Thomas up, who's sort of leading these efforts for the Department of Human Services.

COUNCILWOMAN BLACKWELL: Okay.

COMMISSIONER AMBROSE: There's

actually been a good collaboration between Family Court, the School District of Philadelphia, and DHS in the last couple of years. We've created a new planning process that's led by Erica Washington from the School District, who's really been terrific on trying to get the schools to be a little bit more proactive on the truancy issues.

They've created a checklist of things that the school needs to do before they refer the case to Family Court. So the letters to the family have to be verified; the phone calls to the family have to be verified; the outreach to the family, including home visits, have to be verified before that case can even go Family Court.

And we think that's a more effective, preventive way of getting both children and families engaged in education before it goes the truancy route and Family Court. And so, those efforts have actually been quite

successful.

The numbers have decreased a little because that process just started in January, but we feel very good about the partnership that we've built with the School District at this point.

I don't know if Desirée has anything to add to that, but she's been leading that.

COUNCILWOMAN BLACKWELL: Thanks.

MS. THOMAS: Good afternoon. The numbers are actually down.

COUNCILWOMAN BLACKWELL: Can you give us those numbers?

MS. THOMAS: Yes. For the fiscal year last year, 11,013 youth, grades 1 through 12, were served through Regional and Family Court. And at that time, we took just one approach to managing truancy and intervention.

So all kids that the school deemed eligible for court went to court. So that was the 11,113 kids.

This year, we took a age-

differentiated approach to intervention, where kids in kindergarten to 3rd grade are diverted from court, and they receive Diversion Case- Management Services in the community.

The assumption is that there are family issues that create the chronic absenteeism, and we want to deal with that. And so, kids again that are in kindergarten to 3rd grade are diverted from court.

To date, we started receiving deferrals for that age group in December. And from December to April, there are 241 youth that meet that criteria that are currently being served through our Diversion Case- Management Services.

For grades 4 through 12, there are 6,793 youth that are currently receiving truancy case-management services and being supervised by Truancy Court.

So the numbers are lower. But just as a caveat, during this time of the

year, the numbers also spike. So we can't tell yet if it's a result of our intervention and the School District's screening so far that it's kept the numbers down or whether the numbers are actually going to spike up and we'll be around the same numbers that we were last year.

COUNCILWOMAN BLACKWELL: Do you know how this new system, this new technological system, that the Police Department is engaged in with the schools, if that affects you?

MS. THOMAS: I don't know.

COUNCILWOMAN BLACKWELL: And how that would affect you.

MS. THOMAS: I'm not aware if they --

COUNCILWOMAN BLACKWELL: They do it for kids who are supposed to be on probation, so that they don't have to leave school. A lot of those kids would be truant as well.

COMMISSIONER AMBROSE: I think

you're referring to the in-school suspension protocol that they've developed.

COUNCILWOMAN BLACKWELL: I don't think so.

COMMISSIONER AMBROSE: Okay. Then we aren't a part of that.

We do have a new information-sharing protocol with the School District of Philadelphia so we find an MOU with the Superintendent so that we can share information about children who are common to DHS and the School District, and that's part of our Education Support Center efforts.

So we're able to share information that normally we wouldn't be able to share, so that if the school is concerned about a child who's DHS-involved, we sit down and meet with the counselors and the teachers and whoever is necessary to try to solve those problems.

So that's been a huge

advancement, and we signed that in December of '09.

COUNCILWOMAN BLACKWELL: And how does this work with traditional public schools and charter schools; is the program the same?

COMMISSIONER AMBROSE: We're working on an MOU with the charter schools but we're not there yet. And also the Archdiocesan schools.

COUNCILWOMAN BLACKWELL: All right. Although their attendance is always up anyway. That's one of their successes.

I understand that there's some concern about the intake system, and folks are concerned about the proposed cuts that the State makes and that if they give more money back to the schools, that they're going to hurt DHS, and that part of what you do is take -- if students -- if children needs meds, et cetera, you do that kind of taxi service. You take them there and make sure they

get where they need to be.

My question is: Do you expect to have the finances to continue this? If not, how will you maintain the service? If not, how do you propose that this will operate, given the needs of youngsters who still will need the meds as before?

COMMISSIONER AMBROSE: Yeah. I'm actually not sure what service you're referring to, but we believe, based on the Governor's budget cuts that we won't have any kind of service impact at all.

So that service should continue if it's something that we currently do.

You might be referring to the old consultation and education service that DHS provided, but the School District has taken over that program, so I'm not really sure.

The good news for DHS is that we expect to be able to cut -- cover the initial budget cuts from the Governor's office through staff positions and

underutilization in one of our services.

Now, we are concerned if the legislature decides to do something different, that there could be some impacts on DHS funding.

COUNCILWOMAN BLACKWELL: And my final question is -- and maybe you responded to it. And that is about hiring and vacancies, what vacancies you have and how that affects the service you provide.

COMMISSIONER AMBROSE: Sure. We actually have a lot of vacancies right now. I think we have 142 vacancies at this point.

Part of the reason for our vacancies is that the system has shrunk. As we've continued to move children out of placement and increase permanencies, we have about 4,000 fewer children in the former child welfare system than we had three years ago.

So our caseloads sizes have gone 19, when I first came, to about 12

or 13 right now. And so, we haven't had the need to fill those positions. I think some of my staff might argue with me about that.

We've -- at the same time caseload sizes have been diminished, I think we've created additional quality measures, including monthly visits by DHS staff. So right now, we're in the process of trying to readjust caseload sizes and move staff from non-carrying caseload to carrying caseloads.

And so, that's a process that we're engaged in. We're working with our union leadership on making some of those adjustments, but we don't think at this point it's necessary to fill some of those vacancies in the social work practice areas.

The areas that we're particularly concentrated are on the front end. So Intake, which is the Investigations Unit at DHS, which is really critically important to keep

staffed up, and also hotline.
Traditionally, the department has used a lot of overtime on the hot line, and we don't believe that's best practice. And so, we really want to change the way we staff those two sections. And that will the area of focused concentration to us.

COUNCILWOMAN BLACKWELL: We would like to know how you want to change that. And also caseloads -- if a case is a child, does it not include that family?

COMMISSIONER AMBROSE: So the cases are actually families.

COUNCILWOMAN BLACKWELL: I thought so.

COMMISSIONER AMBROSE: And each of our families has approximately 2.3 children. So some of our case workers have way more children than that should have if they have a big sibling group.

But we now measure caseload size not by just the number of families but the number of children in that family so that we can understand the impact that

it has on that worker's workload.

COUNCILWOMAN BLACKWELL: So you're saying, then, that a worker's caseload is considered 2.3 children in the family?

COMMISSIONER AMBROSE: Well, the caseload is families, and the average family size for each is 2.3 children. That's just an average, so you may have --

COUNCILWOMAN BLACKWELL: So what if there are six children; then what?

COMMISSIONER AMBROSE: Then we try to do some adjustments, but we aren't always able to do that. We don't have the sophisticated way of assigning cases, but we are looking at a weighing system; we're trying to develop a weighing system that would take into conversation not just the number of children in the family, but the complexity of those issues.

So, for instance, some of our

sex abuse cases can be far more complicated than a truancy case -- just kind of making this up. And so, if we create a waiting system, we might be able to more equitably distribute cases so workers aren't overwhelmed.

COUNCILWOMAN BLACKWELL: Well, how can you have 142 vacancies and not have such a system and say you don't need the employees then?

COMMISSIONER AMBROSE: Well, we're in the process of trying to develop that system.

COUNCILWOMAN BLACKWELL: But we -- let me ask you to get this information back to the Chair, because 142 vacancies is a lot of vacancies, and for kids to be out there in large families, when we hear about people passing away and tragedies that happen, it generally involves some instance where somebody wasn't there or wasn't looking, for all kinds of reasons. You know, we've all heard for many, many years about people with these caseloads.

We do not want people and children to be hurt because of the fact that they didn't have a case worker who could follow up because they have so many cases, and they're so -- I mean, it's common. We've heard it as long as I can remember, we've heard about these large cases.

So we would like to -- all of the programs you mentioned that you're interested in starting, we would like specific information to be sent to the President, especially with regard to these vacancies.

Thank you, Madam President.

COUNCIL PRESIDENT VERNA: You're welcome.

The Chair recognizes Councilwoman Brown.

COUNCILWOMAN BROWN: Thank you, Madam President.

Good afternoon, ladies.

PANEL MEMBERS: Good afternoon.

COUNCILWOMAN BROWN: A few

follow-ups to Councilman Goode's line of questioning.

With regards to VisionQuest, is there any other entity in the region that provides the type of services VisionQuest provides?

COMMISSIONER AMBROSE: No. The closest area in the region that provides the type of service is Cornell, which runs a facility in New Morgan, which is a juvenile justice facility.

COUNCILWOMAN BROWN: Mm-hmm.

