

Committee of the Whole
April 29, 2015

COUNCIL OF THE CITY OF PHILADELPHIA
COMMITTEE OF THE WHOLE

Room 400, City Hall
Philadelphia, Pennsylvania
Wednesday, April 29, 2015
10:23 a.m.

PRESENT:

COUNCIL PRESIDENT DARRELL L. CLARKE
COUNCILMAN CURTIS JONES, JR.
COUNCILWOMAN JANNIE L. BLACKWELL
COUNCILWOMAN BLONDELL REYNOLDS BROWN
COUNCILMAN W. WILSON GOODE, JR.
COUNCILMAN WILLIAM K. GREENLEE
COUNCILMAN ED NEILSON
COUNCILMAN DENNIS O'BRIEN
COUNCILMAN BRIAN J. O'NEILL
COUNCILMAN DAVID OH
COUNCILWOMAN MARIA D. QUINONES-SANCHEZ
COUNCILWOMAN MARIAN B. TASCO

BILLS: 150162, 150163, 150164
RESOLUTIONS: 150179

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2 (Councilman Jones sitting as Chair.)

3 COUNCILMAN JONES: Good morning,
4 everyone. This is a Public Hearing of the
5 Committee of the Whole regarding Bills No.
6 150162, 150163, 150164 and Resolution No.
7 150179.

8 Ms. Lewis, would you please read the
9 titles of the bills and resolutions.

10 MS. LEWIS: Bill No. 150162: An
11 Ordinance to adopt a Capital Program for the
12 six Fiscal Years 2016-2021 inclusive.

13 Bill No. 150163: An Ordinance to adopt
14 a Fiscal 2016 Capital Budget.

15 Bill No. 150164: An Ordinance adopting
16 the Operating Budget for Fiscal Year 2016.

17 And Resolution No. 150179: Providing
18 for the approval by the Council of the City
19 of Philadelphia of a Revised Five Year
20 Financial Plan for the City of Philadelphia
21 covering Fiscal Years 2016 through 2020, and
22 incorporating proposed changes with respect
23 to Fiscal Year 2015, which is to be
24 submitted by the Mayor to the Pennsylvania

1 Intergovernmental Cooperation Authority (the
2 "Authority") pursuant to the
3 Intergovernmental Cooperation Agreement,
4 authorized by an ordinance of this Council
5 approved by the Mayor on January 3, 1992
6 (Bill No. 1563-A), by and between the City
7 and the Authority.

8 COUNCILMAN JONES: Thank you very much.
9 Today we'll be hearing testimony from the
10 following departments: The Department of
11 Behavioral Health, the Health Department,
12 the Department of Human Services and
13 Supportive Housing.

14 Will the first group to testify for the
15 Administration please come forward to the
16 table.

17 (Witnesses approaches witness table.)

18 COUNCILMAN JONES: Dr. Evans, welcome
19 back. Thank you very much. And if you will
20 pull the mic a little closer to you, and
21 when you begin testimony, please state your
22 name.

23 DR. EVANS: Okay. Good morning,
24 Councilman Jones and Members of Council. My

1 name is Dr. Arthur C. Evans. I'm the
2 Commissioner for the Philadelphia Department
3 of Behavioral Health and Intellectual
4 Disability Services. And I'm here to
5 present testimony on our FY2016 operating
6 budget. Joining me today is Deputy
7 Commissioner David Jones as well as many
8 senior staff who are in the audience.

9 The FY16 DBHIDS Operating Budget request
10 totals \$1.2 billion: 13.9 million in the
11 General Fund, 254.8 million in the Grants
12 Revenue Fund and 961.6 million in the Health
13 Choices Behavioral Health Revenue Fund.
14 DBHIDS -- the DBHIDS FY16 budget will
15 support 259 positions, 16 in the General
16 Fund and 243 in the Grants Revenue Fund. Of
17 the \$1.2 billion, 61 million or 5 percent is
18 for intellectual disability and early
19 intervention services, an 1.1 million or
20 95 percent is for behavioral health
21 services.

22 Class 100 totals \$24 million. Class 200
23 totals \$1.2 billion. Class 300 totals
24 \$221,000. Class 400 totals 185.9 million --

1 \$185,940. And Class 800 totals
2 \$1.6 million.

3 The department is not requesting City
4 funds beyond those already allocated to
5 support current operations for FY16.
6 99 percent of the Department of Behavioral
7 Health Intellectual Disability Services
8 funding comes from state and federal
9 government, including over 960 million from
10 the state to provide managed behavioral
11 healthcare for 120,000 City residents
12 receiving medical assistance benefits
13 annually.

14 In late March of this year, Drexel
15 University Lindy Institute for Urban
16 Innovation released a report entitled, "The
17 Economic Impact on Behavioral Health and
18 Intellectual Disabilities," spending on the
19 City of Philadelphia. For the 1 percent of
20 funding that comes from the general fund,
21 the report found that the impact of spending
22 by the department on the Philadelphia
23 economy is nearly \$4 billion including
24 25,400 jobs. In terms of annual tax

1 revenues to the City, DBHIDS is responsible
2 for generating \$36.1 million. For every
3 dollar DBHIDS spends, the report continues
4 results in \$2.50 in additional economic
5 activity.

6 The Department Minority Women and
7 Disabled participation target was 8 percent.
8 And the Department achieved 10 percent.
9 Participation by minority and minority and
10 women in both leadership positions and
11 workforce composition among DBHIDS nonprofit
12 contract service providers remains high.
13 Specifically, 91 percent of the total
14 workforce and 72 percent of the executive
15 staff of nonprofit contract agencies are
16 comprised of minority or female employees.
17 The number of contract providers with formal
18 plans to promote supplier diversity has
19 increased from 50 percent in FY13 to
20 65 percent in FY14. And I should note that
21 this initiative has been highlighted by
22 OEA -- OEO as a model practice.

23 In terms of living wage, this department
24 contracts with over 70 agencies to provide a

1 range of behavioral health services for
2 children and adults across the City. I'm
3 pleased to report that while originally 15
4 contractors submitted requests for wage
5 and/or benefit waivers pertaining to the new
6 standards, in dialogue with them, with
7 myself and Deputy Commissioner David Jones,
8 12 of the 15 contractors subsequently
9 achieved compliance and withdraw their
10 waiver petitions. Ultimately, only three
11 contractors pursued and were granted waivers
12 which were based on either collective
13 bargaining or training considerations.

14 The department will continue to
15 encourage and promote universal compliance
16 with the new standards across the contract
17 service network. Over the past ten years,
18 the department has partnered with a broad
19 range of stakeholders to transform how the
20 City approaches behavioral health and
21 intellectual disability issues. Behavioral
22 health and intellectual disability services
23 have traditionally focused on symptom
24 stability and crisis response. DBH has

1 replaced these priorities with services and
2 expectations promoting genuine recovery from
3 behavioral health and addiction challenges,
4 strengthening the resiliency of children and
5 offering individuals with intellectual
6 disabilities opportunities to exercise
7 choice and self determination.

8 Accomplishments achieved during this
9 transformation decade have garnered local,
10 national and international attention due to
11 the fact that our approach is working.

12 Local innovations have attracted visitors
13 from across the United States and around the
14 world who seek to replicate Philadelphia's
15 model.

16 The department's achievements have been
17 recognized by major news outlets including
18 the New York Times, the National Public
19 Radio, the Wall Street Journal, Essence
20 Magazine and even youth oriented media
21 outlets like Matchbook.com. Numerous
22 behavioral health journals and professional
23 organizations have cited the department's
24 progressive forward-thinking approaches

1 frequently referenced as the Philadelphia
2 Model. And recently, I was invited to join
3 the launch of a national awareness campaign
4 that featured First Lady Michelle Obama
5 because of Philadelphia's reputation as an
6 innovator and national leader in this area.

7 The department's emphasis on advancing a
8 public health approach which includes
9 population health promotion, community
10 wellness and a focus on social determinence
11 of health has been a cornerstone of our
12 transformation. We continue to do a variety
13 of topics -- a variety of activities that
14 promote education and promote early
15 intervention for people experiencing mental
16 health challenges.

17 The department also remains committed to
18 our belief that Philadelphia residents who
19 depend upon our services should be afforded
20 ample access to state of the art behavioral
21 health interventions. Based on this
22 commitment, we continue to expand the
23 availability of evidenced-based treatment
24 approaches. To enhance the impact of these

1 approaches, the department has partnered
2 with multiple internationally acclaimed
3 originators of evidence-based practices.

4 The department is also continuing it's
5 Pay For Performance Program. This program
6 provides financial incentives for top
7 performing providers in our Medicaid Managed
8 Care Program, which is administered by CBH.
9 This program significantly improves -- has
10 significantly improved provider performance
11 in a number of areas resulting in better
12 outcomes for people receiving services and
13 significant savings to the department
14 because of increase efficiencies such as
15 reduced avoidable readmissions to inpatient
16 settings.

17 In conclusion, we appreciate the
18 support continuing -- we appreciate the
19 continuing support of Councilmembers in the
20 ongoing effort to highlight public health
21 issues and to secure the resources required
22 to meet the growing demand for behavioral
23 health and intellectual disability services.
24 My staff and I would welcome the opportunity

1 to meet with Councilmembers at your
2 convenience to engage in further discussion
3 regarding these issues.

4 I would also like to extend a personal
5 invitation to you and your staff to
6 participate in mental health first aid
7 training. Our City has emerged as a
8 national leader for raising awareness to
9 fighting stigma to foster safe and
10 supportive community. The Mental Health
11 First Aid Program has exceeded expectations
12 due to the wide interest from the public and
13 private organizations including First
14 Responders like the Police Department, the
15 Fire Department, the School District, faith
16 organizations and individuals across a broad
17 section of our community. And this year we
18 are on track to sup -- surpass 10,000 people
19 trained in mental health first aid.

20 With that, I will end my verbal
21 testimony and I welcome your questions.

22 Thank you.

23 COUNCILMAN JONES: Once again, good
24 morning. Thank you for your testimony.

1 I guess I should start by thanking you
2 for your intervention on Parkside Avenue
3 with the methadone clinic there. We had
4 experienced some interaction issues related
5 to the community and the proper
6 administration of that program. You stepped
7 in. We had, I think, one or two meetings,
8 two at the most. And the problem has been,
9 for the most part, remediated to everyone's
10 satisfaction, to the clients that leave
11 those types of services and to the community
12 that host those kinds of programs.

13 So, I want to thank you publicly on the
14 record. To say that your intervention made
15 a world of difference. There is so much so
16 that there are plans for increased
17 development out in that area that was
18 spurred by the fact that we resolved some of
19 the congregation problems. So, I publicly
20 want to thank you for that.

21 DR. EVANS: Well, I want to thank you.
22 And first of all, I really appreciate as
23 Commissioner of this department your
24 political leadership, your leadership in not

1 just complaining but coming to us. And not
2 only coming to us and asking us to solve the
3 problem, you personally went to that
4 provider, you went to -- along with me to
5 that provider. You sat at meetings. You
6 problem solved. And as a result, that
7 problem was -- that problem was resolved.

8 And I think that the way you approach
9 that really is a model for how we can have
10 services in communities and meet the needs
11 and expectation of communities in terms of
12 development, in terms of community
13 expectations. And I just can't thank you
14 enough for your personal involvement.

15 COUNCILMAN JONES: Now once we got that
16 out of the way, now we get to the hard
17 questions.

18 DR. EVANS: Okay. I wanted to continue
19 the love fest.

20 (Laughter)

21 COUNCILMAN JONES: Can't keep that up
22 for a long period of time.

23 DR. EVANS: Okay.

24 COUNCILMAN JONES: I really -- no hard

1 questions for me. You have a 9-to-1 ratio
2 of City dollars to federal dollars, I think,
3 that are transmitted through the state; is
4 that correct?

5 DR. EVANS: That's correct. So we --
6 our budget, as I said in my testimony, about
7 1 percent of our budget -- \$1.2 billion is
8 City general fund, about \$13 million.
9 Almost all of that \$13 million is used for
10 match to the state to draw down federal and
11 state dollars. So, it's a really great
12 investment on the City's part, 9-to-1
13 dollars for every dollar the City puts in.

14 I also said in my testimony that recent
15 study by Drexel University showed that for
16 that investment, the City gets back
17 \$36 million in direct tax revenue. So, we
18 are way ahead in terms of the investment
19 that City puts into this department.

20 COUNCILMAN JONES: One of the issues
21 that President Clarke, who is going to join
22 us shortly, has been a champion of is
23 wraparound services for public education.
24 Dealing with, I think a couple years ago, a

1 parent advocate for public education said
2 that kids from our neighborhoods come to
3 school with two book bags; one with the
4 books and the lessons of the day, and the
5 other with the troubles of the night before
6 from home.

7 And so to address that, can you explain
8 how you are offering services to some of our
9 more challenged schools in Philadelphia?

10 DR. EVANS: Sure. So, we actually have
11 probably the best relationship with the
12 School District that we've had certainly in
13 my tenure here. I think Dr. Hite has been
14 tremendous in terms of his understanding of
15 the importance of addressing the social and
16 emotional needs of children.

17 I meet with him on a regular basis. We
18 have ongoing staff meetings between my staff
19 and his staff. We, as a department, invest
20 \$75 million each year in direct services
21 that are provided within the schools. Some
22 of those services are school, what are
23 called therapeutic services, some of those
24 are preventions services, some of those are

1 student assistance program services. And
2 that broad range of services really is
3 designed to meet the needs, the behavioral
4 health needs of children to address those
5 needs such that those issues do not impact
6 on their ability to learn.

7 COUNCILMAN JONES: So, what does that
8 mean to a -- what schools qualify and what
9 kind of services -- is it a case by case?

10 DR. EVANS: Sure.

11 COUNCILMAN JONES: Is it a school by
12 school kind of relationship?

13 DR. EVANS: So what I would say is that
14 at the outset is that every child, whether
15 they are in a school that has a specific
16 program or not and who is eligible for
17 behavioral health services, we ensure that
18 they get those services. So whether they
19 receive those services in school or in the
20 community, we -- our role is to make sure
21 they get those services.

22 For the schools that have services, and
23 we're in about 107 different schools --
24 actually 132 schools. Those services have

1 been -- those schools have been identified
2 really based on the number of children who
3 are in those schools who receive Medicaid
4 and who have behavioral health needs. So,
5 where we have resources is, to a large
6 degree, historical based on that. One of
7 the conversations we're having with Dr. Hite
8 right now is a lot of these decisions were
9 made 10 years ago, 15 years ago. And the
10 conversation we're having is, you know, are
11 these schools where you have the highest
12 needs today.

13 So, we're in those conversations. We're
14 in the process of doing some redesign on
15 some of the school-based services. And
16 simultaneously, we're having those
17 discussions about where do we redeploy
18 those -- those services so they're at the
19 schools with the highest need.

20 COUNCILMAN JONES: So, Doctor, I've had
21 an opportunity now to have visited every
22 school based on Councilwoman Sanchez' and
23 Councilwoman Blackwell's insistence. I have
24 actually been in every one of my schools.

1 And some schools are more challenged than
2 others.

3 DR. EVANS: Sure.

4 COUNCILMAN JONES: The spectrum of
5 special needs is a bit higher.

6 So my question kind of relates to, A,
7 how many children in the public school
8 system are eligible for Medicaid and
9 Medicaid services and are covered?

10 And then, how soon will we prioritize
11 schools that have a higher percentage of
12 these types of services or poverty-related
13 stresses that come with that?

14 DR. EVANS: Sure. So, I don't remember
15 what the exact percentage is. But in
16 Philadelphia, just to give you some
17 perspective, in a city of 1.5 million
18 people, we have about a third of the
19 population that is qualified for medical
20 assistance. That's just at the outset. And
21 if you look at children, the proportion of
22 children in the Philadelphia schools is
23 fairly high. I would think in the 60 to
24 70 percent range, but I can get the exact

1 number.

2 So in most schools in Philadelphia, the
3 overwhelming majority of children in those
4 schools are eligible for Medicaid services.
5 And for those children who are not, we have
6 other ways that we can provide services to
7 them.

8 COUNCILMAN JONES: So, I will be anxious
9 to see how you prioritize and what the
10 correlations will be for that connectivity.
11 There are some schools, for whatever reason,
12 poverty related, have greater stressors --

13 DR. EVANS: Sure.

14 COUNCILMAN JONES: -- than others. And
15 in order for children to actually receive
16 the lessons of the day, they have to -- they
17 have to deal with a whole bunch of other
18 related problems that I know you guys are
19 capable of addressing.

20 So, I'm going to turn it over to
21 Chairwoman Tasco who has a -- on the clock
22 also. She's up next. So, I may join you
23 shortly.

24 DR. EVANS: Okay.

1 (Chairwoman Tasco now sits as Chair.)

2 COUNCILWOMAN TASCO: Good morning.

3 DR. EVANS: Good morning.

4 COUNCILWOMAN TASCO: Good morning to all
5 of you who have come out today to testify
6 on, I guess, the whole spectrum of health
7 services that we provide in the City of
8 Philadelphia. And I want to say thank you
9 so much for your leadership in the
10 Department of Behavioral Health and
11 Intellectual Disability Services. I think
12 when we started out it was just behavioral
13 health.

14 DR. EVANS: Yes. We've had a few name
15 changes over the years.

16 COUNCILWOMAN TASCO: Yes. And thank you
17 for the -- your leadership and your role in
18 bringing this department forward. And I
19 just want to say this will be my last
20 budget, and thank you for your support and
21 helping. I have enjoyed working with you,
22 and I know that we are moving forward.

23 We have come a long way from the days
24 that we sat in here with that young lady

1 dealing with some of my constituents out
2 there, advocates who we worked with through
3 the years to change the whole picture of
4 public health in Philadelphia.

5 DR. EVANS: Sure.

6 COUNCILWOMAN TASCO: And so, we thank
7 you for your leadership.

8 I think I just have a couple of
9 questions. You may have read them in your
10 testimony and, of course, my ears were not
11 open.

12 I'm aware of a diversity program for
13 offenders with mental health issues operated
14 as a partnership between the Police
15 Department and the Department of Behavioral
16 Health. Would you please brief us on the
17 program and its current source of funding.
18 Also, has your department and the Police
19 Department taken steps to make this program
20 permanent?

21 DR. EVANS: Sure. So the -- we actually
22 have a very good relationship with Police
23 Department Chief Ramsey. Commissioner
24 Ramsey really understands the importance of

1 behavioral health issues and having a strong
2 partnership.

3 When he came in, the program that you're
4 referring to is the CIT Program, which is
5 Crisis Intervention Training. It's actually
6 a national program. It's done in almost all
7 the major cities around the country. A few
8 years ago we, through conversations with the
9 Police Department, were able to get buy-in
10 from the Police Department. When
11 Commissioner Ramsey came in, he really
12 embraced the program.

13 Then basically what the program is, is a
14 one week training course that teaches police
15 officers how to identify and intervene
16 appropriately with people who are in
17 psychiatric distress. It's been very
18 successful. When Commissioner Ramsey came
19 in, we had on an unfortunately a fairly
20 regular basis incidence where police
21 officers had shot and, in some cases, killed
22 someone who is in psychiatric distress.

23 Since we've implemented this program, we
24 have not had any of those kinds of

1 situations that he and I have been -- that
2 been brought to our attention. We trained
3 about 40 percent of the uniform police
4 officers. That's over 2,000 officers. I
5 can tell you I have done ride alongs with
6 police officers. I have seen CIT trained
7 officers. They really do a good job of
8 handling situations where it's clear that a
9 person has a mental health challenge.

10 And it's one of our strategies to try to
11 divert people who shouldn't be in the
12 criminal justice system out of the criminal
13 justice system and into appropriate
14 treatment.

15 COUNCILWOMAN TASCO: Well, are all -- at
16 any time will all of the police officers be
17 trained? Is that the goal?

18 DR. EVANS: So, what Commissioner Ramsey
19 has said is that he'd like to see every
20 officer in the Police Department get the
21 training. And I think, you know, at the
22 rate that we're going, we're going to reach
23 that number. We are probably 40 percent of
24 uniformed officers. We are not only

1 training police, Philadelphia police, but
2 we're training the university police
3 departments, SEPTA police. We're even
4 training some of the federal agencies in
5 town.

6 So, what we're really trying to do is
7 when people who have mental health
8 challenges come into contact with law
9 enforcement, for that first contact to be
10 people who are trained to recognize, spot
11 and have a differential response in those
12 cases. I should also say that the police
13 are now using -- doing mental health first
14 aid training in the academy. Everyone who
15 comes out of the Academy is getting a
16 one-day course on recognizing mental health
17 challenges, knowing how to support people
18 and connect people to services.

19 So, I think what has evolved over the
20 years is a continuum of trainings from
21 mental health first aid, which is a more
22 introductory training, through CIT training
23 which is a very intensive training that
24 really trains officers not only to recognize

1 but to really have the skill set to
2 intervene in those situations.

3 COUNCILWOMAN TASCO: Okay. Thank you.
4 Maybe at some point it could -- whole
5 training component could be a component of
6 the initial training when the perspective
7 officers are in the Academy be it more --
8 more in depth training at that point, then
9 you get everybody.

10 DR. EVANS: Sure, yes.

11 COUNCILWOMAN TASCO: It would be better
12 I think, so just a point.

13 I'm aware that a Hoarding Task Force was
14 created in 2013 to address the problems of
15 hoarding in Philadelphia. Could you
16 describe the extent of the problem in
17 Philadelphia and how the Philadelphia
18 Hoarding Task Force is addressing this
19 issue?

20 How is the task force funded? And what
21 is your department's role in the task force?
22 And they need to come to my house.

23 DR. EVANS: Probably a lot of houses.
24 But I think the people that most work with

1 are people who really have significant
2 issues.

3 Hoarding is an anxiety disorder. It is
4 usually found -- lots of people who are
5 often older, people in poverty who or at a
6 greater risk for hoarding. The people who
7 get -- for whom this is -- whose attention
8 this is brought to initially are often
9 either Fire Department or L&I. We get
10 called in after the fact, after they've gone
11 in, they see the person has a hoarding
12 problem and there's clearly a mental health
13 challenge there.

14 And our role has been to try to connect
15 people to services. Our department doesn't
16 lead that task force. I think that Fire and
17 L&I are more of the leaders around that task
18 force. I do have a staff person that is
19 on -- on that task force. And again, our
20 role is to make sure that once the public
21 safety issues are addressed, that we are
22 stepping in to make sure people get
23 connected to appropriate treatments.

24 COUNCILWOMAN TASCO: Would you please

1 share your views on an operational scenario
2 where more Philadelphians with health
3 insurance, including Medicaid, are now
4 requesting services through the providers
5 funded by your department.

6 How would you provide for additional
7 demand?

8 DR. EVANS: Not sure if I quite
9 understand the question. Is it --

10 COUNCILWOMAN TASCO: Let me go back.
11 It's not my question.

12 DR. EVANS: Okay.

13 COUNCILWOMAN TASCO: It says, you state
14 on page 1 of your testimony that community
15 behavioral health was founded to provide
16 behavioral healthcare services for
17 Philadelphia's 475,000 Medicaid recipients.
18 The question, please share your views on an
19 operational scenario where more
20 Philadelphians with health insurance,
21 including Medicaid, are now requesting
22 services through the providers funded by
23 your department.

24 How would you provide for the additional

1 demand?

2 DR. EVANS: For the additional demand.

3 Okay.

4 So, well couple of things. One is that
5 Philadelphia has over many years, long
6 before I came in, has developed a very
7 strong network of providers. This is one of
8 the few places in the country where, you
9 know, people have access to services and
10 they don't have very long waiting list. So
11 if you need an inpatient psychiatric
12 admission, there -- you can be admitted in
13 the same day.

14 And a lot of the situations you may be
15 hearing in the national media that there are
16 a lot of communities where people have to
17 wait. They wait on emergency departments.
18 They don't have access for literally
19 sometimes for days before they can have
20 access to that. That's not the case in
21 Philadelphia.

22 Similarly, people who have addictions
23 who need residential treatment, we almost
24 always have residential capacity for people.

1 Again, that's not something that you find
2 typically particularly in a lot of urban
3 settings.

4 So, a couple of things. One is that
5 even though we have lots of access, we still
6 have a challenge as a field and people
7 actually coming to treatment. So,
8 40 percent of the people who have mental
9 health diagnosis don't come to treatment.
10 That's 40 percent of the people in our
11 community have a problem, could get help;
12 but for a variety of reasons, don't access
13 care. 90 percent of the people who have an
14 addiction don't access care. So what that
15 means is that if all of those people
16 suddenly showed up, obviously, we would not
17 have enough capacity.

18 We are not at that point yet as a City.
19 And, in fact, what we've been doing is to be
20 very aggressive at doing outreach. The CIT
21 Program that I just told you about, Mental
22 Health First Aid which I talked about in
23 my -- my testimony. We do community mental
24 health screenings to identify people who

1 might be having issues. All of those are
2 designed to try to get at that 40 percent,
3 to get at that 90 percent so people actually
4 come into treatment.

5 The last piece of your question I think
6 has to do with access and Medicaid
7 expansion. So, you know, that -- excuse
8 me -- with the President's healthcare
9 legislation, that one of the ways that
10 access is being expanded to people is by
11 expanding Medicaid.

12 And in -- with the new administration
13 with Governor Wolf, he has opted to do
14 traditional Medicaid expansion which we
15 believe is a good thing because we already
16 have the infrastructure. It's less costly.
17 It can be more efficient. We are already
18 set up to -- to address the people's needs.
19 And with incremental funding, we can do that
20 pretty efficiently. And so, we think that
21 Medicaid expansion will give us the
22 opportunity to get to another group of
23 people, people who are traditionally people
24 that might be working but not making a lot

1 of money and not in a position where they
2 have health insurance. A lot of those
3 people now have health insurance, and I
4 think will be more likely to reach out for
5 help.

6 That's what's been found in other
7 communities.

8 COUNCILWOMAN TASCO: Thank you very
9 much. Chair will now recognize Councilwoman
10 Blackwell.

11 COUNCILWOMAN BLACKWELL: Thank you.
12 Thank you very much.

13 I wanted to thank, as I did last year, I
14 wanted to say thank you. I call all the
15 time and I always ask for Dr. Arthur Evans.
16 And he always calls me and he always answers
17 all my questions that has to deal with
18 anything regarding Health Department,
19 Behavioral Health, CBH, et cetera. So, I
20 just want to say thank you for always being
21 there and responsive.

22 DR. EVANS: Thank you.

23 COUNCILWOMAN TASCO: I ditto that.
24 Whenever you call regarding issue or health,

1 he responds and he takes action to address
2 the issue for you. So, we appreciate that.

3 Chair recognizes Councilwoman Sanchez.

4 COUNCILWOMAN QUINONES-SANCHEZ: Thank
5 you, Madam Chair.

6 I also want to thank the department. I
7 think that some of the work that they do is
8 probably the most difficult and painstaking
9 as it relates to working in the communities.

10 And I appreciate we're in the process of
11 moving a methadone clinic a hundred feet.

12 And I'm still getting beat up because we're
13 moving it a hundred feet, but in a more
14 conducive environment.

15 Over the years, we've talked about how
16 do we rightsize -- or not rightsize. How do
17 we create environments where the amount of
18 the services we are providing are not
19 disruptive to neighborhoods? Has the
20 department begun to look at that?

21 I know part of the challenge with the
22 placement of methadone clinics is the size.
23 Has the department looked at that and
24 reconfigured how and where the services are

1 provided?

2 DR. EVANS: Yes. So, great question.

3 I think that -- I think that the issue
4 around how do we rightsize the system I
5 think is an important one. I think your
6 issue around or the question around what is
7 the appropriate size of a program is a very
8 important question. And, you know, Roland
9 Lamb who runs our addiction services has
10 said, you know, we have 5,000 people in 13
11 programs, Roland? Thirteen agencies. We
12 have 5,000 people in 13 agencies. Do the
13 math. Those are very large numbers in some
14 of those programs, over a thousand people.

15 We would much prefer to have, you know,
16 maybe 20 or 30 programs with a lot fewer
17 people in them. But as you know, siting a
18 methadone program is really, really
19 difficult. In fact, we are having a program
20 that will be opening later this year. It
21 took us literally seven years from the time
22 that we issued the RFP to the time that this
23 program is going to open. Seven years.

24 So, it's very difficult. You know, this

1 is not an issue that we can solve as a
2 department. It's one that we have to do in
3 collaboration with City Council and with
4 other political leadership. I will say that
5 this year I think we're in a much different
6 place on this issue. You heard Councilman
7 Jones. One of the things I appreciate about
8 what he said was, you know, I'm not asking
9 you to close the program. I just want the
10 program to be a better neighbor.

11 Councilman Henon was very instrumental
12 in getting the program that's open -- that's
13 going to be opening. Councilman Squilla,
14 again, very helpful in terms of addressing
15 problem, deals and those kind of things, but
16 doing it in a way that didn't impact on our
17 ability to site programs.

18 I guess what I would say is that I think
19 it can be done. I think we know -- a year
20 ago I don't know. Today I think that we
21 have some great examples of Council people
22 stepping to the plates, having conversations
23 with us and trying to figure out how do we
24 balance community needs with the needs --

1 the other needs of community, which is to
2 have access to services in communities that
3 they can get to.

4 COUNCILWOMAN QUINONES-SANCHEZ: Last
5 week I hosted a round table with the
6 Alliance for Community Partners. And they
7 gave us kind of a map of district by
8 district of providers providing some of
9 these services throughout the City.

10 Have you -- because one of the questions
11 I've asked in the past is, have we mapped
12 out similar situated programs? And can that
13 data be reviewed as part of this bigger
14 option?

15 DR. EVANS: Sure.

16 COUNCILWOMAN QUINONES-SANCHEZ: As we
17 talk about the possibility of reutilizing
18 schools for community-based services and
19 those things, I think we need that data
20 captured. And I appreciated the fact that
21 they mapped out for us on a district basis
22 who are the providers in that district and
23 what are some of the services.

24 But no one in the Administration seems

1 to want to be in charge of taking that on.
2 We need DHS, the Health Department,
3 Behavioral Health to map out locations. And
4 so that we can be more thoughtful in our
5 process.

6 DR. EVANS: Sure.

7 COUNCILWOMAN QUINONES-SANCHEZ: And look
8 at what are the opportunities to team up
9 folks. Is anybody going to take that on?

10 DR. EVANS: Well, you know, I will tell
11 you, we geomap. We geomap everything. We
12 geomap where our clients are coming from.
13 We geomap who are providers are. In fact,
14 one of the ways that we address disparities
15 is by looking at where do we have high need
16 populations and then our programs in those
17 areas.

18 And in fact, one of the RFPs that we did
19 last year was -- what we noted was that we
20 have a disparity for African-American access
21 to mental health services. If you look at
22 the proportion of people in the Medicaid
23 program who actually -- who are
24 African-American who actually access

1 services, it's about half of what you would
2 expect. So, what we did was actually
3 University of Pennsylvania mapped the
4 population, mapped where we had high
5 utilization and low utilization. And what
6 we found was that we had areas of the City
7 where we had large numbers of
8 African-American, low numbers of providers.
9 And we did RFPs specifically in those areas.

10 So, my only point is this. That we
11 welcome sitting down with you, showing you
12 what we have and, you know, having those
13 discussions.

14 COUNCILWOMAN QUINONES-SANCHEZ: I have
15 to step out, but I will come back for
16 another round. But I wanted you -- I looked
17 at your demographics of your staff. And I
18 wanted you when I come back to tell me
19 what's your plan to address the disparity
20 there, okay? I'll be back.

21 COUNCILWOMAN TASCO: Councilman Neilson.

22 COUNCILMAN NEILSON: Thank you,
23 Councilwoman.

24 COUNCILWOMAN TASCO: I got to follow the

1 numbers.

2 COUNCILMAN NEILSON: Good morning and
3 thank you for coming today.

4 DR. EVANS: Good morning.

5 COUNCILMAN NEILSON: As everybody in
6 here, we really appreciate the hard work you
7 do.

8 I was listening to Councilman Jones'
9 questioning and I listened to some of the
10 statements you had about that you spend
11 75 million in public schools. You serve
12 about 132 other schools. And your formula
13 of 1.5 million and one third of the
14 population qualify for Medicare and
15 Medicaid. And through the basic math that
16 you put in front of us there today, I did a
17 little basic math sitting at my table here.
18 As you can see, the school-based family
19 services centers is something that we are
20 concentrating here on in Council.

21 132 schools, says you spend about
22 \$568,000 per each one of those schools. And
23 as we're trying to get school funding, I
24 wanted to know the department's approach.

1 Because wouldn't it be better to put a full
2 time staffer in each one of those schools
3 and fund a school -- an individual to be
4 there full-time basis? Because we're here
5 and we have no full-time counselors. We
6 have no full-time nurses in our schools.
7 And with that kind of money, it seems to be
8 real easy and beneficial to your department
9 to save resources either way to have
10 full-time people in these schools in our
11 communities.

12 And I was wondering your thoughts on
13 that and getting to that point on how you
14 plan to get there? Because it seems basic
15 to me that it would probably save us money
16 by putting those resources in our schools
17 rather than spending over a half a million
18 dollars. I know the services array in all
19 different services. But for full-time
20 counselor in school, we're talking about
21 probably \$70,000 and half a million dollars
22 in each school.

23 DR. EVANS: Sure.

24 COUNCILMAN NEILSON: I think that's a

1 better way to spend our money and it
2 benefits all of our children.

3 DR. EVANS: Sure. So, the money that we
4 spend in the schools, most of it is
5 Medicaid -- Federal Medicaid dollars. There
6 are rules and regulations around how we can
7 spend the money, where we can spend the
8 money, who can be reimbursed. So while
9 there are those kinds of needs in terms of
10 counselors and nurses, we can't use Federal
11 Medicaid dollars for those purposes.

12 And in fact, the only way we can use
13 those dollars is -- are by providers that
14 are credentialled, who are approved and who
15 are behavioral health providers. So what we
16 do then is in those schools, actually 107
17 that have school-based services. And the
18 difference between 132 and those other
19 schools are schools that have prevention or
20 SAP services, school assistance -- Student
21 Assistance Program services.

22 So what we do then is we have contracted
23 the providers who are deployed in the
24 schools. They actually, in the best case

1 scenarios, are really become a part of the
2 mix of adults in the building, become a part
3 of the culture. They advise the school
4 staff on how to address certain behavioral
5 health issues for not only the children that
6 they're working with and they have
7 responsibility for but for children in
8 general. They help with school climate.

9 When there are crisis in school, when
10 there's a shooting in the community, kids
11 are coming into school. They are in crisis,
12 are traumatized. They are being -- they are
13 there to provide support in those settings.
14 Even though these are not school employees,
15 they play a very critical and vital role in
16 how many of these schools operate. And, you
17 know, so those are the rules and parameters
18 around which we can use the services.

19 COUNCILMAN NEILSON: Sure. We're
20 talking about a half a million dollars per
21 school, right.

22 DEPUTY COMMISSIONER JONES: I was going
23 to add, Councilman -- David Jones. This is
24 David Jones, Deputy Commissioner. I want to

1 add to what the Commissioner said. That we
2 also in terms of the way we use our staff,
3 it allows for greater continuity between
4 school and home. You know, what we try to
5 do is recognizing that most, you know,
6 children are certainly attached to adults.

7 What we have our staff is able to do is
8 to, again, be able to go in home or into
9 general community and work with families.
10 So, they are working with that entire system
11 to then help them, you know, everybody --
12 whatever their needs may be and help them
13 progress towards wellness. So, I think
14 there is actually an added benefit to kind
15 of the way we use staff in addition to what
16 they do in each of the schoolhouses.

17 COUNCILMAN NEILSON: The -- you didn't
18 get saved by the bell. Okay.

19 (Councilman Greenlee now sits as Chair.)

20 COUNCILMAN NEILSON: I just -- is this
21 your staff or is this contracted staff?

22 DR. EVANS: These are contracted staff.
23 We contract with a network of, you know, 200
24 different providers. About half of them are

1 providing children services.

2 COUNCILMAN NEILSON: Has there been any
3 investigation to see if we can save any
4 funding by instead of contracting that
5 staff? Because, I mean, now you cut -- if I
6 cut the 132 down to 107, that's going to
7 push that up to over 600,000 per school.

8 I mean --

9 DR. EVANS: These services --

10 COUNCILMAN NEILSON: That puts --

11 DR. EVANS: Sure.

12 COUNCILMAN NEILSON: That puts 10 people
13 there, 365 days at \$70,000 a year employees.
14 I'm just -- the basic math. I'm just
15 talking basic math. I want to make certain
16 that we provide these kids with great
17 services. And 10 employees, 365 and school
18 is not in all summer. I mean, we're talking
19 about eight months a year that we're
20 spending \$600,000 per school. And I just
21 question that.

22 And if we are contracting it, maybe look
23 at these contracts. Are we spending too
24 much money on the contracts? Would it be

1 cheaper for us to hire a full-time staffer,
2 assign that staff to the school to do all
3 that's necessary to provide these kids help,
4 provide those students the support that they
5 need and the teachers that support that, you
6 just said they needed. But to put that
7 person right there in the community and the
8 school has the space, if we even rent an
9 office off them which you are allowed to do
10 under your funding. I mean, we have \$1.2
11 billion flexible budget here.

12 DR. EVANS: I wish it was flexible.

13 COUNCILMAN NEILSON: You have to spend
14 it on certain things. It's flexible. You
15 can spend more on others and more on this.
16 You have some things that you must do.

17 And I came from the state. I know about
18 the funding streams. I worked in the
19 administration in the Governor's office.
20 And I know how we can utilize these funding
21 streams. I'm not ignorant to that point.

22 DR. EVANS: Sure.

23 COUNCILMAN NEILSON: I just think we
24 have an opportunity within your department

1 to help our children in every school and
2 this is it. And this could do it.

3 I'm just asking, Commissioner, I know
4 it's -- you're not going to be able to fix
5 it by June. I know we're not going to be
6 able to change everything today and say,
7 hey, look, Councilman, you came up with a
8 good idea. We're going to run with it.
9 It's going to take time to put that
10 together. And I just ask that you and your
11 department really investigate and look at
12 this harder because our children need the
13 help. You know it as much as I do. You
14 know more than me because your -- this is
15 your baby, Doctor.

16 Like you said when you started, I
17 appreciate it. But to spend \$600,000 per
18 school, I know we can do better. I know we
19 can do better. And I'm just asking you to
20 take a look at it, please.