COMMISSIONER AMBROSE: But they also have several other placements further away from Philadelphia.

And so, one of the goals that we've had is moving children closer to Philadelphia, so we've been able to do that with our out-of-state population. VisionQuest has been the provider who's been most responsive to that.

So as I was saying earlier, they moved their 120-bed shelter into Philadelphia, creating additional jobs

for our residents and being closer to the families where our kids are from.

They've also moved about 200 beds closer to Philadelphia from Franklin, Pennsylvania, which is way close to the Ohio border and South Mountain.

COUNCILWOMAN BROWN: Mm-hmm.

COMMISSIONER AMBROSE: And they've created additional beds closer to here by a new program called Lighthouse, and they've also created some community-based services at our request, functional family therapy being the biggest one.

So we're trying to move the children closer to Philadelphia.

COUNCILWOMAN BROWN: I see.

COMMISSIONER AMBROSE: And this is a provider who's actually complied with our request and been creative in thinking through on how we could do that.

COUNCILWOMAN BROWN: Okay. So your last statement is a summary of where I was headed to. They get it now, that

Philadelphia cares about keeping our kids as close to home as possible.

COMMISSIONER AMBROSE: That's right.

COUNCILWOMAN BROWN: And they've made the appropriate internal systemic changes if they want to continue to be considered for funding; is that fair to say?

COMMISSIONER AMBROSE: That's fair to say.

COUNCILWOMAN BROWN: Okay.

COMMISSIONER AMBROSE: And we've met with them on many occasions about this.

COUNCILWOMAN BROWN: Okay, all right. So they get it with regards to there being really a policy change for us to move our kids closer.

And then speak to how you've tried to help them understand the policy concern we have around MBE/WBE participation.

COMMISSIONER AMBROSE: So since

we've started meeting with them after hearings of last year, they have hired some additional staff. They're saying that some of their contracts -- so, for instance, we tried to work with them on the food-service contract at the new facility in Philadelphia.

Unfortunately, that's with another company that -- the facility doesn't just service VisionQuest, and the food service is provided by a bigger entity that serves multiple agencies in that location.

COUNCILWOMAN BROWN: Okay, in the region?

COMMISSIONER AMBROSE: Right.

COUNCILWOMAN BROWN: Okay.

COMMISSIONER AMBROSE: And so, that's something we intend on exploring with Angela.

The other areas that we talked about were food for some of their other facilities 'cause they just don't have children in Philadelphia. Clothing and

additional subcontractors that they --

COUNCIL PRESIDENT VERNA:

Excuse me.

Councilman Goode, you have a point of information?

COUNCILMAN GOODE: You said you tried to work with them on what?

COMMISSIONER AMBROSE: We sat down with them and asked them -- told them we're very serious about this goal and that their numbers are not where they need to be and tried to explore with them and their consultant about ways that they can increase those goals.

So we had a meeting as -- last week as well.

COUNCILMAN GOODE: And you suggested what to them?

COMMISSIONER AMBROSE: That they should look at who they contract with for things like clothing for the children --

COUNCILMAN GOODE: And you mentioned food service specifically.

COMMISSIONER AMBROSE: Yes.

COUNCILMAN GOODE: Tell me about that conversation.

COMMISSIONER AMBROSE: So we asked them why they couldn't contract out food service in their new shelter. And there are multiple tenants in the building that they're in, and there was an existing food contract, so they're going to continue to explore how they might maybe take out whatever food service they provide from their lease agreement and contract that out.

So those are some of the conversations that we've had.

COUNCILMAN GOODE: And that food-service contract is part of a larger contract?

COMMISSIONER AMBROSE: Correct.

COUNCILMAN GOODE: And who's that between?

COMMISSIONER AMBROSE: I don't have the name of the company, but I can try to find out.

COUNCILMAN GOODE: So I can tell you specifically, when I questioned the Recreation Commissioner, she specifically talked about food-service contracts and how she pushed on that and was able to push specifically on a food-service contract participation that was in the single digits to 15, 20, 25 percent.

So she's done it.

COMMISSIONER AMBROSE: Okay.

COUNCILMAN GOODE: So maybe you need to talk to her.

COMMISSIONER AMBROSE: I definitely will.

COUNCILMAN GOODE: Thank you.

Thank you, Madam Chair.

COUNCILWOMAN BROWN: So food service, clothing. What other type of --

COMMISSIONER AMBROSE: Various services that children need, like sometimes they need to be seen by doctors.

We explored education, but the

education -- they're in the process of working with the Philadelphia School District on the educational portion of the services that they provide. So that isn't something that we were able to move forward on.

If they have psychiatrists that come in to do med management, there are those kinds of opportunities.

The bulk of their payments, though, are to their employees for salaries.

COUNCILWOMAN BROWN: Okay. When you attend those meetings, does an officer from OEO join you in those meetings with VisionQuest?

COMMISSIONER AMBROSE: VisionQuest has attended two of the forums that OEO sponsored. In these meetings just between us and VisionQuest, I have not included them, but that might be a good idea for me to include Angela or her staff as we move forward.

COUNCILWOMAN BROWN: I would

think so, just to help them understand that there are people in government who are not playing about this. And either they need to get it or they need to be prepared to reckon with the consequence of not getting it.

COMMISSIONER AMBROSE: Okay.

COUNCILWOMAN BROWN: Okay? PHMC, they have a contract with you, with the Health Department, and they also have a contract with DHS.

COMMISSIONER AMBROSE: Correct, they do have a contract with DHS.

COUNCILWOMAN BROWN: What services do they provide?

COMMISSIONER AMBROSE: So the bulk of the services that they provide for DHS is our out-of-school-time contract, which is $32.822,133.

COUNCILWOMAN BROWN: Okay.

COMMISSIONER AMBROSE: And our Parenting Collaborative, which is approximately $6 million.

COUNCILWOMAN BROWN: Okay. So

help me understand. PHMC is a direct-service agency?

COMMISSIONER AMBROSE: No. They're actually an administrative arm that helps support the administrative functions of smaller, more grassroots kinds of provider agencies.

COUNCILWOMAN BROWN: Okay. I thought that to be the case; I just needed to double-check my own thinking about that.

Okay, I guess it's been two or three years that the very sad circumstance regarding the young -- the child Daneale -- help me remember her name.

COMMISSIONER AMBROSE: Daneale Kelly.

COUNCILWOMAN BROWN: Right. Triggered an overall and a re-look-see at how DHS operates. And I know that each year, you've been about the business of rolling out and honoring recommendations that were in that final report.

COMMISSIONER AMBROSE: That is correct.

COUNCILWOMAN BROWN: What was the total of recommendations; do you recall?

COMMISSIONER AMBROSE: Yeah. The total number of recommendations was 37.

COUNCILWOMAN BROWN: And how far are you along in the implementation of those?

COMMISSIONER AMBROSE: So we're in various stages of implementing all of the recommendations. There's really three that need additional attention.

One is the clarification of roles and responsibilities between DHS staff and the provider staff, and that's our Improving Outcomes for Children Initiative that we're working on with the private providers, which is creating the single-case management model of service delivery.

COUNCILWOMAN BROWN: Right.

COMMISSIONER AMBROSE: And then really redefining the role of DHS staff to be more of practice specialists, monitors, technical assistance.

COUNCILWOMAN BROWN: Versus...?

COMMISSIONER AMBROSE: Versus this lack of clarity about who does what.

COUNCILWOMAN BROWN: Okay.

COMMISSIONER AMBROSE: And so, that's really a lesson learned from the Daneale Kelly case and something that we're actively engaged in planning on.

The other two were establishing a local office. And we have determined that based on the Improving Outcomes for Children Initiative, we should wait on that, because, ideally, we'll be working with community groups in the areas where our kids are most likely to live and then creating a local office based on that work that we're doing with the community.

COUNCILWOMAN BROWN: Okay.

COMMISSIONER AMBROSE: And then the third is collocation. And I'm happy

to announce that we have identified a collocation site; it's actually going to be in Councilman Jones' district. And we'll hopefully be moved in there before July of '11.

COUNCILWOMAN BROWN: I see.

COMMISSIONER AMBROSE: So this is one of the things that was important to the Mayor, and we're really pleased that we're moving forward on that. And that's the collocation of Philadelphia Children's Alliance, the Police Department, and DHS to collaborate on investigation so kids aren't retraumatized by multiple re-interviews?

COUNCILWOMAN BROWN: Yes, yes. Congratulations on that achievement.

I too had additional questions around truancy and shared some of those concerns as Councilwoman Blackwell.

So you gave the numbers of 241 for little people, K through 3, correct?

MS. THOMAS: Mm-hmm.

COUNCILWOMAN BROWN: And then

7,000-plus for young people, 4th through 12th grade.

MS. THOMAS: (Inaudible.)

COUNCILWOMAN BROWN: 7,693, correct?

MS. THOMAS: 6,783.

COUNCILWOMAN BROWN: Thank you.

So now, how does the stat compare to last year? I mean, where are we in this continuum of the strategy for executing around truancies. Is it better than last year or what?

MS. THOMAS: I can tell you in terms of the numbers, again, last year, for the whole year, we really can't tell, but we serviced 11,000 kids total last year.

Our strategy this year was to take a age-differentiated approach to truancy overall. And so, in terms of outcomes and whether or not the attendance has improved yet, I can say for the 241 youth that are currently getting services, because the services

they give is a 90-day service, those families are engaged in the services, and the attendance is improving in terms of the 241.

COUNCILWOMAN BROWN: Okay.

MS. THOMAS: Because that's a smaller number for us to manage.

COUNCILWOMAN BROWN: Absolutely.

MS. THOMAS: With the 6,793, truancy is a practice area for the Policy Analysis Center, where we are to develop an evaluation plan of both our process and our outcomes. And so, we presented a plan for that, to look at how we can evaluate our process, to see if it's effective; you know, how we did it last year and looking at how we're doing it this year.

COUNCILWOMAN BROWN: Uh-huh.

MS. DOWD-BURTON: As well as looking at the outcomes for it, so we really don't know yet.

COUNCILWOMAN BROWN: Okay. It's premature to speculate.

MS. THOMAS: Yes.

COUNCILWOMAN BROWN: Okay. I'm curious about one thing, typically the adolescents, young people between the ages of 4th and 8th are broken out, because, you know, their challenges are so different than 9th and 12th graders.

MS. THOMAS: Mm-hmm.

COUNCILWOMAN BROWN: And when you look at when the dropout grade actually begins to happen, it's typically after 9th grade. So, you know, they come in 9th grade and 48 months later, you know, we can't find them.

MS. THOMAS: Mm-hmm.

COUNCILWOMAN BROWN: So is there any particular reason why you've grouped together 4th through 12th-graders? I'm just curious.

MS. THOMAS: I think that --

COUNCILWOMAN BROWN: 'Cause it would seem to me the treatment for a 4th-through a 8th-grader would be different than the treatment you would offer to a

high school student.

MS. THOMAS: It's the -- the case-management services in terms of the 4th to 12th grades are developmentally appropriate.

COUNCILWOMAN BROWN: Oh, okay.

MS. THOMAS: And so, they have in-home case-management services as well. A case manager goes in the home and deals with the family as a whole.

COUNCILWOMAN BROWN: Okay.

MS. THOMAS: And so, they're aware of, you know, developmental issues and how to engage and stuff like that.

COUNCILWOMAN BROWN: Very well.

MS. THOMAS: So we take that approach to the intervention.

COUNCILWOMAN BROWN: Okay.

MS. THOMAS: The issue was what cases actually needed to go to court.

COUNCILWOMAN BROWN: Oh, okay.

MS. THOMAS: And so, we determined that 4th through 12th grade cases needed court attention, so it's

about court. The intervention components are similar.

COUNCILWOMAN BROWN: Well understood.

MS. THOMAS: Okay.

COUNCILWOMAN BROWN: So the n, how do you define success when it comes to truancy? Does this mean that kids are going back to school and flourishing?

MS. THOMAS: It's a tough question. And in terms of defining the role, collaboratively, we're looking at improved school attendance.

COUNCILWOMAN BROWN: Oh, okay.

MS. THOMAS: So if school attendance has improved, that's a measurement of our success.

COUNCILWOMAN BROWN: Oh, okay.

MS. THOMAS: Of course, we want academic improvement --

COUNCILWOMAN BROWN: Achievement.

(Indiscernible; parties talking over each other.)

MS. THOMAS: -- achievement as well. But in terms of the scope of our initial intervention and the refinement of our process, we're looking at improving school attendance and alleviating crime and absenteeism, with the goal that once a child is in school, you know, on a continual basis and is engaged, that school achievement will occur.

COUNCILWOMAN BROWN: Okay. We could have a lot more conversation about truancy, but I'll move on, and I'm going to revisit this with Councilwoman Blackwell and then sit down with you all because we need to, I think, tackle that separate from all of the other work that you do, okay?

MS. THOMAS: Okay.

COUNCILWOMAN BROWN: Okay. You talked about the reduction in caseloads, and that too is a direct outcome or result of the recommendations you talked about, correct?

COMMISSIONER AMBROSE: That's right.

COUNCILWOMAN BROWN: Okay. I'm trying to get through this, 'cause I know Councilman Kenney has questions.

Madam Chair, why don't we allow --

COUNCIL PRESIDENT VERNA: I was just going to ask if you would mind --

COUNCILWOMAN BROWN: And I'll come back.

COUNCIL PRESIDENT VERNA: Yielding to Councilman Kenney.

COUNCILWOMAN BROWN: Okay.

COUNCILMAN KENNEY: I appreciate that, and I also have truancy questions, so I guess it's better that I get mine in before you start to --

COUNCILWOMAN BROWN: You go right ahead.

COUNCILMAN KENNEY: Thank you.

Does your truancy intervention stop at the end of the school year?

MS. THOMAS: Okay. Um...

4.20.11 COMM. OF THE WHOLE - BILL 110137

COUNCILMAN KENNEY: I mean, when May or June rolls around and kids aren't in school, does the contact stop?

MS. THOMAS: It depends on if the family is still actively involved.in the service. And so --

COUNCILMAN KENNEY: But of the 241 families with the youngsters, is there any contact at all during the summer months?

MS. THOMAS: The service for the K through 3rd grade is a 90-day service.

COUNCILMAN KENNEY: Right.

MS. THOMAS: The providers, if they feel that there are issues that need continual monitoring or supervision and support in terms of the family, they can make a request to extend that service.

COUNCILMAN KENNEY: But for the 241 and even the rest of the cohort of kids --

MS. THOMAS: Yes.

COUNCILMAN KENNEY: -- would it

make more sense to start ramping up the contact intervention from mid-July, say, on through early September or so?

COMMISSIONER AMBROSE: Yeah. And I actually --

COUNCILMAN KENNEY: And let me flesh it out a little bit more. I mean, there's got to be some partnerships I guess we could develop with the school itself with organizations that are nonprofits that care about this stuff.

COMMISSIONER AMBROSE: Mm-hmm.

COUNCILMAN KENNEY: I mean, it could be an issue of not having money for clothes, it could be an issue -- I mean, you know the process when you're getting your kids ready to get back to school; it's a pretty long and drawn out and sometimes expensive process.

And my thought is we identify the 241 in the last school year that are having difficulty in that area --

COMMISSIONER AMBROSE: Mm-hmm.

COUNCILMAN KENNEY: Would it

not be better to start with them again in July or so, after the 4th, say, and start reminding schools coming, "Let's get rolling," you know, and send out notices, "School's going to start," and maybe have some contact from some other folks or maybe do something innovative in the way of children's clothing purchases, sales that these folks can get a voucher or a percentage sale thing where they can go to a Boystown or a Girlstown and get ready?

It's more of a like -- as opposed to trying to treat the disease or the illness, if we can, like, encourage people and moms and dads and grandparents and everybody else, like, to kind of get this "we're getting back to school" thing --

COMMISSIONER AMBROSE: Mm-hmm.

COUNCILMAN KENNEY: -- as opposed to waiting till they don't show up for two weeks, and then we have to go do it on the back end.

COMMISSIONER AMBROSE: Yeah, I think those are great ideas.

I think the other thing is that we do target some of those kids for the summer programs that we have. So there is a pretty good partnership with the Philadelphia Youth Network and the School District on the summer programs, and those kids would be priorities to make sure they have those programs.

I think with the younger kids, the issues are far more complicated --

COUNCILMAN KENNEY: Right.

COMMISSIONER AMBROSE: -- which is why DHS is directly involved in case management, 'cause it's -- if you're in 2nd grade and you're not going to school, it's not your fault.

COUNCILMAN KENNEY: Correct.

COMMISSIONER AMBROSE: There's something wrong in the home.

COUNCILMAN KENNEY: But if you're not -- if you have situations where the only issue is the truancy or

it's none of -- or where these youngsters, a 2nd grader, and they're not going to school, is the only issue the truancy, or are there other --

COMMISSIONER AMBROSE: Usually --

COUNCILMAN KENNEY: 'Cause I know there are other issues in the home; are you dealing with any other issues?

MS. THOMAS: Yeah, we're dealing with the family as a whole. And I guess what you're talking about, one of the things that was missing from the planning for developing the truancy intervention was understanding why families were truant.

COUNCILMAN KENNEY: Right.

MS. THOMAS: And so, what we initiated was focus groups with stakeholders to get their reasons why so the school, the providers to find out why they believe kids are truant from school.

And we're also developing a survey for both families and students

that we're involved in now to gather that information to be able to look at data.

COUNCILMAN KENNEY: But, for example, do your folks interface in any way with the elementary school principal?