21 DR. EVANS: I will do that, Councilman.
22 And I would actually would welcome having
23 conversations with you. I think that
24 we're -- as I said, we make a \$75 million

1 investment in schools every year. We have
2 lots of parameters around what we can and
3 can't do because our Federal Medicaid
4 dollars. I agree with you. I think we can
5 always be creative. We can always look at
6 these situations differently. And I would
7 welcome having those conversations with you.

8 COUNCILMAN NEILSON: I look forward to
9 it. Thank you again for testimony.

10 I have nothing further, Mr. Chairman.

11 COUNCILMAN GREENLEE: Thank you,
12 Councilman.

13 Councilman O'Brien, isn't it? Yeah,
14 O'Brien, yes.

15 COUNCILMAN O'BRIEN: Thank you,
16 Mr. Chairman.

17 First, Dr. Evans, I would like to
18 applaud you for your use of Medicaid dollars
19 in ways that no other municipality has ever
20 dreamed of doing. And I also recognize that
21 you've talked about autism. But I want to
22 specifically thank you for your endorsement
23 of the Philadelphia Autism Project.

24 We have created 119 initiatives that

1 resulted out of those discussions over the
2 last years. But I really want to take time
3 to recognize some of the individuals that
4 were on your staff that materially
5 contributed to this. That is Frank Gould
6 from Grants and Procurements. And from
7 Contracts we had Vicky Finnegan and Yasmine
8 Thornton. They were very responsive and
9 diligent. And they were able to take those
10 recommendations from the stakeholders and
11 make them the top priorities.

12 And I can't say enough about Valerie
13 Oldes. She's working with us to implement
14 those initiatives. And -- but she gave us
15 guiding principle when we started. And that
16 was that we had to focus on the
17 underrepresented and under-served groups.
18 And then she further instructed us that we
19 should provide seed money to individuals,
20 groups and faith-based organizations and
21 grass roots organization that range from a
22 few hundred dollars to \$1,500. We had 30
23 applicants. We have 11 awardees they we're
24 going to recognize on May 14. I hope that

1 you're there because we are responsible for
2 this unusual conversation. You took the
3 lead that brought in not only behavioral
4 health but DHS, CBH and the School District
5 in a collaborative that's really making a
6 difference.

7 Also, I had a great experience. And
8 again, you are forward looking inclusive
9 strategies that translate into all the staff
10 people are just extraordinary from the first
11 day I met you. But I met with a group
12 called Spectrum Friends. They're about 40
13 individuals that are self advocates on the
14 autism spectrum. I met with them last
15 Wednesday. They are only 10 or 12 because
16 they have two groups now, the business and
17 the fun group. I'm not the fun group, so
18 only 12 of them showed up.

19 But when you talk about making
20 Philadelphia autism friendly where you are
21 taking the lead, I just sat there and my
22 head just went poosh(makes sound). They
23 started -- I wanted to make Philadelphia the
24 first autism friendly. They just went off

1 on a tear. I thought every policymaker
2 should sit and listen to those individuals.
3 We should have a Spectrum Friends chapter
4 here in Philadelphia. They talked about an
5 individual pursuing his Ph.D. who got his
6 Masters degree and talked about all the
7 barriers in pursuing higher education. And
8 he told me that when he got and he announced
9 his dissertation all the support stopped.
10 And that's why individuals with intellectual
11 disabilities don't pursue their dreams.

12 And they talked about housing. They
13 talked about taxi drivers, which we all have
14 issues with. For them when they drive fast,
15 they don't listen, they run red lights and
16 they can't get back in a cab again.

17 And then one individual talked about the
18 challenges of going to an airport when you
19 have a bag and you're always worried about
20 you're going to lose it. And he said why
21 can't we have a GPS that you get when you
22 come into the airport and track your bag.
23 That's great for everybody. I worry. I
24 always leave my stuff.

1 But, you know, the one thing that they
2 say and you talked about this in your
3 testimony about the employment rate, that's
4 there a 3 percent increase of employment
5 among individuals with intellectual
6 disabilities. 500 individuals with IED and
7 DD. But they expressed to me that they
8 don't want to be poor. And when they're on
9 Social Security, if they get a great paying
10 job, then they're going to lose their MA.

11 And we have to go to Washington and get
12 them to understand that that eligibility
13 criteria is punishing those individuals from
14 success. And further, Valerie also
15 contracted with Karen Krippet from Elwyn to
16 produce three videos. Two that will deal
17 with autism among the African-American
18 community, and one that's going to focus on
19 autism with Hispanic families. Those
20 videos, because of your direction, are going
21 to be available in our free libraries. So,
22 they will become physical hubs so
23 individuals with disabilities are now going
24 to be able to access a broader network of

1 support.

2 So, I just want to thank you for that.

3 Recognize that you have really talented.

4 (Bell rings.)

5 And I got under the wire, and I thank
6 you.

7 DR. EVANS: Well, I want to thank you as
8 well, especially for bringing together the
9 task force and really your commitment to
10 this issue for many, many years. Appreciate
11 you.

12 COUNCILMAN O'BRIEN: Thank you.

13 COUNCILMAN GREENLEE: Thank you,
14 Councilman O'Brien. Thank you.

15 Councilman Oh.

16 COUNCILMAN OH: Thank you very much,
17 Mr. Chairman.

18 Good morning.

19 DR. EVANS: Morning, Councilman.

20 COUNCILMAN OH: I don't have a question.
21 I just wanted to come up and just praise you
22 and your team, your executive team and all
23 your -- all your staff. I mean, I think
24 your department is exceptional. I mean,

1 your entire organization is -- just really
2 reaches out, hits every nook and crannie of
3 Philadelphia, every community. Anywhere I
4 go, your folks are there. And I think it's
5 so important that people, you know, they
6 recognize that you care.

7 And just the amount of innovative
8 programs that you produce. Yesterday, I was
9 at the Network of Care for Veteran Survive
10 Members and Their Families. Another first
11 and first in Pennsylvania. And I said, it's
12 kind of -- it's kind of odd in a way that
13 your organization would be the forefront of
14 this -- this entire project. But in another
15 way, it's not because you've been such a
16 leader.

17 And for those who don't know, this free
18 website which had a tremendous investment in
19 California and, I think, in Maryland perhaps
20 is now in Philadelphia available on the
21 City's website through the Department of
22 Behavioral Health and Intellectual
23 Disability Services. And will coordinate
24 all the Veteran services and continue to

1 grow. But whether it's a -- it's that or a
2 community where folks don't speak English or
3 not familiar with the culture or any section
4 of our City, I have seen your department
5 there.

6 And I think we, oftentimes, don't get a
7 chance to praise the people who work for our
8 City that do such an exceptional job. I
9 think, unfortunately, a lot of people don't
10 appreciate the public service that is done.
11 You don't get, you know, a lot of pay for
12 this. And I just want to say that you
13 deserve the praise for doing this job well.
14 But when you're a national model, you know,
15 it certainly makes all of us very prod. And
16 we support you a hundred percent and keep up
17 the good work.

18 Thank you.

19 DR. EVANS: Thank you, Councilman. And
20 I appreciate all of the kind words from you
21 and from other Councilmembers. And I just
22 want to acknowledge my staff who make all of
23 this -- you know, all of these things
24 happen. I think they work extremely hard.

1 And I don't think you're going to find a
2 more dedicated group of people in government
3 anywhere. So, I really applaud them for
4 their work.

5 (Applause)

6 COUNCILMAN OH: Thank you, Mr. Chairman.

7 COUNCILMAN GREENLEE: Thank you,
8 Councilman.

9 Councilwoman Sanchez.

10 COUNCILWOMAN QUINONES-SANCHEZ: Thank
11 you. I wanted to talk a little bit. We
12 have a language access ballot question on
13 the books. Part of that is to get
14 departments, particular departments like
15 yours who are service delivery, to have a
16 language access plan. And I noticed that in
17 your administrative team as well as your
18 full-time staff, your bilingual numbers are
19 2 percent.

20 Wanted to know if you had a plan,
21 thought moving forward how do you increase
22 language access in your department?

23 DR. EVANS: Sure. We do have bilingual
24 people, Spanish as well as other languages,

1 who are in our -- on our staff. At CBH we
2 have people in provider relations. We have
3 people in our member services. We have care
4 managers.

5 COUNCILWOMAN QUINONES-SANCHEZ: Would
6 you provide that? I think when you look at
7 the CBH budget and whatever billion dollars,
8 we don't get any of that information.

9 DR. EVANS: Sure.

10 COUNCILWOMAN QUINONES-SANCHEZ: That
11 might be helpful.

12 DR. EVANS: Okay. We can provide you
13 those numbers. And in addition to that, we
14 have to have translation services.
15 Although, I don't think translation services
16 particularly for behavioral health is the
17 desired way to go. But we often have
18 communities in Philadelphia who -- where we
19 don't have professionals that speak the
20 language. So, sometimes we have to rely on
21 that.

22 I think -- I mean, I think the issue
23 around language access is really important
24 as it relates to the Latino community. You

1 know -- again, Philadelphia is very unique.
2 We have very strong network of
3 Spanish-speaking Latino providers who are
4 not only speaking the language but know the
5 culture. They're in the community. They
6 know people who are in the community. And
7 as a result, at least for Latinos in
8 Philadelphia, we have actually the highest
9 penetration. So, Latinos who are in the
10 Medicaid program have a very high
11 penetration rate.

12 We have very strong --

13 COUNCILWOMAN QUINONES-SANCHEZ: When you
14 talk about the penetration rate -- you and I
15 have had this conversation before. So one
16 of the issues, you know, and we've talked
17 about the store front medical centers to the
18 pharmacy situation. We had that
19 conversation a lot.

20 If we have a high penetration rate, what
21 are we doing to ensure best quality?

22 And you and I -- told you I was going to
23 put this on the record. We have two medical
24 centers who are under federal jurisdiction.

1 The feds came in, took their files, but they
2 still allowed to take new patients.

3 DR. EVANS: Right. So, let me talk
4 about then what we do for quality. We
5 actually put a lot of emphasis on how we
6 monitor and oversee providers.

7 First of all, in terms of being
8 contracted through CBH, you have to go
9 through a credentialling process. We have a
10 very extensive process where we have staff
11 that go out and who are not just from CBH
12 but from our office of addiction services,
13 from our office of mental health. And we
14 look at everything. It's a -- for large
15 providers, it's a multi-day process.

16 We not only look at charts, we have
17 physicians who look at charts, as well. We
18 have interviews directly with people who are
19 in those programs. We interview staff.
20 It's really a comprehensive look at --

21 COUNCILWOMAN QUINONES-SANCHEZ: I don't
22 doubt that, Arthur.

23 DR. EVANS: -- each provider.

24 COUNCILWOMAN QUINONES-SANCHEZ: I don't

1 doubt that. But if the Feds are coming in,
2 is there anything you can do to say until
3 this review, everybody is innocent until
4 proven guilty. Until this review is
5 completed, can the folks stop taking new
6 patients?

7 DR. EVANS: Sure. Of course we can. We
8 make that decision based on what we see.
9 But in the case where there might be a
10 federal agency that's looking at an
11 organization, one of the things that happens
12 when you have a federal investigation is
13 they don't tell you anything. And so, you
14 can have a federal agency show up at a
15 provider, you know, interview people, take
16 records. We don't get any of that
17 information.

18 The only thing we can base our decisions
19 on is what we see and what we know. We do
20 that in collaboration with the state.

21 COUNCILWOMAN QUINONES-SANCHEZ: You
22 never stopped someone from getting new
23 clients after even after federal?

24 DR. EVANS: Sure. We do that all the

1 time. I get alerts almost every other day
2 of a decision to stop admissions to a
3 provider. Typically, those decisions are
4 based on safety issues.

5 If a provider has someone who has a
6 critical incident, those kinds of things we
7 will stop admissions. Our physicians will
8 review the practices of that provider. And
9 before we will allow that provider to
10 continue admitting people, we will make a
11 determination as to whether those issues are
12 resolved.

13 COUNCILWOMAN QUINONES-SANCHEZ: Well,
14 I -- I --

15 DR. EVANS: What I would say is that if
16 there is an investigation of a provider,
17 again, we will look at are there safety
18 issues? Are there concerns? Can we detect
19 anything? And is the state -- has the state
20 removed that provider's license?

21 COUNCILWOMAN QUINONES-SANCHEZ: No. I
22 get the licensing and I know we have an RFP.
23 I'd like to know for the -- in my district
24 that are under federal review, what thought

1 process, decision making to allow them to
2 continue to do the services?

3 DR. EVANS: Sure.

4 COUNCILWOMAN QUINONES-SANCHEZ: What
5 your announcement was on each one of those
6 individuals to continue to take new clients.

7 DR. EVANS: Sure. When we get any kind
8 of alert about a provider, whether it's --
9 the federal government is looking at them or
10 the state government is looking at them, the
11 first thing that we do is try to talk to
12 those agencies and understand what are their
13 concerns. Now, so that's the first thing.

14 The second thing is we send our own
15 people in to those agencies. And what we're
16 looking for, number one, is are there any
17 safety concerns? Are there practices there
18 that put people at risk? And if there are,
19 we take action. The second thing we look at
20 is are there qualify of care concerns?

21 In the case of a federal investigation,
22 it could be that there may be business
23 practices that they're looking at that have
24 less to do with the safety of people who are

1 coming to those programs. And so, until
2 they come to a conclusion, it would be
3 unfair based on the fact that there's an
4 investigation to stop admissions again if
5 there's not a safety issue or quality of
6 care issue.

7 I can tell you that we have had some
8 providers who have literally had people
9 looking at their agency for multiple years.
10 And if they -- if the Federal Government or
11 state agency doesn't take action, then it's
12 kind of hard for us in the absence of any
13 other information to take action. But
14 again, we do that -- we take that very
15 seriously. We send our own people in. And
16 again, we consult with those agencies to the
17 extent that we can.

18 COUNCILWOMAN QUINONES-SANCHEZ: Okay.
19 My time is up.

20 COUNCILMAN GREENLEE: Thank you. Thank
21 you, Councilwoman.

22 Councilwoman Reynolds Brown.

23 COUNCILWOMAN REYNOLDS BROWN: Good
24 morning, gentleman.

1 DR. EVANS: Good morning.

2 DEPUTY COMMISSIONER JONES: Good
3 morning.

4 COUNCILWOMAN REYNOLDS BROWN: To your
5 Deputy, this is your first opportunity to be
6 in this process?

7 DEPUTY COMMISSIONER JONES: Actually, my
8 second.

9 COUNCILWOMAN REYNOLDS BROWN: Oh, okay.

10 DEPUTY COMMISSIONER JONES: But thank
11 you.

12 COUNCILWOMAN REYNOLDS BROWN: Welcome
13 back. You survived it.

14 So with regards to the School District,
15 can you talk about specifically children
16 with disabilities, the process by which you
17 interface with the School District to get
18 those children on track for the services
19 that they need?

20 The back story is, I've been working
21 myself with one case of a child with autism
22 who I've been -- my office has been involved
23 with since the age of 4. That young man is
24 now 12. And the mother is still struggling

1 with EOPs. That every six months the School
2 District wants to do another EOP, which
3 sends a lot of bad signals on -- period,
4 around systemic breakdown, disengagement
5 whatever.

6 So, I would like to hear from you to
7 what extent is the involvement of your
8 office with the School District? And what
9 milestones or benchmarks do you look for or
10 have that are signal to you that more needs
11 to happen with a particular student?

12 DR. EVANS: Sure. So, for kids who have
13 autism or other disabilities, it really is
14 an interplay between our agency and the
15 School District. So, the School District
16 has to do an IEP.

17 COUNCILWOMAN REYNOLDS BROWN: Right.

18 DR. EVANS: They have to determine what
19 the educational needs are. To the extent
20 that through that process or other processes
21 they identify that there's a behavioral
22 health issue that we can intervene on, we
23 will ensure that, one, that there's an
24 assessment but then also that the

1 appropriate services are -- are --

2 COUNCILWOMAN REYNOLDS BROWN: Rendered.

3 DR. EVANS: Are rendered for those --

4 for those children. But, you know as I was

5 mentioning earlier, that -- that in the best

6 case scenarios, the providers that are

7 providing those services are really doing

8 that in collaboration, close coordination

9 with the schools and with parents to make

10 sure that as people, as you hit those

11 milestones, if there are challenges, that

12 those are being addressed through a --

13 through a refining of the treatment

14 approach.

15 COUNCILWOMAN REYNOLDS BROWN: What point

16 does your agency say enough is enough, we're

17 not doing -- operating the best interest of

18 this kid, let's do something else?

19 I mean, at what point is the plug pulled

20 to say we're not meeting the needs of this

21 child?

22 DR. EVANS: Right. That's a hard

23 question. I mean, I think that's a question

24 that we would -- we would try to answer in

1 collaboration with parents and with the
2 people who are in the school. I don't think
3 that there's a particular formula around
4 that. I do think that one of the things
5 that we're very proud of, I'm very proud of,
6 I should say, I guess all of us, is that we
7 are trying to increase the options that we
8 have for children.

9 And in particular, using evidence-based
10 treatment approaches, we have been working
11 with Aaron Beck who is creator of cognitive
12 therapy, widely used in our field. One of
13 the most effective treatment strategies.
14 But people from his staff are working with
15 some of our school-based programs to infuse
16 evidence-based treatment approaches within
17 the school. Your point is a good one.
18 Sometimes traditional approaches don't get
19 us where we need to. And we need to look at
20 other alternatives, other practices. So,
21 that's one thing.

22 We are also developing evidence-based
23 treatment approaches in the rest of our
24 network. To the extent that children aren't

1 getting their needs met within school-based
2 services, the appropriate thing to do would
3 then be to refer the child to maybe a
4 community-based service that might be more
5 effective given the challenges that they're
6 facing.

7 COUNCILWOMAN REYNOLDS BROWN: So, where
8 are the assurances that a child and children
9 don't get lost in the system?

10 DR. EVANS: We try to -- you know, we
11 try to make sure through the oversight that
12 we give of those programs --

13 COUNCILWOMAN REYNOLDS BROWN: Okay.

14 DR. EVANS: -- that kids who are not
15 having their needs met are being identified
16 and -- and referred. So, I think it's
17 through our oversight process that we can
18 pick those up. I would also say if you are
19 working with a child or a family and you
20 feel like they are not getting the needs
21 met, you know, those are the kinds of things
22 you can bring to our attention.

23 DEPUTY COMMISSIONER JONES: Actually --
24 David Jones.

1 I would add that we actually have staff
2 as Dr. Evans is indicating that parents can
3 reach out directly to, to be in conversation
4 to say both, you know, we would like to see
5 things go differently or to ask a broader
6 question in terms of so what are the -- what
7 are the services, what are the
8 evidence-based practices that we should be
9 looking for to help our child achieve their
10 goals? In fact, our child or family achieve
11 their goals.

12 We have people aboard. We also
13 certainly encourage families to be in
14 contact with, again, our personnel to talk
15 with -- to help them work with the agencies
16 as well so that we always end up growing in
17 the same direction.

18 COUNCILWOMAN REYNOLDS BROWN: So, that's
19 assuming parents are sophisticated enough to
20 know where to look, where to reach. What's
21 the presence of your agency in our school?

22 DR. EVANS: Sure. What I would say to
23 that, which is a very good question.
24 Parents around behavioral health issues tend

1 to be more sophisticated then you might
2 imagine.

3 COUNCILWOMAN REYNOLDS BROWN: Okay.

4 DR. EVANS: We have a lot of parents who
5 advocate through CBH. They are familiar
6 with the appeals process. And in fact, we
7 have had to spend quite a bit of our
8 resources on just building infrastructure to
9 deal with the appeals that come in from
10 parents. A lot of that has to do with
11 parents and providers really looking at the
12 needs of the child, looking at whether or
13 not those needs are being met and then
14 identifying other resources and often from
15 those providers -- those same providers in
16 terms of services that can be provided.

17 COUNCILWOMAN REYNOLDS BROWN: Okay. I
18 have one more.

19 COUNCILMAN GREENLEE: If you have one
20 more, well, wait a minute, I'm sorry.
21 Councilwoman Sanchez is Tee'd up, too.

22 COUNCILWOMAN REYNOLDS BROWN: Okay. Now
23 problem.

24 COUNCILMAN GREENLEE: Okay.

1 COUNCILWOMAN REYNOLDS BROWN: So given
2 the -- the dramatic decrease of counselors
3 in schools, what has been CBH's response to
4 that reality because we don't have enough
5 counselors with ridiculous numbers in our
6 schools now.

7 DR. EVANS: Right. Obviously, we can't
8 supplant with Federal Medicaid dollars --

9 COUNCILWOMAN REYNOLDS BROWN: I see.

10 DR. EVANS: -- the loss of counselors.

11 COUNCILWOMAN REYNOLDS BROWN: Okay.

12 DR. EVANS: But what we have -- one of
13 the first conversations we have had with
14 Dr. Hite was because when we came in, he had
15 a budget crisis, was what can we do to try
16 to -- again, we can't supplant, but can we
17 use those existing behavioral health
18 providers who are in schools to address some
19 of the unmet needs because of the loss of
20 staff.

21 We try to do that in a creative way.
22 You know, one of the conversations that we
23 have had with Dr. Hite and his staff Karen
24 Lynch is, you know, what are the schools

1 that have the highest needs. I think it may
2 have been Councilman Jones that raised
3 this. Where is those places that raise --
4 there is Councilman Jones there. He was
5 there the first time.

6 Where are those places where you have
7 high numbers of kids who have, you know,
8 significant challenges, who met -- you may
9 also not have adequate resources. And can
10 we redeploy some of the resources --

11 COUNCILWOMAN REYNOLDS BROWN: Yes.

12 DR. EVANS: -- that we currently have
13 through the schools? We are going through a
14 process with the School District around
15 that. It's really a two-stage process.

16 One is, how do we change the model and
17 optimize the model that we're using. The
18 other part of that is, how do we make sure
19 that those services are in the places that
20 we have the greatest need.

21 COUNCILWOMAN REYNOLDS BROWN: To wrap up
22 time or the window to achieve what you just
23 talked about is when?

24 DR. EVANS: Sure. So, I think when we

1 really got to down to brass tacks and start
2 to look at this, we though probably we can
3 do this in a year or two. I think
4 realistically to do this, it's probably
5 going to take us two to three years.

6 We have over a hundred programs,
7 school-based programs in schools. It's over
8 half the schools, by the way. These are
9 primarily elementary and middle schools.
10 And, you know, one of the things we don't
11 want to do is to take a resource out of a
12 school in a way that in some way might
13 destabilize a school. And so, we are going
14 to make those decisions very carefully in
15 collaboration with a school. Again, at the
16 same time, looking at changing the model so
17 that the model is actually more effective.

18 COUNCILWOMAN REYNOLDS BROWN: So, I
19 would recommend at whatever point that
20 happens, a briefing with Councilmembers
21 would be useful.

22 DR. EVANS: Oh, absolutely.

23 COUNCILWOMAN REYNOLDS BROWN: That we
24 can know of schools in the councilmatic

1 district what the new structure looks like.

2 DR. EVANS: Okay. We appreciate that.

3 COUNCILWOMAN REYNOLDS BROWN: Thank you.

4 Thank you, Mr. Chair.

5 COUNCILMAN GREENLEE: Thank you,

6 councilwoman.

7 Councilwoman Sanchez, do you? Okay.

8 COUNCILWOMAN QUINONES-SANCHEZ: Yes.

9 A couple of things. And I don't know if
10 Councilman Goode asked this, but I was not
11 here. I noticed that on your contract being
12 services, you didn't list the participation.

13 Is that because it's unavailable or
14 you're reporting out?

15 DR. EVANS: I'm not sure what you're
16 referring to Councilwoman.

17 COUNCILWOMAN QUINONES-SANCHEZ: On page
18 13 when you talk about your providers, kids
19 and family, Goldstar, you don't offer any of
20 the ranges for minority participate. I just
21 wanted to know if that's unavailable or --

22 DR. EVANS: Let me see if I can find
23 what you're referring to.

24 COUNCILWOMAN QUINONES-SANCHEZ: While

1 you're getting that information, again I
2 think your office has been as thoughtful as
3 it possibly can in dealing with the citing
4 of stuff. I am very happy that we have
5 found after six years a location for
6 prevention point. But I notice that in your
7 budget, you are reducing your budget.

8 Is there a reason for that? They are
9 going to get money from other places?

10 DR. EVANS: Reducing the budget for?

11 COUNCILWOMAN QUINONES-SANCHEZ: For
12 Prevention Point.

13 DR. EVANS: I'm being told that we're
14 not. I didn't think we were. Should be
15 flat funding for Prevention Point itself. I
16 don't know if you're looking at the line
17 that has multiple things on it. But
18 Prevention itself, Prevention Point itself
19 is not being reduced.

20 COUNCILWOMAN QUINONES-SANCHEZ: Okay.
21 Because according to this in 2004, the
22 budget was 465; 2005, 390. Now we're going
23 into finally a great location and you still
24 have them at 390 with -- when we know we

1 have expensed the rent. When we talk about
2 them moving, we knew that their expenses,
3 because of the comprehensiveness of the
4 services, was going to be more. But they're
5 flatlined there.

6 DR. EVANS: So, you're saying that the
7 amount is flat, but the expenses are going
8 to go up.

9 COUNCILWOMAN QUINONES-SANCHEZ: Right.

10 DR. EVANS: There may be a discrepancy.
11 That's something that we would look at.

12 COUNCILWOMAN QUINONES-SANCHEZ: You have
13 145,000 in undetermined. I just want to
14 make sure. You know how hard it is for me
15 to cite --

16 DR. EVANS: Well, this is -- we
17 appreciate your support and understanding of
18 the importance of that program, and we're
19 committed to that as I think you are. And
20 whatever that discrepancy is, we're going to
21 figure out a way to accommodate that. I
22 wouldn't be concerned about that at this
23 point. Thank you.

24 COUNCILWOMAN QUINONES-SANCHEZ: Okay. I

1 will make sure that before the end of the
2 budget.

3 The other question that I have as it
4 relates to the schools, because you
5 mentioned earlier that you do have kind of
6 the best collaboration.

7 Without the violation of HIPPA laws, how
8 do you track how many different providers
9 are touching a child?

10 A child may have a TSS worker. A child
11 may go to a special afterschool program. A
12 child may get a home visit.

13 How are we tracking how many providers
14 touch a child? I know we tried it in the
15 past as comprehensive.

16 DR. EVANS: Right. It's not something
17 that we typically do from a central
18 standpoint. That's something that we expect
19 providers to do and to identify. So if
20 you're working with a child, you're
21 providing a service, part of your job is to
22 know what are the other services. Not only
23 behavioral health services but what are the
24 physical health services that a child might

1 be receiving.

2 COUNCILWOMAN QUINONES-SANCHEZ: Okay.

3 So, you leave that up to the --

4 DR. EVANS: We leave it up to the
5 individual provider.

6 COUNCILWOMAN QUINONES-SANCHEZ: Okay.
7 And then the last question.

8 We've been dealing with a recovery
9 houses situation. And again, this is an
10 area where Roland has been fabulous and
11 going out with me and getting screamed at
12 with me. You know, we can take it.

13 Where are we with asking providers to
14 conduct site visits? Have some of the
15 providers conducted site visits where we
16 have multiple addresses for behavioral
17 health services? Have any been conducted
18 and have providers been willing to do that?

19 DR. EVANS: I'm not sure if I
20 understand.

21 COUNCILWOMAN QUINONES-SANCHEZ: So, the
22 recovery house has twelve men living in the
23 house. They all go to the same provider.
24 Part of the request a few years ago was when

1 we have multiple addresses, the providers
2 should go and visit the facility to make
3 sure it's appropriate.

4 DR. EVANS: What do you mean multiple
5 addresses?

6 COUNCILWOMAN QUINONES-SANCHEZ: We have
7 12 men living in a house.

8 DR. EVANS: Right.

9 COUNCILWOMAN QUINONES-SANCHEZ: The one
10 provider.

11 DR. EVANS: Right.

12 COUNCILWOMAN QUINONES-SANCHEZ: The
13 provider looks at there's a five-plus match.
14 We had this conversation last time.

15 DR. EVANS: Right, I know. When you
16 said in the past, which we agreed with and I
17 know Roland has followed up on, one of the
18 things you said, just to make sure I do
19 listen, is that, you know, how do we use our
20 leverage as a payer to ensure that people
21 are going to appropriate recovery houses.
22 And I know that Roland has followed up on
23 that.

24 Just as a way of background, you know,

1 that there are recovery houses that we
2 directly fund.

3 COUNCILWOMAN QUINONES-SANCHEZ: I get
4 that.

5 DR. EVANS: Okay.

6 COUNCILWOMAN QUINONES-SANCHEZ: My thing
7 is because we couldn't track state license
8 versus City-funded but we still have a
9 robust list --

10 DR. EVANS: Sure.

11 COUNCILWOMAN QUINONES-SANCHEZ: -- that
12 has been wonderful in working with other
13 stuff. We, as a mental health provider,
14 that has multiple matches, addresses. Part
15 of the request was why can't we get them to
16 help us when they see that to visit the
17 site, providing counseling, group individual
18 counseling to 12 people at an address?

19 I want to know have people willingly
20 cooperated? Have we gotten any reports
21 back?

22 DR. EVANS: Sure. I'm going to let
23 Roland talk about what they've -- they've
24 done in that area.

1 MR. LAMB: Good morning, Councilwoman.
2 Good morning, Chair and Members of City
3 Council. My name is Roland Lamb. I'm the
4 Director for the Office of Addiction
5 Services.

6 Your request two years ago did not fall
7 on deaf years. We have initiated a program
8 over the past year, really even before that,
9 where we are now holding the treatment
10 providers accountable for site control over
11 the recovery houses that people are -- that
12 they are accepting people into their
13 programs from. We are also saying to them
14 that the treatment services must be first.

15 We can't have a situation where we have
16 recovery houses farming bodies out to
17 treatment programs. We want to make sure
18 that the person has choice in the matter.
19 We are going to pilot it. We have four
20 providers that are now exercising site
21 control over the recovery houses. By that
22 we mean is we are holding the treatment
23 provider accountable for the behavior of the
24 recovery houses.

1 And by the way, in order to be in this
2 pilot, the recovery houses has to meet our
3 criteria. As you well know from talking
4 with Fred, it's a very stringent criteria
5 that requires a lot of support from the
6 community. We still have a problem. And
7 the problem is that we have all these
8 unattached recovery houses across
9 Philadelphia that are doing their own thing.
10 Many of them have been around for a while
11 and doing good work. We have a bunch that
12 are not.

13 Therefore, we are looking through the
14 states now policy of DDAP overseeing, you
15 know, the recovery house system and the
16 recommendations that are coming out of that
17 to then put those recommendations in play
18 here in Philadelphia. But we've begun to
19 get ahead of the curve by saying we are now
20 going to hold the treatment provider, the
21 licensed treatment provider accountable.

22 And hopefully, over the next year, we
23 can go from that 4 to 8 to 16 and see if we
24 can't have better controls over the recovery

1 houses that are working with people who are
2 in our treatment programs.

3 COUNCILWOMAN QUINONES-SANCHEZ: So, how
4 are you going to measure this?

5 MR. LAMB: Two ways. One, we are again
6 looking at the treatment provider. First,
7 we are saying that the choice must be the
8 person who is in treatment, you know, as far
9 as the treatment provider is concerned.

10 Two, the treatment provider must do an
11 adequate assessment that suggests that this
12 person would benefit from that kind of
13 housing.

14 And three, we are now putting it through
15 the Office of Addiction Services housing
16 unit. We are going out with the -- the
17 provider has to go out, too. We are going
18 out into the community. We are looking at
19 the providers. We are certifying the
20 houses. And we are also requiring that the
21 houses, you know, meet certain criteria as
22 far as reporting back to us.

23 COUNCILWOMAN QUINONES-SANCHEZ: And I
24 will tell you, I think that the work between

1 Fred and, obviously, you and this task force
2 we had with L&I really has helped a lot.

3 Moving forward as we educate folks and,
4 you know, I'm happy to hear that pilot and
5 we move forward. What should we be asking
6 residents to do when they suspect there's a
7 bad actor?

8 I will tell you, a lot of my Frankford
9 folks have really bonded together. The good
10 actors want the bad actors out. They
11 learned that this is not a good thing to do.
12 And we did utilize L&I on the code
13 enforcement stuff.

14 What is it that we need to be saying now
15 to our community partners to make them
16 reassure in case another one does pop up or
17 something pops up? How do you want us to
18 relate that?

19 MR. LAMB: Well, two things. One, I
20 want to continue the marvelous collaboration
21 that we've had with your office. I think
22 that the communication we've had over the
23 years has been more than helpful. That's
24 number one.

1 Number two, I'd like to make sure that
2 everyone in the community is educated. You
3 have a number of entities that are in your
4 community and you have not had an easy job
5 of it at the least. You have community
6 corrections programs. You have boarding
7 homes. You have recovery houses. You also
8 have licensed treatment programs. And then
9 you also have folks that are calling
10 themselves all kinds of different things in
11 your community that are just not consistent
12 with what good practice is.

13 So, we want to make sure the people are
14 educated as to what's what. The state has,
15 you know, a community corrections program
16 where no one in the City has, you know,
17 pretty much any authority over or has any
18 control over. The same thing is true with
19 certain licensed drug and alcohol treatment
20 programs. In fact, I would like to
21 encourage folks at this level to begin
22 thinking about asking the Department for
23 drug and alcohol programs to seek city
24 support for a program before it licenses

1 that program in a particular community
2 because we have no say over that.

3 Those are the kinds of things we would
4 like to be able to have. We would like to
5 als be able to know when folks are
6 "establishing" something in the community.
7 As you well know, we had our housing unit be
8 responsive to you and anyone who has called
9 them and actually gone out and taken a look
10 at recovery houses that are not even under
11 our purview to make sure that, you know,
12 what we're looking at here makes sense or it
13 doesn't make sense.

14 So, those are the kinds of things we
15 want to continue to do. Been able to go out
16 and meet with certain civic groups in the
17 community. And we certainly want to
18 continue the collaboration that we have had
19 with you and the community.

20 COUNCILWOMAN QUINONES-SANCHEZ: Yes. We
21 do have a lot more work to do with the
22 state. And -- and I -- I know that state
23 officials are starting to have hearings
24 about it. My concern is always that when we

1 engage the state, because there is so many
2 unfriendly people at the state as a result
3 the work that we're doing, the treatment,
4 there's always a concern because what they
5 end up doing is making it harder, not easier
6 for us to monitor the good and bad. Their
7 idea is let's cut the money as opposed to
8 how do we provide support so you can better
9 monitor site and do all the other things
10 that we're talking about.

11 That is definitely something. And the
12 reason to bring the community, the alliance
13 folks is we need to begin to have those
14 conversations because they have a different
15 relationship with the state also and the
16 legislators and being able to get people
17 around the table to say these services are
18 necessary. They need to be in every
19 neighborhood because every neighborhood has
20 people who need methadone and everything
21 else. How do we better license, approve,
22 identify and do those things. It's a very
23 delicate conversation. Because when I have
24 it at the state, people think punitive. I

1 don't want to be punitive. These are people
2 who need services.

3 And so, now that we have a democratic
4 governor who I think gets this and the
5 elimination of the asset tax and maybe
6 general assistance will come back, I don't
7 know, it's the right time to figure out what
8 are the regulatory issues that we need to
9 request.

10 I think we need the leadership from your
11 department to give us that. If we're going
12 to go for new regulations, what does that
13 look like so that Councilman Jones can talk
14 to the state delegation, I can talk to any
15 state delegation and others to say, you
16 know, when I was having a conversation be
17 Senator Shirley Kitchen around the
18 pharmacies, they're already moving in that
19 direction in terms of figuring out, you
20 know, the pill factories and those types of
21 things.

22 MR. LAMB: Right.

23 COUNCILWOMAN QUINONES-SANCHEZ: So we
24 can have a getter conversation. I don't

1 know what those all are because I don't know
2 their protocols, but I don't want it to be
3 punitive and then hurt.

4 MR. LAMB: You'll be happy to know I
5 agree with you on the fact that this is --
6 we have an opportunity now. Across the
7 state, the recovery house issue is an issue
8 as well nationally. So, we have an
9 opportunity to take the lead. You'll be
10 happy to know not only do we support Fred
11 and par on the state's work group for
12 recovery housing, my deputy Marvin Levine is
13 also on the work group for recovery housing
14 that goes up to Harrisburg and meets.

15 So, we are very much involved in the
16 leadership of direction and the
17 recommendations that are going to be coming
18 out of the state around recovery housing.
19 And in some cases, what we're doing here in
20 Philadelphia is actually being used as a
21 model. So, I think that we have an
22 opportunity to make some real substantive
23 changes in the recovery house arena.

24 COUNCILWOMAN QUINONES-SANCHEZ: All

1 right. Thank you. Thank you, Mr. Lamb.

2 COUNCIL PRESIDENT CLARKE: Thank you,
3 Councilwoman. Chair -- let me real quick,
4 Councilman, one second. Since I -- excuse
5 my, I don't know if it's called tardiness
6 because I am way over traditionally late. I
7 want to thank you all. Apologize.

8 I do have one question. My
9 understanding that in earlier testimony, and
10 good morning.

11 DR. EVANS: Good morning.

12 COUNCIL PRESIDENT CLARKE: Is that you
13 all committed in its entirety to the
14 school-based family services model.

15 DR. EVANS: You heard that? Of course.

16 COUNCIL PRESIDENT CLARKE: Councilman
17 te -- okay.

18 DR. EVANS: It's a done deal.

19 COUNCIL PRESIDENT CLARKE: I understand
20 that some of the challenges associated with
21 implementation. You know, I mean, this is
22 not some short term thing.

23 DR. EVANS: Sure.

24 COUNCIL PRESIDENT CLARKE: We had a

1 really good presentation. People understood
2 it's going to take time. In Cincinnati, I
3 think they took five years to fully
4 implement theirs in all of their schools. I
5 understand. I want to thank you. This is
6 something that we really need to do.

7 I referenced -- when I talk about it, I
8 reference Councilman Jones district in 86
9 and that -- all that empty space that we had
10 that actually faces out onto the Ridge
11 Avenue commercial corridor. And the thought
12 that we can actually put other services and
13 Councilman Jones can put his office in that
14 place and we get free rent, because we are
15 paying right now for his district office.
16 We can put that thing up there and cut back
17 on that budget would be very helpful.