MS. THOMAS: Yes, the --

COUNCILMAN KENNEY: Okay. So the --

MS. THOMAS: Yes. The -- the --

COUNCILMAN KENNEY: Okay. So you --

MS. THOMAS: Yes.

COUNCILMAN KENNEY: No, I'm talking about in the summer months, as we're just starting to --

(Indiscernible; parties talking over each other.)

MS. THOMAS: Not the --

COUNCILMAN KENNEY: -- ramp up to get back to school --

MS. THOMAS: Once it's a active case and we're open, then no.

COUNCILMAN KENNEY: Okay.

Well, I would like to talk to you at some point in time, maybe during the summer or right after school gets out, to start trying to figure out how to meet -- you see on TV at -- towards the end of July, you start seeing the back-to-school commercials and the Staples and the clothing and the stuff. I mean, it's just getting people's heads around that school's coming back.

And I think if we wait until school starts up and the kids don't show up, then we're in a different --

COMMISSIONER AMBROSE: Yeah, I mean, we actually do that.

COUNCILMAN KENNEY: We're in a different climate.

COMMISSIONER AMBROSE: We do the Backpack Challenge every year.

COUNCILMAN KENNEY: Right, right.

COMMISSIONER AMBROSE: -- for our AIC students, but we could certainly make that bigger. We actually have a

very good partnership with the radio station that sponsored us last year.

COUNCILMAN KENNEY: All right.

COMMISSIONER AMBROSE: And we could make that more of a department-wide effort for all kids in the City --

COUNCILMAN KENNEY: Okay.

COMMISSIONER AMBROSE: -- instead of just the older kids.

And we really focused on those kids that were going to college and didn't necessarily have the financial resources to buy the kinds of things that youth need when they're on their way to college --

COUNCILMAN KENNEY: Okay.

COMMISSIONER AMBROSE: -- but we could certainly expand that --

COUNCILMAN KENNEY: Okay.

COMMISSIONER AMBROSE: -- and would be happy to have conversations with you about doing that.

COUNCILMAN KENNEY: All right. I'll get with you after the election.

COMMISSIONER AMBROSE: Okay.

(Laughter.)

COUNCILMAN KENNEY: Sometime around May 18th, I'll (inaudible).

COMMISSIONER AMBROSE: Okay.

COUNCILMAN KENNEY: Thank you.

COUNCIL PRESIDENT VERNA: You're welcome.

Councilwoman Brown.

COUNCILWOMAN BROWN: Thank you, Madam President.

I would like to be a part of those discussions too, after the election.

COMMISSIONER AMBROSE: Okay.

COUNCILWOMAN BROWN: Okay. What is the total number of young people in the DHS system?

COMMISSIONER AMBROSE: About over a 100,000 if you include out-of-school-time kids.

COUNCILWOMAN BROWN: Okay.

COMMISSIONER AMBROSE: So the services that we provide, there's a huge

continuum of services right from children that are in the Prevention Division, who receive services in out-of-school-time-programs, to children in secure detention on the Juvenile Justice side.

So the total number is usually over a 100,000 kids served a year.

COUNCILWOMAN BROWN: Okay. So let's break that down into the two categories you just talked about.

The young people in the out-of-school side, that number is what?

COMMISSIONER AMBROSE: At any one time, it's 10,233 slots that we have available.

COUNCILWOMAN BROWN: Okay. And the other 85-plus thousand are in secured facilities?

COMMISSIONER AMBROSE: Oh, no, no, no, no.

So some of those slots rotate. So there's not -- at any one time throughout the year, those slots can rotate.

COUNCILWOMAN BROWN: Oh, okay.

COMMISSIONER AMBROSE: And then we have a whole continuum of prevention services, including the truancy youth and children that Desirée talked about, children involved in our pre Rs and Rs, which is Alternative Response Service System.

COUNCILWOMAN BROWN: Okay.

COMMISSIONER AMBROSE: Children receiving services through Family Stabilization Services.

COUNCILWOMAN BROWN: Okay.

COMMISSIONER AMBROSE: So there's a huge continuum that we have. And we look at least intrusive to most intrusive, and that's the playing field that we have, yeah.

COUNCILWOMAN BROWN: Okay, that's a better picture.

I clearly remember after the report, the discussion around training and professional development for professionals at DHS.

COMMISSIONER AMBROSE: Mm-hmm.

COUNCILWOMAN BROWN: So give us a update on where that is, how often it happens, when you have training, how impacts that staffing, et cetera, et cetera.

COMMISSIONER AMBROSE: So according to my staff, it happens far too often, and I think that that's true. We've had tremendous mandates on our staff to change as a result of the Daneale Kelly case.

The biggest area where we've really done tremendous amounts of training is the Safety Model of Practice.

COUNCILWOMAN BROWN: Okay.

COMMISSIONER AMBROSE: So we've adopted a Safety Model of Practice. The criticisms of the agency were that we became too many things to too many families in the City and that we really needed to focus in the Children and Youth Division on those children that were at risk for abuse and neglect.

And so, we've adopted, through work with the Community Oversight Board, a new way of taking cases, which is the hotline guide decision-making tool, which is a differential response tool that looks at safety as being the reason why we would accept a case for service after investigation.

COUNCILWOMAN BROWN: Okay.

COMMISSIONER AMBROSE: And then a very sophisticated assessment tool that required tremendous amounts of training for our staff in order to be able use that tool.

And so, I think staff are right when they are concerned about the number of hours they've spent in training. And so, that's been a huge area of focus.

The other area of focus that we worked on is supervisory training, so we haven't necessarily always given staff at DHS the tools that they need when they become supervisors. And so, we went through a practices process of looking at

a better -- through a steering committee, what would be a better training model for them to use. And we went through with the support of Casey Family Programs.

And what we found after the initial pilot phase is that we didn't include some of the nuts and bolts. So we're now working on revising that training.

The other training that we're mandated is, every staff person on the children youth side is required to do 20 hours of training every year to be in compliance with the State regulations.

COUNCILWOMAN BROWN: Is that right? Was that in place prior to Daneale Kelly?

COMMISSIONER AMBROSE: Yes.

COUNCILWOMAN BROWN: Okay.

COMMISSIONER AMBROSE: And so, staff do -- we've implemented a bunch of new models that are best-practice models. So Family Group Decision-Making requires training family, finding requires

training.

COUNCILWOMAN BROWN: Okay.

COMMISSIONER AMBROSE: We've done training on fatherhood. And the real urgency in DHS is doing a better job at reaching out to fathers as potential resources for kids.

The other thing that we've started doing in the last year is planning for something we're calling "DHS University." And that's a way of looking at training not just as substance but how do we give our staff the competencies to move up in the agency? How do we give them an opportunity to enhance their skills in a way that allows them to be better workers, better supervisors, better administrators and directors?

So that would be, hopefully, something that we're able to do online. So you could have staff do it on their own time instead of having to come over to talk and sit, do it on their own time with a pre- and post-test so it's more

convenient for them.

COUNCILWOMAN BROWN: And you discussed this new model of treating young people and families. And when you consider the mission of DHS, who is -- and when you factor in the Daneale Kelly case, 'cause that really changed life for everybody in a needed way, who's ultimately responsible, the service provider or DHS?

COMMISSIONER AMBROSE: DHS.

COUNCILWOMAN BROWN: Okay. Council Lady/Majority Leader Tasco has some additional questions.

Under Governor Corbett's budget, significant cuts have been proposed for the State education funding. If cuts are shifted from State education funding to the State human services funding, what areas at DHS are most likely to be impacted by those reductions?

COMMISSIONER AMBROSE: So we've been on a pretty aggressive lobbying

campaign to make sure that doesn't happen. We spent a couple of days up in Harrisburg a couple weeks of ago meeting with legislators.

But I think, unfortunately, what would be most vulnerable, if the legislator decides to make additional cuts, would be our prevention services. So the safety nets that we've really tried to build, that have definitely impacted our improved outcomes for kids would be at risk.

So the reason we've been able to reduce placements, I think, and increase permanencies is because we have prevention services available for families that are at risk in Philadelphia.

And I think by definition, almost every family in Philadelphia who lives in certain zip codes is at risk because of the poverty levels here, and the poverty levels that are here are much higher than any other county in the

Commonwealth.

And so, that's something that we really hope doesn't happen, and would appreciate any support from Council that we could get to maintain our current funding in prevention.

COUNCILWOMAN BROWN: So let's walk that. When you say "we," you're going to Harrisburg and actually meeting with State officials and elected officials there?

COMMISSIONER AMBROSE: Yes.

COUNCILWOMAN BROWN: I see.

COMMISSIONER AMBROSE: So we've met with the new Secretary for the Department of Public Welfare, we've met with several legislators, talking about the importance of prevention services, talking about the improved outcomes that we've been able to achieve.

COUNCILWOMAN BROWN: Okay.

COMMISSIONER AMBROSE: Talking about how Philadelphia is different, and that this is a really important service

to maintain in order to continue to provide better services to kids and families.