18 I want to appreciate, you though, for
19 talking about the way that we can
20 collaborate and get this in place.

21 DR. EVANS: Sure.

22 COUNCIL PRESIDENT CLARKE: Thank you.

23 Chair recognizes Councilman Jones.

24 COUNCILMAN JONES: Thank you from all my

1 constituents to look out for us like that.

2 On the level of what Councilwoman
3 Sanchez talked about, just briefly can
4 you -- I know you monitor all of your
5 subcontractors. And I would imagine it's in
6 the performance-based --

7 DR. EVANS: Sure.

8 COUNCILMAN JONES: -- manner. And I
9 don't know if it's a pass/fail or a -- you
10 got a B. You can get an A if you do the
11 following things. I don't know if it's on
12 that kind of measurement.

13 DR. EVANS: Sure.

14 COUNCILMAN JONES: If it is, is it
15 appropriate for you to share that with us?

16 DR. EVANS: Sure.

17 COUNCILMAN JONES: Because if we're
18 talking about the numbers that you
19 mentioned, it's a major commitment by your
20 department, but it's a major commitment of
21 our budget. And we constantly -- we are
22 going to ask the same thing of DHS.

23 But is there a way that you can kind of
24 constantly inform us, hey, we're doing good

1 in this aspect of it. We need to do better
2 in recovery. And by doing that, I think a
3 couple years ago you guys did a wonderful
4 presentation showing the inner locking
5 relationship between you, DHS and, I think
6 it was, the Health Department. And I just
7 thought it was an excellent way to get us to
8 understand how this major budget
9 classification works.

10 So, if you can share that again.

11 DR. EVANS: Let me just tick off a
12 couple things just so you have a sense of
13 comprehensiveness of the way we approach it.

14 I mentioned we have what we call, for
15 lack of a better word, integrated monitoring
16 teams. That's not what we call them
17 internally, but that's probably more
18 descriptive of people who work across my
19 agency from CBH to Office of Addiction
20 Services to mental health. We do a
21 comprehensive look at each provider every
22 year or every other year depending on how
23 long they're credentialed.

24 We do Pay For Performance where we look

1 at data and we -- we determine which
2 providers are performing well and which are
3 performers -- providers are not performing
4 so well. In fact, we have been written up
5 about our Pay For Performance system as one
6 of the few places in the country that have a
7 pay-for-performance behavioral healthcare
8 system. It's pretty extensive.

9 We have -- just a quick aside, on the
10 Pay For Performance, we have been literally
11 saved millions of dollars because we're able
12 to do is by incentivizing providers to
13 provide better care, we have been able to
14 reduce things like unnecessary readmissions
15 to inpatient settings which at 5/600 dollars
16 a day can be quite expensive. We literally
17 saved millions of dollars. We more than
18 paid for the program.

19 So in addition to Pay for Performance,
20 in addition to the monitoring, we also have
21 consumer satisfaction team. There is a
22 separate contract, people who go out and
23 talk directly to people in the programs
24 independent of us. And what they are asking

1 is, how were you treated? Are your needs
2 being met?

3 They give us a report on each provider
4 every year. I meet with them, with the
5 executive director of that agency that does
6 that report with my executive staff. We go
7 over those reports, over their findings.
8 And we deploy them to do other kinds of
9 work. Within CBH, we also have compliance
10 that goes out and looks at their -- at
11 providers, whether or not they are adhering
12 to Medicaid rules.

13 We also have quality checks where if
14 there is an issue, a critical incident,
15 where we will send staff from CBH and often
16 physicians into providers to look at what,
17 you know, the practice or providers. If you
18 kind of put all of that together, you know,
19 we have a pretty comprehensive view of any
20 particular provider. You know, the issue
21 around sort of carrot sticks, we have I
22 think a good combination of carrot sticks.
23 The Pay For Performance is a carrot.

24 If you achieve really highly, you will

1 get financially rewarded. We also have
2 sticks so that if providers aren't doing
3 what they need to do, we will extrude them
4 from the network. We've done that last
5 year. I think we terminated the contracts
6 for two or three different providers who
7 weren't meeting muster.

8 I think we have a good comprehensive
9 range of things. We try to be very
10 thoughtful. Couple of other things that I
11 will just mention in terms of quality, we
12 have a very extensive evidence-based
13 practice initiative where we are bringing in
14 the best practices literally in the world in
15 terms of state of the art. And, you know,
16 people in South Philly and North Philly and
17 West Philly are really getting start of the
18 art treatments in some of our treatment
19 programs.

20 And you know, all of that together, I
21 think, gives us, you know, a level of
22 confidence that, for the most part, people
23 are getting good services.

24 COUNCILMAN JONES: So, we have over the

1 years found -- we kind of in this body kind
2 of know which departments kind of really
3 give us what we need by way of information
4 and trusting that -- you're one of them, so
5 that you know.

6 One of the things that I hope you might
7 consider, friendly submitted, is that a
8 certain point in some departments what we
9 realize that we are contracting out,
10 contracting out, contracting out. And it
11 felt good. Cost effective when we first
12 started. We started realizing that the cost
13 of it started inching up. And some
14 departments actually took the direction to
15 say, no, I'm not going to contract. I'm
16 going to -- it hit the equilibrium point
17 where I want to higher someone.

18 The Recreation, Public Property has done
19 that. They have done in-house units now
20 where they realize it just doesn't pay for
21 me to keep contracting out.

22 DR. EVANS: Sure.

23 COUNCILMAN JONES: In your field of
24 endeavor, is there a equilibrium point or is

1 there an evaluation where you say, you know
2 what, we spend a lot on this, a lot on this.
3 Maybe it comes a time where we should within
4 our own employment base hire somebody to
5 just cover that. Do you evaluate for that
6 kind of thing particularly around schools?

7 At what point is it better to just go
8 ahead and get a counselor that has a degree
9 in social work or even better a doctorate in
10 healthcare or mental health?

11 DR. EVANS: Sure. I think this comes
12 down to how we're funded. We're not funded
13 like most other city agencies. Most of the
14 dollars that we get are state/federal
15 dollars. Most of those dollars are Medicaid
16 dollars. And obviously, Medicaid has
17 certain rules around what you can pay for,
18 what you can't pay for.

19 We cannot pay ourselves to provide
20 services, for example. I think your
21 question was should we just hire people and
22 deploy them. Not really. Because what we
23 have to do and what we're required to do is
24 identify providers who are licensed and have

1 those providers pay their service. And our
2 role is then to pay for and oversee that
3 system.

4 COUNCILMAN JONES: Okay. Understood.
5 Thank you, Mr. Chairman.

6 COUNCIL PRESIDENT CLARKE: Thank you,
7 Councilman.

8 Chair recognizes Councilman Neilson.

9 COUNCILMAN NEILSON: Just a real quick
10 follow up to Councilman Jones.

11 You cannot pay yourselves for those
12 services. However, are we able to pay the
13 School District? That's not yourselves.

14 DR. EVANS: Right. No, I understand.

15 COUNCILMAN NEILSON: Can you register as
16 a provider, kind of on the line what I was
17 talking about earlier, that we could put
18 people full time in those school facilities?
19 I mean, we can -- it's there.

20 DR. EVANS: We certainly can look at
21 that. Let me give you an example. It's a
22 good question.

23 So typically, we contract with two types
24 of providers: Either license programs, so

1 community mental health center; a hospital,
2 so Temple, University of Pennsylvania
3 hospital systems. We contract with them for
4 inpatient services or residential services
5 or outpatient services and then we also
6 contract with individual practitioners at
7 the doctorate level, so psychiatrist and
8 psychologist. We independently can be a
9 part of our network.

10 Those are the only two types of
11 providers that we reimburse for Medicaid
12 reimbursable services. So, it could be that
13 a -- the School District, I mean, we can
14 talk through this. I am sure that somebody
15 back there that wants to kick me at this
16 point.

17 COUNCILMAN NEILSON: I know.

18 DR. EVANS: They can't reach me yet, so
19 I am going to just tell you what I think.

20 COUNCILMAN NEILSON: Every other
21 commissioner had Rebecca to the rescue. I
22 don't see Rebecca coming up right now. How
23 about if we just do this, Commissioner,
24 because we know where this is going to go.

1 Can you make a commitment on the record
2 that you work with us --

3 DR. EVANS: Absolutely.

4 COUNCILMAN NEILSON: -- Councilmembers
5 to take a hard look at this. And maybe by
6 the end of the summer period, we have
7 answers that we can report back to the
8 public and say, hey, we're trying to make
9 our schools better. This way we can have a
10 program in place by September by the time
11 school starts if we have to -- if we come to
12 some creative way to do this.

13 DR. EVANS: We absolutely can do that.
14 You know, I read Councilman Clarke's, you
15 know, the whole concept. And, you know,
16 it's a very good concept. It's a very
17 strong concept. We are certainly willing to
18 sit down with you and figure out how do we
19 creatively use the funding that we have to
20 both address the needs that you have or that
21 you are identifying but to do it in a way
22 that sort's of consistent with the way
23 you're discussing.

24 We would welcome those conversations.

1 COUNCILMAN NEILSON: And again, thank
2 you, Commissioner. And thank you for all
3 the work.

4 I have nothing further, Mr. President.

5 COUNCIL PRESIDENT CLARKE: Thank you,
6 Councilman.

7 I just had one question. How many
8 district schools do not have a full-time
9 behavior or mental health specialist on
10 staff?

11 DR. EVANS: That we fund or in general?
12 Because the School District, I think, they
13 have lost most of their counselors.

14 COUNCIL PRESIDENT CLARKE: How many do
15 you fund?

16 DR. EVANS: We are in 107 schools
17 providing school therapeutic services and
18 then another 30 or so -- 25 schools where we
19 are providing prevention-type services.

20 COUNCIL PRESIDENT CLARKE: So, we --

21 DR. EVANS: We are in over half of the
22 schools.

23 COUNCIL PRESIDENT CLARKE: We have like
24 267 schools?

1 DEPUTY COMMISSIONER JONES: I think
2 there's 218 schools. Of the 218, we are in
3 132. About 61 percent.

4 COUNCIL PRESIDENT CLARKE: All right.
5 So 218? When the School District
6 representative was here earlier, actually
7 late last year, she said it was 267.

8 DEPUTY COMMISSIONER JONES: I think that
9 that 267 includes their preschools, their
10 alternative schools.

11 COUNCIL PRESIDENT CLARKE: Okay.

12 DEPUTY COMMISSIONER JONES: When I'm
13 saying 218, I'm referring to specifically K
14 through 12.

15 COUNCIL PRESIDENT CLARKE: Okay.

16 DR. EVANS: Which is where we have
17 services.

18 COUNCIL PRESIDENT CLARKE: Okay. All
19 right. Thank you.

20 Appears to be it for today. Thank you
21 very much for your testimony.

22 DR. EVANS: Thank very much. I want to
23 congratulate and thank Councilwoman Tasco.
24 I know this is your last testimony, so.

1 (Applause)

2 DR. EVANS: Thank you for all your
3 support over the years.

4 COUNCIL PRESIDENT CLARKE: We talked her
5 out of it. She's going to hang around.

6 (Laughter)

7 DR. EVANS: I don't know. She's got
8 that retirement look in her eyes. I don't
9 think.

10 Thank you.

11 COUNCIL PRESIDENT CLARKE: Thank you so
12 much for your testimony.

13 Health Department is next.

14 - - -

15 (Brief break taken as Health Department
16 gathers towards Witness Table.)

17 - - -

18 COUNCIL PRESIDENT CLARKE: We are going
19 to start now. Thank you.

20 Good afternoon. Please proceed.

21 DR. BUEHLER: Good afternoon, Council
22 President Clarke and Members of City
23 Council. My name is James Buehler. I'm the
24 Health Commissioner for the Philadelphia

1 Department of Public Health. I'm pleased to
2 be here today with you. I'm joined by Tara
3 Mohr who is our Deputy Commissioner for
4 Finance and Jane Baker who is the Chief of
5 Staff for the department. Thank you very
6 much for the opportunity to present the
7 Department of Public Health's operating
8 budget for Fiscal Year 2016.

9 The FY16 Budget will continue to support
10 our mission to protect and promote the
11 health of all Philadelphians and to provide
12 a safety net for the most valuable. You
13 have my full written testimony, so I will
14 summarize.

15 With the support of council and the
16 collaboration of many partners throughout
17 the City, the department has extended the
18 progress made under the leadership of my
19 predecessor Dr. Donald Schwarz, and we have
20 addressed new challenges, as well. The
21 department's fiscal year budget request
22 totals \$354 million of which 160 million is
23 in the General Fund, 75 million in the
24 Grants Fund and 163 million in the Acute

1 Hospital Care Assessment Fund.

2 For the General Fund request, this
3 represents an increase of approximately
4 \$31,000 over FY15's estimated obligations.
5 This increase is due to anticipated salary
6 increases or to help cover those for DC33
7 and DC47 staff.

8 The budget will support 983 full-time
9 positions. Among 830 currently filled
10 positions as of last December, nearly
11 three-fourths are held by people of minority
12 race ethnicity. A proportion that is
13 similar for the 51 new full-time staff hired
14 through December 2014 for the current fiscal
15 year. Women account for 70 percent and
16 61 percent respectively for all full-time
17 staff and new hires. People who are
18 bilingual or multilingual represent 29
19 percent of full-time staff and 30 percent of
20 new hires with the predominant language
21 being Spanish, but a list that includes many
22 other languages from around the world.
23 35 percent of our contract dollars spent
24 with for-profit companies are for companies

1 with MWD status above our target set by OEO
2 of 20 percent.

3 Key highlights from our program include
4 the following. Our ongoing efforts to
5 discourage smoking and promote smoking
6 cessation and prohibit tobacco sales to
7 minors have been accompanied by declines in
8 tobacco use. According to the latest survey
9 conducted by the Public Health Management
10 Corporation, smoking rates among
11 Philadelphians are at an all time low. We
12 are continuing our collaborations with the
13 Philadelphia School District and others to
14 promote health among youth. And we have
15 seen continuing declines in the rate of teen
16 births, sexually transmitted diseases among
17 teens. And we have seen continuing declines
18 in the obesity rate among children.

19 We continue to see improvements in air
20 quality in Philadelphia reflecting our work
21 to monitor air quality and to regulate
22 emissions.

23 Regarding our Food Service Inspection
24 Program, we are continuing to upgrade the --

1 our service to food service owners
2 automating our services. In addition, we
3 have -- are adding more sanitarians to
4 improve the timeliness of our inspections
5 and we have provided new training to our
6 sanitarians to improve the consistency of
7 their work around the City.

8 Dr. Schwarz has previously spoken to you
9 about our work over the past few years to
10 become accredited by the National Public
11 Health Accreditation Board. Earlier this
12 year we submitted documentations of our
13 accomplishments and capacities to fulfil
14 approximately 300 criteria that are acquired
15 to become accredited. We are hoping that
16 following the site visit this summer, that
17 we will achieve full accreditation. Going
18 forward, this will make us more competitive
19 for federal grants in the future.

20 Dr. Schwarz has also spoken previously
21 about our work to install an electronic
22 health records system in our eight community
23 health centers. This has been a huge effort
24 requiring upgrades to our information

1 technology infrastructure, a step by this
2 roll out and successful centers and training
3 of administrative nursing and physician
4 staff in the use of this new tool. The
5 electronic record system is now up and
6 running in all eight of our clinics. Over
7 the current year, we will continue to build
8 out the capacity so we will be able to take
9 full advantage of that system.

10 We are also proud to continue our
11 tradition of providing high quality care to
12 people of Philadelphia. Roughly half our
13 patients are ensured either by Medicaid or
14 Medicare and few by private insurance.
15 Roughly, half of our patients are uninsured.
16 We are very proud to learn that this year
17 among our patients who have been surveyed,
18 91 percent would recommend to their family
19 members to come to our clinic, which is the
20 highest patient satisfaction score for any
21 other organization in Philadelphia that
22 provides community health centers.

23 We also know that the community health
24 survey conducted by BHMC, that the

1 percentage of Philadelphians 18 to 64 years
2 in age who lack health insurance has dropped
3 from around 18 and a half percent in 2012 to
4 12 percent this year. This is a trend that
5 does not yet reflect the impact of Medicaid
6 expansion in Pennsylvania. We have not yet
7 seen the increase in overall percentage of
8 patients at our clinics that are insured.
9 We expect the Medicaid Expansion will make a
10 difference and our benefits counselors
11 continue to work actively with our clients
12 to determine their eligibility and to get
13 them enrolled.

14 The Ebola outbreak in West Africa, which
15 is ongoing, although beginning to decline as
16 well as occurrences of two cases of Ebola of
17 nurses in Dallas last fall shook the nation
18 Headlines screamed about the fear of Ebola.
19 In collaboration, both the state and the
20 federal governments, we work with the
21 healthcare community to assure their
22 readiness. We provided information to the
23 public and we collaborated with groups that
24 represent our large West African community

1 in Philadelphia to address their concern and
2 to confront the problem of fear-bola.

3 In addition, we've been in daily contact
4 with travelers who are entering Philadelphia
5 from the three effected countries in West
6 Africa out to 21 days from their departure.

7 On any given day, seven days a week this has
8 involved calls between 30 and 50 people.

9 And altogether, we have now worked with
10 approximately 500 travelers of whom just a
11 very few have required further medical
12 evaluation. And none have had Ebola.

13 Also in the news this year was the
14 nationwide measles outbreak, but that
15 outbreak bypassed Philadelphia. That's
16 probably due in some part to luck, but it's
17 also a testament to our immunization
18 program, to the diligence of doctors and
19 nurses throughout Philadelphia, and the fact
20 that our level of measles vaccine coverage,
21 over 95 percent of children in Philadelphia
22 between 1930 and five months of age have had
23 more than one dose of measles vaccine is
24 over 95 percent and is higher than both the

1 state and the national averages.

2 Lastly, the Pope is coming to
3 Philadelphia in September and working with
4 the City's office of Emergency Management to
5 be prepare to protect the health of
6 Philadelphia and the estimated 2 million
7 visitors who will be coming to our City
8 during this event.

9 I thank you Council President and
10 Members of the Council for your continuing
11 support of public health in Philadelphia.
12 And I will delighted to answer your
13 questions.

14 COUNCIL PRESIDENT CLARKE: Thank you.

15 One quick question and I will defer to
16 my colleagues. How many health centers do
17 we have?

18 DR. BUEHLER: We have eight.

19 COUNCIL PRESIDENT CLARKE: All of them
20 located in publicly owned facilities?

21 DR. BUEHLER: That's correct. I
22 believe -- they're either City-owned
23 facilities. Right now Health Center 2 is
24 operating a temporary space that's rented

1 because that health center is being
2 renovated in collaboration with the
3 Children's Hospital of Philadelphia, the
4 Parks and Recreation Department and the
5 Library. There will be a new multi --
6 agency multi-organization center in South
7 Philly that will house Health Center 2.

8 COUNCIL PRESIDENT CLARKE: Okay.

9 If the cost associated, because it's
10 publicly owned, if -- I'm assuming that
11 being able to be a publicly-owned site
12 reduces significantly the cost of operating;
13 am I correct?

14 DR. BUEHLER: I would assume so, but I'd
15 have to double check to be sure.

16 COUNCIL PRESIDENT CLARKE: All right.
17 See you smiling at me saying where is this
18 guy going. As we continue to deal with the
19 challenges of, I think you're going to hear
20 some questions shortly about not having
21 enough health centers -- if we were in a
22 position to utilize other publicly-owned
23 space, essentially be nominal cost in terms
24 of our use of the space for rent purposes,

1 would that significantly help or help to
2 some degree your ability to expand the
3 health care center?

4 DR. BUEHLER: Right. Just to back up a
5 bit. Our eight centers are also
6 complemented by over 30 other, what are
7 called federally qualified health centers or
8 FQHCs, community health centers.

9 COUNCIL PRESIDENT CLARKE: Do we pay for
10 those?

11 DR. BUEHLER: No. They are
12 independently operated.

13 COUNCIL PRESIDENT CLARKE: Okay.

14 DR. BUEHLER: They serve a clientele
15 somewhat similar to ours. We tend to see a
16 higher percentage of patients who are
17 uninsured. We don't turn anybody away.

18 Clearly, if we were going to expand our
19 capacity, then moving into space that the
20 City already owns would be substantial
21 savings. We know that average square
22 footing of our health centers is about
23 23,000 feet. We also have some special
24 information technology infrastructure

1 requirements to support the various
2 technologies that -- that we have. So, the
3 expense to move into existing space would
4 need to accommodate our footprint as well as
5 IT infrastructure needs.

6 COUNCIL PRESIDENT CLARKE: Okay. All
7 right. Thank you.

8 Chair recognizes Councilman Greenlee.

9 COUNCILMAN GREENLEE: Thank you,
10 Mr. President. And you're right, I think I
11 want to talk about that same subject, too.

12 First, let me just say it was great
13 working with your department on the
14 regulation of electronic cigarettes. Has
15 that -- has been any studies done on that to
16 show the effect of that yet as far as people
17 cutting that -- first children not using it
18 and then any other effects?

19 DR. BUEHLER: We don't have local data
20 for Philadelphia yet. We know at the
21 national level that, unfortunately -- the
22 good news is that regular tobacco use is
23 declining among young people. But that's
24 almost made up for -- that is being offset

1 by increase in use of electronic cigarettes
2 by youth.

3 COUNCILMAN GREENLEE: Right. Something
4 we got to keep working on. On the health
5 center issue --

6 DR. BUEHLER: Yes.

7 COUNCILMAN GREENLEE: I ask this every
8 year as a number of people do. And I was
9 thinking along the same lines as Council
10 President. One of the question I bring up
11 all the time is Health Center 10, which is a
12 problem. I know.

13 (Applause)

14 COUNCILMAN GREENLEE: I did that just to
15 make Allison Rosenthal happy.

16 But obviously, that's got the longest
17 waiting list. Councilman Neilson and I were
18 talking about how it encompasses such a
19 large area. I mean, they all encompass an
20 area. But that, I think, where it, is that
21 area north of it has grown over the years.
22 And I think the need from the people in that
23 area have obviously grown.

24 And I think -- I think you were kind of

1 talking about this where the Council
2 President was going. Is there any way to
3 make, for lack of word, satellite offices or
4 something?

5 DR. BUEHLER: Let me say a little bit
6 more about the health centers and Health
7 Center 10. Just want thank you for the
8 opportunity to talk about the situation at
9 Health Center 10.

10 So overall, City-wide our average wait
11 time for a new patient visit, median wait
12 time, is about 49 days. It's substantially
13 longer. It's four or five months at Health
14 Center 10. The wait time for an existing
15 patient is considerably shorter. The wait
16 time for a pediatric patient is much
17 shorter. The wait time for a new prenatal
18 patient is very short.

19 But Health Center 10 is clearly right
20 now the pressure point. We are taking
21 several steps to address that. One is that
22 we are soon to bid out for expanding the
23 number of examination rooms at Health Center
24 10. We have applied for a new federal grant

1 that would allow us to expand the
2 operational hours at Health Center 10 as
3 well as to add more behavioral mental health
4 services. Part of that is tied up with our
5 status of what's called a federally
6 qualified health center lookalike. We
7 transitioned -- are looking to transition
8 with Health Center 10 to a full fledged
9 federally qualified health center.

10 That will allow us to take advantage not
11 only of federal subsidies to supplement the
12 Medicaid reimbursement rates, but it will
13 also if we are successful in that
14 application, that allows us to apply for
15 federal funding for both capital and
16 operational dollars. We are hopeful about
17 that.

18 We -- we have looked at a possible
19 space. I believe I mentioned there in the
20 capital budget hearing that it's great space
21 but a terrible location. And so, we've met
22 once with PIDC. We are planning to have a
23 follow-up meeting with them to explore
24 possibilities for expanding that. And the

1 options would include either developing a
2 satellite or building an entirely new
3 center.

4 COUNCILMAN GREENLEE: Okay. I know
5 money is always an issue and part of our
6 problem, I guess. Has there been any study
7 done as far as where the people come from
8 that go to Health Center 10?

9 For example, I would expect over the
10 years that the folks that came from the more
11 northern part of that area has increased.
12 Is that a fair statement?

13 DR. BUEHLER: So in order to apply for
14 that additional federal funding that I
15 mentioned, we did have to do a needs
16 assessment.

17 COUNCILMAN GREENLEE: Right.

18 DR. BUEHLER: That clearly validated
19 what we all know that indeed there is an
20 unmet need for care in that part of the
21 City. I think in part because of the growth
22 and the changing nature of the population.
23 So, that is definitely a part of it.

24 We're also collaborating with a group at

1 the University of Pennsylvania on a study
2 that they're doing to look at the
3 relationship between population and where
4 access to primary care is located. We will
5 be looking forward to their results.

6 COUNCILMAN GREENLEE: Okay. I
7 appreciate. And again, I know you don't
8 like those wait times any more than anybody
9 else does. We're certainly not blaming.
10 But by the same token, seems that every year
11 we talk about the same issue.

12 DR. BUEHLER: I hope that next year we
13 will be able to have more progress.

14 COUNCILMAN GREENLEE: First off, we hope
15 you're here to ask you those questions.

16 Thank you, Mr. President.

17 COUNCILMAN NEILSON: All right. I'm
18 going to pick up right where Bill left off.
19 Because unfortunately, if we wait till next
20 year to solve this issue and with people
21 waiting four to five months to see a doctor,
22 they are going to die. They are not going
23 to be here next year. I mean, that's real.
24 They are going untreated.

1 Tomorrow, what is your solution for
2 this? I mean, we brought up year after
3 year. I know you're new. You and I got
4 sworn in probably the same time, so I don't
5 want to put the pressure on you but we need
6 to because these people are in dire need.
7 And it's not -- it's just not fair the way
8 it's laid out. And we talked it, fairness
9 and equality. Everything we talk about down
10 here at City Council is this.

11 So, we have people waiting four to five
12 months. What can we do in the immediate
13 response? Can we transport them to other
14 health centers? Can we make them because
15 they can't get around? Is there something
16 we can provide these people service to cut
17 this time down because this is one of those
18 unacceptable situations.

19 And for us to say, well, maybe next year
20 we'll fix it, I mean, that's what you just
21 said, I couldn't let that go. That's not
22 acceptable to me or any other Member of
23 Council.

24 DR. BUEHLER: I appreciate --

1 COUNCILMAN NEILSON: I know we did a
2 study. We did the assessment. We all know
3 what we know. What are we going to do
4 tomorrow? Not next year, tomorrow.

5 DR. BUEHLER: Another point that is
6 important to emphasize is that roughly
7 one-fourth of all of our patient visits you
8 see around 300,000 patient visits a year.
9 Among about 80,000 -- 70, 80, 90,000 people.
10 About a quarter of all our patient visits
11 are walk ins. We do reserve space on our
12 agenda at every one of our centers for
13 walk-in clients.

14 The second thing that we can do is
15 that -- we'd be happy to get back to you
16 with information about the differences in
17 wait times at different facilities. It's
18 substantially less at other places. Any
19 resident of Philadelphia can go to any one
20 of our health centers. They don't have to
21 wait to get into Health Center 10.

22 COUNCILMAN NEILSON: Because that's what
23 we just said -- four, five months wait.

24 DR. BUEHLER: At Health Center 10 wait

1 time.

2 COUNCILMAN NEILSON: That's's what at
3 issue here is 10. If it's that bad there,
4 we have to be able to compensate for the
5 other ones. Seems just like a shift of
6 services because the population and the
7 demographics and the people who need the
8 help most are moving around the City, and we
9 ought to be able to shift along with them.

10 We just had it from our previous
11 commissioner came in about the mental health
12 services. Are you teaming up with them to
13 get some of their funding to try and provide
14 some of these services within your centers?

15 DR. BUEHLER: We have started a pilot at
16 two of our health centers. The numbers are
17 not -- at the tip of my tongue to on a pilot
18 basis offer mental health services that are
19 really integrating the mental, behavioral
20 and physical healthcare at two of our
21 centers. If that works, then we will
22 continue to expand that.

23 We are seeking to get -- to be able to
24 seek reimbursement from CBH for those mental

1 health services. We are stepping down that
2 path.

3 COUNCILMAN NEILSON: Wonderful. Also in
4 your testimony, you mentioned a percentage
5 of the people that come in to your facility
6 are uninsured. What was that percentage?
7 Do you remember what you said?

8 DR. BUEHLER: It's roughly half. We
9 expect that's going to change with Medicaid
10 expansion. It's really too early to see
11 that yet.

12 COUNCILMAN NEILSON: So the -- by
13 National Healthcare Reform, still we're
14 going through some transitions and getting
15 treatments first most important.

16 After we treat an individual or person,
17 are we attempting to get them the insurance
18 they need? Because a lot of people from my
19 experience in my previous office, we got a
20 lot of people that were uninsured come in
21 looking for insurance. They were qualified
22 but they just didn't know it.

23 DR. BUEHLER: Right.

24 COUNCILMAN NEILSON: After you provide

1 their healthcare services, do you provide a
2 counseling mechanism. Say, hey, look, you
3 need to go get insurance? Because I am sure
4 probably there has to be a high percentage
5 of people without insurance that do qualify.
6 It's just a matter of getting them to the
7 right spots.

8 DR. BUEHLER: Absolutely. So, we have
9 benefits counselors at our clinics. Right
10 now when we call you to remind you about
11 your appointment, we also remind you that if
12 you're not insured, what documents you would
13 need to bring that would enable us to get
14 you insured. In the first two quarters of
15 the current fiscal year, we successfully
16 enrolled nearly 2,000 people who would be
17 previously being uninsured in health
18 insurance. We hope to continue that.

19 We also work with other partners in the
20 community who are doing outreach to improve
21 the awareness about new opportunities to
22 become insured. So, we are doing everything
23 like we can within our clinics to make sure
24 that our clients are aware of their

1 eligibility and get signed up.

2 COUNCILMAN NEILSON: Thank you. Thank
3 you for your testimony. Doctor, you're
4 doing a great job. We both are I think.
5 But time will tell and thanks for coming
6 this.

7 No further questions, Mr. President.

8 COUNCIL PRESIDENT CLARKE: Thank you,
9 Councilman.

10 Chair recognizes Councilman Jones.

11 COUNCILMAN JONES: Thank you,
12 Mr. President, and welcome to government.

13 We give a customary free pass first year
14 to every new commissioner because that's
15 what we do. So these questions, even if you
16 cannot answer them, will be ready for next
17 year, God willing, that you're still with
18 us.

19 Just a couple of quick things because I
20 heard some of the answers to my questions
21 by -- submitted by other people.

22 Just real quick. What is our obesity --
23 child obesity situation? Adult and child
24 obesity circumstance in Philly as you see

1 it?

2 DR. BUEHLER: So, adult obesity has
3 continued to gradually increase. The
4 childhood obesity has declined. Perhaps I
5 can say a little bit more about what we're
6 doing to address childhood obesity.

7 Much of that work is with the School
8 District. We have worked with the School
9 District to help them meet the guidelines
10 for healthy foods. We have helped them
11 assure that the school kids have access to
12 water to drink instead of sugar-sweetened
13 beverages. We have supported them in
14 wellness counsels and different activities
15 to increase opportunities to get up and move
16 around as well as things like fundraisers to
17 sell things that are not going to contribute
18 to obesity.

19 A variety of different things to work
20 with, with the schools to promote healthy
21 eating and active lifestyle.

22 COUNCILMAN JONES: Do you think
23 Councilwoman Reynolds Brown menu labeling
24 bill has helped out?

1 DR. BUEHLER: Well, we know -- we
2 know -- thank you for mentioning that.

3 We know that from the evaluation that
4 had been done, when we look at a chain
5 company that's got one of our restaurants or
6 a chain company that's in Philly and the
7 same company outside, but they have the
8 label on ours, inside Philly we know that
9 the buying patterns are different among
10 clients that coming to the restaurant that
11 have the menu labels.

12 You may also be aware that right now
13 although we are promulgating our regulation
14 and restaurants are adhering to that, our
15 restaurant inspectors when they go out to
16 the restaurants are looking at the menu
17 labels to assure it adheres to that. That
18 more aggressive implementation is now -- we
19 are preempted by the federal law. The main
20 difference between the federal law and our
21 law is that our regulation requires labeling
22 of salt content, which is also important.
23 It's a major contributor to high blood
24 pressure and morbidity and premature death.

1 We've applied to the FDA for a waiver or an
2 exemption so that we can use our labeling
3 bill that adds that requirement.

4 COUNCILMAN JONES: Between Councilman
5 Greenlee and Councilwoman Reynolds Brown,
6 major contributors which of paid sick leave
7 to getting us healthy in Philadelphia. I
8 thank both of my colleagues for that.

9 One of the reasons I supported menu
10 labeling, because I come from an economic
11 development background. Some of the small
12 businesses were really upset with the bill
13 because it cost them like 30,000 to change
14 their menu boards and things like that. But
15 one of the compelling reasons I went with it
16 was that Councilwoman Reynolds Brown showed
17 me a map where obesity was, where
18 hypertension in the City was, where organ
19 failure, kidney failure, other compelling
20 health reasons and also correlated it with
21 food deserts. So, she won me over through
22 the mapping and the statistics of it.

23 By way of hypertension, things like that
24 where -- is there a correlation between

1 poverty, food choices and other things that
2 these illnesses go up?

3 DR. BUEHLER: So there's a correlation
4 between poverty and many health risks or
5 adverse health outcomes. The risk of
6 disease or the risk of having a complication
7 of disease is widely recognized to be higher
8 in areas with high rates of poverty. That's
9 compounded by the lack of opportunities to
10 be healthy.

11 We worked with many other departments
12 around the City to try to expand
13 opportunities to be healthy to get exercise.
14 We also worked with the food trucks to
15 expand access to farmers markets. We worked
16 with corner stores all around the City to
17 help provide access to fresh fruits and
18 vegetables there. We have a food bucks
19 program that people can go to a farmers
20 market and amplify the food stamp benefit
21 that they get to buy fresh fruits and
22 vegetables.

23 We have done a number of things to try
24 to improve that situation all around the

1 City.

2 One other thing I mentioned is not our
3 program but the food trust recently was
4 awarded a \$5 million grant from Glaxo
5 Smith -- GSK to partner with youth
6 organizations to promote even greater access
7 to healthy food among young people. That's
8 not our program, but we worked with them and
9 supported that. So, our collaboration with
10 the Food Trust is providing them opportunity
11 to amplify our work.

12 COUNCILMAN JONES: How are we doing by
13 way of infant mortality. A couple of years
14 back it was a startling statistic that
15 suggested we had a higher,
16 disproportionately so, rate of infant
17 mortality in Philadelphia. Have we made any
18 headway with that?

19 DR. BUEHLER: This is an area where
20 we've made some progress, but clearly not
21 enough. Our infant mortality rates are
22 lower than they were ten years ago, but the
23 overall infant mortality rate in
24 Philadelphia for the last few years have

1 hovered around ten deaths for every --

2 COUNCILMAN JONES: How does that compare
3 to other cities?

4 DR. BUEHLER: It's comparable to other
5 cities with high levels of poverty and
6 comparable demographics.

7 COUNCILMAN JONES: Once again, the
8 poverty issue.

9 DR. BUEHLER: Right. We also see a very
10 sadly, again, this is not just a
11 Philadelphia problem. It's a national
12 problem that the infant mortality rate among
13 African-American infants is about three
14 times that for whites. The rate for
15 Hispanic infants is a little higher than
16 whites, but nearly -- not nearly that high.
17 It's a really tragic situation.

18 You know, we work to provide prenatal
19 services. We, through different funding
20 that we have from the Federal Government
21 either directly or through the state, have
22 different home visiting services. Other
23 organizations in the communities are doing
24 home visiting to mothers and families to

1 help them get their kids get the healthiest
2 possible start.

3 COUNCILMAN JONES: Last year you gave
4 out 37,000 condoms in 12 high schools in
5 order to try to deal with STDs.

6 A, how did you pick the high schools?
7 And, B, was it successful?

8 DR. BUEHLER: So, our goal is to have
9 free condoms available in every high school.
10 We pick the high schools by targeting every
11 high school. Right now, free condoms are
12 available to kids in every -- all but one
13 high school here in Philadelphia. And then
14 dispensing machine that they can go to. We
15 also do annual STD screening at high
16 schools. We went to, I think, 50 public
17 schools and seven charters the past school
18 year. As part of that, we offer voluntary
19 STD screening. We also make condoms
20 available. So it becomes available through
21 that screening effort but also through a
22 dispenser that kids can very without having
23 to ask for it, you can just get it.

24 We've also, through social media,

1 targeted education -- we are seeing the STD
2 rates coming down. That's -- the two most
3 common STDs are gonorrhea and chlamydia.
4 The rates on chlamydia and gonorrhea among
5 teenagers are coming down. We had some of
6 the highest rates in the country. Now for
7 the past several years, we have seen that
8 turn around and it's coming down.

9 COUNCILMAN JONES: Thank you,
10 Mr. President.

11 COUNCIL PRESIDENT CLARKE: Thank you,
12 Councilman.

13 Chair recognizes Councilwoman Reynolds
14 Brown.

15 COUNCILWOMAN REYNOLDS BROWN: Thank you.
16 Good morning, Mr. President.

17 COUNCIL PRESIDENT CLARKE: Good morning.

18 COUNCILWOMAN REYNOLDS BROWN: Did you
19 say all but one high school have condoms?

20 DR. BUEHLER: Yes.

21 COUNCILWOMAN REYNOLDS BROWN: Are you at
22 liberty to say which school does not and
23 why?

24 DR. BUEHLER: I'm sorry?

1 COUNCILWOMAN REYNOLDS BROWN: Which
2 school does not have the availability of
3 condoms and why?

4 DR. BUEHLER: It's believe it's Girls
5 High School. I'd have to follow up to get
6 the specifics on why they haven't joined on
7 yet.

8 COUNCILWOMAN REYNOLDS BROWN: You have
9 to follow up to let us know why they are not
10 in the mix?

11 DR. BUEHLER: Yeah. I don't know
12 exactly why they haven't signed on to the
13 program yet. We know that they are the one
14 high school that has not yet signed up yet
15 to allow us to provide the free condom
16 dispenser.

17 COUNCILWOMAN REYNOLDS BROWN: Okay. I
18 think it was three years ago I worked
19 closely with HAPCO, Homeowners Association
20 of Philadelphia because evidence suggested,
21 evidence data collected by PCCY, indicated
22 that too many of our children were still
23 being poisoned by lead. And since then, I
24 know the department has put some

1 infrastructure in place.