And, ultimately, it's more fiscally responsible because the high-end things that we don't have to do anymore are because we don't have the safety net for at-risk families.

COUNCILWOMAN BROWN: Mm-hmm, okay. On page 2, you discuss an initiative to create -- we've actually talked about that -- the single case management tool, have we not?

COMMISSIONER AMBROSE: Correct.

COUNCILWOMAN BROWN: Okay. And you've stipulated that this model will have a stronger emphasis on keeping children with providers in their home communities.

COMMISSIONER AMBROSE: That's right.

COUNCILWOMAN BROWN: What steps will be taken to ensure that all providers indeed have the ability to

sustain that level of service for the children?

COMMISSIONER AMBROSE: I'm not sure --

COUNCILWOMAN BROWN: I guess it boils down to accountability and/or monitoring of providers.

COMMISSIONER AMBROSE: So I think what we would do is actually work with other jurisdictions that have done this as created lead agency models, with one performance-based contract for that lead agency that would include certain requirements.

So easily, we could include the OEO requirement of 25 percent, and that lead agency would be responsible for maintaining that and reporting out on that level.

The lead agency would be able to provide the administrative support that's necessary to comply with the federal and state regulations that DHS has.

COUNCILWOMAN BROWN: Okay. With the increased pressure to reduce costs due to budget constraints, what is the cost-benefit analysis of outsourcing staffing; for example, nurses? Do you outsource nurses?

COMMISSIONER AMBROSE: Yes. So we have hired nurses at DHS since the Daneale Kelly case; that was one of the requirements of the Community Oversight Board.

COUNCILWOMAN BROWN: Okay.

COMMISSIONER AMBROSE: And we're continuing to do that based on Dr. Christian's assessments of the needs of the kids and families that we serve at DHS.

COUNCILWOMAN BROWN: Is that indeed more cost-effective?

COMMISSIONER AMBROSE: Based upon our initial analysis, it is more cost-effective.

COUNCILWOMAN BROWN: Wow. Okay. I want to make sure I've gotten

through all of my questions as well.

I'm going to take a page out of Councilman Goode's book and ask Angela Dowd-Burton to come back to the table, please.

(Ms. Dowd-Burton returns to witness table.)

MS. DOWD-BURTON: Good afternoon, Councilwoman.

COUNCILWOMAN BROWN: Thank you very, very much.

Simply state for me, define what is "best efforts." What does that mean?

MS. DOWD-BURTON: The individual that is responding to a request for a proposal or a bid will have to take certain actions to demonstrate that they have seriously looked for a minority- or a female-owned business that can support the effort of a particular contract.

COUNCILWOMAN BROWN: Mm-hmm.

MS. DOWD-BURTON: So, for

example, they would go into our registry and see if there are companies that have the commodity codes that support the contract that they're pursuing.

COUNCILWOMAN BROWN: Okay.

MS. DOWD-BURTON: They can also adver --

COUNCILMAN GOODE: (Inaudible, off-mic.)

COUNCIL PRESIDENT VERNA: Councilman Goode.

COUNCILMAN GOODE: Ms. Dowd-Burton, if that's the case in terms of implementing the contract in terms of the RFP, why would best efforts ever be used as a goal?

MS. DOWD-BURTON: When we have identified few or no companies in our registry. So the first place they would start is the new registry, if there are any.

If there are none there, they would altogether look at various industry associations to locate companies.

COUNCILMAN GOODE: That's the technical answer, but on any number of contracts with this department and a number of contracts in other departments, best efforts was used without actually looking at subcontract opportunities. That's been proven already.

So sometimes best faith efforts is just giving someone a pass.

MS. DOWD-BURTON: Well, the legislation that was passed last year strengthened the good and best-faith efforts that we include --

COUNCILMAN GOODE: That relates to the implementation of the contract; that does not relate to what you set as goals in the RFP.

In terms of setting goals in the RFP, OEO staff and departmental staff should be doing due diligence to actually see what opportunity actually exist.

MS. DOWD-BURTON: Mm-hmm.

COUNCILMAN GOODE: And so, sometimes best-faith efforts is put in as

a goal because no one actually looked to see whether opportunities existed or not, so that's just a simple truth.

MS. DOWD-BURTON: Well, Councilman, I take exception --

COUNCILMAN GOODE: You can --

MS. DOWD-BURTON: -- to that.

COUNCILMAN GOODE: You can, but I've proven it this year and last year that that's the case.

And in particular, the contract related to VisionQuest, best-faith efforts was put in the RFP, best-faith efforts was put into the contract. You've only achieved 0.5 percent, and you've said yourself that you don't know whether subcontract opportunities exist or not.

MS. DOWD-BURTON: Well, what I said was, the contract was put in place in 2008.

COUNCILMAN GOODE: I get that.

MS. DOWD-BURTON: And since that time, we've put additional actions

and requirements in place --

COUNCILMAN GOODE: Should best-faith efforts have been put in the RFP?

MS. DOWD-BURTON: It depends on the kinds of information that --

COUNCILMAN GOODE: That's really a yes or no question --

MS. DOWD-BURTON: Well --

COUNCILMAN GOODE: -- in terms of the actual VisionQuest contract. Should best-faith efforts have been put in the RFP and the contract, or were there more subcontract opportunities that should have been identified? And should a goal, some goal, even it's single digits, possibly double digits if someone actually did the work, but single digits, single digits has to --

MS. DOWD-BURTON: I --

COUNCILMAN GOODE: -- have been able to get achieved.

MS. DOWD-BURTON: Councilman, I would absolutely say at least single

digits given the time period for food, for clothing, for stationery supplies, for maintenance on facilities, yes, those are --

COUNCILMAN GOODE: Then it should have --

MS. DOWD-BURTON: -- all kinds of --

COUNCILMAN GOODE: Then it should have been best-faith efforts.

Thank you, Madam President.

MS. DOWD-BURTON: Councilwoman, your question?

COUNCILWOMAN BROWN: Wow. We thank my for --

MS. DOWD-BURTON: I thank you, Councilman.

COUNCILWOMAN BROWN: It's really important.

MS. DOWD-BURTON: Yes.

COUNCILWOMAN BROWN: You know, we're beginning to sound like a broken record.

MS. DOWD-BURTON: Mm-hmm.

COUNCILWOMAN BROWN: But we, of course, have to do better.

MS. DOWD-BURTON: Absolutely.

COUNCILWOMAN BROWN: And so with that, have you or your designee sat down with the Law Department to help them understand that best-faith efforts in RFPs based on the description as outlined by my colleague, quite frankly, is probably unacceptable, because if you look far enough -- if not in the City, in the region -- you might -- we might look up and find an MBE/WBE that could honor some of the particulars of that contract.

MS. DOWD-BURTON: Mm-hmm.

COUNCILWOMAN BROWN: That's number one.

Number two, have you worked with the Law Department to craft stronger, more explicit language? 'cause you were very explicit in the way you just described it here.

MS. DOWD-BURTON: Mm-hmm.

COUNCILWOMAN BROWN: But any

conversations with the Law Department towards that end?

MS. DOWD-BURTON: We work very closely with the Law Department on the language that goes into our requests for proposals, our bid language, into our economic opportunity plans, absolutely.

And the definition of "good and best-faith efforts" is not a pass. It is a clear demonstration that companies have taken deliberate steps to pursue the identification.

Now, some companies -- and I'll say this really clearly -- in for example, the Procurement organization, where we have that list of few and no companies --

COUNCILWOMAN BROWN: Okay, I got that.

MS. DOWD-BURTON: And the fact of the matter is, we rely on a lot of companies to look across a broader region and across their industry to identify minority- and female-owned businesses

that can support a contract, and that there have been more subcontracts this year than ever before in certain areas that we've never seen subcontracting before, because companies are competing to ensure that they get participation on their contracts in order to achieve the goal and to win the bid or the request for proposal.

COUNCILMAN GOODE: Point of information.

COUNCILWOMAN BROWN: Councilman Goode?

COUNCIL PRESIDENT VERNA: The Chair recognizes Councilman Goode.

COUNCILMAN GOODE: The staff people that are assigned to the OEO staff, people that are assigned to the Health Department, DHS, and other related departments --

MS. DOWD-BURTON: Yes.

COUNCILMAN GOODE: -- have they ever put goals in RFPs? Or have they always generally put best-faith efforts.

MS. DOWD-BURTON: Oh, they've put goals in, absolutely.

COUNCILMAN GOODE: Can you prove it?

MS. DOWD-BURTON: Yes.

COUNCILMAN GOODE: Okay. Give me goals for -- just name any contract under Health in the past, under Health and Human Services.

MS. DOWD-BURTON: Um...

COUNCILMAN GOODE: All right. Give me the most aggressive goal that you know of.

MS. DOWD-BURTON: I don't have my --

COUNCILMAN GOODE: Okay. The truth of the matter is that MBEC always gave those departments a pass in terms of setting goals in RFPs. It was hands-off.