2 Provide an update, please.

3 DR. BUEHLER: We very aggressively
4 follow up on every child screening that has
5 an elevated blood level. We go out to the
6 house. We identify what the needs for
7 remediation of the house are and work to
8 resolve that situation. We also have a new
9 grant from -- federal grant that's allowing
10 us to be proactive. It's --

11 COUNCILWOMAN REYNOLDS BROWN: That's
12 good.

13 DR. BUEHLER: We identify neighborhood
14 and try to reach out in advance of a child
15 becoming lead poisoned.

16 COUNCILWOMAN REYNOLDS BROWN: And so, do
17 you have enough data to suggest that there's
18 been an improvement in those numbers?

19 DR. BUEHLER: We have seen overall rates
20 of lead poisoning in kids come down.

21 COUNCILWOMAN REYNOLDS BROWN: Very good.

22 DR. BUEHLER: The new effort to prevent
23 is too early in the going to show an impact.

24 COUNCILWOMAN REYNOLDS BROWN: Okay. I

1 would ask that you share that information
2 with HAPCO because they were a major
3 partners in trying to find some common
4 ground to address this issue. And I think
5 they deserve to know that their partnership
6 and us crafting, finding some middle ground,
7 has had great benefits.

8 DR. BUEHLER: Be delighted to make sure
9 you got that.

10 COUNCILWOMAN REYNOLDS BROWN: To the
11 leadership and membership of HAPCO.

12 I have a couple other questions linked
13 to Councilman Jones. Hopefully, they'll
14 come back to me.

15 Currently, what is the wait time to be
16 treated at any one of Philadelphia's health
17 centers?

18 DR. BUEHLER: It's going to vary by
19 whether you're a new patient, we've never
20 seen you before or whether you're an
21 existing patient and you're coming back.
22 The median wait time overall as of just
23 earlier this month was 49 days. The range
24 there is anywhere from a little over 31 out

1 to 127 with 127 being an outlier. That's
2 Health Center 10. It's less than that.

3 The median is 25 days if you are an
4 existing patient. If you are a pediatric
5 patient, the median is 5 days for a new
6 visit. And if you are a prenatal patient,
7 the middle point of that is 11 days.

8 COUNCILWOMAN REYNOLDS BROWN: Is what?

9 DR. BUEHLER: Eleven for prenatal.

10 COUNCILWOMAN REYNOLDS BROWN: Is that
11 improvement over past years? Does that
12 remain the same or no?

13 DR. BUEHLER: It's gotten a little bit
14 worse over the past year. Part of that is
15 because coincident with insulation --

16 COUNCILWOMAN REYNOLDS BROWN: Talk
17 deeper into the mic so I can hear you.

18 DR. BUEHLER: The wait times have
19 stretched out a little longer over the past
20 year in part because of the, you might say,
21 the disruption of installing the electronic
22 health record.

23 COUNCILWOMAN REYNOLDS BROWN: Okay.

24 DR. BUEHLER: We're not alone there.

1 The medic -- the whole country, every
2 clinic, every doctor, every hospital is
3 dealing with that transition. When you
4 install this new system, it takes time to
5 learn it, to accommodate to that.

6 COUNCILWOMAN REYNOLDS BROWN: Sure.
7 Sure. Let me do a rewind.

8 When you do the update with HAPCO, copy
9 me on that correspondence.

10 DR. BUEHLER: Sure.

11 COUNCILWOMAN REYNOLDS BROWN: Okay. So,
12 you are now in the world of electronic
13 records?

14 DR. BUEHLER: Yes.

15 COUNCILWOMAN REYNOLDS BROWN: Were there
16 multiple bidders on this new system, or is
17 there one electronic record system for the
18 entire city or for the entire country? Who
19 is the lucky provider?

20 DR. BUEHLER: The selection of a product
21 was made before I came on board. I know
22 there was a very extensive and thoughtful
23 consideration. The particular vendor that
24 we're working with is called the Clinical

1 Works. They have a strong track record of
2 working with primary care providers and
3 providers like ours. I know that they are
4 the provider that New York City used before.

5 COUNCILWOMAN REYNOLDS BROWN: Is that
6 right?

7 DR. BUEHLER: I'm sorry. The rest of
8 the question about the --

9 COUNCILWOMAN REYNOLDS BROWN: We have a
10 new provider. How old is that contract or
11 what's the span of that contract?

12 DR. BUEHLER: I believe it's -- Tara,
13 perhaps you can help me. The length of the
14 existing contract.

15 DEPUTY COMMISSIONER MOHR: It was a
16 multi-year contract. It was funded by
17 capital funds. It was a multi-year
18 contract. I believe that it initiated -- I
19 have the information.

20 COUNCILWOMAN REYNOLDS BROWN: Multi-year
21 means what? Two? Three? Four?

22 DEPUTY COMMISSIONER MOHR: Four years.
23 And we anticipate continuing work with the
24 vendor for several more years due to

1 maximizing/optimizing some of the other
2 additional features of the system.

3 COUNCILWOMAN REYNOLDS BROWN: Okay. The
4 bell has rung, so I will continue on the
5 next round. Thank you.

6 Thank you, Mr. President.

7 COUNCIL PRESIDENT CLARKE: Thank you,
8 Councilwoman.

9 Chair recognizes Councilwoman Tasco.

10 COUNCILWOMAN TASCO: I don't have a
11 question. They answered it. Thank you.

12 COUNCIL PRESIDENT CLARKE: Thank you.
13 Chair recognizes Councilman Jones.

14 COUNCILMAN JONES: Real quick,
15 Mr. President.

16 How are you dealing with the pricing of
17 the private sector compared to public sector
18 wages? Are we holding our own? How are you
19 addressing that?

20 DR. BUEHLER: Right. Our contractors
21 are compliant with the City's minimum wage
22 requirements.

23 COUNCILMAN JONES: That means?

24 DR. BUEHLER: Oh. This is constantly an

1 issue for us. There have been some areas
2 where we have been able to improve our
3 salaries and have greater guarantee with the
4 private sectors. Dr. Schwarz a few years
5 ago made extensive effort to try to improve
6 the salary level for physicians to make them
7 more competitive. We recently in our
8 medical examiner's office have also work to
9 make those salaries more competitive.

10 The scenario where the supply of people
11 coming into that training pipeline is
12 much -- doesn't meet the demand. I think
13 we're -- we do pretty well, but we can do
14 better.

15 COUNCILMAN JONES: Has anybody in the
16 personnel department did a comparable job
17 description to what a nurse's assistant or
18 nurse, a doctor working at Roxborough
19 Memorial Hospital would make compared to one
20 working in the Health Center?

21 Have you done an apples-to-apples
22 comparison on that?

23 DR. BUEHLER: I don't know that we've
24 done that come kind of comparison. But we

1 do know that the nursing area is an area
2 where we have a pretty high turnover because
3 it is a competitive market. We do tend to
4 lose nursing staff to outside providers.

5 COUNCILMAN JONES: By your next budget
6 testimony, God willing, can you provide that
7 to us? Because as we make decisions as to
8 our appropriations, I mean, it's helpful.
9 If there is a turnover problem for
10 registered nurses and it's because there's a
11 15, 17 percent differential in price, we may
12 beat the private market on the benefit side
13 but we're not holding our own on the wage
14 side. We would like to know that from a low
15 end of the spectrum to the higher end.

16 DR. BUEHLER: Will do.

17 COUNCILMAN JONES: Thank you,
18 Mr. Chairman.

19 COUNCIL PRESIDENT CLARKE: Thank you.
20 Chair recognizes Councilman Jones -- did you
21 want to follow Councilwoman Brown? You have
22 follow up?

23 COUNCILWOMAN REYNOLDS BROWN: Not a
24 follow up. Just the next round.

1 COUNCIL PRESIDENT CLARKE: Well, you're
2 the only one.

3 COUNCILWOMAN REYNOLDS BROWN: Okay. All
4 right. So, back to this question about the
5 health centers and the operational pieces of
6 that.

7 So, you've spoken about electronic
8 records. Are they transferable across the
9 system? A patient moves -- if they are
10 electronic, it's just a matter of plugging
11 in, correct?

12 DR. BUEHLER: Right. That's the goal of
13 electronic health record is that, first of
14 all, within our own network, it -- it's the
15 same system.

16 COUNCILWOMAN REYNOLDS BROWN: Okay.

17 DR. BUEHLER: That the patient can be
18 seen at any one of our clinics and we can
19 access their record at any other clinic.
20 The -- one of the dimensions of our
21 continued work is to make sure that we have
22 the capacity so that if one of our patients
23 is referred to a specialist or if one of our
24 patients is seen at an emergency department

1 if one of our patients requires
2 hospitalization, that we can have an
3 electronic handshake from their record
4 system to ours to do that.

5 COUNCILWOMAN REYNOLDS BROWN: That's
6 improvement.

7 DR. BUEHLER: That's part of where we
8 are headed this coming year.

9 COUNCILWOMAN REYNOLDS BROWN: Does that
10 work the same with Medicaid and Medicare?
11 Are patients -- when patients show up at the
12 health centers, you are able to make a
13 determination quickly because of electronic
14 records whether or not they have Medicare or
15 Medicare?

16 DR. BUEHLER: There is two parts of the
17 electronic health record system. One is the
18 administrative side, which the registration
19 would have information on the demographics
20 address, insurance status. The other piece
21 of the system is really the medical record
22 part. So, yes, we can look at our medical
23 record to know what we have known about that
24 patient before. But then in addition, every

1 time that we look at our list of who is
2 coming today, we double check. We can go
3 out to the state's system to see if they
4 were enrolled in Medicaid or not.

5 COUNCILWOMAN REYNOLDS BROWN: How
6 quickly are you reimbursed by Medicaid and
7 Medicare?

8 DR. BUEHLER: So, we -- there are two
9 steps to our reimbursement. One is the
10 immediate reimbursement and then there's
11 so-called wraparound payment that Medicaid
12 guarantees to help us break even, basically,
13 for those patients.

14 COUNCILWOMAN REYNOLDS BROWN: Okay. Can
15 you provide that information to me, please?

16 DR. BUEHLER: Yeah. I'd have to come
17 back.

18 COUNCILWOMAN REYNOLDS BROWN: Okay. I
19 would imagine the budgets for the health
20 centers are driven by what?

21 Complete the sentence.

22 DR. BUEHLER: They are driven by the
23 needs of our patients.

24 COUNCILWOMAN REYNOLDS BROWN: No two

1 health centers budgets are exactly the same?

2 DR. BUEHLER: I doubt it.

3 COUNCILWOMAN REYNOLDS BROWN: Okay.

4 What is the nature of follow up after a
5 patient leaves the health center?

6 DR. BUEHLER: It depends on what the
7 plan is that's worked out during the patient
8 encounter. If there is a plan that I want
9 to see you back in a couple of days, there
10 is room to do that in our scheduling. There
11 is immediate. They don't have to wait that
12 longer wait time or there's a follow-up plan
13 to come back at a specified time.

14 COUNCILWOMAN REYNOLDS BROWN: Two final
15 questions. President Clarke made it clear
16 at the very beginning of this budget hearing
17 process that departments needed to fit in
18 any one or all three of those categories.

19 What is the department's connectedness
20 to the Philadelphia public school system?

21 DR. BUEHLER: We have a pretty deep
22 connection with the Philadelphia School
23 District. Our aids program through
24 collaboration with a -- through one of our

1 community partners provides education and
2 counseling services around sexually
3 transmitted diseases and HIV.

4 COUNCILWOMAN REYNOLDS BROWN: All right.

5 DR. BUEHLER: We have a bunch of
6 different services that are in the schools.

7 COUNCILWOMAN REYNOLDS BROWN: So, could
8 one have a chart of all the schools in
9 Councilwoman Tasco's area and you would be
10 able to show by a chart where you are
11 connected to those schools?

12 DR. BUEHLER: Right.

13 COUNCILWOMAN REYNOLDS BROWN: Because
14 coordination is a big word. Means nothing
15 if it's not broken down by health center,
16 for example.

17 DR. BUEHLER: Right. So for the
18 different services that we offer, different
19 programs that we offer whether it's through
20 STD and HIV counseling, whether it's STD
21 screening, whether it's condom dispenser,
22 whether it's advise from between child
23 health program or reproductive health
24 issues, we know where those services are

1 being delivered either by our staff or by
2 partners in the community. Some of what we
3 do is more the policy level, working with
4 the School District around nutrition
5 standards or we work with their health staff
6 to make sure that they have questions about
7 infectious diseases or vaccinations, so that
8 would be school wide.

9 COUNCILWOMAN REYNOLDS BROWN: Okay.
10 That's not getting to where I want to go.

11 DR. BUEHLER: Okay.

12 COUNCILWOMAN REYNOLDS BROWN: That is
13 there are fewer nurses in schools.

14 DR. BUEHLER: Yeah.

15 COUNCILWOMAN REYNOLDS BROWN: Government
16 has to work smarter in how we complement
17 what the needs are amongst children across
18 the system. And so, if we know there are
19 fewer nurses and we know that that's the
20 business you're in, I am curious as to where
21 links are being drawn to schools that need
22 the service? Or is there some engagement of
23 universities where everybody argues they
24 should do more given the tax breaks they

1 get? Where are the links?

2 DR. BUEHLER: We can tell you where our
3 services are and be happy to follow up if
4 there's some concern about that
5 distribution.

6 COUNCILWOMAN REYNOLDS BROWN: Just
7 curious as we prepare for the School
8 District budget hearings. We know that
9 their needs are great. We know the struggle
10 that comes with funding every year. So, we
11 need to look to see what services we have
12 where people do that already for a living.
13 And unfortunately, burden in this case the
14 Health Department further so that we're
15 meeting the needs of these kids. But we
16 can't get to where we want to go if we don't
17 know what we have.

18 DR. BUEHLER: We'd be happy to provide
19 that report.

20 COUNCILWOMAN REYNOLDS BROWN: I would be
21 curious to see that by councilmatic
22 district.

23 DR. BUEHLER: Sure.

24 COUNCILWOMAN REYNOLDS BROWN: Okay.

1 Lastly, the Health Department has an ally in
2 Dr. Don Schwarz.

3 DR. BUEHLER: Yes.

4 COUNCILWOMAN REYNOLDS BROWN: What
5 opportunities have you seized in terms of
6 grant funding from the Robert Wood Johnson
7 Foundation stacked against needs that you
8 know we need here in Philadelphia?

9 DR. BUEHLER: Well, I think Dr. Schwarz
10 has to, for some period after joining his
11 new organization RWJ, maintain some
12 separation from his previous employer.

13 COUNCILWOMAN REYNOLDS BROWN: Okay.

14 DR. BUEHLER: But we do have a
15 relationship with the Robert Wood Johnson
16 Foundation. They funded much of our initial
17 work to help get accredited. They have
18 tremendous interest in what we do,
19 particular with our Get Healthy Philly
20 program. There are some other projects that
21 they funded.

22 COUNCILWOMAN REYNOLDS BROWN: Anything
23 around children and youth?

24 DR. BUEHLER: I'd have to double check

1 on that.

2 COUNCILWOMAN REYNOLDS BROWN: Please and
3 forward that to the Chair.

4 DR. BUEHLER: Sure.

5 COUNCILWOMAN REYNOLDS BROWN: Okay. Let
6 me close out by -- what Councilman Jones'
7 raised early about the issue of obesity.

8 After the implementation of the menu
9 labeling, I believe the Health Department
10 received a grant from the Centers for
11 Disease Control, is that not so? Is that
12 grant still in play or no?

13 DR. BUEHLER: Right. Much of our
14 Chronic Disease Program, much of our Get
15 Healthy Philly Program is supported by grant
16 dollars from CDC. Those different grants
17 tend to come and go, but we still have
18 substantial support from CDC for chronic
19 disease prevention activities.

20 COUNCILWOMAN REYNOLDS BROWN: What's the
21 goal or yield of Get Healthy Philly?

22 DR. BUEHLER: I think the goal is to
23 continue to provide opportunities for the
24 people of Philadelphia to be -- to be

1 healthy. The main focus is on eating,
2 physical activity and smoking. This coming
3 year there will be a new push around
4 physical activity. We're currently in the
5 midst of campaign around the education about
6 the hazards of excessive salt consumption.

7 COUNCILWOMAN REYNOLDS BROWN: Where will
8 we see that? Who are the lucky audiences
9 that are going to benefit from that?

10 DR. BUEHLER: Most of what we do is
11 really City-wide. We tend to target our
12 information in ways that reach those parts
13 of the population that are at highest risk
14 in terms of where we might put signs or
15 radio stations that we get on. We try to be
16 strategic in how we are delivering our
17 messages.

18 COUNCILWOMAN REYNOLDS BROWN: Okay.
19 Okay, then, thank you very much.

20 DR. BUEHLER: Thank you.

21 COUNCILWOMAN REYNOLDS BROWN: Thank you,
22 Mr. President.

23 COUNCIL PRESIDENT CLARKE: Thank you
24 Councilwoman.

1 Well, thank you very much for your
2 testimony.

3 DR. BUEHLER: Thank you for the
4 opportunity to be here.

5 COUNCIL PRESIDENT CLARKE: Hold on one
6 second, please.

7 COUNCILWOMAN REYNOLDS BROWN: So, safe
8 streets and kids and bikes, one second --
9 the Safe Routes Philly Program, just give us
10 an update on that. Has it been successful?
11 What's the status of it?

12 DR. BUEHLER: I'm sorry. What's the --

13 COUNCILWOMAN REYNOLDS BROWN: Safe
14 Routes Philly.

15 DR. BUEHLER: I don't know. But perhaps
16 I can ask our Director of Get Healthy Philly
17 Giridhar Mallya to come up and --

18 COUNCILWOMAN REYNOLDS BROWN: Give us an
19 update.

20 DR. MALLYA: Good afternoon. Thank you
21 for the question. So Safe Routes Philly is
22 a program that is --

23 COUNCIL PRESIDENT CLARKE: Sorry. State
24 your name for the record, please.

1 DR. MALLYA: Sure. It's Giridhar
2 Mallya, Director of Policy and Planning.

3 COUNCIL PRESIDENT CLARKE: Thank you.

4 DR. MALLYA: Thank you for the question
5 about Safe Routes to School. This is a
6 program that the Health Department
7 collaborates with a few organizations on.
8 The Bike Coalition of Greater Philadelphia,
9 the School District of Philadelphia and also
10 the Mayor's Office of Transportation
11 Utilities.

12 We continue to work actively with those
13 organizations. We are engaging with
14 approximately 25 schools this year with a
15 particular focus on elementary schools. And
16 we do a couple things. One through
17 teachers, everything from health classes to
18 English classes. We focus on promoting safe
19 walking and biking among youth and getting
20 parents involved in that.

21 Two, we also work with the
22 Transportation Office to make sure that
23 inner sections and corridors particularly
24 around schools are as safe as they can be.

1 Everything from installing countdown timers
2 so people can cross the street before the
3 cars do to even doing re-striping on
4 crosswalks because we know small changes
5 like that can make a big difference in terms
6 of safety.

7 COUNCILWOMAN REYNOLDS BROWN: Who are
8 the lucky 25 schools? How do you arrive --
9 how do those schools end up in the group?

10 DR. MALLYA: Sure. So, we look at a
11 couple different factors. One, we look at
12 what parts of the City have the highest rate
13 of the bicycle and pedestrian crashes.

14 COUNCILWOMAN REYNOLDS BROWN: Okay.

15 DR. MALLYA: We want to make sure we
16 focus on areas that are at the highest risk
17 so we can bring that risk down.

18 Two, we try to look for areas of the
19 City where there are multiple schools. If
20 we make interventions in the set of
21 intersections, we're not just maybe
22 effecting one school directly but multiple
23 schools indirectly.

24 Three, we try to coordinate our Safe

1 Routes to School interventions with things
2 other City agencies might be doing. So,
3 some resources from Public Health may go to
4 one set of schools and then another set of
5 resources from the Transportation Office
6 could go to another set really to make sure
7 we're reaching the largest number of schools
8 that we can.

9 COUNCILWOMAN REYNOLDS BROWN: Is it fair
10 to say then that most of that program is
11 concentrated in Center City and Old City?

12 DR. MALLYA: No. No. Really most of
13 our efforts around Safe Routes to School are
14 outside of the Center City area and
15 neighborhoods.

16 COUNCILWOMAN REYNOLDS BROWN: Okay. All
17 right then. I would be curious to know --
18 see the list. If you can forward that to
19 the Chair, thank you very much.

20 Thank you, Mr. President.

21 COUNCIL PRESIDENT CLARKE: Thank you,
22 Councilwoman. Thank you again for your
23 testimony.

24 DR. BUEHLER: Thank you.

1 COUNCIL PRESIDENT CLARKE: Council will
2 take a break till, like, two o'clock.

3 - - -

4 (The Committee of the Whole recessed at
5 1:01 p.m.)

6 - - -

7 - - -

8 (The Committee of the Whole recommenced at
9 2:19 p.m.)

10 - - -

11 (Councilman Jones sits as Chair.)

12 COUNCILMAN JONES: Good afternoon,
13 everyone.

14 ("Good afternoon.")

15 This is a -- they answered back. That's
16 nice. This is a continuation of the public
17 hearings with regards to the budget. Would
18 you please read the title and the -- we
19 don't have to do that.

20 Going to dispense with that and ask the
21 next department, which is the Department of
22 Human Services, to approach the witness
23 table.

24 (Witnesses approach witness table.)

1 COUNCILMAN JONES: Good afternoon,
2 everyone.

3 COMMISSIONER HARLEY: Good afternoon.

4 COUNCILMAN JONES: So if you can pull
5 that mic a little closer to you and state
6 your name for the record, and please begin
7 your testimony.

8 COMMISSIONER HARLEY: Good afternoon.

9 My name is Vanessa Garrett Harley,
10 Commission for the Department of Human
11 Services.

12 COUNCILMAN JONES: Good afternoon.

13 COMMISSIONER HARLEY: Good afternoon,
14 President Clarke in his absences, Councilman
15 Jones, Members of City Council, I'm Vanessa
16 Garrett Harley, Commissioner of the
17 Department of Human Services. With me today
18 to my left is Kimberly Ali, my Chief
19 Implementation Officer for Improvement
20 Outcomes for Children. And to my right is
21 the acting Deputy Commissioner for Finance,
22 Chanell Hanns as well as other members of my
23 leadership team. Thank you for allowing me
24 to testify today.

1 DHS' Fiscal Year 16 general grants
2 revenue budget request is for \$673,558,375.
3 This is \$510,929 below the FY15 estimated
4 obligation level of \$674,069,345. DHS'
5 general fund budget request is \$102,729,321.
6 I would like to highlight a few of DHS'
7 accomplishments this year as well as share
8 some of the challenges we faced.

9 During Fiscal Year 15, DHS continued on
10 the path of implementation of Improving
11 Outcomes for Children. As you know,
12 Improving Outcomes for Children, or IOC as
13 we call it, is based on a belief that a
14 community-based delivery of child welfare
15 services will result in a better quality of
16 services for children and families, which
17 will ultimately lead to better outcomes. I
18 am proud to say that at this point, we have
19 opened all ten community umbrella agencies.

20 They are accepting cases and providing
21 services to the children of families of
22 Philadelphia. While we are still in the
23 process of transitioning cases from DHS to
24 the community umbrella agencies, we have

1 reached the point that more cases are with
2 the CUAs. In fact as of March 31, 2015,
3 3,618 families are being serviced by the
4 CUAs. One of the core components of the IOC
5 transformation is family team conferencing,
6 a process by which the family is given a
7 voice in their child welfare case.

8 These conferences which occur for the
9 most part in the community, are held
10 throughout the life of the case in key
11 decision making points. Families are
12 encouraged to attend these conferences with
13 their support system. Social service
14 professionals from various disciplines such
15 as behavioral health, education and physical
16 health also attend the conferences when
17 appropriate.

18 Since the inception of IOC in
19 January 2013, DHS has facilitated over 6,000
20 conferences. I'm also proud to say that
21 this year we have expanded our presence in
22 and support for the community and our
23 education system by increasing our
24 collaboration with the School District of

1 Philadelphia.

2 This year, we co-located ten social work
3 service managers and Philadelphia School
4 District schools and assigned them to work
5 with the community umbrella agencies and
6 their regions. This staff is responsible
7 for helping to remove educational barriers
8 for children involved with DHS and for
9 assisting school staff with making linkages
10 to DHS services when appropriate. We also
11 have a social work service manager assigned
12 to the School District's Reengagement Center
13 to consult with youth who have dropped out
14 of high school and seek re-entry as well as
15 those who are currently enrolled but are
16 severely overaged and under-credited.
17 Similarly, we have staff whose work is
18 dedicated to early childhood and early
19 intervention issues.

20 DHS has also made significant progress
21 in reducing the number and percentage of
22 children placed in congregate care settings.
23 DHS firmly believes that children and youth
24 deserve to be with their own families. And

1 when that's not possible, we strive to find
2 other permanent family settings for
3 children. Our goal is to only use
4 congregate care when absolutely necessary
5 and primarily for treatment purposes.

6 Since Fiscal Year 08, the percentage of
7 youth in congregate care that's both group
8 home and institution settings has decreased
9 from approximately 22.5 to approximately
10 14.5 percent. As we continue with our IOC
11 system transformation, DHS is also working
12 to strengthen and expand our hotline and
13 investigation divisions. We are currently
14 experiencing a rise in the number of calls
15 in the hotline and a rise in the number of
16 investigations.

17 Specifically, hotline reports are up
18 41 percent when comparing the first quarter
19 of Calendar Year 2014 to the first quarter
20 of Calendar Year 2015. The total number of
21 investigations for this same time period is
22 also up 32 percent. We believe that this
23 increase in volume is primarily due to a
24 sweeping overhaul of child welfare laws

1 after the Jerry Sandusky case, which
2 ultimately resulted in 27 new laws. Some of
3 the major changes expanded the definition of
4 child abuse, expanded who can be labeled a
5 perpetrator, increased the number of
6 mandated reporters and increased the
7 penalties for mandated reporters who fail to
8 report abuse.

9 Additionally, these laws mandated new
10 electronic reporting and data collection
11 requirements. In addition and possibly some
12 were related to growth in our hotline and
13 investigation divisions, we are experiencing
14 a steady rise in the number of children in
15 placement. At the time of budget testimony
16 last year, we had approximately 4,500
17 children in care. We now have approximately
18 5,300 children in placement. Similarly, we
19 have seen a rise in the number of families
20 receiving in-home services. As of
21 March 2015, approximately 4,200 children
22 were receiving in-home services.

23 Finally in closing, I would like to
24 stress that we are committed to completing

1 the full implementation of IOC. We are
2 working collaboratively with our staff and
3 the provider community to ensure that
4 quality child focus and family-centered
5 services are delivered to the children and
6 families in Philadelphia.

7 Thank you very much for your
8 consideration. Our staff and I are
9 available to answer any questions that you
10 may have about my testimony.

11 COUNCILMAN JONES: Thank you once again.
12 It is always, believe it or not, good to see
13 you. Sometimes we go at it a little bit,
14 but it -- in both cases, it is my sincere
15 belief it's for the benefit of the kids.

16 COMMISSIONER HARLEY: Absolutely.

17 COUNCILMAN JONES: Therefore, that
18 respect will always be maintained, and it is
19 good to see you.

20 A couple of quick questions that I would
21 have is on your testimony you mentioned
22 reunifications -- well, no. You mentioned
23 those in out-of-care services and those who
24 are in foster care.

1 What were those numbers again? I know
2 4,200 were in-home, I believe.

3 COMMISSIONER HARLEY: So 4,200 children
4 were receiving in-home services. We have
5 approximately 5,300 children in placement or
6 out-of-home care.

7 COUNCILMAN JONES: Okay. That's what I
8 needed to do. So, you also talked about
9 your expanded role, I believe it was, in the
10 school system.

11 COMMISSIONER HARLEY: Yes.

12 COUNCILMAN JONES: Can you describe
13 that? You said ten schools. And I would be
14 interested -- we ask this of, I think it
15 might have been Behavioral Health earlier
16 today.

17 How were those schools chosen, and what
18 were the services provided?

19 COMMISSIONER HARLEY: Okay. So DHS has
20 been expanding this Education Support
21 Center. We actually have a center that that
22 staff, that is what they're dedicated to do.
23 They work very collaboratively with the
24 School District. In fact, I'm happy to say

1 that hopefully on May 20 that we will
2 actually be co-locating the bulk of that
3 staff in the 440 North Broad building so
4 that they are actually there and they can
5 work even closer together.

6 The 10 staff specifically that you
7 referenced are -- each one is assigned to a
8 school. One school that is in each of the
9 CUA areas, you know our CUAs are
10 geographically determined across the city.
11 We have a total of 10.

12 And so, there was one school selected.
13 And I will give you some examples of those
14 schools, however, that staff is still
15 available to be a resource for other schools
16 in the catchment area of where the Community
17 Umbrella Agency is.

18 So for example, in the district of CUA 1
19 Net, Edison High School was a school that
20 was selected. CUA 2 is at Kensington CAPA
21 High School. CUA 3 is Lincoln High School.
22 CUA 4 is Northeast High School. CUA 5 is
23 Wagner Middle School. CUA 6 is Martin
24 Luther King High School. CUA 7 is Robert

1 Morris Elementary. CUA 8 is South
2 Philadelphia High School. CUA 9 is Tilden
3 Middle School. And CUA 10 is Overbrook High
4 School.

5 And so, there were a number of decisions
6 that were made, many of them at the table
7 with the School District to make a
8 determination as to where we felt the
9 presence was most needed. We were trying in
10 our rudimentary way to try and sort of
11 support the School District knowing that
12 they had fewer counselors in these schools.
13 So, some of these decisions was about where
14 the need looked like based on the number of
15 students and number of counselor and also
16 sort of what we see where we get a lot of
17 our cases from.

18 COUNCILMAN JONES: So, I am very pleased
19 that you made those decisions.
20 Particularly, the one dealing with my alma
21 mater, not to be selfish about Overbrook,
22 but I'm glad you're there.

23 But to me, we do a monitoring system.
24 Every 7:00 a.m. we have what is called a

1 Safe Avenues Meeting. It's a role call with
2 all of the principals. And some of the
3 things that we hear by way of what is
4 causing some of the students inability to
5 actually grasp lessons is said that two book
6 bags that they bring to school. One is full
7 of the lessons of the day; the other is full
8 of the troubles from home the night before.
9 So, we are glad that you are taking this
10 approach.

11 What are the things you are
12 discovering -- it might be too early to say.
13 What are the things you're discovering by
14 way of need for services in those particular
15 schools?

16 COMMISSIONER HARLEY: So, I don't know
17 if it's too early to say or that it's
18 particular to those schools. But in
19 general, I think what you said is very true.
20 Many of our children do come to school with
21 a lot of other things that they have to deal
22 with based on situation in the home. So,
23 just trying to address them, trying to help
24 school personnel know how to navigate what

1 is sometime the complicated system of social
2 service world and where the right place is
3 to get help.

4 We are also doing some new things with
5 our truancy. And we are collaborating now.
6 We have sort of totally revamped the way we
7 are doing truancy. Issue the truancy RFP
8 and just awarded ten different providers,
9 each one attached to the community
10 umbrella -- not attached but in that
11 community umbrella agency area so that they
12 can get to know those people there. We are
13 doing the new truancy approach is a very
14 different model than what we used to do.
15 It's more of a prevention model, which is we
16 have a three-tiered approach. Tiers one,
17 two and three. Trying to get involved with
18 children before they become chronically
19 truant.

20 So the first tier starts with kids who
21 have missed five to nine days of school, for
22 example, or unexcused absence so the --

23 COUNCILMAN JONES: Excuse me a second.

24 We have a slight change. I'll be over

1 there.

2 COMMISSIONER HARLEY: No problem.

3 COUNCILMAN JONES: Mr. President.

4 (Council President Clarke retakes Chair seat.)

5 COUNCIL PRESIDENT CLARKE: Thank you,
6 Councilman. I'm sorry, you have to start
7 from the beginning. Just kidding. Just
8 kidding.

9 Thank you.

10 COMMISSIONER HARLEY: You settled? I
11 can finish? Okay.

12 Again, I was talking about what we were
13 doing with truancy. Now we are doing it in
14 a prevention based approach. It's a tiered
15 program where we try to get involved with
16 the kids before they become chronically
17 truant. And hopefully, can make a better
18 difference by starting earlier. And the
19 level of the intervention or intensity of
20 the intervention is different depending on
21 which tier you are on; tier one, tier two,
22 tier three.

23 We are also doing in a collaborative
24 process with the Family Court as well as the

1 School District of Philadelphia. So when we
2 issue the RFP this time on the selection
3 committee was representatives from the
4 School District as well as the Court, so
5 that we can make sure that all of those
6 needs are being covered. There are ten
7 different providers who were selected and
8 will be working within that community
9 umbrella agency area. And the benefit of
10 that is it helps build those relationship
11 and sort of linkages again between the
12 community umbrella agencies and the schools
13 in their area as well as with the truancy
14 providers who are in those areas and can
15 offer services to them, as well.

16 COUNCILMAN JONES: So if you note the
17 chart, and now the President can represent
18 it, school-based family service center he's
19 taken a real strong advocacy for. So, it's
20 good to hear that you, Behavioral Health,
21 all of you guys are in there.

22 One of my schools which won't be named,
23 one of the teachers took it upon themselves
24 to bring in ten pairs of shoes of different

1 sizes for the kids that would come to
2 school. And some of them in the rain have
3 holes so bad that their feet were soaked.
4 And so, they just started giving them away.

5 How do you learn, you have to navigate
6 your way to school on keeping your feet dry
7 is just beyond me. What I will do is I'll
8 yield this portion to allow some of my
9 colleagues to speak. I will get your
10 questions on the next round.

11 COMMISSIONER HARLEY: Thank you.

12 COUNCIL PRESIDENT CLARKE: Thank you,
13 Councilman. Chair recognizes
14 Councilwoman -- not here.

15 Okay, Councilwoman Tasco.

16 COUNCILWOMAN TASCO: Thank you. Good
17 afternoon.

18 COMMISSIONER HARLEY: Good afternoon.

19 COUNCILWOMAN TASCO: Have a couple of
20 questions here.

21 How are the CUAs doing in Philadelphia?
22 Are they moving along as planned or as hoped
23 to evolve into the master plan?

24 COMMISSIONER HARLEY: So the -- your

1 question is how are the CUAs doing? And so,
2 I would like to say the CUAs are evolving.
3 I think that some progress is being made.
4 We see some progress in several areas, in
5 many area. Obviously, it's a new endeavor.
6 We are in still what many would say are the
7 preliminary or implementation phases. We
8 are also still realizing some challenges,
9 looking at the model, trying to determine
10 where it may need to be tweaked.

11 Ultimately, trying to ensure that the safety
12 and well being of our children are met.

13 But we are beginning to -- I believe it
14 is beginning to take a foothold in the
15 communities. People are beginning to
16 recognize the community umbrella agencies.
17 Many of the other changes that we talked
18 about, some of which for example is, the
19 collaboration with the School District. And
20 the schools in these areas and the CUAs are
21 have become very familiar with all the
22 schools in the area. We wanted the
23 principals to be able to meet them. In
24 conjunction with the School District, we've

1 held some town hall meetings kind of where
2 everybody can meet each other and talk
3 about, you know, where we have services that
4 could be helpful. There are a number of
5 other things we do in the community.

6 We are beginning to measure and see that
7 more kids are being able to be maintained in
8 their own community than they were before.
9 We -- the Family Team Conferencing Model is
10 a large part of improving outcomes and the
11 community umbrella agency system. We are
12 beginning to see much stronger participation
13 level of families in the process and
14 families having more voice in the process.

15 We are happy that our numbers in
16 congregate care, which is kids who are in
17 group home or institutions, are continuing
18 to decrease. We do believe that every child
19 deserves a home. And we are trying to move
20 forward with that. There is, I think, the
21 transfer of learning from DHS and DHS staff
22 and DHS technical staff to the community
23 umbrella agencies is continuing to increase
24 and progress.

1 And also, in the community we are doing
2 a number of things that are kind of strength
3 based such as parent and cafes. Many of the
4 community umbrella agencies are involved
5 with grass roots agencies and stuff in the
6 community. That is beginning to develop.
7 Most of the family team conferences we do
8 are in the community. We hold them in
9 churches, rec centers, other community spots
10 or organizations. And that helps build some
11 collaboration and support, as well.

12 So, some of -- those are some of the
13 positives that we have seen since we
14 instituted the CUAs. It is still really
15 very, very early, though, in the process.
16 Half of the community umbrella agencies
17 just -- really, we call it standing or
18 opened up and started taking cases in Fiscal
19 Year 2015. So, five of them just really
20 started getting their cases in Fiscal Year
21 2015. So, it's really preliminary in terms
22 of results and outcomes for many of them.

23 COUNCILWOMAN TASCO: I know that you
24 were not the commissioner when this whole

1 idea came about, and this may put you on the
2 spot. Do you think that we have engaged the
3 organizations to -- in the training session
4 to understand what they were going to take
5 on to be a CUA might have helped with more
6 in-depth kind of engagement; and once they
7 open as a CUA, may have had less problems?

8 COMMISSIONER HARLEY: I think hindsight
9 is 20/20. And I think certainly maybe we
10 attempted or thought we attempted. It was a
11 very careful and thought out plan process
12 because the planning went on for about three
13 or four years even before I came to DHS, you
14 know, in terms of the implementation
15 process. But I do think that -- I'm not
16 sure that the full understanding was there
17 as to the real level of the work and the
18 volume of the work and the intensity of the
19 work, you know, in the beginning. And
20 again, maybe that is something that we could
21 have done differently and certainly have
22 tried to address as we go along and sort of
23 pick up those challenges.

24 I do think that those CUAs who open

1 later, though, the ones that open in 2015
2 sort of had the benefit of that. The
3 earlier CUAs kind of helped us work through
4 the growing pain and the phases. So, they
5 were able to learn and see some of the
6 things that the earliest CUAs had opened and
7 already gone through and maybe benefitted
8 from the knowledge of other CUAs. I do
9 think the community umbrella agencies do a
10 good job of interacting with each other and
11 trying to learn from each other and share
12 what works, what doesn't work, so strengths
13 and weaknesses with each other, as well.

14 COUNCILWOMAN TASCO: Am I done? I can
15 go on? Okay.

16 What is the estimated date for the
17 completion of the IOC transition? Who will
18 provide services to the cases on the back
19 end?