MS. DOWD-BURTON: Councilman, I'll be happy to provide you with additional information; I don't have it with me.

COUNCILMAN GOODE: Okay, thank

you.

COUNCIL PRESIDENT VERNA: Anything else, Councilwoman Brown?

COUNCILWOMAN BROWN: So will there be new language regarding minority contracts with regard to best-faith efforts so that will continue to be the phrase that's used?

MS. DOWD-BURTON: We will use "good and benefit faith efforts" in instances where we cannot definitively identify a goal.

As an example, companies now -- you know, if we have no goals, it's zero. Good and best-faith efforts gives us an opportunity to look at those opportunities that companies come to us with, where they've identified companies that can support their contract as participants.

COUNCILWOMAN BROWN: Okay. Let me ask you the follow-up question, 'cause we've known this to be true.

Where companies do that, and

unless we, on our side of the table, do the look-see, the investigation to ensure that they are who they purport to be, then we end up getting surprised on the back end to discover that they're not MBE and WBEs.

MS. DOWD-BURTON: And I'll share with you, when companies are put on the solicitation and commitment forms -- and these are the forms that we actually use -- where the minority or female actually is identified, or the disabled-owned business, the percentage of the contract is placed on that form along with the commercially acceptable function that that company, that minority- or female-owned business, is expected to provide.

So there's detail there that ultimately goes into the contract when that contract is awarded. The companies that are identified on that solicitation and commitment form go into the prime's contract.

4.20.11 COMM. OF THE WHOLE - BILL 110137

COUNCILWOMAN BROWN: Okay.

MS. DOWD-BURTON: And we hold them accountable.

We also contact the subcontract -- the companies that are on that solicitation and commitment form prior to award to confirm that they, yes, were called, they did agree they were going to provide that kind of product or service.

COUNCILWOMAN BROWN: Okay.

MS. DOWD-BURTON: And this is the price that they committed to.

COUNCILWOMAN BROWN: Okay.

MS. DOWD-BURTON: So that confirmation is done prior to award.

COUNCILWOMAN BROWN: Okay. So that's an improvement from years past.

Commissioner?

MS. DOWD-BURTON: Okay. So the Commissioner has just identified a few of the contracts from Fiscal Year 2011 where we've identified the goals for minority- and women-owned businesses.

COUNCILMAN GOODE: That wasn't

my question. My question was related to MBEC, my question was related to pre-OEO and what the practice was before.

And, therefore, unless you've hired new staff, they're not used to setting goals, they're not used to going through contracts, they're not used to actually looking at contracts that are renewable contracts and say, "Let's go back and set goals now."

That's the problem.

MS. DOWD-BURTON: Okay. So we -- I hear that you're talking about the previous contracts that are in place and whether or not we've ever taken a renewable contract and put goals in it. That is a focus that is emerging for us; we're absolutely going to do that.

The contracts that we are, in fact, placing requests for proposals in the marketplace and bids that are going into the marketplace have more ranges on them and goals than we've ever had before so --

4.20.11 COMM. OF THE WHOLE - BILL 110137

COUNCILMAN GOODE: Since last year.

MS. DOWD-BURTON: -- we hear you. Yes, absolutely, yes.

COUNCILWOMAN BROWN: So there continues to be a lot of discussion and conversation about the business of running DHS as well as the programmatic piece of DHS. Both matter equally.

MS. BURTON: Yes.

COUNCILWOMAN BROWN: My last question is a rewind back in time. Now with the benefit of hindsight and the Daneale Kelly case again, did we lose anything by no longer having SCOH services, which is, you know, a place where I come from, and the value they help to service their children.

COMMISSIONER AMBROSE: So we -- in my opinion, I don't believe that we lost anything, and let me tell you why.

We still have services for children in their own homes. So, remember, SCOH was services to children

in their own homes.

We now have a continuum of services for children in their own homes that depends on the risk level of that family.

COUNCILWOMAN BROWN: Okay.

COMMISSIONER AMBROSE: So when we do a safety assessment, if there's a safety risk to that child, we implement in-home protective services, which is the highest level of service that we can provide in-home.

COUNCILWOMAN BROWN: Okay.

COMMISSIONER AMBROSE: And that service is supposed to mitigate that safety threat.

And for families that don't present with intensive need, we try to divert them out of the formal child welfare system because, usually, the families that come to us where there aren't safety issues poverty-related.

And families don't deserve to be in the formal child welfare system

'cause they're poor; they deserve to get services that help them keep their children and families together in the community.

And so, I believe what we've tried to create here is better than SCOH, because SCOH was one-size-fits-all, and it labeled too many families as being part of the abuse and neglect crowd; when, in fact, they actually just need some supportive services in the community.

COUNCILWOMAN BROWN: I see. Okay, well, thank you for that explanation.

So in closing, I want to restate how Councilwoman Jannie Blackwell and Member Jim Kenney and I are interested in this truancy question and want to be a part of that conversation after the election.

And on the staffing piece, there are X-number of -- you said 140 vacancies?

COMMISSIONER AMBROSE: Yeah. And not all of those are social-work positions.

COUNCILWOMAN BROWN: Okay, all right.

COMMISSIONER AMBROSE: Some of them -- we are a large agency, so we're always going to have some vacancies. Some of those vacancies haven't been filled because we don't believe there's a need to.

COUNCILWOMAN BROWN: Okay.

COMMISSIONER AMBROSE: Others are in various stages of the process to get positions filled, particularly in the area of Finance and Revenue Enhancement activities.

COUNCILWOMAN BROWN: All right, okay.

COMMISSIONER AMBROSE: We're in the process of filling a number of those vacancies. And there are also some vacancies in the Juvenile Justice section for Youth Study Center staff.

COUNCILWOMAN BROWN: Okay. And so, given whatever that number is, when do you anticipate the next class of professionals to help move and fill those vacancies?

COMMISSIONER AMBROSE: We haven't planned a new class for social work service managers yet. We have students, C well students and C web students, coming onboard that we'll be hiring.

And then after we do some of the readjustments that we've sat down and discussed with our union leadership, we'll determine whether we need to hire a new class.

COUNCILWOMAN BROWN: Okay. All right, then.

Well, I do want to -- given where we were last year on the program side, to commend you for -- because it is an enormously big undertaking to save so many children. So know that I appreciate all of the work that you and your team of

professionals do.

COMMISSIONER AMBROSE: Thank you.

COUNCILWOMAN BROWN: Thank you, Madam Chair.

COUNCIL PRESIDENT VERNA: You're welcome.

Councilman Goode.

COUNCILMAN GOODE: Thank you, Madam President.

Commissioner who handles RFPs and contracts for your department?

COMMISSIONER AMBROSE: Joe Kronhour (sp?) is actually the Assistant Commissioner who handles contracts. And since last year, we've assigned Yvonne Farrell as our point person on all OEO issues.

COUNCILMAN GOODE: And how long have they worked in those capacities?

COMMISSIONER AMBROSE: Joe has worked in that capacity since I've been the Commissioner.

And Yvonne has worked in that

capacity since last year; however, she has extensive experience in working with contracts at the Department of Human Services. And so, we thought she was a good fit for the jobs since she knows the providers. And she's the one who meets with Angela and her staff on a consistent basis.

COUNCILMAN GOODE: So her history of -- her contract history with DHS goes back how far?

COMMISSIONER AMBROSE: Hold on one second.

Twenty years.

COUNCILMAN GOODE: Is she available to come to the table?

COMMISSIONER AMBROSE: Sure.

(Yvonne Farrell comes forward.)

MS. FARRELL: Good afternoon.

COUNCILMAN GOODE: Good afternoon. Simple question. What percentage of contractors start --

COUNCIL PRESIDENT VERNA: I'm sorry, Councilman.

Please identify yourself for the record.

MR. FARRELL: Yvonne Farrell, Department of Human Resources.

COUNCILMAN GOODE: Simple question. Historically, what percentages of contracts under DHS have had good-faith effort historically?

MS. FARRELL: I looked at the RFPs only back into FY '10.

COUNCILMAN GOODE: That doesn't work for me.

MS. FARRELL: Then I have to come back.

COUNCILMAN GOODE: Okay. Thank you, Madam President.

COUNCIL PRESIDENT VERNA: Are there any other questions?

(No response.)

COUNCIL PRESIDENT VERNA: Are there any other questions from members of the committee?

(No further questions.)

COUNCIL PRESIDENT VERNA: Thank

you very much.

COMMISSIONER AMBROSE: Thank you.

COUNCIL PRESIDENT VERNA: Thank you, Commissioner.

MR. McPHERSON: Our next department is the Office of Supportive Housing.

COUNCIL PRESIDENT VERNA: (Pounds gavel.) We're still trying to conduct business. Please leave quietly.

Good afternoon.

MS. MINTZ: Good afternoon.

COUNCIL PRESIDENT VERNA: Kindly identify yourself for the record.