20 COMMISSIONER HARLEY: The estimated date
21 right now loosely for completion is the end
22 of 2015. The end of Calendar Year 2015.
23 And at that point, who will be providing
24 services on the back end would be the

1 community umbrella agencies. We currently
2 have approximately 3,600 cases already over
3 at the community umbrella agencies. There
4 is probably about another 2,000 still left
5 at DHS. We very carefully have to look at
6 each case and each child within each case to
7 make sure that the transition is the right
8 and timely and, you know, no disruption or
9 minimal amount of disruption for the child
10 and the family.

11 So, that's the estimated goal right now
12 is the end of Calendar Year 2015 for all of
13 the cases in the back end to have been moved
14 to community umbrella agencies.

15 COUNCILWOMAN TASCO: If the CUA process
16 is going well, then why are you holding up
17 transfers of staff for case-carrying units
18 to non case-carrying units?

19 COMMISSIONER HARLEY: It's sort of
20 complicated right now. Because as we are
21 moving staff into non case-carrying units,
22 primary for me always has to be the safety
23 of the children and families. And we have
24 been experiencing a real increase or rise in

1 the number of kids that are coming to our
2 system. Our system is much larger now than
3 it had been before. I think I testified
4 earlier that last year at this time we had
5 about 4,500 kids in care. Right now we have
6 about 5,300 kids in care.

7 My hotline reports are up tremendously.
8 Number of calls and number of investigations
9 are up, I will give you some numbers,
10 tremendously. When I compare the beginning
11 of Calendar Year 2014 January to March of
12 2014, with the beginning of this Calendar
13 Year January to March of 2015, I have a
14 41 percent increase in hotline calls. So,
15 that's 2,000 more calls into my hotline and
16 a 32 percent increase in investigation.
17 That's 1,200 more investigations.

18 COUNCILWOMAN TASCO: What are you seeing
19 as the cause for the increase?

20 COMMISSIONER HARLEY: I believe -- and
21 part of the reason that I am using that
22 calendar year is because the new laws that
23 were as a result of the Jerry Sandusky case,
24 there was a sweeping overhaul of child

1 welfare laws. There were about 27 new laws.
2 The majority of them went into effect
3 January 1, and so that's why we're looking
4 at that portion of the calendar year, the
5 difference that's it's made. And it had
6 some real differences because it did major
7 changes to the definition of abuse. Major
8 changes to the definition of who was a
9 perpetrator. Expanded the number of
10 mandated reporters, increased the penalties
11 if you don't report.

12 For example, we're seeing many more
13 calls from our professional reporters as a
14 result and just in general. And so, it's
15 not just Philadelphia. When I talk to my
16 counterparts across the state, people are
17 experiencing huge increases in both the
18 hotline calls and their investigations. So,
19 some of the reason I've not been allowed --
20 able to allow DHS staff to transition is I
21 have to make sure that we have enough staff
22 to be able to cover those investigations and
23 that initial work particularly on our front
24 end. And the front end needs expanding

1 right now.

2 So, we have had to hold the transfer of
3 some staff or stagger the transfer of some
4 staff until we can try and get a better
5 handle on this volume increase that we're
6 still experiencing. Hopefully, it will
7 start to stabilize.

8 COUNCILWOMAN TASCO: What I can conclude
9 that the -- as a result of the Sandusky
10 case, the hotline calls are related to child
11 abuse, around sexual child abuse.

12 COMMISSIONER HARLEY: It's not just
13 sexual child abuse, though. The Sandusky
14 case was about sex abuse, so yes we have
15 seen some increases obviously in that area,
16 as well. But in general calls to the
17 hotline about abuse and neglect situations
18 in general, we are seeing an increase.

19 I think some of it is when you have a
20 lot of attention and advertising about child
21 abuse awareness, sometimes people realize
22 some things that they saw that they should
23 have called in about and didn't, they are
24 calling in. I think another thing that

1 changed was the structure in how School
2 District personnel call in. Before many
3 schools had a tiered approach where if a
4 teacher saw something, she had to go through
5 her counselor or her principal and then she
6 made a determination and called. Now it
7 mandates that the teachers, you know, call
8 straight through. So, a lot of it is about
9 the changes that came about the law and the
10 change. The other thing is, a lot of cases
11 that we would have screened out before
12 because they didn't meet the legal
13 definition of abuse are now screened in.
14 You can't screen them out because they have
15 expanded those definitions.

16 COUNCILWOMAN TASCO: And one other
17 question, since nobody else has no
18 questions, with children who are moved from
19 a home, what happens in the home? What
20 services are provided to the adults or the
21 perpetrator or a situation in the home where
22 the mother just may be afraid of the kid or
23 something like that?

24 What kind of services do you provide to

1 the person left behind at the home?

2 COMMISSIONER HARLEY: So first of all,
3 we only try to move a kid out of a home when
4 it is absolutely necessary. Removal from a
5 home is the last resort. We try to provide
6 in-home services, try to work with
7 stabilizing the family. But if our workers
8 go in, do an investigation, identify safety
9 threats and we feel that those threats can
10 not be mitigated within home services or
11 that is the only way the child will be safe
12 if we are forced to remove. But absolutely,
13 we work with the family and are required to
14 by law. We have to offer services to the
15 family.

16 The nature of the services differs.
17 It's a very individualized approach
18 depending on what the need in that family
19 is. For some families, it's a drug and
20 alcohol treatment. For some it might be
21 behavioral health services. For some it
22 might be parenting classes. For -- you
23 know, for others, it may be that they need
24 appropriate housing or housing things. And

1 so, we try to work with them and all those
2 different areas. And a plan is developed
3 for the family that addresses all of the
4 areas that need to be looked at and in
5 improved before a child might be able to be
6 returned home.

7 COUNCILWOMAN TASCOS: Now, is all of this
8 done by the CUA that's in charge of the
9 young person or the person taken from the
10 home? The CUA does that, or what about your
11 department downtown?

12 MS. ALI: It's actually done. If the
13 case is with the community umbrella agency,
14 then certainly is done by the CUA case
15 manager and the other teams that are at the
16 CUA. And we also do it by way of our family
17 team conferences. With our family team
18 conferencing, we actually have a DHS social
19 worker who is the team coordinator. They
20 are responsible for engaging that
21 perpetrator, engaging that parent to bring
22 them to the table so that we can hear their
23 voice in terms of what services they need in
24 order to address the needs of their family.

1 And we also have a DHS practice
2 specialist which is a Master's prepared DHS
3 social worker whose facilitates the
4 conference. During the conference, we
5 actually outline the goals and objectives of
6 the family. The DHS social worker will
7 facilitate it. But the CUA case manager
8 actually carries out the objectives and
9 carry out and put in the interventions
10 that's necessary to return that particular
11 child home.

12 COUNCILWOMAN TASCO: One other question
13 I think I will be done.

14 How many employees are waiting for
15 lateral transfers and opportunities to
16 transfer to other City departments? And
17 what is the delay and when will they be able
18 to transfer? And what happens to cases on
19 the back end when staff are transferred to
20 the CUAs?

21 And you answered a little bit.

22 COMMISSIONER HARLEY: So, I don't have
23 the number with me. Can get back to you
24 with that of the number of employees who are

1 waiting for lateral transfers to other
2 departments. There has been a hold on
3 lateral transfers, to be honest with you,
4 for quite some time just because of the
5 condition that the department is in. And we
6 have that immediate need to have
7 case-carrying social work staff in the
8 department to make sure that we meet all of
9 the public safety needs of the children and
10 families in Philadelphia.

11 Right now, we just have so many
12 investigations and calls coming in that we
13 don't have the ability or the liberty to let
14 the lateral transfers go through. I would
15 hope that as soon as we can get stabilized
16 to a point where we feel we can handle
17 adequately what we have, then we might be
18 able to lift that moratorium on letting
19 lateral staff transfer to other departments.

20 I don't have the exact number, though,
21 but I can try to get that for you.

22 COUNCILWOMAN TASCO: Thank you. Thank
23 you, Mr. President.

24 COUNCIL PRESIDENT CLARKE: Thank you,

1 Councilwoman.

2 Chair recognizes Councilman Jones.

3 COUNCILMAN JONES: Thank you,
4 Mr. President.

5 So again, I'm emphasize the fact that I
6 could not do your job. And emphasize the
7 fact that thank God you do your job. And we
8 thank the fact that kids in the City of
9 Philadelphia have some measure of protection
10 from family abuse, external abuse. And so,
11 I'm grateful for what you do. All of us
12 from time to time have to take a look in the
13 mirror and see if we can do it better and
14 how are we doing.

15 On Councilwoman Tasco's point, if you
16 were to take a snapshot of last year having
17 the CUA systems all in place, at least the
18 ones that have been around for a year, and
19 overlap a map of those same areas the year
20 before, what things are changed?

21 What type of -- are we making progress?
22 And quantify what that progress is.

23 COMMISSIONER HARLEY: So, I do think
24 we're making some progress in some of the

1 areas. Many of them are things I outline in
2 response to Councilwoman Tasco's question.
3 And that is, we are definitely making
4 progress with a community presence which was
5 something that we did not have at all. DHS
6 had no presence in the community.

7 And the inception of IOC went back to
8 the Child Welfare Advisory Board after that
9 Danielle Kelly case. And one of the
10 recommendations, several of the
11 recommendations that they made is that we
12 did not have a community presence and we had
13 not developed any type of relationship with
14 the community. So, that is definitely in a
15 much better place than it ever was.

16 I think the development of we did not do
17 a good job of giving families voice in the
18 process or making sure the families always
19 truthfully understood the process in terms
20 of what was happening to them when they got
21 involved in the child welfare system. The
22 Family Team Conferencing Model is making a
23 huge difference in terms of bringing
24 families to the table, allowing them to

1 understand kind of what's going on to give
2 them some voice in the planning and in the
3 process.

4 And also at that table is a
5 multi-disciplinary approach. Depending on
6 the need of that individual family, if there
7 are some issues, for example, in the
8 education area that somebody from our
9 education support center staff would be
10 there. If we need to, we have somebody from
11 the School District there. If it's a
12 medical problem, one of our DHS nurses or
13 the DHS medical director nurses would be
14 present. If it's behavioral health,
15 behavioral health might be at the table.

16 It allows the planning and approach to
17 be done in a much more sort of team and
18 multi-disciplinary fashion than we were
19 doing prior to IOC.

20 COUNCILMAN JONES: So, what would be
21 helpful to me and not in this hearing but to
22 provide a apples-to-apples comparison of the
23 years before CUAs and the years after. You
24 can measure like, for example, I will ask

1 this question here.

2 What were the number of child fatalities
3 last year, and how did that compare to the
4 year before?

5 COMMISSIONER HARLEY: I can get that for
6 you.

7 COUNCILMAN JONES: I would ask that you
8 say ones in foster care and -- versus the
9 ones that you just come upon based on a
10 complaint or some unfortunate circumstance.

11 COMMISSIONER HARLEY: So, the number of
12 fatalities you're asking me as of last year?

13 COUNCILMAN JONES: If you go from this
14 time last year, fiscal year -- we're in
15 Fiscal Year 15.

16 COMMISSIONER HARLEY: Understood.

17 COUNCILMAN JONES: Fiscal Year 15 to
18 Fiscal Year 14.

19 COMMISSIONER HARLEY: Understood. So,
20 let me go back a little bit. In 2013, there
21 were 11 child fatalities. In 2014, there
22 were 5.

23 COUNCILMAN JONES: Okay. Is that
24 generally in the City as opposed to in

1 childcare and foster care? Is that in
2 general or in both?

3 COMMISSIONER HARLEY: So, I believe that
4 that is in total.

5 COUNCILMAN JONES: In total.

6 COMMISSIONER HARLEY: In total. Those
7 are -- I'm sorry. I misspoke. Those are --
8 if I'm looking at which fatalities were
9 reported to the department that over time
10 that it was determined that the reason for
11 the fatality was the result of abuse.

12 COUNCILMAN JONES: Okay.

13 COMMISSIONER HARLEY: That's what that
14 is. That's not -- total it was 50 was the
15 total number of deaths that were reported to
16 the hotline in 2014.

17 COUNCILMAN JONES: So when you say
18 reported, somebody called in and said --
19 finish the sentence.

20 COMMISSIONER HARLEY: Ordinary, if I say
21 reported, the call primarily comes from
22 either the law enforcement police, sometimes
23 the medical examiner's office, sometimes the
24 hospital.

1 COUNCILMAN JONES: So there were 50
2 deaths.

3 COMMISSIONER HARLEY: In 2014, there
4 were 50 total deaths; whereas in 2016, there
5 was 61 total deaths. So the number of total
6 deaths has started to decrease some.

7 COUNCILMAN JONES: Okay.

8 COMMISSIONER HARLEY: And then the stat
9 that I gave you a little bit earlier was out
10 of them how many of those once the
11 investigation took place was it determined
12 that the death was a result of abuse. So in
13 2013, 11 of them it was determined that the
14 death was a result of abuse or what we call
15 an indicated or, you know, finding in the
16 investigation. And then 2014, it was only
17 5.

18 COUNCILMAN JONES: So in the case of
19 Sebastian, the Life of Sebastian, the
20 article written by the Inquirer, can you --
21 can you talk about what went wrong there?

22 COMMISSIONER HARLEY: I don't know, to
23 be honest with you, I remember everything
24 that was in that article.

1 COUNCILMAN JONES: Just OxyContin. And
2 what was disturbing that there were five
3 reports before that to that household that
4 there was a problem there. And then, you
5 know, we find him dead. So -- I don't know
6 if that was a CUA or a direct supervision
7 but --

8 COMMISSIONER HARLEY: So, that was not a
9 community umbrella case. That was direct
10 DHS involvement. Little bit difficult for
11 me to talk about that case without having
12 reviewed the case file or anything. But the
13 CUA was not involved in that case. It had
14 nothing to do with IOC. And so, some of it
15 would be -- I would have to go back and look
16 at what the reports were, what the nature of
17 the reports were, what the investigation was
18 at the time that those investigations took
19 place and kind of what they found and what
20 the disposition of them was.

21 I don't know, you know, off the top of
22 my head whether or not they were founded,
23 unfounded or what services we put in or did
24 not put in as a result.

1 COUNCILMAN JONES: So based on the
2 article, they were five calls. They were
3 found unfounded. That's one. And then
4 there's the Bridesburg case where there were
5 a number of calls.

6 I think -- what was that fatality? He
7 was -- that's the one where he was allegedly
8 held hostage and then escaped and wind up
9 killing his mother and father. I say that
10 and what they have in common is that there
11 were calls made before. That is the part
12 where --

13 COMMISSIONER HARLEY: Understood.

14 COUNCILMAN JONES: -- if somebody cries
15 out for help -- maybe we can't do them now,
16 but we need to figure out what we can do
17 better.

18 COMMISSIONER HARLEY: Absolutely.

19 COUNCILMAN JONES: To make sure that if
20 there are five calls, you know, and they are
21 found unfounded, we need to change the
22 criteria.

23 COMMISSIONER HARLEY: I can tell you
24 that some of the things we are looking at

1 sort of from a -- I understand what you're
2 saying now in terms of a theme. It is
3 important the prior history.

4 We certainly took some lessons learned
5 from those particular cases as well as other
6 cases. We have a robust Act 33 team, which
7 is the legislation that requires every death
8 to be looked at. And there's a
9 multi-disciplinary team. Our is Chaired by
10 the medical examiner. On that team is the
11 First Deputy District Attorney Ed McCann as
12 well as the Police Special Victims Unit,
13 representatives from CHOP,
14 St. Christopher's, Behavioral Health, the
15 State.

16 All of the entities that would be --
17 need to be involve. And so, they do a very
18 careful job of looking through the evidence
19 and making recommendations. We track those
20 recommendations over time to make sure they
21 are not hollow and are actually implemented.
22 We certainly talked about the very area you
23 are talking about, the need to do additional
24 stuff.

1 We are doing some additional stuff at
2 DHS in terms of trying to -- it's a little
3 difficult to try and quantify what is the
4 right number, but trying to put some flags
5 in place in terms of when you see X-number
6 of reports come in on a family within
7 X-amount of time, do you take a look at it
8 differently. And that puts some red flags
9 in the computer system, some other things.
10 Certainly, though, the prior history is
11 really important and trying to make sure
12 that we get that across the staff, the
13 importance of reviewing that prior history.
14 It kind of might tell you a story in terms
15 of what's going on. And so, some of it also
16 depends on how long ago the reports were.

17 I do think we are doing a lot of things
18 much better than many years ago when some of
19 these reports were called in. And
20 certainly, our investigation staff is pretty
21 experienced and sophisticated and some of
22 these we handle very difficultly.

23 For example, one of the changes we made
24 in recent years were our fatalities and near

1 fatalities when they come in are
2 investigated by, we call it MDT, our
3 Multi-Disciplinary Team Unit. It tends to
4 be your very experienced investigators who
5 handle these cases in a different way. We
6 didn't always do it that way. We always
7 changed some other things that was in
8 existence in our intake.

9 For example, used to be if a case came
10 in and then within 60 days another report
11 came in on the same family, it went back to
12 the same worker to do the investigation.
13 Well, I took that requirement away because
14 sometimes a fresh set of eyes may get you a
15 different, you know, set of circumstances.
16 So, we are trying to look at all of those
17 components that would help to make sure that
18 we try and weed in that prior history piece.

19 COUNCILMAN JONES: So, I don't want you
20 chasing frivolous cases because sometimes
21 one motivation or another, a neighbor calls
22 on somebody that they don't like; an ex
23 calls on somebody that didn't get custody.
24 I don't want you chasing, you know,

1 windmills and things like that. But when
2 five calls come in, red light, yellow light,
3 green light kind of system that says that
4 maybe there is -- if there is smoke, there
5 has to be fire. And we need to figure out
6 what that is because, no, you're not going
7 to play perfect percentages there. But we
8 have to -- we have to up the percentages.
9 And it needs to be a tipping point that,
10 wow, after the third call, we need to send
11 in that multi-disciplinary team to take a
12 real forensic look.

13 I am going to hold the rest of my
14 questions.

15 COUNCIL PRESIDENT CLARKE: You were the
16 only round until just now.

17 Chair recognizes Councilwoman
18 Quinones-Sanchez.

19 COUNCILWOMAN QUINONES-SANCHEZ: Thank
20 you. Thank you, Commissioner.

21 Want to first say I know that
22 transitioning in with all of these CUAs has
23 been quite difficult and quite challenging.
24 And I'm glad that as a result of the

1 hearings and other stuff, there's more
2 increased communication. So, part of what
3 the challenge was, was CUAs doing all the
4 services, the prevention services.

5 If you had to articulate what your --
6 this budget calls for moving forward around
7 prevention and groups like the stakeholders
8 groups that you funded, how would you
9 articulate what DHS' prevention strategy for
10 the new year is going to be?

11 COMMISSIONER HARLEY: So, we have not
12 moved. The bulk of the prevention stuff at
13 DHS is still remaining with DHS. We have
14 not moved it to the CUA. And I don't
15 foresee we're going to move it within this
16 fiscal year, FY16. I think the bulk of the
17 prevention will probably stay at DHS. All
18 the truancy contracts that still -- that
19 comes under the prevention are maintained at
20 DHS.

21 What we call the family empowerment
22 service, which is another in-home service
23 that is provided in those cases where there
24 has not been an identified safety threat,

1 but family might be right on the cusp. You
2 see that they need help. Those will remain
3 at DHS. Our parenting programs for right
4 now are still at DHS.

5 So the bulk of our prevention, if I was
6 looking at the prevention landscape, will
7 remain at DHS and remain with the other
8 providers who have been providing those
9 services.

10 COUNCILWOMAN QUINONES-SANCHEZ: And what
11 is going to be the decision moving forward
12 around the stakeholders groups?

13 COMMISSIONER HARLEY: I'm not sure I
14 understand your question about the
15 stakeholders.

16 COUNCILWOMAN QUINONES-SANCHEZ: The
17 community stakeholders groups that we have.
18 I have Kensington stakeholders, Hunting Park
19 stakeholder groups that are funded through
20 DHS. What is the thinking moving forward?
21 Because at one point it was a discussion
22 that the CUAs were going to manage it and
23 then they weren't going to manage it. So,
24 where are we with that?

1 COMMISSIONER HARLEY: I'm hoping I
2 understand your question right,
3 Councilwoman. If we are talking about, for
4 example, the SCOP. We do a number of -- we
5 call them SCOP, which are basically
6 contracts with smaller providers in the
7 communities that tend to be community
8 groups. Those are staying with DHS. I'm
9 not sure if you're talking about EPIC
10 Stakeholder groups, which were community
11 based.

12 COUNCILWOMAN QUINONES-SANCHEZ: EPIC
13 Stakeholders.

14 COMMISSIONER HARLEY: Those will most
15 likely be phased out if they have not
16 already been phased out eventually. We have
17 been -- those are going to be taken over by
18 the community umbrella agencies. Some of
19 which have already taken place. Some of the
20 community umbrella agencies have worked very
21 well with the group.

22 And then the EPIC groups in their CUA
23 catchment area, some better than others.
24 Some have hired some of the EPIC staff to be

1 part of their community engagement staff.
2 But the CUAs are required to do community
3 engagement. And they are all required to
4 have a community advisory board and to have
5 a member of that community advisory board
6 that serves on the board of the community
7 umbrella agency.

8 COUNCILWOMAN QUINONES-SANCHEZ: So, it's
9 going to be up to the CUA to determine
10 whether they want to continue to contract
11 with the agency that's providing the
12 services or they want to bring it in house?
13 Again, I am just doing the issue of folks
14 wanting to bring everything in house.

15 COMMISSIONER HARLEY: It is not up to
16 the CUA. Pretty much the decision was made
17 at DHS that the EPIC groups will be phased
18 out over time because it is part of what the
19 CUA is required to do and part of the IOC
20 plan or the CUA model, if you will, that
21 they do community engagements. It would
22 have been a duplicity of services to
23 continue to have the EPIC group in some
24 fashion do that under a paid contract.

1 But we have been trying to make sure
2 that we try and work together because you
3 don't want to lose the traction that those
4 groups were able to develop in the
5 communities. And so for some of the CUAs
6 that have been working closely with those
7 groups. It has been transitioning pretty
8 well. We are trying to the extent we can
9 help facilitate those transitions, as well.

10 COUNCILWOMAN QUINONES-SANCHEZ: Okay.
11 So three months, six months from now, if the
12 same type of community outreach is not
13 happening, who is going to be monitoring
14 that?

15 COMMISSIONER HARLEY: So, we monitor
16 community engagement. There is a community
17 engagement group. We have a IOC Steering
18 Committee that is sort of the stakeholders
19 from around the City and various areas that
20 are part of that. One of the subgroups
21 under the IOC Steering Committee is
22 community engagement. They would definitely
23 be looking at it and trying to develop where
24 it's working, where it's not, what's better

1 plans, how do we do it.

2 But in addition, it is something that we
3 are very cognizant of on a -- at DHS. And
4 certainly, we will also be monitoring where
5 it's taking place and not taking place.

6 COUNCILWOMAN QUINONES-SANCHEZ: In some
7 communities, you know, I will take for
8 instance my Frankford community, it's very
9 diverse. It's really been hard to build up
10 the level of confidence to bring certain
11 people around the table. I want to make
12 sure we don't lose that kind of in this
13 transition because there are a lot of
14 partners, a lot of grass roots partners at
15 the table. And we want to make sure that
16 they stay engaged at that level.

17 I want to be able to come back here in
18 three months and say what's the plan. So, I
19 should be able to go to my CUA folks and say
20 what's your community outreach engagement
21 plan.

22 COMMISSIONER HARLEY: Yes. And one of
23 the things I'm also doing, my communications
24 director is working with the sort of

1 community engagement people. And we are
2 actually working on developing or revising.
3 There were plans already, but also revising
4 and maybe developing some new community
5 engagement plans and structures.

6 I have to take a little bit more robust
7 look at it myself to be honest with you.
8 Sort of was focusing on some other things as
9 I came in. But I will be beginning to go to
10 some of the community advisory board
11 meetings so that I can meet the board, so
12 that I can see them and see what's going on.

13 And we're also -- Kim is my
14 implementation officer who takes a real
15 interest in that kind of stuff. She also
16 does and attends as well as my deputies and
17 some others, some community meetings and
18 some other stuff so we can try and help
19 bridge that gap and to try and make sure
20 that it's actually taking place.

21 COUNCILWOMAN QUINONES-SANCHEZ: Okay.
22 There's a group -- and I had asked about the
23 group before, but we are getting ready to do
24 a major renovation. And it will impact.

1 You have Little Red Boxing Gym at
2 \$50,000 at Rivera Recreation Center. They
3 are never there. I don't know what their
4 schedule is. I don't know who they report
5 to. I don't know who participates. We are
6 going to do a major renovation at that
7 facility, so I would like to see whatever
8 they are supposed to do for that \$50,000 and
9 who they are supposed to serve.

10 COMMISSIONER HARLEY: Absolutely.

11 COUNCILWOMAN QUINONES-SANCHEZ: Because
12 we may need to move them around as we
13 renovate that facility. They are never
14 there, so I don't --

15 COMMISSIONER HARLEY: And I will take a
16 look at that, too. I need to take a look at
17 the prevention contract myself to see
18 exactly what the contract entails. And we
19 will definitely get back to you. All I know
20 is that it is a boxing --

21 COUNCILWOMAN QUINONES-SANCHEZ: It's a
22 boxing gym. We have been going there a lot
23 because we are getting ready to gut the
24 place out.

1 COMMISSIONER HARLEY: Understood.

2 COUNCILWOMAN QUINONES-SANCHEZ: They are
3 never there, so I want to make sure. So,
4 one of the things that Council President's
5 been talking about is this kind of
6 co-locating similar to what we did with the
7 SUV unit. How are we doing around trying to
8 get local placements for, you know, programs
9 like the Bridge?

10 How are we doing in terms of planning so
11 that we are not sending kids when we have to
12 place them so far away from their homes?

13 COMMISSIONER HARLEY: So, we are
14 definitely continuing to plan in that area.
15 And that's one of the outcomes that we are
16 measuring for improving outcomes to make
17 sure that -- we try to keep kids as close to
18 home as possible. We know that that's the
19 best for them as well as their families. It
20 helps with reunification in terms of
21 proximity from visits and other things. We
22 continue to monitor that.

23 We do regularly monitor how many kids
24 are placed out of their homes and how far

1 from their homes in terms of how many miles
2 is a kid placed from their home. And I
3 believe for those kids who are not in a kin
4 placement, meaning with family, about 52
5 percent of them are placed within five miles
6 of the home that they originally came from.
7 So, we are beginning to monitor that. That
8 is one of the progresses of IOC that we have
9 seen that we allow kin homes to -- we waive
10 that requirement because we know that it's
11 more important to put a kid with a family
12 member than in the proximity of the
13 community. Even if family member lives
14 further, we will still let them reside with
15 the family.

16 COUNCILWOMAN QUINONES-SANCHEZ: Have we
17 talked to any of our partners? I have two
18 or three close school facilities in the
19 district. Have we begun to talk to some
20 providers to see if we can build some more
21 slots within the City grounds?

22 COMMISSIONER HARLEY: Well, we're always
23 having conversations with providers. I
24 think some of it is about what is the

1 service needs that we need and what is the
2 continuum of services. So, really try to
3 look at the array of services that we have
4 in terms of where the need is.

5 Truthfully, our service need for some of
6 those kinds of slots that you were referring
7 to would be considered more group home or
8 institution. We are actually shrinking the
9 system in that way because we are trying to
10 get more kids in family-like settings. So,
11 we are trying to have more kids in foster
12 care or in kinship care if they cannot
13 remain in the home because we believe that
14 they do better and certainly better for them
15 overall to be with a family.

16 I don't know that we've actually started
17 full fledge negotiations with some. I have
18 talked to some and there are some facilities
19 who are close by who have expanded a little
20 bit that are either within the City arena or
21 whatever. We are really trying to shrink.

22 COUNCILWOMAN QUINONES-SANCHEZ: Yeah.
23 There is a group. I was dealing with a
24 young woman who, unfortunately, had been

1 raped at home. She was fostered out. So,
2 she was 19 years old. You know, Covenant
3 House does such a great work, job on
4 Kensington Avenue in terms of providing kind
5 of studio, very affordable housing.

6 Are we looking to do any more of that?
7 I just find that there's a group of kids who
8 are like not home and are -- they are
9 technically homeless because they end up
10 living with different people. I'm just
11 wondering if there is a model as we talk
12 about housing moving forward, if there's a
13 model. As much as I hate these 450-foot
14 square apartments, I just feel like that's a
15 request we get all the time that we are
16 unable to meet.

17 COMMISSIONER HARLEY: We are very
18 conscious of the need for housing. It's a
19 huge need for our families in terms of
20 parents often. But in particular, that
21 population of kids that you're talking
22 about, I would say that 18 to 21 year olds
23 for us that definitely need housing.

24 We do have a number of housing programs

1 that we are working on and trying to
2 enhance. We actually started, which was a
3 model one. I don't believe there are any
4 others in the country. I program with PHA
5 where they gave us, we call them quads,
6 where there are, like, four apartments in
7 one building they gave us. Three of our
8 kids reside in all of them. Then the fourth
9 quad, they put a disabled person and kind of
10 pay or develop a job that our kid helps to
11 do some things in the common areas or for
12 that person.

13 That model has worked well. We actually
14 have some meetings coming up to talk about
15 expansion of that model with PHA. We are
16 also looking at some other things with PHA
17 around some scattered sites. It goes to
18 that particular population that you are
19 referring to, that 18 to 21 year old. Yes,
20 we are trying to expand.

21 COUNCILWOMAN QUINONES-SANCHEZ: It would
22 be important, and I will mention this to
23 you. I have about 200 folks who are
24 over-house or what PHA consider over-housed.

1 They are in big homes that, you know, at one
2 point, you know, there were more people
3 living in the house. And PHA has to over
4 the next couple of years transition those
5 folks out.

6 For me, the thought of having someone
7 who has lived in a house for 47 years and
8 remove that senior from that house, that
9 model that you talked about might be one
10 where we can keep some of those seniors
11 particularly scattered sites. In my case, I
12 have a lot of Latinos who are in scattered
13 sites -- well, not a lot because PHA's
14 numbers is, like, 2 percent. In those
15 situations, I like to entertain that kind of
16 kinmanship relationship where maybe that's a
17 place where we can put some of these
18 fostered-out overaged kids with a senior in
19 a home but keep that senior in their home.

20 COMMISSIONER HARLEY: Right.

21 COUNCILWOMAN QUINONES-SANCHEZ: Just to
22 introduce that to you. That is something I
23 am very concerned about. Because
24 neighborhoods where I live in Norris Square

1 where I live, I have 40, 50 people that are
2 going to be impacted in this, what they are
3 calling, over-housed situation.

4 COMMISSIONER HARLEY: Yes. Understood.

5 COUNCILWOMAN QUINONES-SANCHEZ: Okay.
6 Thank you.

7 COUNCIL PRESIDENT CLARKE: Thank you,
8 Councilwoman.

9 Chair recognizes Councilman Jones.

10 COUNCILMAN JONES: He said Jones? I
11 thought he said Johnson. All right. Thank
12 you, sir.

13 Couple of quick questions.

14 Number one, on special ed programs in
15 the school that you're administering and
16 you're trying to come up with a truancy
17 plan, are you taking into account school
18 refusal versus school truancy? Because that
19 is a subtle difference by way of some young
20 people who feel bullied or intimidated
21 because of their special needs just aren't
22 going to school. That kind of counts
23 against their attendance record.

24 Are you making a delineation between

1 those two different things?

2 COMMISSIONER HARLEY: I don't know about
3 delineation in terms of the numbers, but
4 very cognizant of the issues that -- my rate
5 of issues, why kids are saying that they're
6 not going to school. Often safety and
7 bullying is one of them. That's why we were
8 trying to work and redesign the model so
9 that we work so closely with the School
10 District so that they're staff is at the
11 table. The climate in the school would be
12 something that they control as opposed to
13 us. Our truancy providers are very aware of
14 that and will try to assist the family in
15 working through those issues and try to
16 determine how we can find out what's best
17 for that particular child.

18 And then our education support center is
19 there at the table to help make sure we have
20 the child in the best school. Or if for
21 some reason it needs to be navigated that
22 the child is moved or something, that they
23 help navigate through the School District
24 sort of red tape, so to speak, to make sure

1 we get them where the are. They are working
2 on those kind of what are the underlying
3 issues contributing to the truancy.

4 COUNCILMAN JONES: In a case where a
5 kid, a child or a parent, identifies the
6 fact that their child doesn't feel
7 comfortable and they feel intimidated and/or
8 bullied, do you make an adjustment -- work
9 with the School District to move them?

10 COMMISSIONER HARLEY: Well, we would
11 work with the School District to see what
12 goes on. In terms of whether or not it's
13 truancy, if the child is not going to
14 school, they are still counted as not going
15 to school. If their unexcused absences, it
16 might still be counted that way. But we
17 would be willing, yes, to work with the
18 family and assist them in working with the
19 School District to try and come up with a
20 resolution to that problem.

21 COUNCILMAN JONES: That was brought to
22 my attention by a parent, so I just wanted
23 to put that in your hands.

24 Last year -- we have asked this question

1 before and it's an uncomfortable question
2 for me, but I'm going to ask it anyway.

3 How many children have registered abuse
4 cases while in custody of foster parents
5 last year?

6 COMMISSIONER HARLEY: I will try to find
7 that answer for you.

8 COUNCILMAN JONES: And has it gone down
9 from fol -- from previous years?

10 COMMISSIONER HARLEY: In Fiscal Year 14,
11 13 children were abused while in DHS care.
12 That's approximately about 3.6 percent of
13 all of the reports that we get of kids in
14 care. And it actually has gone down.
15 Because in FY13, 14 kids was abused. That
16 was 4.5 percent of all reports. The reason
17 the percentage is lower is we have more kids
18 in care. Even though we have more kids in
19 care, it went down a little bit in terms of
20 the number of kids who were abused while in
21 care.

22 COUNCILMAN JONES: So in those cases,
23 what have -- are the -- what has been the
24 disposition of those cases? Meaning, was it

1 founded? Unfounded? Prosecuted? Not
2 prosecuted?

3 What was the disposition?

4 COMMISSIONER HARLEY: So the 13 I'm
5 giving your were all cases either founded or
6 indicated. Because what happens is if an
7 allegation is made that a kid is being
8 injured while they're in care, then the
9 State does the investigation. And then the
10 State makes a determination as to whether
11 they are going to found or indicate. So,
12 those 13 kids were indicated or found. I
13 cannot tell you whether or not the
14 perpetrators were -- law enforcement
15 proceeded against the perpetrators. That, I
16 don't have with me.

17 COUNCILMAN JONES: So in a case where
18 there's an allegation, is the foster
19 provider, foster care provider immediately
20 taken out of the system so that, you know,
21 no other child will wind up in that similar
22 circumstance?

23 COMMISSIONER HARLEY: So what happens is
24 the State is actually the one, Pennsylvania

1 Department of Human Services, who licenses
2 foster homes and facilities. We don't do
3 the licensing.

4 However, if I find out that there's an
5 allegation against a foster parent, we do
6 obviously and immediately remove all
7 children who are in their care that aer
8 foster children for us. I don't have the
9 ability to shut a home down, meaning they
10 can never get kids. But I do have the
11 ability to control which Philadelphia kids
12 go. And what we do is we flag it in our
13 system so that we don't send any other
14 Philadelphia kids once we get the notice
15 from the State.

16 COUNCILMAN JONES: Share that
17 information with other providers?

18 COMMISSIONER HARLEY: Once we flag it in
19 our system, there's something like a
20 provider code. So, the home can't get a
21 code. It can't operate if it does not have
22 a code in it.

23 COUNCILMAN JONES: What I'm -- maybe I
24 didn't say it right. I understand you cease

1 and desist placing kids there. Do you share
2 that with other agencies that may have
3 different sources of young people?

4 COMMISSIONER HARLEY: I'm not -- we
5 don't go to other counties, for example, and
6 share it. But certainly, if we don't
7 place -- one of our providers can't place a
8 kid there if we already closed the home to
9 that.

10 COUNCILMAN JONES: There is no
11 reciprocity.

12 So for example, suppose somebody outside
13 of your system uses the same foster care
14 people and they have a allegation. Do they
15 let you know that there might be an open
16 investigation in that facility or site?

17 COMMISSIONER HARLEY: There is registry,
18 a foster parent registry that they would go
19 on that is maintained by the State that they
20 would put on. And all of us in whatever
21 county across the state would have access to
22 it, would be able to look at it. There is a
23 registry that is maintained.

24 COUNCILMAN JONES: Okay. And in cases

1 of alleged abuse, are -- I think there was
2 an article that talked about allowing them
3 to use pseudo names because they didn't -- a
4 lot of kids feel the stigma, oh, I was
5 abused, I was attacked or I was bothered.
6 Are they given anonymity so they don't wind
7 up ostracized or picked on or any of those
8 things?

9 COMMISSIONER HARLEY: I don't know
10 anything about allowing kids to use pseudo
11 names. However, certainly whenever a
12 investigation is conducted, the child is
13 talked to privately as part of the
14 investigation. And when we remove a child,
15 we would remove a child. Often where they
16 are moved to, depending upon what's going
17 on, may not have any information as to what
18 happened before.

19 I don't know of too many instance where
20 a child has been abused that it follows them
21 or it becomes, you know, another problem or
22 pattern for them. Because everything is
23 done confidentially surrounding the
24 investigation into the initial home.

1 COUNCILMAN JONES: Finally, by way of
2 selection of foster care parents' homes, I
3 know it's difficult to recruit good foster
4 care parents. How are we doing in that
5 particular area by way of service providing
6 for children?

7 COMMISSIONER HARLEY: So, it is very
8 difficult to recruit good foster care homes.
9 We call them resource homes sometimes. We
10 are trying very hard to recruit more
11 resource homes. We are beginning to do some
12 work and trying to do some work within, say,
13 the faith-based community hoping that maybe
14 we can recruit some homes because other
15 jurisdiction have had success recruiting out
16 of that, out of the faith-based community or
17 congregations of various type.

18 It is difficult. It is also difficult
19 to make sure that you have the children in
20 the right home when you put them in the
21 home. And so, we are doing okay. But we
22 have a lot more work to do in terms of
23 needing to develop foster care and
24 resources.

1 COUNCILMAN JONES: I don't know what we
2 can do as a legislative body budget
3 appropriating body. But whatever we can do
4 to help you up the level of recruitment and
5 then quality, please let us know. Because
6 the outcomes are real clear that when you
7 get it right, you can save a life. When you
8 get it wrong, you set them on a track of
9 problems throughout their life. We are
10 watching -- which leads me to my final,
11 final point.