MS. MINTZ: My name is Dainette Mintz. I'm the Director of the Office of Supportive Housing.

COUNCIL PRESIDENT VERNA: Please proceed.

MS. MINTZ: Good afternoon, President Verna and distinguished members of City Council. My name is Dainette Mintz, and I am the Director of Office of

4.20.11 COMM. OF THE WHOLE - BILL 110137

Supportive Housing.

The mission of OSH is to assist homeless individuals and families in moving towards self-sufficiency and the operation of Riverview Home, providing housing to low-income elderly and persons with disabilities. We plan and coordinate Philadelphia's response to homelessness.

I am pleased to offer this testimony outlining the OSH Budget request for Fiscal Year 2012, which totals $93,962,391.

The Fiscal Year 2012 Budget includes an allocation of $36,466,253 in General Fund, 39 percent; and $57,496,138 in Grants Funds, 61 percent.

A breakdown by class is as follows:

Class 100: $8,498,376.

Class 200, $84,093,773.

Class 300: $1,201,871.

Class 400: $135,950.

Class 500: $32,421.

4.20.11 COMM. OF THE WHOLE - BILL 110137

The Fiscal Year '12 OSH Budget supports a total of 167 positions. OSH has 118 General Fund positions, of which 56 are Riverview Home's staff and 62 are OSH homeless-specific.

There are 49 state and federal grant-funded positions. Fourteen employees, or 8.5 percent, are bilingual or trilingual, with fluency in languages Spanish, French, Yoruba, Igbo, Chinese, Mandarin, and to Malayalam. To replace a bilingual service representative, OHS sought a selective factor certification for Spanish-speaking candidates and filled the position.

For a health-care aide vacancy, we requested a general and a bilingual list, and a test was given in September 2010.

A summary of the OSH Fiscal '11. After the submission and adoption of our Fiscal Year '11 budget OHS's state grant funds were reduced by a million dollars. The impact of this reduction in

the first quarter of Fiscal Year '11 included the loss of 80 units of capacity for families in both emergency and transitional housing. Its immediate impact was the reduced availability of vacancies to address last fall's and winter's very high homeless-family demand for emergency housing.

We were able to overcome this crisis by utilizing existing housing opportunities through the City and Philadelphia Housing Authority Homeless Partnership and the Rapid Rehousing Rental Assistance Component of the federal Homelessness Prevention and Rapid Rehousing Grant.

To minimize the loss of 48 beds at Riverview Home, the City's personal care home, OSH worked with the State Department of Public Welfare to offer all residents alternative housing options.

OHS also eliminated 70 slots in a year-round overnight café, which provided a safe overnight place for the

chronically-homeless street population. While this reduction increased the fall and winter street counts of homeless individuals, the City continues to utilize PMA vouchers and the Pathways to Housing Program to provide housing options to this vulnerable population.

OHS's largest accomplishment thus far this year is the continued provision of housing opportunities and assistance to 3,200 households to address and prevent homelessness.

We are making continued progress towards the goals set in Philadelphia's ten-year plan to end homelessness, 2005 through 2015, specifically to close the front door into homelessness prevention assistance and open the back door out of homelessness through the creation and provision of permanent housing opportunities.

Over the past two years, I am pleased to report that the City has assisted 3,200 households from October

2009 to the end of March to avoid or end homelessness through the Recovery Act-funded Homeless Prevention and Rapid Rehousing Program, which provides rental assistance and housing-focused services to prevent and end homelessness.

Nine hundred of the households were homeless and used the assistance to move out of emergency or transitional housing and into scattered-site housing in the community through the Rapid Rehousing Component.

A total of 2,300 of the households received financial assistance to help them stay in their homes through the prevention component. By the end of this program next fall, we anticipate that more than 4,700 households will have benefited from HPRP assistance.

During a recent HUD monitoring review, OSH was lauded for three administrative operational processes that HUD deemed best-practice models nationally.

We increased the inventory of permanent supportive housing for homeless people by 50 percent, to a total of more than 6,000 beds, through the creation of new housing programs in the community. This was a combination of leased units or new construction rehabilitation and the City's partnership with the Philadelphia Housing Authority, PHA.

With PHA assistance, more than 1,000 family members moved from emergency housing, shelter, and transitional housing to permanent PHA housing through the Blueprint Housing Partnership since Fiscal Year '09.

In 2008, Philadelphia extended a invitation to Pathways to Housing to join our existing housing-first partners, Horizon House and 1260 Housing Development Corporation, in our efforts to end street homelessness. Pathways is the innovator of the housing-first approach, which provides housing for men and women with long histories of street

homelessness, and provides Assertive Community Treatment (ACT) team services to help individuals remain housed.

Pathways to Housing Philadelphia is currently serving 135 men and women with serious mental illness and/or addiction. Pathways has a 92 percent retention rate for program participants who are housed, and has exceeded other predicted outcome measures for health, wellness, and meaningful daytime activity.

The OSH Fiscal Year '12 Budget summary. We proposed a budget that reflects level funding for Fiscal Year '11 in the General Fund.

The proposed budget supports 120 annual OSH contracts, providing 5,600 emergency transitional and permanent supportive housing beds for homeless men, women, and children in Philadelphia.

At the beginning of Fiscal Year '11, we had 5,900 beds. However, by the end of Fiscal Year '12, we project we

will have 5,600 beds due to the State grant reductions, a net reduction of 300 beds.

The outlook for Fiscal Year '12 is extremely challenging. The Governor's current budget proposal to eliminate the Human Services Development Fund, HSDF, may reduce OHS's operating budget by another $2.4 million.

Currently, HSDF funding provides funding for 41 OSH positions and $300,000 for a citywide program delivering home care services to disabled individuals in their homes.

City staff includes City workers at both of the City's centralized emergency housing intake sites; social workers in the citywide Emergency Relocation Unit, which assists individuals who are homeless due to fire, building condemnations, et cetera; and social workers in the emergency housing monitoring unit.

If the HSDF Program is

eliminated, OSH will seek to preserve 17 of the 41 HSDF positions with general funds instead by shifting costs from our Class 200 to Class 200 budget. This would result in the layoff of 24 staff positions and reduce operating hours at both family and single-adult emergency shelter intake sites and increase wait time for placement in emergency housing.

We serve more than 13,000 unduplicated individuals annually.

The loss of the State Grant Funds would reduce availability of social workers, and emergency relocation efforts would eliminate protective services for abused and neglected individuals, 70 monthly. It would eliminate homemaker services to disabled individuals, and would result in a reduction in emergency housing monitoring staff.

In addition, the Homeless Assistance Program, HAP, which supports nearly every emergency and transitional housing program through the provision of

operating and/or family case-management funding, is also slated for reduction through the State budget, although we are unaware of the amount at this time.

The outlook for Community Services Block Grant, CSBG, Funds for Fiscal Year 2012 is also very poor. Multiple federal budget proposals include the elimination of the program, which would result in an additional $500,000 Fiscal Year '12 OSH Budget reduction. OSH uses CSBG funds to support case-management costs in emergency housing.

Also in Fiscal Year '12, OSH will be phasing out the City's largest emergency housing site for single men at 1360 Ridge Avenue, which has the capacity to serve up to 340 men. The building is outdated, and the program size exceeds national best-practice standards.

Although we are currently seeking alternatives for relocation, it is unlikely that we will be able to fully replace all of the beds, given the budget

limitations and the difficulty of finding properties in communities where we can relocate the program.

We are currently seeking two facilities with the capacity to serve 75 to 150 men each within the existing Ridge budget.

In addition, the three-year $23 million Homeless Prevention and Rapid Rehousing Program, funded through the American Recovery and Reinvestment Act, will end in the first quarter of Fiscal Year 13. Additional federal funds for this activity will be much more limited.

In Fiscal Year '12, we're hopeful that an announcement of the 2010 HUD McKinney Award will provide funding for 95 new units of housing, including an expansion of the Pathways to Housing Program for the chronically homeless living on the streets of Philadelphia.

During Fiscal Year '12, OHS is continuing the provision of trauma-informed training system-wide for a

contracted staff in emergency and transitional housing programs to strengthen their ability to respond to the needs of women and children in crisis.

We will also continue to support contracted housing and service providers in their efforts to identify developmental delays in homeless children and ensure that they are connected to services to reduce those delays.

Our minority business participation rate. Historically, the expertise of providing homeless housing and supportive services lies in the nonprofit provider community. Seventy-two percent of these contracts are with organizations that provide housing to homeless individuals, and the remaining 28 percent of the contracts are awarded to agencies to provide supportive services. That includes case management, food services, and employment training.

Funding for 95 percent of the

agencies contract dollars goes to nonprofit providers. OSH has a total of 120 contracts with 59 distinct entities; 5 are for-profit organizations, and 54 are nonprofits.

In partnership with the Office of Economic Opportunity, OSH surveyed all 54 of our nonprofit contractors to determine the diversity levels their boards and workforce.