12 How are we doing with those that age out
13 of the system? And are we improving on
14 those outcomes as opposed to the past?

15 COMMISSIONER HARLEY: So, kids who age
16 out of the system continue to be a challenge
17 in making sure that when they age out, they
18 get the services that they need. It happens
19 to be an area that I'm very interested in.
20 And we are trying to do better in a number
21 of ways. I think in some ways we are doing
22 better and some ways we still have a long
23 way to go, quite honestly.

24 We are trying to improve our IL

1 services, which are independent living
2 services, to try and make them be able to be
3 self sufficient when they leave. We have
4 made a lot of progress with our Achieving
5 Independence Center. Now we are housed at
6 Broad and Master in the Old Leon Sullivan
7 building. It's sort of the one-stop shop
8 for independent living services for our
9 kids. It's kind of a model.

10 And they have everything there from
11 assisting them with tutoring or issues that
12 they may be having academically or school,
13 to helping them to fill out college
14 applications, financial aid applications,
15 employment applications. They do employment
16 readiness with them. They do mock
17 interviews. We have a little boutique where
18 they can go and get clothes so they have
19 appropriate clothing for job interviews,
20 things of that nature.

21 But they also teach them basic, what
22 some people would consider, basic skills.
23 What might not be as basically taught for
24 our kids, things such as budgeting and

1 planning and how to balance a checkbook and
2 banking and, you know, just other
3 skill-building type of things. We are
4 trying to work on that. Very difficult.

5 Philadelphia, of many of the counties
6 across the state, we actually have a large
7 number of kids who are age 18 to 21 because
8 we believe in trying to help our kids as
9 long as we can help them and help them to
10 transition out. We have been doing that for
11 a long time. We actually try to put as many
12 services in place as we can for our kids
13 that are 18 to 21.

14 I talked a little bit earlier in
15 response to Councilwoman Sanchez' question
16 in terms of us having a concern about that
17 population and the housing need also.
18 Within that population are kids who age out.
19 Sort of creative model programs we are
20 trying to work out with PHA and others to
21 try and assist them with housing needs and
22 other needs that they have.

23 We also do, in response to law, Act 91
24 came out which is a reentry program. What

1 we find is sometimes you have a young
2 person, they turn 18 and they say, I want
3 out of the system. Because legally they are
4 an adult, although I might not think they
5 are ready to go out there on our own like
6 most of our kids who are not ready at 18 to
7 go out into the world on their own.

8 Sometimes they want to and they do, and then
9 they realize they made a mistake. And so,
10 years ago it was nothing I could do. If you
11 left at 18, we cannot use our money or
12 anything else to bring you back.

13 But recent law changes allow us now.
14 They can apply for reentry into the system.
15 We can bring them back in up until age 21 to
16 help them get whatever the services are that
17 they need. It allows us to be able to help
18 them connect with everything from, you know,
19 they need housing or their behavioral health
20 services or whatever else that they need.

21 Also under the Obama legislation, we've
22 been trying to help them connect and know
23 that they can still get medical benefits up
24 until age 26. And so, just getting that

1 word out there and trying to help them
2 navigate the services that are available to
3 them.

4 COUNCILMAN JONES: I see you have Former
5 Mayor Wilson Goode with you. And, you know,
6 you brought your big gun today. And I
7 understand he deals with issues related to
8 families that are incarcerated and provided.
9 Could you talk about that for a moment. And
10 I'm really, really proud that he's still
11 giving of himself to public service in that
12 regard.

13 COMMISSIONER HARLEY: So, Mayor Goode's
14 Program, obviously, he would be able to talk
15 about it much better than this. I do know
16 that it is a program that provides
17 mentoring. It's a model mentoring program
18 for incarcerated people. Mentoring is
19 something that we are trying to work on and
20 develop more. We need it for our older
21 youth and we are in need of mentors.

22 If you know of anybody who is willing,
23 have them contact us. We are definitely in
24 need of mentors for our teenage kids in

1 particular. They are developing mentoring
2 programs at our Achieving Independence
3 Center. We are now embarking on what's
4 called sort of natural mentoring. Which
5 means we have our kids sometimes identify
6 who they might want to mentor them.

7 Sometimes they now found a teacher or
8 coach or somebody else who wants to mentor
9 them. One of the things we have done,
10 though, in recent years is try and increase
11 our outreach to incarcerated parents.
12 Because while they are incarcerated, they
13 still have a right to see their children,
14 still have a right to participate in the
15 planning for their children in DHS care.

16 And so, we now started doing some video
17 conferencing with them. We now have, you
18 know, some equipment at the department in
19 the room where they can be involved
20 sometimes in the team meeting that might be
21 taking place through conferencing. We've
22 some visitation through that. Also, we
23 tried to emphasize more and have done much
24 better with our workers in terms of working

1 around taking kids to visit their parents
2 and trying to -- we've done, I call it
3 commercial. I think they called it
4 infomercial -- that runs at the prisons at
5 the City of Philadelphia prisons, which
6 tells incarcerated people what their rights
7 are kind of but also what their obligations
8 are. Because the clock doesn't stop ticking
9 on you because you're incarcerated because
10 of what you are supposed to do on behalf of
11 your child. We have that running in English
12 and Spanish, which runs throughout on the --
13 in the common areas of the prison and on the
14 TVs there that gives them other information.

15 And we've also in recent years sort of
16 expanded working with prison social workers
17 around trying to make sure that certain
18 programs are offered or that the parents who
19 are incarcerated have access to those
20 programs, as well.

21 COUNCILMAN JONES: Mr. President, I
22 just -- it's incredible to me that sometimes
23 we have generational attendance in some of
24 our prison facilities where father and a son

1 and a grandfather all in the same
2 institution. So, this is God's work working
3 to prevent some of those negative outcomes
4 and provide those services. Because it is a
5 victim, but there are other victims by the
6 actual perpetrators. Because if he has
7 children, that's a household that doesn't
8 have a father, a mother and another parent
9 to be a helping hand to help with homework
10 and stuff like that. So, there are number
11 of victims once something happens like that.

12 Thank you for what you're doing.

13 COMMISSIONER HARLEY: You're welcome.

14 COUNCIL PRESIDENT CLARKE: Thank you,
15 Councilman.

16 Chair recognizes Councilwoman
17 Quinones-Sanchez.

18 COUNCILWOMAN QUINONES-SANCHEZ: I have
19 just one last question.

20 We -- one of the things I had asked
21 Dr. Evans that I'm going to ask for your
22 department is if you can map out by district
23 what are your service providers both on the
24 prevention and then the CUA. One of the

1 things we have to get a hold of, and I
2 wasn't here for the Health Department, is
3 for people in the community, service is
4 service. I think it's important for us to
5 get a good visual of what kind of services
6 we have in every single neighborhood. And
7 now that you have the CUAs that have given
8 you a foothold in the community, I would
9 like to see what all of those things like
10 look.

11 I notice you have a robust list of
12 prevention services and other things, I
13 think that would be beneficial. If you can
14 forward that with like phone numbers and
15 contacts, sometimes we get tons of calls
16 from some of these agencies. I just want to
17 be clear, like, what is your role. It's
18 easy for you to give us constituent
19 services. Sort of like where are you
20 located in all of this and how we can be
21 more proactively helpful, so that would be
22 helpful if you can forward that.

23 And I have a question. You know, we are
24 starting this police oversight. We see

1 what's going on in Baltimore, clearly the
2 scenes are graphic. The mother hitting her
3 son.

4 If we were to be in a similar situation,
5 what would be DHS protocols in helping us?
6 I would hate to see -- I know you have some
7 really good model programs about first
8 offenders. What could we be doing or what
9 could DHS be doing to help us? You know,
10 you see these scenes, kids beating up kids
11 underneath SEPTA.

12 How many of those kids are in your
13 system, and what else could we be doing?

14 COMMISSIONER HARLEY: I don't know
15 exactly how many of the kids you are
16 referring to are in our system. I do have
17 my deputy sitting out here for Timene Farlow
18 for Juvenile Justice who probably can answer
19 some of these questions a little bit better
20 than I could and is very committed to trying
21 to come up with diversionary programs and
22 programs that will decrease recidivism for
23 those kids who do come into our system, so
24 that hopefully we help them successfully

1 reintegrate back into their communities and
2 we no longer need to come back in.

3 I think we do have the school diversion
4 program that we sort of support with the
5 Police Department, which is I think the
6 program that you might have been referring
7 to. Where at this point over 400 kids have
8 been diverted that are first-time offenders.
9 We are excited about that program because
10 that's 400 kids that would have been
11 incarcerated somewhere or in our detention
12 center. Many of them were DHS children on
13 the dependent side. Okay. So, it gave them
14 the opportunity to have another children for
15 sometimes what is seemingly a small
16 infraction and then you put a kid on that
17 trajectory and that's the road that they
18 sort of go on.

19 Definitely looking at that. We have a
20 delinquency leadership meeting coming up,
21 which are the stakeholders in the
22 delinquency around the City. The DAs, the
23 Police, ourselves and Family Court, being
24 housed at Family Court soon so we can talk

1 about kind of where we are. Actually, our
2 numbers are going down in terms of number of
3 arrests our City for youth have gone down
4 some to the extent that some of our
5 facilities are experiencing shrinking in
6 terms of placing there.

7 There are a number of -- we have evening
8 reporting centers. There are number of
9 other centers that we are trying to use.
10 And that has been going so well. That is
11 sort of pre-adjudication that we are now
12 trying to --

13 COUNCILWOMAN QUINONES-SANCHEZ: I saw
14 the reporting centers. Again, where are
15 they located? Kind of how do they work?

16 COMMISSIONER HARLEY: I'm going to ask
17 Timene if she can come up. She probably can
18 provide these answers a little bit better
19 than I can.

20 COUNCILWOMAN QUINONES-SANCHEZ: I don't
21 know if that was kind of taking place for
22 our truancy centers that we had, our evening
23 centers.

24 DEPUTY COMMISSIONER FARLOW: Good

1 afternoon.

2 COUNCILWOMAN QUINONES-SANCHEZ: It's
3 evolution of our centers.

4 DEPUTY COMMISSIONER FARLOW: Good
5 afternoon. I'm Timene Farlow. I'm Deputy
6 Commissioner for Juvenile Justice Services.
7 There are two evening reporting centers.
8 One of which is run by Northeast Treatment
9 Centers located at about 2nd and Berks. And
10 the other is Philadelphia Youth Advocacy
11 Programs. That is --

12 COUNCILWOMAN QUINONES-SANCHEZ: That's a
13 perfect example. I live around the corner.
14 I talked to -- I didn't know that was
15 considered one of the drop off centers.
16 That is right around the corner from my
17 house.

18 DEPUTY COMMISSIONER FARLOW: Okay.

19 COUNCILWOMAN QUINONES-SANCHEZ: I didn't
20 know that.

21 DEPUTY COMMISSIONER FARLOW: Well, the
22 evening reporting centers are actually
23 alternatives to secure confinement. They
24 are not for your run-of-the-mill young

1 person. It is really a diversion, an
2 opportunity for a young person to experience
3 being at home with his own -- his or her own
4 family instead of being locked in a secure
5 facility. Both of those programs are --

6 COUNCILWOMAN QUINONES-SANCHEZ: Who
7 takes the kid there? An incident happens --

8 DEPUTY COMMISSIONER FARLOW: So, it's at
9 judicial discretion. The judges make the
10 decisions as to which young people will get
11 that as an opportunity and which won't. So,
12 judges make those decisions based on a
13 number of risk factors. They are using now
14 the Detective Risk Assessment Instrument.
15 And provided a young person scores within a
16 range that suggests that he or she can be
17 safely managed in the community without
18 creating new victims, then the child is
19 referred.

20 COUNCILWOMAN QUINONES-SANCHEZ: Okay.
21 Thank you. And one last thing.

22 One of the things that came out at the
23 last hearing was the issue of when CUA
24 members and folks have to go to court. And

1 we heard some complaints for more advocates
2 in the court system. Has that process
3 gotten better in terms of training staff to
4 be able to go in front of the Court and be
5 prepared?

6 In our hearings last time, that was one
7 of the items that came up. Have we improved
8 that?

9 COMMISSIONER HARLEY: I'm sorry,
10 Councilwoman. I think I missed the
11 beginning. You're asking me about CUA
12 performance in court?

13 COUNCILWOMAN QUINONES-SANCHEZ: Yeah.
14 She mentioned the court in terms of court
15 ordered stuff. One of the complaints or the
16 criticism we got was that some staff is
17 unprepared to go into court with some of the
18 children. And so, she's saying about a
19 referral.

20 Have we strengthened that? What have we
21 done since the last hearing around the
22 communication?

23 COMMISSIONER HARLEY: So, what we have
24 done since the last hearing around that is a

1 number of things to try and help to improve
2 the quality of preparation and the quality
3 of performance before the courts with the
4 community umbrella agency staff.

5 One of the things that we have done
6 since the last hearing is we have developed
7 a Department of Technical Assistance, which
8 comes under my DHS university which is
9 typically our training arm that provides
10 coaching and other things for the CUA and
11 CUA staff. They have started doing what we
12 call DRO, which means Disposition or Review
13 Order. In other words, court-ordered
14 clinics.

15 Which means that CUA staff can come,
16 bring a court order that they have. They
17 can help explain that court order, help them
18 understand if there's some language on there
19 or other things that they don't know how to
20 navigate or what the judge wants, what the
21 time requirements are. So, we put that in
22 place. There has been some work done with
23 our law department has been going out to
24 different CUAs, talking to them, trying to

1 develop some things in terms of training and
2 other things.

3 So, we are also developing some booster
4 trainings, if you will, around how to
5 prepare for court. I have personally, along
6 with Kimberly Ali, been going out and
7 meeting with the line level staff in each of
8 the CUAs. I've been to eight so far. I
9 think I have two more coming up.

10 One of the things that I found as I'm
11 talking to staff and trying to see, is we do
12 ask the staff to do a lot. Sometimes it's
13 about how do you prioritize. I talk to them
14 a little bit about the prioritization of
15 what it is we ask them to do. Also, I talk
16 to them about court preparation and having,
17 you know, practice in family court. You
18 know, kind of what it is the judges are
19 looking for. How you, you know, address
20 that.

21 I do think that court performance is
22 getting better. I have regular meetings
23 with Family Court Administration. And we do
24 talk about some of these things. We are

1 also beginning to track different things.
2 In terms of, I have a DHS court
3 representative, we call them, in each
4 courtroom. They are also there in trying to
5 assist and help bring some closure. We have
6 some of those DHS representatives sit in our
7 law department and sort of facilitate
8 getting information between the City
9 solicitors and the dependents.

10 And then I've also done some going to
11 some staff meetings and talking to our
12 lawyers around, you know, how they can be
13 useful in prepping and helping particularly
14 staff who may not be as useful in going to
15 court as much.

16 MS. ALI: In addition to the stuff that
17 the department has done to help the CUAs
18 enhance their preparation, presentation at
19 court, we also talk to CUA leadership and
20 their administrators. Their case management
21 directors on up will actually go to court
22 every other month so they can observe the
23 presentation of their staff so that they can
24 also provide constructive feedback to the

1 staff to help enhance their preparation and
2 their presentation at court.

3 So, we look at a two-prong process.
4 Both the department helping to enhance as
5 well as CUA leadership helping to enhance
6 the practice at court, as well.

7 COUNCILWOMAN QUINONES-SANCHEZ: That's
8 so important. Because that interaction with
9 the courts and whether this child ends up in
10 a situation that, you know, potentially
11 could be permanently damaging to their
12 record versus diverting them because we know
13 the problems.

14 I had an opportunity to visit a couple
15 of centers. And I will tell the story
16 because it's really, really telling. At one
17 of the centers, you know, you have a child
18 who gets in trouble in school. If people
19 don't ask the right questions, this child
20 ends up in the situation within our judicial
21 system when they could have had a death or
22 you know, the trauma situation that we have
23 seen.

24 So, that is important about what

1 happened in what context, what was going on
2 in the child's life to make sure that
3 whatever the decisions happen in the court
4 are in the best interest of the child not
5 only short term but long term.

6 Thank you. Thank you very much,
7 Mr. Chair.

8 COMMISSIONER HARLEY: Thank you.

9 COUNCIL PRESIDENT CLARKE: Thank you,
10 Councilwoman.

11 Chair recognizes Councilwoman Blackwell.

12 COUNCILWOMAN BLACKWELL: Thank you,
13 Mr. President. Thank you, Commissioner. I
14 want to thank your deputy with whom I met at
15 Youth Study Center. And it's such a special
16 place. And they really, really care about
17 the kids there. So, I hope she will maybe
18 privately we can talk about a young lady who
19 is there that we were so worried about.

20 It's so sad that these children when
21 they're ready to finish school get
22 transferred since they don't stay there.
23 It's a big issue. In fact, I talked to
24 Kevin Dougherty on one of the campaign stops

1 about that issue of us losing kids who are
2 doing so well in the environment when people
3 care about them. And then about 19 days
4 later, they are sent to the suburbs
5 someplace and they fall down and don't
6 finish school because it's not local. We
7 really have to do something about allowing
8 our children to stay here.

9 But thank you for your efforts. And
10 really would like to explore that any way
11 you can.

12 COMMISSIONER HARLEY: So, thank you for
13 recognizing those efforts. We are blessed
14 that we have a very good education program
15 at the Philadelphia Juvenile Justice
16 Services Center, our new name for Youth
17 Study Center. And it is actually a School
18 District principal who is very dedicated and
19 committed to these young people. The
20 educational opportunities there are really,
21 really good.

22 I do definitely understand what you're
23 saying in terms of some of the kids do well
24 there. I am sure that I or Timene would be

1 happy to talk to you about this young lady.
2 Timene certainly knows them all much better
3 than I do because she is very into the
4 trajectory for all of these kids. But thank
5 you for recognizing the center and Timene.

6 COUNCILWOMAN BLACKWELL: Thank you.
7 Thank you, Mr. President.

8 COUNCIL PRESIDENT CLARKE: Thank you,
9 Councilwoman. Commissioner, thank you so
10 much for your very thoughtful and in-depth
11 testimony and you responses. Most
12 definitely going to have a follow up with
13 you.

14 I'm not sure have you gotten -- have you
15 had a chance to look at this family-based
16 services?

17 COMMISSIONER HARLEY: I don't think I
18 have. I think I might be familiar with
19 parts of it. I haven't seen the document.

20 COUNCIL PRESIDENT CLARKE: I would like
21 to give you a copy of it and ask for you to
22 just kind of look through it and just give
23 us some suggestions. You know, the theme as
24 we go through some of the department's

1 testimony today, it's clear that there are a
2 number of certain levels of resources that
3 address these concerns and a significant
4 number of cases you all are already doing
5 this, the approach to some degree kind of
6 consolidating some of those services in a
7 particular location.

8 COMMISSIONER HARLEY: Yes.

9 COUNCIL PRESIDENT CLARKE: I think we
10 all understand the proximity of services
11 makes a whole lot of sense. And we've been
12 working with a number of stakeholders that
13 had a really great presentation. All the
14 presenters were from outside the City. It
15 gave us a different perspective.

16 Baltimore, we talked about the
17 Cincinnati model. We really would like to
18 be in a position to follow up with you so
19 you can give us some recommendations and
20 suggestions. The universities are involved.
21 They are excited about possibilities in some
22 of the hospitals. So we really would look
23 for your very, very critical --

24 COMMISSIONER HARLEY: Absolutely.

1 COUNCIL PRESIDENT CLARKE: -- solutions
2 to some of these activity that we'd like to
3 embark on. Thank you so much for your
4 testimony.

5 COMMISSIONER HARLEY: Thank you.

6 COUNCIL PRESIDENT CLARKE: We will
7 follow up.

8 COMMISSIONER HARLEY: Thank you all.

9 COUNCIL PRESIDENT CLARKE: Thank you.

10 Next up we will have Office of
11 Supportive Housing.

12 (Witnesses approach witness table.)

13 - - -

14 (Councilman Greenlee sitting as Chair.)

15 COUNCILMAN GREENLEE: Good afternoon,
16 everyone. We have your -- obviously, we
17 have your -- what you sent us already,
18 written testimony. If you could briefly
19 state your position and then we can have
20 some questions.

21 MS. NAHIKIAN: Good afternoon, Members
22 of the City Council.

23 COUNCILMAN GREENLEE: Pull the
24 microphone just a little closer. Yeah.

1 There you go. Thank you.

2 MS. NAHIKIAN: I am Marie Nahikian. I'm
3 the Director of the Office of Supportive
4 Housing.

5 How might Philadelphia end homelessness?
6 We know how. On April 10 the Office of
7 Supportive Housing joined in announcing that
8 Philadelphia will end homelessness for our
9 Veterans by November 11, 2015. When that
10 happens, Philadelphia will be the largest
11 city in our nation to accomplish this.

12 How did it happen? And it's a critical
13 lesson for how we might look at homelessness
14 in the City today. Three critical factors:

15 Leadership. The efforts for Vets began
16 in 2013 with a commitment from top leaders
17 from our City, from the Federal Government
18 and the local community that provides
19 services.

20 Collaboration and partnership. There is
21 an unprecedented system designed by multiple
22 partners with one point of entry for persons
23 who are Vets and who are homeless.

24 And finally, resources. The Federal

1 Government has provided sufficient types of
2 resources that with effective local
3 stewardship ensures that a Veteran no longer
4 has to be homeless. The mission of the
5 Office of Supportive Housing is to help
6 individuals and families do the same thing,
7 moving toward independent living and self
8 sufficiency and stable housing.

9 OSH fulfills this mission by
10 incorporating leadership, working closely
11 with national and regional leaders and the
12 many public and private partnerships that
13 support our system. We balance diverse
14 needs capturing as many resources as
15 possible through multiple sub-populations.

16 For example, we have the federally
17 funded homeless continuum of care where OSH
18 plans the development of new initiatives and
19 is provided over 5,500 units of permanent
20 supportive housing since the beginning of
21 the continuum. The continuum includes over
22 50 local nonprofit organizations. OSH
23 manages the Riverview Home, where up to a
24 hundred low income persons in needs of

1 personal care now can reside.

2 In 2014, OSH provided food for
3 1.6 million meals served in Philadelphia's
4 soup kitchens and 4.2 million onsite meals
5 and emergency shelter. We provide support
6 to many City agencies including L&I where
7 our trained emergency assistant staff carry
8 out cease and desist orders. OSH provides
9 emergency housing to individuals and
10 families. And since the beginning of
11 FY2014 -- 2015, excuse me, OSH has placed
12 632 persons in permanent housing and 408
13 persons in transitional housing. These
14 resources largely coming from the
15 Philadelphia Housing Authority.

16 The Homeless Prevention Program has
17 assisted over 600 persons in FY2015
18 preventing evictions, mortgage foreclosures
19 and providing relocation security deposit
20 assistance. I'm pleased to tell you
21 something about the OSH budget request for
22 Fiscal Year 2016.

23 The proposed FY16 budget is \$91 million.
24 It includes an allocation of \$45.2 million

1 in general funds representing 49 percent,
2 and 46.5 percent in grant funds, about 51
3 percent. The general fund proposed
4 allocations is a bit higher than FY15
5 currently because of employee salary
6 increases as a result of union contracts.
7 The title FY16 proposed operating budget to
8 OSH is, however, on par with our FY current
9 projections for FY15.

10 FY16 challenges include a growing demand
11 for emergency housing. Although
12 Philadelphia's nationally recognized for our
13 homeless programs and our homeless
14 prevention programs, the need for affordable
15 housing, the high levels of poverty and
16 unemployment continue to increase the number
17 of the persons at OSH front door. A growing
18 number of low income and poor citizens, many
19 with full-time jobs, 30 percent of our
20 single men are in shelter have jobs.

21 They turn to the homeless system for
22 affordable housing. On any given day, OSH
23 is operating at full capacity. On average,
24 about 30 families come daily to our

1 Appletree Family Intake Center. The OSH
2 front door is a safety net for these
3 families. Our No Vacancy signs leaves
4 family with the reality of not being
5 assisted and the painful job for OSH staff
6 who must say no. OSH continues to assist
7 with prevention strategy and seeking
8 resources from family, friends or other
9 relatives whenever it's possible and safe to
10 do so when we have to say no.

11 In FY16, OSH will join the federal goals
12 of ending chronic homelessness in 2016,
13 family homelessness in 2017. And with any
14 good luck, youth homelessness in 2020.

15 Since August 2013 through March 2015,
16 the City and partners including the Vets
17 Administration, Public Housing Authority,
18 HUD and nonprofits have ended homelessness
19 for 905 Veterans. OSH wishes -- is planning
20 to extend the Philly Vets team home goal for
21 Vets to all Philadelphia residents so that
22 future homelessness will be rare, brief and
23 non-reoccurring.

24 We're happy to answer questions. With

1 me is Rodney Cherry, our fiscal officer; Joy
2 Presson, our -- my Chief of Staff as well
3 our deputies in the various program areas.

4 COUNCILMAN GREENLEE: Okay. Thank you
5 very much. Thank you for all the work you
6 do. I have just a couple questions
7 regarding the work you do with domestic
8 violence -- domestic violence issue.

9 First, I know there has been money
10 consistently in the budget last couple years
11 for the second domestic violence shelter.
12 And I wasn't real clear because I know money
13 in the budget is kind of in a lump sum. I
14 believe there should be \$2.7 million
15 directed towards women against abuse for
16 that second shelter. Is that part --

17 MS. NAHIKIAN: 2.5 million. And then
18 they got an additional transfer ordinance
19 for another 200,000.

20 COUNCILMAN GREENLEE: Okay.

21 MS. NAHIKIAN: It's a total of 2.7.

22 COUNCILMAN GREENLEE: It's a total of
23 2.7. Good. Good. And then you talk about
24 in the written testimony about the issue of

1 the Citywide coordinated response to
2 domestic violence. Could you just go in a
3 little bit on what exactly OSH does in that
4 effort.

5 MS. NAHIKIAN: We are participant as are
6 many organizations. I think that are staff
7 participating on a regular basis has
8 provided leadership. And we will continue
9 to participate.

10 COUNCILMAN GREENLEE: And I think you --
11 who else is involved in that; do you know?

12 MS. NAHIKIAN: You mean in terms of OSH
13 or in terms of the City?

14 COUNCILMAN GREENLEE: Well, both in this
15 case? How about with the City?

16 MS. NAHIKIAN: Department of Behavioral
17 Health. I know the Deputy Mayor for Health
18 and Opportunity has been involved. I'm
19 trying to think what other. I know DHS has
20 been involved.

21 COUNCILMAN GREENLEE: Okay.

22 MS. NAHIKIAN: It's been a pretty broad
23 group from the City.

24 COUNCILMAN GREENLEE: Okay. All right.

1 Appreciate that. Thank you.

2 MS. NAHIKIAN: You know, the largest
3 number of women in our system has been
4 domestically abused. And we keep a
5 full-time person in our intake center that
6 can screen for domestic abuse. We're
7 getting ready to do special training with
8 all of our workers in shelters and our
9 housing facilities to help them more readily
10 spot issues of domestic abuse which are --
11 sometimes people can't talk about it.

12 COUNCILMAN GREENLEE: Yeah. They won't
13 talk about it. I know that often. I
14 remember years ago there was a concern with
15 a bill we did to give people some -- victims
16 time off to deal with the issues around
17 domestic violence. And some concern was
18 raised that people would lie about that they
19 were victims of domestic violence. I said,
20 that's not the problem that they lie about
21 that. The problem is they don't tell you
22 when they really are victims.

23 But again, I appreciate all you do in
24 that effort, too.

1 Councilman Jones.

2 COUNCILMAN JONES: I just want to thank
3 you, Mr. Chairman, for all your work in
4 lobbying you and Kenyatta and Councilwoman
5 Blackwell do to deal with domestic violence
6 and also homelessness in general. Thank you
7 guys for what you do. Seven years I've been
8 here, I been able -- my first constituent
9 service case after all of the confetti had
10 fallen to the ground and sworn me in, the
11 people were sitting at the little party we
12 had outside my office. Little family.
13 First case I got was a homeless case. They
14 told me, yeah, party was nice, but we don't
15 have anywhere to go.

16 I'll never forget that. And I thank you
17 for being responsive. They sent over a team
18 and we got them -- it was almost like a
19 salesman at a store. I wanted to solve my
20 first case. And thanks to you guys, I've
21 been able to do that. So, thank you for
22 what you do.

23 Let me ask a few questions. How many
24 homeless people are there in the City of

1 Philadelphia?

2 MS. NAHIKIAN: There a couple of ways to
3 answer the question. But if you count
4 everybody that is in shelter and everybody
5 that is privately placed in shelter or
6 supportive housing, about 15,000.

7 COUNCILMAN JONES: 15,000. Of that
8 15,000, how many then wind up recurring
9 recipients of shelter service, or how many
10 matriculate out into some form of permanent
11 housing?

12 MS. NAHIKIAN: The majority once they're
13 in the system do move out. The repeats, I
14 don't really have -- I'll have to get back
15 to you on that.

16 COUNCILMAN JONES: It's an interesting
17 statistic. We are successfully
18 transitioning them into permanent housing,
19 that's one thing. If they are coming back
20 because of circumstances, we need to address
21 it differently.

22 MS. NAHIKIAN: And we know that happens.

23 COUNCILMAN JONES: Okay. What I'm
24 intrigued about is some of the foresight

1 that you had on preventing homelessness. I
2 understand there's a program. And we've
3 used it actually where if you find out
4 someone's in imminent circumstances where
5 they are going to be evicted or things like
6 that, you step up to try to prevent that
7 because it's cheaper to keep them in place
8 then to actually shelter them through the
9 system. Is that close to correct?

10 MS. NAHIKIAN: That's absolutely --

11 COUNCILMAN JONES: Can you describe that
12 program, please?

13 MS. NAHIKIAN: That's absolutely
14 correct. Our Housing Prevention Program can
15 step in when a family is facing eviction.
16 For the most part, it's very low income
17 families. In fact, it's always very low
18 income families.

19 And the events that trigger eviction are
20 interestingly enough reduction of hours of
21 work. Someone who suddenly gets reduced to
22 20 hours a week from 40, a family event like
23 needing to provide money for a burial or a
24 catastrophic event. And sometimes we just

1 have families who spend badly, and they may
2 have not budgeted correctly.

3 We do step in to prevent them from being
4 evicted with funds generally not more than a
5 thousand dollars per family. And the
6 families generally have to pay down some of
7 their arrears to match that.

8 In FY15, we have assisted I think 400 --
9 a total of 689 families to date with either
10 security deposits because they're moving
11 into a new unit, rent to forestall evictions
12 or funds to assist with mortgage to stop a
13 mortgage foreclosure.

14 COUNCILMAN JONES: Generally, how much
15 money out of your budget goes towards those
16 efforts?

17 MS. NAHIKIAN: I'm not sure about the
18 exact percentage, but I think the funding --
19 what's about 3 million percentage of 90
20 something. It's a small percentage of the
21 budget. And we know -- we know that it's
22 effective.

23 COUNCILMAN JONES: My point in asking
24 the question is that find out that

1 percentage and provide it to the Chair. I'm
2 of the opinion that if you do the cost
3 analysis, it's cheaper to keep them. And if
4 we can be penny wise and pound foolish, I
5 think we should appropriate more money
6 towards that end as opposed to catching them
7 on the back end and taking them through the
8 entire system, which is more financially
9 burdensome to the taxpayer. I mean, even my
10 most conservative colleagues would argue and
11 be able to agree, actually, that if we can
12 do a thousand dollars here versus five
13 thousand, ten thousand dollars on the other
14 end makes sense.

15 And I realize this because at the middle
16 of the year, it's probably a lot of demand
17 for that. And it's gone by the middle of
18 the year. We are winding up spending even
19 more at the tail end.

20 If you can justify that in a
21 quantitative manner, there might be some
22 support for that. That guy right up there
23 is a soft touch for helping people. Maybe
24 we can convince him and eight others.

1 MS. NAHIKIAN: We will be glad to
2 provide that information.

3 COUNCILMAN JONES: Thank you, Mr. Chair.

4 COUNCILMAN GREENLEE: Thank you,
5 Councilman.

6 Councilwoman Blackwell.

7 COUNCILWOMAN BLACKWELL: Thank you. Let
8 me say thank you and thank the whole team
9 whom I have known forever for the great job
10 you are doing. Let me ask you again. Can
11 you repeat those numbers.

12 We know we're saying we're going to get
13 rid of homeless Vets. When?

14 MS. NAHIKIAN: November 11, 2015. There
15 about 1,538 identified homeless Vets. We
16 have housed a few over 900. We know where
17 about 400 of the 600 left are because they
18 are in shelter and ready to move into
19 permanent supportive housing. So, we have a
20 little over 200 that we are looking for.

21 COUNCILWOMAN BLACKWELL: That's great.
22 Give me the other statistics you mentioned
23 for me. 16? 17?

24 MS. NAHIKIAN: Oh, ending family

1 homelessness in 20 -- wait a minute. Let me
2 make sure.

3 COUNCILWOMAN BLACKWELL: I didn't know
4 if I live long enough for this day. I'm
5 writing these statistics down.

6 MS. NAHIKIAN: The federal goals are to
7 end chronic homelessness in 2017, family
8 homelessness, excuse me, in 2016 -- family
9 homelessness in 2017 and youth homelessness
10 in 2020. I'll be glad to forward some
11 information about those goals.

12 COUNCILWOMAN BLACKWELL: Thank you. I
13 would appreciate that.

14 Again, thank you. And thanks to the
15 whole team. All the folks who you worked
16 with over the years. Thank you.

17 MS. NAHIKIAN: Thank you, Councilwoman.

18 COUNCILWOMAN BLACKWELL: Thanks.

19 COUNCILMAN GREENLEE: Thank you,
20 Councilwoman.

21 Again, thank you for all the work you
22 do. It's obviously very important part of
23 the City.

24 No further questions, that concludes our

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1 hearing for today. Again, thank you all
2 very much. This Committee will be continued
3 until next Tuesday, May 5, 2015 at
4 10:00 a.m.

5 Correction everybody. This Committee
6 will stand in recess until five o'clock
7 today, at which time we will have Public
8 Testimony here in Room 400, City Hall.

9 Thank you.

10 (Committee of the Whole recessed at 4:00 p.m.)

11 - - -

12 (Public Testimony commences at 5:00 p.m.)

13 COUNCILWOMAN BLACKWELL: Good evening.
14 We thank all of you for coming and we are
15 very, very happy to have you here tonight to
16 testify. This is a continuation of the
17 Public Hearing of the Committee of the
18 Whole.

19 Public testimony ground rules. We are
20 here this evening to hear from you about the
21 Proposed 2016 Operating and Capital Budgets
22 and where you believe the City should focus
23 it's spending priorities. To ensure that
24 there's an opportunity for all here this

1 evening to be heard, certain ground rules
2 have been established as follows.

3 Number one, your testimony should be
4 about the budget and proposed spending
5 priorities. Copies are available on the
6 table where you signed in.

7 Two, all speakers must sign up in order
8 to testify. If you have not already signed
9 up, please do so now by signing your name on
10 the list at the same table to my left. Your
11 name will be called in the order in which
12 you signed up. You will have up to three
13 minutes to speak. In order to be fair and
14 give the public an opportunity to speak, we
15 intend to hold to the three-minute limit.

16 Finally, we have a timer that will be
17 set to three minutes. When the timer
18 buzzes, please complete your sentence and
19 allow the next speaker to approach the
20 microphone.

21 Ms. Lewis, please read the name of our
22 first speaker.

23 MS. LEWIS: I will call them in groups
24 of three.

1 COUNCILWOMAN BLACKWELL: Thank you.

2 MS. LEWIS: Bob Previdi; Waffiyyah
3 Murray and Sarah Stuart.

4 MR. PREVIDI: Can we have Cindy go in
5 the place of Sarah Stuart?

6 COUNCILWOMAN BLACKWELL: We can't hear
7 you, Bob.

8 MR. PREVIDI: Can we have somebody else
9 go in the place of Sarah?

10 Hi. It's Bob Previdi from the Bicycle
11 Coalition. Sarah Stuart is not able to
12 attend. We'd like to have Principal Cindy
13 join us.

14 COUNCILWOMAN BLACKWELL: Yes. Just
15 identify yourself for the record before you
16 speak. Thank you.

17 MR. PREVIDI: Why don't you go ahead.

18 MS. FARLINO: Good afternoon and thank
19 you for the opportunity to speak. I'm here
20 today to really urge you -- louder?

21 Oh, my name is Cindy Farlino. I'm the
22 principal of --

23 COUNCILWOMAN BLACKWELL: Say that again.

24 MS. FARLINO: Cindy Farlino, Farlino. I

1 am the principal of Meredith Elementary
2 School in Queen Village. I'm here today to
3 urge you to consider restoring the funding
4 to the Safe Routes Philly. We have been
5 working with Safe Routes Philly since 2012
6 as a school. We are one of six schools that
7 received a grant to support a biking
8 program. And I just want to tell you from
9 our point of view, it has changed our school
10 in immeasurable ways as I know it has the
11 other five schools.

12 We have bike to school days once a week.
13 Well over 100 people take place,
14 kindergarten through eighth graders. We are
15 able to do an entire science curriculum that
16 has to do with environmental impact, that
17 has to do with science fair project, energy
18 conservation. And all of that happened
19 because of the grant we got from Safe
20 Philly -- from Safe Routes Philly.

21 I also want to say that I think because
22 it's really important that our City, and I'm
23 looking at the signs behind you, have a
24 clear sustainability both policy and

1 problematic approach, that this is very much
2 in keeping with who are the future citizens.
3 Do they decide to ride a bike instead of
4 getting in the car? Do they decide to walk
5 instead of using transportation that would
6 use up energy?

7 For us and Meredith Elementary School
8 this has been an inspirational journey. The
9 money was incredible. We were able to
10 outfit kids who could not afford a helmets,
11 safety vests, bells on their bikes, all
12 kinds of things that make this an amazing
13 and engaging youth program that I think has
14 changed our schools and the other schools
15 that are involved.

16 So, I urge you again to restore the cuts
17 in this program. Thank you.

18 COUNCILWOMAN BLACKWELL: Thank you.

19 MS. MURRAY: Hello. My name is
20 Waffiyyah Murray, and I coordinate the Safe
21 Routes Philly Program for the Bicycle
22 Coalition for Greater Philadelphia. If
23 you're not familiar, Safe Routes Philly is a
24 program. And we promote walking and biking

1 as a fun and healthy form of transportation
2 from Philadelphia Elementary Schools. We
3 really promote safety, making sure that
4 students are safe when they're going to and
5 from school.

6 We are here today because last month we
7 learned that the Health Department zeroed
8 out it's \$50,000 contribution to our Safe
9 Routes Philly Program. And that cut would
10 take place in their 2016 budget, which goes
11 into effect July 1. With the elimination of
12 that \$50,000, that's half of our Safe Routes
13 Philly budget, which is \$100,000. And
14 without that money from the Health
15 Department, we would be unable to continue
16 funding our Safe Routes Philly program. It
17 would have to be eliminated completely.

18 Just to give you a few things about Safe
19 Routes Philly. Since 2010, we have worked
20 with over 75,000 students in 133 schools.
21 And we have trained over 150 PE teachers on
22 our Safe Routes Philly bike and pedestrian
23 safety curriculum. We worked with schools
24 to provide one-on-one training with teachers

1 and school officials on our curriculum and
2 other programs.

3 We have assisted 22 schools with
4 walkability audits. That's where we work
5 with the City and the school to check,
6 identify physical changes that can increase
7 safety for students going to and from
8 schools. We work with schools to create
9 safe routes map so that students know the
10 safest routes to take when going to and from
11 school. We work with schools to implement
12 walking clubs and biking clubs.

13 We promote district-wide Walk and Bike
14 To School Day. This year we have 15 schools
15 sign up for Walk To School Day in October.
16 And we had nine schools register for Walk to
17 School Day next month. And that's the most
18 that Philadelphia has ever had, so we are
19 really excited about that. And we just work
20 with schools to encourage anything around
21 walking and biking and physical activity.

22 As we all know, it's important to
23 promote that among students with the rates
24 of obesity and childhood diabetes. It's

1 important that they get around and are
2 physically active. And it's important that
3 they are being safe when going to and from
4 school and just in their community. So,
5 Safe Routes Philly is a very important
6 program. So, I hope that you guys would
7 consider putting that money back into the
8 budget.

9 Thank you.

10 COUNCILWOMAN BLACKWELL: Thank you.

11 Bob.

12 MR. PREVIDI: Hi. I'm Bob Prevdi from
13 the Bicycle Coalition. I'm not going to
14 reiterate the things that were said here,
15 but I just want to focus on a couple of key
16 points.

17 One is that the program is relatively
18 cheap given the outcomes, impacting 75,000
19 kids and 133 schools, public schools,
20 throughout the City I think is outstanding.
21 And when you think about that horrible case
22 where the four-year-old in Southwest was run
23 over because she happened to be running
24 between two cars, it's important that we

1 teach our young people how to walk and bike
2 to school safely.

3 There was actually a story in -- on the
4 NPR Philly and in New York last year where
5 in just one year, 1,800 students were hit by
6 cars at dropoff and pickup time going to
7 school. We all -- many of us know the chaos
8 that goes on around our public schools. I
9 think it's a good idea that we train the
10 students to be aware about what they need to
11 be doing because clearly some of -- they're
12 not learning it from anywhere.

13 And this is one of those programs we all
14 know the problems that the School District
15 is under right now. This is one of those
16 programs that if we can pull the money out
17 of transportation budget to help our
18 schools, we can. So, we are looking for you
19 to put the \$50,000 back into the Health
20 Department's budget so we can take advantage
21 of the other 50,000 that's provided by
22 NITSA, which is National Safety Program
23 coming out of the Federal Government.

24 We hope you'll reconsider and get that

1 money back in. Thank you very much.

2 COUNCILWOMAN BLACKWELL: Thank you very
3 much. Any questions?

4 (No questions.)

5 Thank you. Thank you very much.

6 MS. LEWIS: The next three speakers:
7 Hans Kersten, Judith Robinson and Jeannine
8 Lisitski. Hans Kersten, Judith Robinson and
9 Jeannine Lisitski.

10 How about Beth McConnell and Margaret
11 Lukoski?

12 (Witnesses approach witness table.)

13 COUNCILWOMAN BLACKWELL: Good evening.
14 Please give us your name for the record and
15 begin your testimony.

16 MS. LISITSKI: Jeannine Lisitski,
17 Executive Director, Women Against Abuse.

18 COUNCILWOMAN BLACKWELL: Go ahead.

19 MS. LISITSKI: Good evening. We
20 appreciate the ongoing support of City
21 Council in addressing issues concerning
22 family violence. As many of you are aware,
23 Women Against Abuse is the largest domestic
24 violence service provider and advocate in

1 Pennsylvania serving approximately 15,000
2 individuals each year. And in addition to
3 those we're able to serve, last year we had
4 to turn away 12,000 who were in need of safe
5 shelter due to our 100-bed safe haven
6 operating consistently at full capacity.

7 Thanks to you, we did open our second
8 safe haven this fiscal year. But given that
9 we will still not be able to serve all the
10 victims of domestic violence that come
11 forward in need of a myriad of services, we
12 are constantly working to intervene earlier
13 in the cycle of violence. Understanding
14 that there is up to a 75 percent overlap
15 between domestic violence and child
16 maltreatment, creating safe family, safe
17 children and safe communities will require
18 us to work collaboratively to address the
19 ways in which domestic violence interacts
20 with all systems.

21 For over a year, we have been working
22 attentively with the Department of Human
23 Services to infuse domestic violence inform
24 care into their practice in a way that would

1 be sustainable. DHS has been a supportive
2 and open partner. To that end, we want to
3 emphasize four interventions that we've
4 created in collaboration with DHS that we
5 hope to be able to identify funding for in
6 Fiscal Year 16.

7 One is continued funding for the Safe
8 Families Legal Project. This provides legal
9 expertise to support DHS through direct
10 intervention with families in their care and
11 consultation for DHS staff.

12 Second, implementing a comprehensive
13 domestic violence training and evaluation
14 plan for child welfare workers that includes
15 all CUA staff.

16 Third, preventing teen dating violence
17 among the highest risk population through an
18 expansion of our school-based healthy
19 relationships curriculum to the highest risk
20 children.

21 And lastly, the largest of these
22 initiatives, implementing our Safe Families
23 Equals Safe Children Project that would
24 expand the capacity of both DHS and the CUAs

1 to protect children by embedding a part-time
2 domestic violence specialist into each CUA
3 to serve as a resident expert on the
4 intersection between domestic violence and
5 child welfare.

6 I just want to thank you again for all
7 of your support.

8 COUNCILWOMAN BLACKWELL: Thank you. We
9 thank you for all the work that you do.
10 Thank you.

11 MS. ZUKOSKI: Good evening, Members of
12 City Council. My name is Margaret Zukoksi.
13 And I'm the Associate Director of the
14 Pennsylvania Council of Children Youth and
15 Family Services, a statewide provider
16 association that represents private agencies
17 that deliver a vast array of services to
18 Philadelphia's children and youth including
19 prevention services such as out of school
20 time, family intervention services, in-home
21 services to families and an array of foster
22 care services.

23 Today you heard from Commissioner -- DHS
24 Commissioner Vanessa Garrett Harley much

1 about Improving Outcomes of Children
2 initiative. I want to follow up on the
3 Commissioner's testimony and talk to you
4 about the providers perspective about the
5 IOC initiative in Philadelphia. I'd also
6 like to take this opportunity to remind
7 everyone that private providers in
8 Philadelphia have been delivering services
9 through DHS contracts for many decades to
10 citizens of Philadelphia.

11 At this moment, DHS private providers
12 and those we serve are experiencing some
13 very serious challenges. And you heard
14 earlier today from our commissioner that the
15 number of active cases in DHS has exploded
16 over the past two years. Currently, over
17 two years the number of cases -- active
18 cases has risen 46 percent. Two years ago
19 there were approximately 4,000 children in
20 placement. And currently, there are 5,400
21 children in the foster care system.
22 Simultaneously, the number of children
23 receiving in-home services has grown almost
24 50 percent.

1 Why are we seeing these increase in
2 numbers? Well, there are a number of
3 reasons that we can look at right now to see
4 why our numbers going up so dramatically.
5 First of all, as Commissioner Garrett Harley
6 addressed, there were significant changes in
7 Pennsylvania Child Protective Service Law
8 this year. In fact, 27 separate pieces of
9 legislation were interacted. What this did
10 is it changed and expanded the definition of
11 child abuse, the definition of perpetrator
12 and who is required to be a mandated
13 reporter. As a result of these changes, we
14 have seen and I -- Commissioner again spoke
15 to this -- a dramatic increase in the number
16 of reports coming into the DHS hotline.

17 Additionally, along with the number of
18 reports, when we compare the first two
19 quarters of last fiscal year to this fiscal
20 year, we have seen a 13 percent increase in
21 the spike of cases. That's not the only
22 reason that we are seeing an increase in the
23 number of kids/children in placement. Along
24 with the increase in numbers coming in,

1 there has been a decrease in the number of
2 children exiting the system.

3 This is not a new phenomena. Several
4 years now providers, DHS, advocates and the
5 court have been addressing issues of delays
6 in court hearing. This is a result in
7 several years ago there was a effort to
8 increase the number of hearings that each
9 child and family would have in a year. We
10 went from six-month hearings to 90-day
11 hearings. The 90-day hearing along with the
12 increase and the numbers of care have backed
13 up our court system.

14 I also want to reference that other
15 systems, other jurisdictions around the
16 country have implemented lead case
17 management models like Philadelphia's IOC
18 model. When these are implemented, it's
19 very natural and expected that systems will
20 go through an adjustment period. And we
21 have gone through an adjustment period and
22 we're still going through that adjustment
23 period as the last five CUAs under IOC have
24 been on board for less than a year.

1 As the number of kids in the system has
2 increased, we know DHS is faced with some
3 very hard choices. How do they meet the
4 needs of all the children in the system?
5 How do they provide mandated services like
6 foster care and non-mandated prevention
7 services? We feel very strongly that we
8 need to keep both levels of service,
9 mandated and non-mandated services, as we
10 move through with this system
11 transformation.

12 Already we have heard that DHS might be
13 contemplating cutting prevention services
14 this upcoming fiscal year. We saw some out
15 of school time slots cut already. This is a
16 very shortsighted view and we would really
17 strongly advocate against any system
18 changes. And I'm going to finish up.

19 We have some suggestions from the
20 provider community. We must bring all
21 stakeholders together to address this
22 increase of children in the system.
23 Providers who are delivering services under
24 the IOC system have several recommendations.

1 First of all, again, do not cut
2 prevention services. They will be the first
3 line of keeping children out of the system.

4 Secondly, we must reduce IOC CUA case
5 manager case loads. Recently, DHS raised
6 the case loads for the case managers from 10
7 to 13 families. That's about 30 children
8 now in each case manager's case load.

9 That's double what national recommendations
10 suggest. Fifteen children is recommended by
11 the Child Welfare League of America Council
12 on Accreditation. We also believe that CUAs
13 need to have the opportunity and flexibility
14 to implement some innovative programming
15 such as supporting foster care parents and
16 foster children in the home.

17 These are not budget neutral
18 recommendations. And at this point in the
19 state funding cycle, we know that the state
20 has already allocated dollars from DHS.
21 It's a complicated funding stream. They're
22 federal dollars, state dollars and you're
23 providing \$102 of local match. We are here
24 today to say we hope that the City considers

1 contributing more dollars to support the IOC
2 and CUA agencies as we go through this
3 period of growth in Philadelphia. This
4 is -- your budget reflects your values. And
5 what is more valuable than the children in
6 our City.

7 This is a critical juncture. And again,
8 we recommend that we look at how we are
9 allocating dollars in DHS so that more can
10 reach the folks that need the services and
11 that, again, we might have to consider
12 raising the City's share to meet the need.

13 Thank you very much.

14 COUNCILWOMAN BLACKWELL: You're welcome.

15 MS. McCONNELL: Good evening. My name
16 is Beth McConnell, Policy Director at the
17 Philadelphia Association Community
18 Development Corporations, PACDC. Thank you
19 for the opportunity to testify, Councilwoman
20 Blackwell, Councilman Goode, Councilman
21 Neilson.

22 I am going to submit some longer written
23 testimony, so I will abbreviate. I just
24 want to note some of the materials that I'm

1 handing out focus on our neighborhood
2 commercial corridor programs, a map of our
3 corridor programs, a map of our neighborhood
4 advisory committee. I'm going to talk
5 about, as well.

6 In general, PACDC is urging that the
7 City provide a million dollars in new
8 general fund revenue for our commercial
9 corridor programs, but I am going to focus
10 my three minutes on the Store Front
11 Improvement Program tonight as well as the
12 Neighborhood Advisory Committee Program.

13 SIP, store front improvement program,
14 has been a dramatically powerful tool to
15 transform our neighborhood commercial
16 corridors, but the program is at risk right
17 now. SIP provides grants to small
18 neighborhood-based businesses to fix up
19 their facades. It is leading to an increase
20 in sales revenue that the businesses are
21 seeing as well as leveraging other private
22 investment on our corridors. But the
23 program is in danger.

24 The Commerce Department was forced to

1 revise the guidelines in December in order
2 to comply with federal rules that require
3 paying contractors prevailing wage if more
4 than \$2,000 in federal funds are involved.
5 And then also submit very complex and time
6 consuming paperwork to provide approved
7 compliance. And since these new guidelines
8 were put in place, applications to SIP have
9 dropped by more than half. In fact, just
10 last -- just two weeks ago, the Tacony CDC
11 had to cancel plans to do 11 store fronts on
12 Torresdale Avenue because the prevailing
13 wage bids were just too high for the
14 businesses to comply with.

15 Some neighborhood-based contractors are
16 simply declining to even bid on the projects
17 because of the complex paperwork for just a
18 few thousand dollars worth of work. We do
19 believe that contractors should be paid a
20 fair wage for their work. But the federal
21 rules are leading to fewer jobs and are
22 overly burdensome for small projects that
23 are valued at just a few thousand dollars.

24 The only way to avoid the federal rules

1 and design a storefront improvement program
2 that works for Philadelphia small businesses
3 is to use a different source of funding.
4 So, we're calling on the Council and Mayor
5 Nutter to put 531,000 in general funds to
6 the SIP program. That would free up federal
7 funds for the Neighborhood Advisory
8 Committee program. So, we're urging that
9 the freed up federal funds go to help
10 strengthen and expand the NAC program that
11 has suffered more than \$700,000 in federal
12 cuts just over the last few years.

13 And in closing, this is a program that
14 is literally helping people save their homes
15 from foreclosures, distributing turkeys on
16 Thanksgiving, helping people find jobs and
17 affordable homes. We really need to bolster
18 that program or restore some of the cuts
19 that have decimated it.

20 Thank you for the opportunity to
21 testify.

22 COUNCILWOMAN BLACKWELL: Do we have any
23 questions?

24 Councilman Goode. I'm sorry, Councilman

1 Goode.

2 COUNCILMAN GOODE: Thank you, Madam
3 Chair. Just one question for Ms. McConnell
4 just for clarity of the record. I'm
5 supportive of the request. I just wanted to
6 say for the record that I think the request
7 assumes that we are and will be at least
8 half a million dollars above the mandate
9 that 5 percent of CDBG money go toward CDC
10 development. I don't want to see us fall
11 below that. We are above that, have been
12 above that, I mean, at 5 percent threshold.
13 But I don't want us to get into a pull where
14 on an annual basis where are pulling between
15 economic development needs and housing needs
16 where we set aside at least 5 percent of
17 that money for CDC economic development.

18 If this assumes that we are at least a
19 half a million dollars above, I'm definitely
20 supportive of the proposal.

21 MS. McCONNELL: Thank you, Councilman.

22 COUNCILMAN GOODE: Thank you, Madam
23 Chair.

24 COUNCILWOMAN BLACKWELL: Thank you very

1 much. Any other questions?

2 (No further questions.)

3 Thank you very much.

4 MS. LEWIS: The next presenter is
5 Charles Younger, David Fare and Angel
6 Rodriguez. Charles Younger, David Fair and
7 Angel Rodriguez.

8 Is Kelly Davis here?

9 MS. DAVIS: Yes.

10 (Witnesses approach witness table.)

11 COUNCILWOMAN BLACKWELL: Good evening.
12 Thank you very much. Identify yourself for
13 the record and begin your testimony. It's
14 nice to see you.

15 MS. DAVIS: Kelly Davis, Executive
16 Director of Lutheran Settlement House.

17 Hi, Councilmembers. Thank you so much
18 for having me. This is actually my first
19 time testifying in front of the City
20 Council, so I'm excited to be here. I'm the
21 Executive Director of Lutheran Settlement
22 House. We are a multi-services citywide
23 agency.

24 In Fishtown we run domestic violence

1 program, which includes medical advocacy in
2 the main hospitals in Philadelphia. And a
3 STAR Program and afterschool program and
4 summer Work Ready Program. We also have an
5 adult literacy program, an urban farm that
6 links our teens with our senior center. And
7 what I'm here to talk about, though, today
8 is our family shelter in West Philadelphia
9 that Councilwoman Blackwell is very familiar
10 with, Jane Adams place.

11 We need more money. We have not had any
12 increase in our budget since we've opened.
13 That's a little bit of an exaggeration. A
14 few years ago, we had \$9,000 more to run our
15 family shelter. What that has meant is that
16 we have had to cut positions. We no longer
17 have a maintenance -- full-time maintenance
18 person. We no longer have an assistant
19 director. We have not really given raises.
20 But any raises that we have had to do, has
21 meant collapsing positions.

22 We run a shelter for 100 people for 365
23 days a year on less than \$1.1 million, so
24 that's \$1.09 million for 25 staff, all of

1 the food, all of the maintenance,
2 everything. So, it's really not enough. We
3 need some money to meet the \$12 an hour. We
4 need about \$24,000. We went a couple years
5 ago to 10.88. Please help us.

6 Our courtyard is closed because of
7 leaks. We're begging for any small amount
8 of money.

9 Thank you very much.

10 COUNCILWOMAN BLACKWELL: Thank you. Mr.
11 Fair, good to see you.

12 MR. FAIR: Good afternoon. My name is
13 David Fair, F-a-i-r. I'm Deputy Chief
14 Executive Officer for Turning Points for
15 Children. I'm delivering this testimony
16 this afternoon on behalf of the seven
17 agencies contracted with the Department of
18 Human Services to provide community umbrella
19 agencies family services as part of the
20 Improving Outcomes for Children initiative.

21 We testify today in full support of DHS
22 and the IOC initiative and with the request
23 that this Council invest additional City
24 general funds to ensure its success.

1 This historic advance in the delivery of
2 child welfare services, which is still in
3 its infancy is being watched across the
4 nation. As child welfare across the country
5 seeks to redesign itself to support 21st
6 century families with 21st century
7 solutions. DHS and its leaders are to be
8 commended for its courage in recognizing the
9 limitations of past approaches to protecting
10 an advancing the safety and well being of
11 our most vulnerable children. But DHS has
12 been hampered in maximizing the full
13 potential of the IOC project by a number of
14 factors far beyond its own control.

15 The Commissioner and the Pennsylvania
16 Council have already shared with you the
17 data on the explosion in new demand for
18 child welfare services. Add to these
19 children the number of children requiring
20 foster care services has jumped at and the
21 number of foster families available to them
22 has stayed relatively constant. Meaning,
23 that we are running out of foster homes in
24 which to place these children.

1 All of this is happening in a system
2 that receives significantly less funding
3 today than it did ten years ago. DHS is
4 doing the best it can within limited
5 resources. But as a result of this lack of
6 resources, case loads continue to increase
7 endanger the very children we are charged to
8 protect. This lack of resources for child
9 welfare services is a tragedy waiting to
10 happen.

11 The failure to adequately fund child
12 welfare services has created a crisis
13 similar to that affecting our public
14 education system. But unlike the public
15 schools, the fate of the almost 11,000
16 children in the child welfare system is not
17 the stuff of front page headlines or mayoral
18 debates.

19 This is an emergency, one that worsens
20 Philadelphia's ability to protect the
21 thousands of vulnerable children charged to
22 its care. With federal and state agencies
23 failing to do their part, it falls on the
24 City with its own funds to fill the gap. We

1 strongly encourage you to increase the
2 City's portion of the DHS budget to ensure
3 that these children are safe and their well
4 being is ensured.

5 Thank you for allowing me to testify.

6 COUNCILWOMAN BLACKWELL: Thank you.

7 Mr. Rodriguez.

8 MR. RODRIGUEZ: Good evening, esteemed
9 Councilmembers. Thank you for having me.
10 My name is Angel Rodriguez, Vice President
11 of Asociacion of Puertorriquenos En Marcha,
12 APM for short. I'm here before you today in
13 support of an allocation of additional
14 \$1 million in general funds to support our
15 neighborhood small businesses and commercial
16 corridors and the NAC Program, Neighborhood
17 Assistance Committees. I have submitted
18 written testimony so I will be brief and hit
19 just the high points.

20 The NAC program is a critical program in
21 terms of redevelopment in our neighborhoods
22 throughout Philadelphia. As many of you may
23 know, the NAC program connects residents to
24 services that will help them stop

1 foreclosures on their homes, find them --
2 help them find affordable homes, help them
3 with their heat, address food and security
4 which is a growing concern in Philadelphia
5 and find employment.

6 It's also an area where Philadelphians
7 are able to understand and involve
8 themselves with what's happening in
9 Philadelphia as it goes with physical
10 development. It's very important as we
11 become a world class city and we have
12 transformative neighborhoods, that we are
13 actually bringing our current residents into
14 that new city and understand what the impact
15 of new development in the City is. That
16 happens throughout the -- with the NAC
17 Program.

18 Done well, a NAC program is also an
19 opportunity to leverage other resources and
20 funds. Typically, you will see a NAC
21 program funded at about \$75,000. In our
22 situation at APM, we've been able to
23 leverage that 75,000 to bring in an
24 additional half million dollars which has

1 allowed us to do crime prevention programs,
2 lead and healthy home services, energy
3 savings initiative and basic systems repairs
4 and numerous health initiatives.

5 We ask you today, myself and my
6 colleague Beth McConnell, to actually
7 reallocate an additional million dollars.

8 Thank you.

9 COUNCILWOMAN BLACKWELL: Thank you very
10 much. Are there any questions?

11 Councilman Neilson?

12 COUNCILMAN NEILSON: Thank you, Madam
13 Chair.

14 COUNCILWOMAN BLACKWELL: Mr. Rodriguez,
15 thank you for your work with -- in housing
16 and rebuilding. Thank you.

17 COUNCILMAN NEILSON: The NAC program,
18 can you tell us how many people are on the
19 waiting list right now to get help and
20 assistance in some of the maintenance
21 problems with their homes?

22 MR. RODRIGUEZ: You mean in terms of
23 basic systems repair?

24 COUNCILMAN NEILSON: Basic systems

1 repair.

2 MR. RODRIGUEZ: Well, I would say that
3 in this past year in conjunction with our
4 NAC coordinator, we've been able to provide
5 20 houses this year. In terms of basic
6 systems repair, I can tell you that in
7 eastern North Philadelphia, we have about
8 twelve blocks that need more. So, you
9 figure about 16 -- on one side of a block
10 about 16 units.

11 COUNCILMAN NEILSON: Out on the trail
12 someone told me that what you have projected
13 on your list to do currently, that would
14 take you two and a half years with current
15 funding levels that you have just to try
16 and --

17 MR. RODRIGUEZ: Just to have an impact,
18 yes, correct.

19 COUNCILMAN NEILSON: I just wanted to
20 put that on the record because we're not
21 funding enough to stretch that out.

22 MR. RODRIGUEZ: Clearly not enough.
23 Especially when you look at the impact of
24 what immediate equity means to homeowners

1 and senior homeowners in Philadelphia where
2 you have basic systems repairs. And
3 immediately, they can weather the storm
4 where taxes go up and you have new
5 development in certain neighborhoods. It
6 actually helps knit the community together
7 and allow us to have mixed-income
8 communities in Philly.

9 COUNCILMAN NEILSON: Thank you, Madam
10 Chair. I have no further questions. Thank
11 you for your testimony today.

12 COUNCILWOMAN BLACKWELL: Thank you very
13 much. Any other questions?

14 (No further questions.)

15 Thank you very much.

16 MS. LEWIS: Maurice D. Jenes --

17 COUNCILWOMAN BLACKWELL: Jones.

18 MS. LEWIS: Maurice Jones. I'm going to
19 read the names of folks who have signed up
20 that didn't come to the table. Sarah
21 Stuart, Sarah Stuart? Hans Kersten, Hans
22 Kersten? Judith Robinson, Judith Robinson?
23 Charles Younger, Charles Younger?

24 (Witness approaches witness table.)

1 COUNCILWOMAN BLACKWELL: Good afternoon,
2 Mr. Jones. Always a pleasure, sir.

3 MR. JONES: Always a pleasure to see
4 you, Councilwoman.

5 COUNCILWOMAN BLACKWELL: Thank you.

6 MR. JONES: I have prepared testimony
7 and materials for Sergeant of the Arms.

8 COUNCILWOMAN BLACKWELL: Thank you.

9 MR. JONES: There's one for each
10 Councilmember present.

11 COUNCILWOMAN BLACKWELL: Thank you.

12 MR. JONES: I will start off. My name
13 is Maurice Jones. I'm coming from the Henry
14 C. Lea School in West Philadelphia. My
15 testimony is concerning the Safe Routes
16 program.

17 Starting off, this is a decision that I
18 regret the most of my mayoral service. That
19 was something said by Mayor Nutter. These
20 words were spoken by Mayor Nutter in the
21 beginning of March in his last budget
22 address. He was referring to libraries. In
23 an attempt to reduce spending across the
24 government, he attempted to close 11

1 libraries based on incomplete information by
2 well meaning members of his administration.

3 As we come into 2016 with the
4 expectation of internal budget cuts at the
5 Philadelphia Department of Public Health,
6 which will effect safe routes, the words
7 rang true for this program, as well. The
8 fact that \$50,000 in cuts will be
9 devastating to programming which will create
10 hardship for those who can least afford it.

11 As we found with the decision to close
12 libraries, there are nuances which are not
13 being looked at in this decision.

14 This cut in Safe Routes will also cause
15 the loss of matching NHTSA funding. The
16 communities that most need those services
17 have no recourse to replace them. So if you
18 look, there is an attachment on there of the
19 community health improvement plan for 2014
20 to 2018. And one of the key priorities is
21 increasing physical activity among children
22 and adults.

23 So although violent crime in the City
24 has gone down over the years, there are

1 still dangerous and concerns with children
2 traveling to school. In the last few years,
3 24 schools were closed which created
4 additional travel in some of the
5 communities. Safe Routes was a resource
6 which was geared on making that travel
7 safer. Lea was one of the schools affected
8 by these closings by having the Wilson
9 school merge with it. Children have to
10 travel past extremely busy streets and cross
11 some of the top ten most traveled SEPTA
12 routes. This created a danger for students
13 and increased stress for parents.

14 Safe Routes is a program whose mission
15 is to lessen the safety issues with children
16 traveling to school. It is also geared
17 towards helping to train them in best
18 practices of walking and riding which in
19 turn directly affects their physical being.
20 And there is a safety report concerning the
21 merger of the two schools that will
22 highlight that.

23 Considering the fact that 54 percent of
24 children, Philadelphia children, age 6 to 11

1 are overweight or obese with an outstanding
2 70 percent in North Philadelphia, this is
3 more than just an issue; but, in fact, a
4 crisis. To take away a program which could
5 directly affect change in those numbers is
6 ill conceived especially considering the
7 nominal costs of this program. As we look
8 at budgets and what is important or not
9 important, we must set priorities.

10 With the Philadelphia Department of
11 Public Health making children's physical
12 activity one of its priority for the
13 2014/2018 that is a great start. To cut a
14 program from the budget which could
15 economically facilitate this could be a
16 decision which would be in the future called
17 "the decision I regret the most."

18 So, I thank you -- I ask for the health
19 and safety of the children of Philadelphia
20 that this funding be restored. And I thank
21 you for allowing me to testify.

22 COUNCILWOMAN BLACKWELL: Thank you,
23 Mr. Jones. And I thank you for fighting for
24 this since they closed Wilson school. And

1 any of you who know the area realized that
2 46 and Woodland where you have to cross
3 Woodland and Chester/Springfield get over to
4 Baltimore. Then after you even get to
5 Baltimore as large as that intersection is,
6 you still got to find your way to Spruce
7 Street. It's absolutely unbelievable.

8 We thank you for sticking with this.
9 And I don't know how we -- frankly, I don't
10 know how we survived this long because it's
11 just unconscionable that these little
12 children have to go that far.

13 Thank you. Any questions for Mr. Jones?
14 I will be in touch with you on this again.
15 Thank you, sir.

16 MS. LEWIS: Pastor Rob Harrison,
17 Stenton -- oh, Pastor Rob Harrison of
18 Stenton and Family Manor.

19 PASTOR HARRISON: Good evening.

20 COUNCILWOMAN BLACKWELL: Good evening.

21 PASTOR HARRISON: I come this afternoon
22 on behalf of the homeless initiative and the
23 homeless family shelters. I also come on
24 behalf of Bishop Ernest Carl Morris who is

1 CEO of Stenton Family Manor.

2 Since 1991, Stenton Family Manor has
3 been a part of the homelessness in providing
4 homeless shelter for families within the
5 City of Philadelphia. That has been since
6 1991. Since that, we have been providing
7 not just for shelters but we have been one
8 of the only homeless family shelters that
9 have been providing shelter for teenagers
10 living with their parents. We also have
11 been providing for homeless fathers who
12 wanted to be a part of their children's
13 family.

14 So, we have done pretty unique things.
15 The City of Philadelphia has been a great
16 asset to that. However, since 2005, we have
17 been told under the budget that we are to be
18 able to survive with what is called equal
19 funding. No addition. Since that time, we
20 have been able -- we have had and been
21 forced to cut back on our providing shelter,
22 food, transportation for these homeless
23 individuals over 75 families, 250 people,
24 175 on the average individual children

1 within the City of Philadelphia.

2 We have been told that we have to
3 receive cutbacks because of this. I am
4 coming on behalf of Stenton Family Manor and
5 all of the other shelters that you may have
6 heard from today to ask that there be some
7 prohibition that would be allotted for some
8 type of increase for us.

9 Since 2004, we have had equal funding,
10 level funding and not one dime more. Cost
11 of living has gone up, gas has gone up
12 astronomically but jobs have been decreasing
13 within us. We are basically working on a
14 skeleton, and I mean skeleton, crew. I have
15 a staff of individuals. 50 percent of my
16 staff which are approximately 52 people.
17 Approximately, 42 of them are ex or prior
18 homeless individuals who we have employed to
19 working with us. However, with the way the
20 cost of living and the funding is going, we
21 may be forced to cut those people back that
22 they may be put back in the same recidivism
23 of being homeless again.

24 What I'm coming forth on behalf of

1 Stenton Family Manor and the Office of
2 Supportive Housing is that you look at OSH
3 and some type of funding that we may be able
4 to be adequate in our level funding. We
5 have received orders from the Mayor that we
6 are to raise our funding to become where we
7 first started back in 2004. The average
8 person was being paid \$8.25 an hour. That
9 same individual is required to pay \$12 an
10 hour now and potentially \$12.30 come
11 January 2016. That with the same
12 coordinates -- the same ordinance of us
13 having to work with the same equal level
14 funding that we have since 2004.

15 This is a very hard labor that has been
16 put on the shelters, Stenton Family Manor as
17 well. We ask that you take into
18 consideration on this budget of some of the
19 acknowledgements that is needed to support
20 those who are homeless that we may be able
21 to have some type of increase knowing what
22 it is. But I can't see us telling homeless
23 people or telling homeless families we can't
24 provide you with housing, jobs, funding or

1 anything because we don't have enough.

2 I thank you for your time.

3 COUNCILWOMAN BLACKWELL: Thank you,
4 Pastor Harrison. You have met with OSH?

5 PASTOR HARRISON: Yes, ma'am.

6 COUNCILWOMAN BLACKWELL: All right.
7 Well, I will work on this with you and we
8 will see what we can do always.

9 PASTOR HARRISON: Thank you,
10 Councilwoman.

11 COUNCILWOMAN BLACKWELL: Thank you. How
12 is your family?

13 PASTOR HARRISON: Everybody is fine.
14 Mom is 90.

15 COUNCILWOMAN BLACKWELL: My goodness.
16 Thank you. This is a gentleman I've known
17 all his life. Yes. Thank God you still
18 have her.

19 PASTOR HARRISON: Yes, ma'am.

20 MS. LEWIS: Councilwoman, there are no
21 more speakers on the list.

22 COUNCILWOMAN BLACKWELL: All right. Is
23 there anyone else who would like to make a
24 statement or speak? My colleagues okay?

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1 All right, having seen none, then this
2 Committee will stand in recess until
3 Tuesday, May 5, 2015 at ten o'clock a.m. At
4 which time, we will reconvene here in Room
5 400, City Hall.

6 Thank you all.

7 (Committee of the Whole adjourned at
8 5:50 p.m.)

C E R T I F I C A T I O N

I, hereby certify that the
proceedings and evidence noted are
contained fully and accurately in the
stenographic notes taken by me in the
foregoing matter, and that this is a
correct transcript of the same.

ANGELA M. KING, RPR
Court Reporter - Notary Public

(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.)

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City of Philadelphia

Recessed Hearing Notice

April 28, 2015

The **Committee of the Whole** of the Council of the City of Philadelphia held a Public Hearing on **Tuesday, April 28, 2015**, and recessed the public hearing until **Wednesday, April 29, 2015 at 10:00 AM**, in **Room 400, City Hall**, to hear further testimony on the following:

- 150162** An Ordinance to adopt a Capital Program for the six Fiscal Years 2016-2021 inclusive.
- 150163** An Ordinance to adopt a Fiscal 2016 Capital Budget.
- 150164** An Ordinance adopting the Operating Budget for Fiscal Year 2016.
- 150179** Resolution providing for the approval by the Council of the City of Philadelphia of a Revised Five Year Financial Plan for the City of Philadelphia covering Fiscal Years 2016 through 2020, and incorporating proposed changes with respect to Fiscal Year 2015, which is to be submitted by the Mayor to the Pennsylvania Intergovernmental Cooperation Authority (the "Authority") pursuant to the Intergovernmental Cooperation Agreement, authorized by an ordinance of this Council approved by the Mayor on January 3, 1992 (Bill No. 1563-A), by and between the City and the Authority.

Immediately following the public hearing, a meeting of the Committee of the Whole, open to the public, will be held to consider the action to be taken on the above listed items.

Copies of the foregoing items are available in the Office of the Chief Clerk of the Council, Room 402, City Hall.

Michael Decker
Chief Clerk



City of Philadelphia

City Council
Chief Clerk's Office
402 City Hall
Philadelphia, PA 19107

BILL NO. 150164

Introduced March 5, 2015

**Councilmember Jones
for
Council President Clarke**

**Referred to the
Committee of the Whole**

AN ORDINANCE

Adopting the Operating Budget for Fiscal Year 2016.