OSH also partners with OEO to survey the top 100 nonprofit contractors of the Health & Opportunity cluster, and OSH is the lead agency for nine of those top 100 nonprofit contractors. All nine of these nonprofits have diversity in their workforce, either through race or gender.

Eight of the nonprofits have a workforce that is 50 to 90 percent African-American, and one has a workforce that is 52 percent female.

In Fiscal Year '11, the OSH for-profit minority-, women-, and

disabled-owned business participation going is 31.2 percent. OSH anticipated contracting with eight for-profit entities; however, we only contracted with five.

As of the second quarter of Fiscal Year '11, OSH has achieved a total of 31.4 percent participation.

For Fiscal Year '12, the OEO minority, women, and disabled for-profit goal for OSH is 25 percent. This goal is based on the fewer for-profit contracts realized in Fiscal Year '11.

Additionally, OHC will require all entities, nonprofit and for-profit, to establish a written supplier diversity program that describes their efforts to increase minority, women, and disabled participation and submits expenditure reports that detail dollars spent with those businesses.

In addition, for nonprofit entities, OSH will establish a goal of 5 percent participation for purchased

services.

Overall, OSH remains committed to its mission of addressing the housing needs of Philadelphia's homeless population.

I appreciate the opportunity to testify before you today, and I would be happy to answer any questions you may have.

Thank you.

COUNCIL PRESIDENT VERNA: Thank you.

The Chair recognizes Councilman Blackwell.

COUNCILWOMAN BLACKWELL: Thank you.

Thank you, Ms. Mintz's staff. We appreciate all that you do.

Your testimony does, in fact, frighten me, and I hope that the Administration is listening and will realize that in 2011 and '12, we do not need to go backward and have more people on the streets of our city.

4.20.11 COMM. OF THE WHOLE - BILL 110137

(Applause.)

COUNCILWOMAN BLACKWELL: It took us a while around this city to try to have homeless people not in front of every Wawa and every shop you'd stop at if you wanted to get a cup of coffee. And we are really, really frightened with that. We're frightened about the closing of Ridge shelter.

(Applause.)

COUNCILWOMAN BLACKWELL: And we are hopeful that the Administration will hear how important it is that we do not have homeless people on the streets.

I have only one specific question, and that is: Someone asked me to ask you before they left about Ridge Avenue and -- no, about our senior shelter, not Ridge. You know what I'm trying --

MS. MINTZ: Riverview?

COUNCILWOMAN BLACKWELL: Riverview. And their concern was that it was closed, and people were let go, labor

people, union people, and that it opened up without union people.

Could you talk a little bit about that for the record?

MS. MINTZ: Sure. At the beginning of Fiscal Year '11, when we realized the State reductions, we looked at where we could provide and absorb the impact.

And one of the things that we did was to reduce the census at Riverview. We decided to close one of the cottages. And in my testimony, I made reference to the fact we partnered with DPW to relocate.

So one cottage has capacity reduce the capacity by 48 persons, so we were attempting to reduce the capacity by 48 individuals, single men. And we worked with them to make those reductions concurrent with the reduction of the census and the closing of that cottage. We no longer needed to have the same number of health care aids because we had

a reduced census. So we also laid off four health-care aides at Riverview.

And the ability for us to move forward was that we also had utilized a empty cottage to provide some overflow housing for homeless families, and we also eliminated that and relocated those families with -- using our Homeless Prevention Rapid Rehousing component.

I believe that what folks may be concerned about is that when we eliminated using that cottage for families, we no longer needed to have the Riverview staff providing continued services. And so, that eliminated some overtime, et cetera.

But we did not hire non-City staff because we no longer had the activities occurring there.

COUNCILWOMAN BLACKWELL: So that's --

MS. MINTZ: But the facility is still opening and still operating. It currently has a census of about 99

people, and that's one male and one female cottage.

COUNCILWOMAN BLACKWELL: About how many, did you say?

MS. MINTZ: About 99 are -- we want the census to be no more than a hundred, and I think we have one vacancy.

COUNCILWOMAN BLACKWELL: Okay. So the closing of one facility --

MS. MINTZ: It was closing one cottage. There's a number of cottages on the campus.

COUNCILWOMAN BLACKWELL: Yes.

MS. MINTZ: And we just closed one cottage that was housing disabled and elderly residents. And then we also stopped using one other cottage that we were using for extra space for homeless families.

COUNCILWOMAN BLACKWELL: Okay. Thank you. That will answer his question.

And I would love to hear from the Administration. I saw our...

4.20.11 COMM. OF THE WHOLE - BILL 110137

(Ms. Rhynhart comes forward.

MS. RHYNHART: Good afternoon. Rebecca Rhynhart, Budget Director.

Councilwoman Blackwell, to your point, the Administration definitely understands the gravity of the cuts that the State -- that the Governor's proposed budget is making to homeless services, and that's something that we are working on right now.

So we agree with you that this is a deep concern, so we're working on the possibility of what to do here.

COUNCILWOMAN BLACKWELL: Well, I hope we have some specific plans. We knew that this year would come from the blueprint that Carl Greene helped negotiate with the City, and that was a big, big, big help. So we are grateful for that and to him for that.

But we knew this year would come, irrespective of the change in administrations and that we would need -- that we would need this help also with

this plan to cut -- certainly to get rid of Ridge Shelter; that's no news, either, which is another tragedy for 340 men, when we don't have anything.

I know it's more popular to do smaller shelters. But the issue is, you know, that people don't disappear. And we have to have safe, clean, well-cared-for people and facilities that offer the best possible kind of care.

And we really are concerned about what happens, and we're asking you to ask the Administration to come up with plans as to what's going to happen.

I mean, we have our night programs. And often, they don't last in the summer. And in the summer, we realize that more people, more homeless people, prefer to be outside than inside.

But it still doesn't lend for the best situation in our city because all of the people who come here, who visit here, complain, and then the Administration has the other problem.

So it behooves us all. We have to do what we can to have specific problems to deal with the population that we know exists.

Madam President, I say it every year. We know who our homeless are, we know where they are. We know everything about them. We have their case history.

We're not someplace big that accepts them like New York. In New York, they accept 'em. They have job training, they have places just for vets, you know, a place as big as the Convention Center just for vets.

We have a couple years where we pay for their lodging and job training at the same time because they accept that there are people who, through fire, through domestic problems, through all kinds of reasons, who have issues with where they stay.

And I think that our city has not yet arrived to the point where we accept this as part of life and

something -- all of those who deal with it, you know, certainly, Ms. Mintz and all of her crew realize, this but our city has to accept the fact that this is an issue that we will have to deal with and plan for these eventualities and plan when we know problems may occur.

So what I'm asking is that you would send to the Chair a plan as to what we will do, given cuts, if they are cut, and what -- and given the cuts that are mentioned here about what this department is supposed to do with homeless people on the streets of Philadelphia.

(Applause.)

COUNCILWOMAN BLACKWELL: We are very committed to this issue. The late Lucien Blackwell started homelessness as an agency being funded during the beginning of the Rizzo years. And we still believe that in a city as great as ours, we should not have people who still have to sleep in subways or on the streets, on benches and parks. It

shouldn't be that way.

(Applause.)

COUNCILWOMAN BLACKWELL: And I continue to hope that one of these days, while I am still here, that we will see a plan for everybody such that the only people in the streets would be a person who's had a fire that day or evicted that day or had a problem at home that day because we have a plan for everybody else we see out there.

(Applause.)

COUNCILWOMAN BLACKWELL: So we are prevailing to you to have a plan submitted to the President of Council that will address all of these issues so that we know what the plans are.

There always should be some areas that are exempt from cuts; homelessness should be one. My goodness, people have to eat, people have to have someplace to stay. This is one of those areas that we believe should be exempt.

Since it is not, then the

second-best thing is that we have a plan to address all cuts. And, again, we request that that be submitted to the President.

MS. RHYNHART: Sure. We are working on that as we speak, so we'd be happy to, when we're completed with that, submit that to the Chair.

COUNCILWOMAN BLACKWELL: Thank you.

Thank you, Madam President.

COUNCIL PRESIDENT VERNA: You're welcome.

Since there is no one else to -- I don't think anyone else here has any questions beside you and me.

So thank you. We appreciate your testimony. Thank you.

MS. MINTZ: It's been a pleasure working with you. I wish you all the best in your retirement.

COUNCIL PRESIDENT VERNA: Thank you. Thank you so much.

This committee will stand in

4.20.11 COMM. OF THE WHOLE - BILL 110137

recess until Tuesday, April the 26th, at 10 o'clock.

(Proceedings end at 4:18 p.m.)

* * *

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 Wednesday, April 20, 2011, and that this is a true and correct statement of same.

_____

JOSEPHINE CARDILLO
Registered Professional Reporter

(The foregoing certification of this transcript does not apply to any reproduction of the same by any means, unless under the direct control and/or supervision of the certifying reporter.)