WHEREAS, The Mayor on March 5, 2015 submitted to Council his operating budget message and his estimate of revenues available for appropriations for Fiscal Year 2016 pursuant to Section 4-101 of The Philadelphia Home Rule Charter; therefore

THE COUNCIL OF THE CITY OF PHILADELPHIA HEREBY ORDAINS:

SECTION 1. The following financial program is hereby adopted for the Fiscal Year 2016 and appropriations are hereby made from the various operating funds to the various offices, departments, boards and commissions as indicated in the following sections:

SECTION 2. Appropriations in the sum of three billion, nine hundred fifty-four million, nine hundred sixty-one thousand (3,954,961,000) dollars are hereby made from the GENERAL FUND, as follows:

2.1 TO THE COUNCIL

Personal Services	\$ 14,309,858
Purchase of Services	1,804,485
Materials, Supplies and Equipment	410,650
Contributions, Indemnities and Taxes	100
Payments to Other Funds	100
Advances and Other Miscellaneous Payments	100

City of Philadelphia

BILL NO. 150164 continued

Total\$ 16,525,293

2.2 TO THE MAYOR - OFFICE OF THE INSPECTOR GENERAL

Personal Services\$ 1,470,611

Purchase of Services192,975

Materials, Supplies and Equipment5,225

Total\$ 1,668,811

2.3 TO THE MAYOR

Personal Services\$ 4,166,124

Purchase of Services990,336

Materials, Supplies and Equipment50,165

Total\$ 5,206,625

2.4 TO THE MAYOR - SCHOLARSHIPS

Contributions, Indemnities and Taxes\$ 200,000

Total\$ 200,000

2.5 TO THE MAYOR - OFFICE OF LABOR RELATIONS

Personal Services\$ 559,029

Purchase of Services5,277

Materials, Supplies and Equipment8,160

Total\$ 572,466

2.6 TO THE MAYOR - OFFICE OF INNOVATION AND TECHNOLOGY

Personal Services\$ 19,900,681

Purchase of Services54,383,430

Materials, Supplies and Equipment9,598,351

Total\$ 83,882,462

City of Philadelphia

BILL NO. 150164 continued

2.7 TO THE MAYOR - OFFICE OF HOUSING AND COMMUNITY DEVELOPMENT

Purchase of Services\$ 2,520,000

Total\$ 2,520,000

2.8 TO THE MAYOR - OFFICE OF ARTS AND CULTURE AND THE CREATIVE ECONOMY - MURAL ARTS PROGRAM

Personal Services\$ 464,216

Purchase of Services1,181,800

Total\$ 1,646,016

2.9 TO THE MAYOR - OFFICE OF TRANSPORTATION AND UTILITIES

Personal Services\$ 474,340

Purchase of Services259,930

Total\$ 734,270

2.10 TO THE MAYOR - OFFICE OF COMMUNITY EMPOWERMENT AND OPPORTUNITY

Personal Services\$ 605,000

Total\$ 605,000

2.11 TO THE OFFICE OF SUSTAINABILITY

Personal Services\$ 537,979

Purchase of Services279,508

Materials, Supplies and Equipment17,840

Total\$ 835,327

2.12 TO THE MANAGING DIRECTOR

Personal Services\$ 16,316,293

Purchase of Services17,589,271

City of Philadelphia

BILL NO. 150164 continued

Materials, Supplies and Equipment538,979

Total\$ 34,444,543

2.13 TO THE MANAGING DIRECTOR – LEGAL SERVICES

Purchase of Services\$ 43,159,131

Total\$ 43,159,131

2.14 TO THE MANAGING DIRECTOR - OFFICE OF FLEET MANAGEMENT

Personal Services\$ 16,544,893

Purchase of Services5,104,396

Materials, Supplies and Equipment24,963,211

Total\$ 46,612,500

2.15 TO THE MANAGING DIRECTOR - OFFICE OF FLEET MANAGEMENT - VEHICLE PURCHASE

Purchase of Services\$ 4,500,000

Materials, Supplies and Equipment10,465,000

Total\$ 14,965,000

2.16 TO THE POLICE DEPARTMENT

Personal Services\$ 622,058,347

Purchase of Services7,262,807

Materials, Supplies and Equipment13,417,702

Total\$ 642,738,856

2.17 TO THE DEPARTMENT OF STREETS

Personal Services\$ 22,485,373

Purchase of Services8,426,338

Materials, Supplies and Equipment2,201,750

Contributions, Indemnities and Taxes5,000

City of Philadelphia

BILL NO. 150164 continued

Total\$ 33,118,461

2.18 TO THE DEPARTMENT OF STREETS - SANITATION DIVISION

Personal Services\$ 50,238,759
Purchase of Services40,393,117
Materials, Supplies and Equipment1,608,212
Contributions, Indemnities and Taxes48,171

Total\$ 92,288,259

2.19 TO THE FIRE DEPARTMENT

Personal Services\$ 196,783,581
Purchase of Services5,895,975
Materials, Supplies and Equipment7,556,014
Payments to Other Funds8,847,226

Total\$ 219,082,796

2.20 TO THE DEPARTMENT OF PUBLIC HEALTH

Personal Services\$ 50,298,254
Purchase of Services59,953,424
Materials, Supplies and Equipment5,490,768
Payments to Other Funds500,000

Total\$ 116,242,446

2.21 TO THE DEPARTMENT OF PUBLIC HEALTH - OFFICE OF BEHAVIORAL HEALTH AND INTELLECTUAL DISABILITY

Personal Services\$ 1,000,066
Purchase of Services12,875,510

Total\$ 13,875,576

2.22 TO THE DEPARTMENT OF PARKS AND RECREATION

Personal Services\$ 43,429,053
Purchase of Services9,319,525
Materials, Supplies and Equipment2,673,805

City of Philadelphia

BILL NO. 150164 continued

Contributions, Indemnities and Taxes2,289,500

Total\$ 57,711,883

2.23 TO THE MAYOR - OFFICE OF ARTS AND CULTURE AND THE
CREATIVE ECONOMY- ART MUSEUM SUBSIDY

Contributions, Indemnities and Taxes\$ 2,550,000

Total\$ 2,550,000

2.24 TO THE MAYOR - OFFICE OF ARTS AND CULTURE AND THE
CREATIVE ECONOMY - BOARD OF TRUSTEES OF ATWATER
KENT MUSEUM

Personal Services\$ 243,498

Contributions, Indemnities and Taxes50,000

Total\$ 293,498

2.25 TO THE DEPARTMENT OF PUBLIC PROPERTY

Personal Services\$ 8,400,083

Purchase of Services26,787,008

Materials, Supplies and Equipment1,338,535

Payments to Other Funds23,367,706

Total\$ 59,893,332

2.26 TO THE DEPARTMENT OF PUBLIC PROPERTY-CITY SUBSIDY
FOR SEPTA

Purchase of Services\$ 74,215,000

Total\$ 74,215,000

2.27 TO THE DEPARTMENT OF PUBLIC PROPERTY - UTILITIES

Purchase of Services\$ 33,092,334

Total\$ 33,092,334

City of Philadelphia

BILL NO. 150164 continued

2.28 TO THE DEPARTMENT OF PUBLIC PROPERTY - SPACE RENTALS

Purchase of Services	\$ 20,624,429
Total	\$ 20,624,429

2.29 TO THE DEPARTMENT OF HUMAN SERVICES

Personal Services	\$ 24,637,310
Purchase of Services	76,779,935
Materials, Supplies and Equipment	<u>1,312,076</u>
Total	\$ 102,729,321

2.30 TO THE DEPARTMENT OF PRISONS

Personal Services	\$ 133,469,579
Purchase of Services	105,351,301
Materials, Supplies and Equipment	4,768,744
Contributions, Indemnities and Taxes	<u>1,306,757</u>
Total	\$ 244,896,381

2.31 TO THE DEPARTMENT OF HUMAN SERVICES - OFFICE OF SUPPORTIVE HOUSING

Personal Services	\$ 8,281,213
Purchase of Services	36,586,621
Materials, Supplies and Equipment	344,127
Contributions, Indemnities and Taxes	<u>32,421</u>
Total	\$ 45,244,382

2.32 TO THE DEPARTMENT OF LICENSES AND INSPECTIONS

Personal Services	\$ 19,770,711
Purchase of Services	10,261,906
Materials, Supplies and Equipment	<u>1,443,941</u>
Total	\$ 31,476,558

City of Philadelphia

BILL NO. 150164 continued

2.33 TO THE DEPARTMENT OF LICENSES AND INSPECTIONS - BOARD OF LICENSE AND INSPECTION REVIEW

Personal Services	\$ 157,354
Purchase of Services	<u>10,436</u>
Total	\$ 167,790

2.34 TO THE DEPARTMENT OF LICENSES AND INSPECTIONS - BOARD OF BUILDING STANDARDS

Personal Services	\$ <u>73,970</u>
Total	\$ 73,970

2.35 TO THE DEPARTMENT OF LICENSES AND INSPECTIONS - ZONING BOARD OF ADJUSTMENT

Personal Services	\$ 337,749
Purchase of Services	<u>34,541</u>
Total	\$ 372,290

2.36 TO THE DEPARTMENT OF RECORDS

Personal Services	\$ 3,058,832
Purchase of Services	1,618,779
Materials, Supplies and Equipment	143,758
Contributions, Indemnities and Taxes	<u>1,456</u>
Total	\$ 4,822,825

2.37 TO THE DEPARTMENT OF PUBLIC PROPERTY - PHILADELPHIA HISTORICAL COMMISSION

Personal Services	\$ 422,771
Purchase of Services	980
Materials, Supplies and Equipment	<u>809</u>
Total	\$ 424,560

2.38 TO THE DIRECTOR OF FINANCE

City of Philadelphia

BILL NO. 150164 continued

Personal Services	\$ 8,801,920
Purchase of Services	4,370,961
Materials, Supplies and Equipment	110,774
Contributions, Indemnities and Taxes	<u>3,950,000</u>

Total	\$ 17,233,655
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2.39 TO THE DIRECTOR OF FINANCE - FRINGE BENEFITS

Personal Services-Employee Benefits	\$ <u>1,172,182,395</u>
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Total	\$ 1,172,182,395
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2.40 TO THE DIRECTOR OF FINANCE - COMMUNITY COLLEGE OF PHILADELPHIA

Contributions, Indemnities and Taxes	\$ <u>30,309,207</u>
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Total	\$ 30,309,207
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2.41 TO THE DIRECTOR OF FINANCE - HERO AWARD

Contributions, Indemnities and Taxes	\$ <u>25,000</u>
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Total	\$ 25,000
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2.42 TO THE DIRECTOR OF FINANCE - REFUNDS

Contributions, Indemnities and Taxes	\$ <u>250,000</u>
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Total	\$ 250,000
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2.43 TO THE DIRECTOR OF FINANCE - INDEMNITIES

Contributions, Indemnities and Taxes	\$ <u>38,000,000</u>
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Total	\$ 38,000,000
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2.44 TO THE DIRECTOR OF FINANCE - WITNESS FEES

Purchase of Services	\$ <u>171,518</u>
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City of Philadelphia

BILL NO. 150164 continued

Total\$ 171,518

2.45 TO THE DIRECTOR OF FINANCE - CONTRIBUTION TO SCHOOL DISTRICT

Contributions, Indemnities and Taxes\$ 69,184,673

Total\$ 69,184,673

2.46 TO THE DEPARTMENT OF REVENUE

Personal Services\$ 19,617,564

Purchase of Services5,352,949

Materials, Supplies and Equipment800,976

Total\$ 25,771,489

2.47 TO THE DEPARTMENT OF REVENUE - SINKING FUND COMMISSION

Purchase of Services\$ 104,546,913

Debt Service141,398,213

Total\$ 245,945,126

2.48 TO THE PROCUREMENT DEPARTMENT

Personal Services\$ 2,472,351

Purchase of Services2,316,267

Materials, Supplies and Equipment49,054

Total\$ 4,837,672

2.49 TO THE CITY TREASURER

Personal Services\$ 985,689

Purchase of Services118,444

Materials, Supplies and Equipment22,224

Total\$ 1,126,357

City of Philadelphia

BILL NO. 150164 continued

2.50 TO THE CITY REPRESENTATIVE

Personal Services	\$ 418,201
Purchase of Services	561,730
Materials, Supplies and Equipment	<u>54,000</u>
Total	\$ 1,033,931

2.51 TO THE DIRECTOR OF COMMERCE

Personal Services	\$ 1,943,211
Purchase of Services	1,433,481
Materials, Supplies and Equipment	26,654
Contributions, Indemnities and Taxes	<u>500,000</u>
Total	\$ 3,903,346

2.52 TO THE DIRECTOR OF COMMERCE - ECONOMIC STIMULUS

Purchase of Services	\$ <u>3,294,448</u>
Total	\$ 3,294,448

2.53 TO THE DIRECTOR OF COMMERCE - CONVENTION CENTER SUBSIDY

Purchase of Services	\$ <u>15,000,000</u>
Total	\$ 15,000,000

2.54 TO THE MAYOR - OFFICE OF ARTS AND CULTURE AND THE CREATIVE ECONOMY

Personal Services	\$ 201,367
Purchase of Services	593,800
Materials, Supplies and Equipment	7,000
Contributions, Indemnities and Taxes	<u>2,070,688</u>
Total	\$ 2,872,855

2.55 TO THE LAW DEPARTMENT

City of Philadelphia

BILL NO. 150164 continued

Personal Services	\$ 7,383,566
Purchase of Services	7,010,034
Materials, Supplies and Equipment	<u>248,676</u>
Total	\$ 14,642,276

2.56 TO THE BOARD OF ETHICS

Personal Services	\$ 924,511
Purchase of Services	96,000
Materials, Supplies and Equipment	<u>14,000</u>
Total	\$ 1,034,511

2.57 TO THE YOUTH COMMISSION

Personal Services	\$ 92,660
Purchase of Services	46,000
Materials, Supplies and Equipment	<u>4,080</u>
Total	\$ 142,740

2.58 TO THE CITY PLANNING COMMISSION

Personal Services	\$ 2,309,534
Purchase of Services	79,592
Materials, Supplies and Equipment	<u>40,652</u>
Total	\$ 2,429,778

2.59 TO THE BOARD OF TRUSTEES OF THE FREE LIBRARY OF PHILADELPHIA

Personal Services	\$ 35,777,252
Purchase of Services	2,922,077
Materials, Supplies and Equipment	<u>2,302,659</u>
Total	\$ 41,001,988

2.60 TO THE COMMISSION ON HUMAN RELATIONS

Personal Services	\$ 2,099,408
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City of Philadelphia

BILL NO. 150164 continued

Purchase of Services	34,657
Materials, Supplies and Equipment	<u>13,031</u>
Total	\$ 2,147,096

2.61 TO THE CIVIL SERVICE COMMISSION

Personal Services	\$ 147,343
Purchase of Services	29,500
Materials, Supplies and Equipment	1,094
Advances and Other Miscellaneous Payments	<u>6,906,535</u>
Total	\$ 7,084,472

2.62 TO THE OFFICE OF HUMAN RESOURCES

Personal Services	\$ 5,399,621
Purchase of Services	964,070
Materials, Supplies and Equipment	<u>69,932</u>
Total	\$ 6,433,623

2.63 TO THE OFFICE OF PROPERTY ASSESSMENT

Personal Services	\$ 10,424,420
Purchase of Services	2,078,126
Materials, Supplies and Equipment	<u>782,600</u>
Total	\$ 13,285,146

2.64 TO THE AUDITING DEPARTMENT

Personal Services	\$ 7,772,885
Purchase of Services	497,450
Materials, Supplies and Equipment	<u>25,000</u>
Total	\$ 8,295,335

2.65 TO THE BOARD OF REVISION OF TAXES

Personal Services	\$ 819,627
Purchase of Services	<u>20,200</u>

City of Philadelphia

BILL NO. 150164 continued

Materials, Supplies and Equipment15,727

Total\$ 855,554

2.66 TO THE REGISTER OF WILLS

Personal Services\$ 3,232,166

Purchase of Services75,486

Materials, Supplies and Equipment33,210

Total\$ 3,340,862

2.67 TO THE DISTRICT ATTORNEY

Personal Services\$ 32,490,021

Purchase of Services2,467,172

Materials, Supplies and Equipment525,021

Total\$ 35,482,214

2.68 TO THE SHERIFF

Personal Services\$ 17,104,325

Purchase of Services715,267

Materials, Supplies and Equipment393,207

Total\$ 18,212,799

2.69 TO THE CITY COMMISSIONERS

Personal Services\$ 5,624,276

Purchase of Services3,497,350

Materials, Supplies and Equipment541,617

Total\$ 9,663,243

2.70 TO THE FIRST JUDICIAL DISTRICT OF PENNSYLVANIA

Personal Services\$ 97,206,858

Purchase of Services10,656,574

Materials, Supplies and Equipment2,391,868

City of Philadelphia

BILL NO. 150164 continued

Total\$ 110,255,300

SECTION 3. Appropriations in the sum of seven hundred sixty-seven million, three hundred fourteen thousand (767,314,000) dollars are hereby made from the WATER FUND, as follows:

3.1 TO THE MAYOR - OFFICE OF INNOVATION AND TECHNOLOGY

Personal Services\$ 6,265,289
Purchase of Services14,706,497
Materials, Supplies and Equipment2,025,150

Total\$ 22,996,936

3.2 TO THE MAYOR - OFFICE OF TRANSPORTATION AND UTILITIES

Personal Services\$ 138,550

Total\$ 138,550

3.3 TO THE MANAGING DIRECTOR - OFFICE OF FLEET MANAGEMENT

Personal Services\$ 2,969,317
Purchase of Services1,489,000
Materials, Supplies and Equipment4,274,640

Total\$ 8,732,957

3.4 TO THE DEPARTMENT OF PUBLIC PROPERTY

Purchase of Services\$ 4,042,633

Total\$ 4,042,633

3.5 TO THE WATER DEPARTMENT

Personal Services\$ 102,961,600
Purchase of Services151,645,200

City of Philadelphia

BILL NO. 150164 continued

Materials, Supplies and Equipment	47,460,200
Contributions, Indemnities and Taxes	100,000
Payments to Other Funds	<u>65,000,000</u>
Total	\$ 367,167,000

3.6 TO THE DIRECTOR OF FINANCE - FRINGE BENEFITS

Personal Services-Employee Benefits	\$ <u>110,915,262</u>
Total	\$ 110,915,262

3.7 TO THE DIRECTOR OF FINANCE - INDEMNITIES

Contributions, Indemnities and Taxes	\$ <u>6,500,000</u>
Total	\$ 6,500,000

3.8 TO THE DEPARTMENT OF REVENUE

Personal Services	\$ 11,138,839
Purchase of Services	4,484,480
Materials, Supplies and Equipment	640,920
Contributions, Indemnities and Taxes	<u>5,000</u>
Total	\$ 16,269,239

3.9 TO THE DEPARTMENT OF REVENUE - SINKING FUND COMMISSION

Debt Service	\$ <u>227,139,336</u>
Total	\$ 227,139,336

3.10 TO THE PROCUREMENT DEPARTMENT

Personal Services	\$ <u>77,383</u>
Total	\$ 77,383

3.11 TO THE LAW DEPARTMENT

City of Philadelphia

BILL NO. 150164 continued

Personal Services	\$ 2,506,206
Purchase of Services	691,614
Materials, Supplies and Equipment	<u>43,010</u>
Total	\$ 3,240,830

3.12 TO THE OFFICE OF SUSTAINABILITY

Personal Services	\$ 63,874
Purchase of Services	<u>30,000</u>
Total	\$ 93,874

SECTION 4. Appropriations in the sum of thirty-four million, seven hundred twenty-four thousand (34,724,000) dollars are hereby made from the WATER RESIDUAL FUND, as follows:

4.1 TO THE WATER DEPARTMENT

Payments to Other Funds	\$ <u>34,724,000</u>
Total	\$ 34,724,000

SECTION 5. Appropriations in the sum of four million, nine hundred fifty thousand (4,950,000) dollars are hereby made from the COUNTY LIQUID FUELS TAX FUND, as follows:

5.1 TO THE DEPARTMENT OF STREETS

Personal Services	\$ 3,734,000
Purchase of Services	861,000
Materials, Supplies and Equipment	336,330
Payments to Other Funds	<u>18,670</u>
Total	\$ 4,950,000

City of Philadelphia

BILL NO. 150164 continued

SECTION 6. Appropriations in the sum of twenty-nine million, five hundred thousand (29,500,000) dollars are hereby made from the SPECIAL GASOLINE TAX FUND, as follows:

6.1 TO THE DEPARTMENT OF STREETS

Personal Services	\$ 3,000,000
Purchase of Services	15,558,550
Materials, Supplies and Equipment	9,926,450
Payments to Other Funds	<u>15,000</u>

Total	\$ 28,500,000
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6.2 TO THE DIRECTOR OF FINANCE-FRINGE BENEFITS

Personal Services-Employee Benefits	\$ <u>1,000,000</u>
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Total	\$ 1,000,000
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SECTION 7. Appropriations in the sum of nine hundred sixty-one million, five hundred fifty-two thousand (961,552,000) dollars are hereby made from the HEALTHCHOICES BEHAVIORAL HEALTH REVENUE FUND, as follows:

7.1 TO THE DEPARTMENT OF PUBLIC HEALTH - OFFICE OF BEHAVIORAL HEALTH AND INTELLECTUAL DISABILITY

Purchase of Services	\$ 960,002,000
Materials, Supplies and Equipment	50,000
Payments to Other Funds	<u>1,500,000</u>

Total	\$ 961,552,000
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SECTION 8. Appropriations in the sum of sixty-two million, seven hundred thousand (62,700,000) dollars are hereby made from the HOTEL ROOM RENTAL TAX FUND, as follows:

8.1 TO THE DIRECTOR OF COMMERCE

City of Philadelphia

BILL NO. 150164 continued

Contributions, Indemnities and Taxes	\$ 62,700,000
Total	\$ 62,700,000

SECTION 9. Appropriations in the sum of one billion, five hundred fifty-eight million, six hundred thirty-four thousand (1,558,634,000) dollars are hereby made from the GRANTS REVENUE FUND, as follows:

9.1 TO THE MAYOR

Personal Services	\$ 1,043,688
Personal Services-Employee Benefits	72,576
Purchase of Services	658,412
Materials, Supplies and Equipment	<u>9,336</u>
Total	\$ 1,784,012

9.2 TO THE MAYOR - OFFICE OF INNOVATION AND TECHNOLOGY

Purchase of Services	\$ 967,655
Payments to Other Funds	<u>44,702,879</u>
Total	\$ 45,670,534

9.3 TO THE MAYOR - OFFICE OF HOUSING AND COMMUNITY DEVELOPMENT

Purchase of Services	\$ <u>128,117,000</u>
Total	\$ 128,117,000

9.4 TO THE MAYOR - OFFICE OF COMMUNITY EMPOWERMENT AND OPPORTUNITY

Personal Services	\$ 2,349,085
Personal Services-Employee Benefits	451,559
Purchase of Services	13,075,621
Materials, Supplies and Equipment	<u>48,125</u>
Total	\$ 15,924,390

City of Philadelphia

BILL NO. 150164 continued

9.5 TO THE OFFICE OF SUSTAINABILITY

Personal Services	40,000
Total	\$ 40,000

9.6 TO THE MANAGING DIRECTOR

Personal Services	\$ 1,864,474
Purchase of Services	4,021,103
Materials, Supplies and Equipment	383,008
Total	\$ 6,268,585

9.7 TO THE POLICE DEPARTMENT

Personal Services	\$ 5,900,458
Personal Services-Employee Benefits	349,468
Purchase of Services	6,276,769
Materials, Supplies and Equipment	14,402,546
Total	\$ 26,929,241

9.8 TO THE DEPARTMENT OF STREETS

Personal Services	\$ 720,000
Purchase of Services	31,905,144
Materials, Supplies and Equipment	3,604,856
Total	\$ 36,230,000

9.9 TO THE FIRE DEPARTMENT

Personal Services	\$ 5,434,360
Personal Services-Employee Benefits	4,057,636
Purchase of Services	1,388,014
Materials, Supplies and Equipment	368,681
Total	\$ 11,248,691

9.10 TO THE DEPARTMENT OF PUBLIC HEALTH

City of Philadelphia

BILL NO. 150164 continued

Personal Services	\$ 11,141,642
Personal Services-Employee Benefits	4,217,090
Purchase of Services	56,755,608
Materials, Supplies and Equipment	1,701,279
Payments to Other Funds	<u>865,555</u>

Total\$ 74,681,174

9.11 TO THE DEPARTMENT OF PUBLIC HEALTH - OFFICE OF BEHAVIORAL HEALTH AND INTELLECTUAL DISABILITY

Personal Services	\$ 15,278,526
Personal Services-Employee Benefits	7,864,363
Purchase of Services	231,221,587
Materials, Supplies and Equipment	357,190
Payments to Other Funds	<u>76,248</u>

Total\$ 254,797,914

9.12 TO THE DEPARTMENT OF PARKS AND RECREATION

Personal Services	\$ 3,352,225
Personal Services-Employee Benefits	484,127
Purchase of Services	922,703
Materials, Supplies and Equipment	6,405,874
Contributions, Indemnities and Taxes	<u>110,000</u>

Total\$ 11,274,929

9.13 TO THE DEPARTMENT OF HUMAN SERVICES

Personal Services	\$ 79,773,120
Personal Services-Employee Benefits	37,175,926
Purchase of Services	451,172,464
Materials, Supplies and Equipment	<u>2,707,544</u>

Total\$ 570,829,054

9.14 TO THE DEPARTMENT OF PRISONS

Purchase of Services	\$ <u>30,000</u>
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City of Philadelphia

BILL NO. 150164 continued

Total\$ 30,000

9.15 TO THE DEPARTMENT OF HUMAN SERVICES - OFFICE OF SUPPORTIVE HOUSING

Personal Services\$ 710,423

Purchase of Services44,956,142

Materials, Supplies and Equipment887,489

Total\$ 46,554,054

9.16 TO THE DEPARTMENT OF LICENSES AND INSPECTIONS

Purchase of Services\$ 4,500,000

Total\$ 4,500,000

9.17 TO THE DIRECTOR OF FINANCE - PROVISION FOR OTHER GRANTS

Advances and Other Miscellaneous Payment.....\$ 203,800,721

Total\$ 203,800,721

9.18 TO THE DEPARTMENT OF REVENUE

Purchase of Services\$ 21,150,000

Total\$ 21,150,000

9.19 TO THE DIRECTOR OF COMMERCE

Personal Services\$ 49,814

Purchase of Services10,811,988

Total\$ 10,861,802

9.20 TO THE MAYOR - OFFICE OF TRANSPORTATION AND UTILITIES

Personal Services\$ 127,583

Purchase of Services1,698,435

City of Philadelphia

BILL NO. 150164 continued

Materials, Supplies and Equipment2,500

Total\$ 1,828,518

9.21 TO THE CITY PLANNING COMMISSION

Personal Services\$ 333,614

Personal Services-Employee Benefits141,647

Purchase of Services955,206

Payments to Other Funds1,600

Total\$ 1,432,067

9.22 TO THE BOARD OF TRUSTEES OF THE FREE LIBRARY OF PHILADELPHIA

Personal Services\$ 1,093,985

Personal Services-Employee Benefits132,099

Purchase of Services3,921,223

Materials, Supplies and Equipment3,366,737

Total\$ 8,514,044

9.23 TO THE AUDITING DEPARTMENT

Materials, Supplies and Equipment\$ 249,999

Total\$ 249,999

9.24 TO THE DISTRICT ATTORNEY

Personal Services\$ 14,930,000

Personal Services-Employee Benefits545,000

Purchase of Services1,124,880

Materials, Supplies and Equipment110,462

Total\$ 16,710,342

9.25 TO THE CITY COMMISSIONERS

Personal Services\$ 100,000

Purchase of Services600,000

City of Philadelphia

BILL NO. 150164 continued

Materials, Supplies and Equipment200,000

Total\$ 900,000

9.26 TO THE FIRST JUDICIAL DISTRICT OF PENNSYLVANIA

Personal Services\$ 34,698,587

Personal Services-Employee Benefits16,017,324

Purchase of Services6,775,539

Materials, Supplies and Equipment815,479

Total\$ 58,306,929

SECTION 10. Appropriations in the sum of four hundred forty million, three hundred eighty-three thousand (440,383,000) dollars are hereby made from the AVIATION FUND, as follows:

10.1 TO THE MAYOR - OFFICE OF INNOVATION AND TECHNOLOGY

Personal Services\$ 297,690

Purchase of Services8,607,358

Materials, Supplies and Equipment715,000

Total\$ 9,620,048

10.2 TO THE MAYOR - OFFICE OF TRANSPORTATION AND UTILITIES

Personal Services\$ 191,299

Total\$ 191,299

10.3 TO THE OFFICE SUSTAINABILITY

Personal Services\$ 63,873

Purchase of Services30,000

Total\$ 93,873

City of Philadelphia

BILL NO. 150164 continued

10.4 TO THE MANAGING DIRECTOR - OFFICE OF FLEET MANAGEMENT

Personal Services	\$ 1,364,188
Purchase of Services	588,000
Materials, Supplies and Equipment	<u>1,493,000</u>
Total	\$ 3,445,188

10.5 TO THE MANAGING DIRECTOR - OFFICE OF FLEET MANAGEMENT-VEHICLE PURCHASE

Materials, Supplies and Equipment	\$ <u>4,800,000</u>
Total	\$ 4,800,000

10.6 TO THE POLICE DEPARTMENT

Personal Services	\$ 15,611,887
Purchase of Services	77,500
Materials, Supplies and Equipment	<u>93,000</u>
Total	\$ 15,782,387

10.7 TO THE FIRE DEPARTMENT

Personal Services	\$ 6,563,366
Purchase of Services	15,000
Materials, Supplies and Equipment	125,000
Payments to Other Funds	<u>23,000</u>
Total	\$ 6,726,366

10.8 TO THE DEPARTMENT OF PUBLIC PROPERTY - UTILITIES

Purchase of Services	\$ <u>26,900,000</u>
Total	\$ 26,900,000

10.9 TO THE DIRECTOR OF FINANCE

Purchase of Services	\$ <u>4,146,000</u>
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City of Philadelphia

BILL NO. 150164 continued

Total\$ 4,146,000

10.10 TO THE DIRECTOR OF FINANCE - FRINGE BENEFITS

Personal Services-Employee Benefits\$ 57,194,271

Total\$ 57,194,271

10.11 TO THE DIRECTOR OF FINANCE - INDEMNITIES

Contributions, Indemnities and Taxes\$ 2,512,000

Total\$ 2,512,000

10.12 TO THE DEPARTMENT OF REVENUE - SINKING FUND COMMISSION

Debt Service\$ 123,505,128

Total\$ 123,505,128

10.13 TO THE DIRECTOR OF COMMERCE

Personal Services\$ 46,218,000

Purchase of Services96,372,841

Materials, Supplies and Equipment12,050,000

Contributions, Indemnities and Taxes4,205,000

Payments to Other Funds24,600,000

Total\$ 183,445,841

10.14 TO THE LAW DEPARTMENT

Personal Services\$ 1,563,803

Purchase of Services432,439

Materials, Supplies and Equipment24,357

Total\$ 2,020,599

City of Philadelphia

BILL NO. 150164 continued

SECTION 11. Appropriations in the sum of ninety-four million, one hundred sixty-one thousand (94,161,000) dollars are hereby made from the COMMUNITY DEVELOPMENT FUND, as follows:

11.1 TO THE MAYOR - OFFICE OF HOUSING AND COMMUNITY DEVELOPMENT

Personal Services	\$ 4,632,873
Purchase of Services	54,626,411
Materials, Supplies and Equipment	281,000
Payments to Other Funds	<u>30,000</u>

Total	\$ 59,570,284
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11.2 TO THE DEPARTMENT OF LICENSES AND INSPECTIONS

Personal Services	\$ <u>514,818</u>
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Total	\$ 514,818
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11.3 TO THE DIRECTOR OF FINANCE-FRINGE BENEFITS

Personal Services-Employee Benefits	\$ <u>4,236,559</u>
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Total	\$ 4,236,559
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11.4 TO THE DIRECTOR OF FINANCE - COMMUNITY DEVELOPMENT BLOCK GRANT - TO BE ALLOCATED

Advances and Other Miscellaneous Payment.....	\$ <u>20,000,000</u>
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Total	\$ 20,000,000
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11.5 TO THE DIRECTOR OF COMMERCE

Personal Services	\$ 935,454
Purchase of Services	8,461,248
Materials, Supplies and Equipment	<u>8,000</u>

Total	\$ 9,404,702
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11.6 TO THE LAW DEPARTMENT

City of Philadelphia

BILL NO. 150164 continued

Personal Services\$ 154,637

Total\$ 154,637

11.7 TO THE CITY PLANNING COMMISSION

Personal Services\$ 280,000

Total\$ 280,000

SECTION 12. Appropriations in the sum of six million (6,000,000) dollars are hereby made from the CAR RENTAL TAX FUND, as follows:

12.1 TO THE DEPARTMENT OF REVENUE-SINKING FUND COMMISSION

Purchase of Services\$ 6,000,000

Total\$ 6,000,000

SECTION 13. There is hereby authorized nine million nine hundred seventy-one thousand (9,971,000) dollars to be paid from the MUNICIPAL PENSION FUND, the recurring costs of administering the functional activities of the Board of Pensions and Retirement. The Director of Finance is authorized to transfer these costs to the appropriate funds based on the appropriate allocation plan, as he/she shall determine:

13.1 TO THE BOARD OF PENSIONS AND RETIREMENT

Personal Services\$ 3,750,000

Personal Services-Employee Benefits3,420,000

Purchase of Services2,538,000

Materials, Supplies and Equipment138,000

Payments to Other Funds125,000

Total\$ 9,971,000

City of Philadelphia

BILL NO. 150164 continued

SECTION 14. Appropriations in the sum of twenty-four million, five hundred thousand (24,500,000) dollars are hereby made from the HOUSING TRUST FUND, as follows:

14.1 TO THE MAYOR - OFFICE OF HOUSING AND COMMUNITY DEVELOPMENT

Personal Services	\$ 1,250,000
Purchase of Services	<u>23,250,000</u>
Total	\$ 24,500,000

SECTION 15. Appropriations in the sum of one hundred sixty-three million, one hundred sixty-six thousand (163,166,000) dollars are hereby made from the ACUTE CARE HOSPITAL FUND, as follows:

15.1 TO THE DEPARTMENT OF PUBLIC HEALTH

Personal Services	\$ 5,058,008
Purchase of Services	6,638,915
Materials, Supplies and Equipment	81,000
Payments to Other Funds	<u>2,000,000</u>
Total	\$ 13,777,923

15.2 TO THE DEPARTMENT OF PUBLIC HEALTH - STATE PAYMENT

Purchase of Services	\$ <u>149,000,000</u>
Total	\$ 149,000,000

15.3 TO THE DIRECTOR OF FINANCE

Personal Services	\$ <u>75,000</u>
Total	\$ 75,000

15.4 TO THE DIRECTOR OF FINANCE-FRINGE BENEFITS

Personal Services-Employee Benefits	\$ <u>268,077</u>
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City of Philadelphia

BILL NO. 150164 continued

Total\$ 268,077

15.5 TO THE DEPARTMENT OF REVENUE

Personal Services\$ 30,000

Materials, Supplies and Equipment15,000

Total\$ 45,000

SECTION 16. General Provisions.

(1) The sums herein appropriated under Items 2.41, 3.7, and 10.10 "To the Director of Finance-Indemnities" shall be used for the purpose of settling claims against the City. Payments therefore shall be made by the Director of Finance only upon the authorization of the City Solicitor or his/her designated representative for this purpose.

(2) If any function is transferred from one office, department, board or commission to another office, department, board or commission, the Director of Finance may not, without Council approval by ordinance, transfer to the successor office, department, board or commission those portions of the appropriations which appertain to the function transferred.

(3) Whenever, pursuant to the provisions of Section 8-401 of The Philadelphia Home Rule Charter, employees of any office, department, board or commission are used by another office, department, board or commission, the compensation of such employees for the period of such use may, at the discretion of the Director of Finance, be charged against the applicable appropriations to the using office, department, board or commission. The Director of Finance shall notify the President of Council, the Chief Clerk of Council and the Chair of the Appropriations Committee at least two (2) days prior to making any such charge against appropriations.

(4) In respect to any grant received by the City under Sections 5, 6, 7 or 9 of this Ordinance, the Director of Finance may, upon written authorization by the grantor transfer non-City funds between and among classes. The authorizations for such transfers shall be transmitted by the Director of Finance to the Clerk of Council within two (2) working days of any such transfer, along with a statement explaining the reason for such transfer. Transfers between and among departments respecting grants of two hundred fifty thousand (250,000) dollars or greater shall not be made except with the prior approval of the Council by resolution or ordinance. Approval shall not be granted

City of Philadelphia

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to any such transfer request submitted to Council unless it is accompanied by a copy of the grant proposal (and, if received, the grant award) which has caused the transfer request to be made. Transfers between and among departments respecting grants of less than two hundred fifty thousand (250,000) dollars shall be made upon written authorization of the Director of Finance; provided however, that such authorization, along with a full description of the grant affected is transmitted to the President of Council at least two (2) days before the effective date of such authorization.

In respect to funds from the Department of Housing and Urban Development's Community Development Block Grant (CDBG) appropriated under Section 11 of this Ordinance, the limitations set forth in the provisions of Chapter 21-1100 of The Philadelphia Code shall govern any transfer of CDBG funds between and among classes, departments and elements (grants).

(5) In respect to the appropriation made in Item 11.4 of this Ordinance "To the Director of Finance-Community Development Block Grant-To be Allocated", the sums shall not be construed as being available for commitment prior to the adoption of any ordinance appropriating moneys to be made available by the Department of Housing and Urban Development for the Fiscal Year 2016.

(6) The Director of Finance may make adjustments for obligations incurred in Fiscal Year 2015 and prior years. These may be made out of the appropriations therefore to the respective offices, departments, boards, commissions and agencies for Fiscal Year 2016. Within one week of taking any action authorized by this subsection (6), the Director of Finance shall provide written notice to the President and all members of the Council, with a copy to the Chief Clerk of Council, detailing such action.

(7) Except as otherwise provided by this Ordinance, special funds heretofore established pursuant to ordinance or statute, shall continue to be utilized in Fiscal Year 2016 for the purposes and in the manner prescribed by such ordinance or statutes to the extent that they are consistent with the provisions of The Philadelphia Home Rule Charter.

When under The Philadelphia Home Rule Charter an appropriation is a prerequisite to payments of money from such special funds, this paragraph should be construed as an appropriation of the full receipts of such funds for the purpose heretofore authorized by such ordinance or statutes, except that this paragraph shall not be construed as an appropriation of any funds contained in the Housing Trust Fund created under Chapter 21-1600 of The Philadelphia Code, and expenditures from the Housing Trust Fund shall be made only pursuant to appropriations made in Section 14 of this Ordinance. The provisions in the prior sentence relating to the Housing Trust Fund are not severable from the remainder of that sentence or from any of the other provisions of this subsection

City of Philadelphia

BILL NO. 150164 continued

(7), but are essentially and inseparably connected with those provisions, it being Council's intent that no portion of this subsection (7) would have been enacted if it did not also contain the provisions relating to the Housing Trust Fund.

The Director of Finance is authorized and directed to impound the balance of any special fund with respect to which he/she finds that the purposes for which the fund is being expended were intended by ordinance or law to be funded by an appropriation made in other Sections of this Ordinance.

(8) The City Treasurer is authorized and directed to make temporary advances in such amounts as the Director of Finance shall specify between any of the operating funds receiving appropriations in this Ordinance or between any operating fund and the Capital Projects Fund, and the Industrial and Commercial Development Fund, in anticipation of the collection of revenues or other receipts which are estimated to be receivable during the Fiscal Year 2016. Such advances shall bear interest at such rates as the City Treasurer, upon approval of the Director of Finance, shall determine.

(9) The amounts herein appropriated for Purchase of Services; Materials, Supplies and Equipment; Contributions, Indemnities and Taxes; and Debt Service shall be deemed to be available for encumbrance upon the effective date of this Ordinance, to the extent necessary to facilitate the operations of the various offices, departments, boards and commissions for Fiscal Year 2016; provided, that no service shall be rendered prior to July 1, 2015 and no materials, supplies or equipment acquired shall be used in Fiscal Year 2015 except to the extent required to prepare for Fiscal Year 2016.

Such portions of the appropriations herein made for debt service to the Sinking Fund Commission may be paid over to the City's fiscal agent prior to July 1, 2015 as in the judgment of the Director of Finance is necessary to meet interest and principal on the debt of the City due on July 1, 2015.

(10) The Director of Finance is authorized to charge or credit fund balances available for appropriations as of June 30, 2015 to record properly actual charges for Interfund Services for the Fiscal Year 2015.

(11) The Director of Finance is authorized to charge to fund balance payment of any obligation properly incurred in Fiscal Year 2015 or in any prior year, provided that at the time such obligation was incurred an appropriation was available against which it could have been charged, but that such appropriation shall have ceased to exist due to merger into surplus. It is further provided that the payment of any such obligation be in the same manner and subject to the same controls as would have been followed had the obligation been paid in a timely manner. Within one week of taking any action authorized by this subsection (11), the Director of Finance shall provide written notice to

City of Philadelphia

BILL NO. 150164 continued

the President and all members of Council, with a copy to the Chief Clerk of Council, detailing such action.

(12) Provided that the appropriation contained in Sections 7, 9 and 11 of this Ordinance shall be made available for encumbrances and/or expenditure only when the Director of Finance has certified that he/she has been responsibly advised that funds necessary to finance such appropriation or portion thereof have been received or are to be forthcoming from another government or from a nongovernmental source.

In such event the Director of Finance is authorized to accept the award for the City and to provide for the appropriation as may be required to execute the program covered by the award.

(13) The Director of Finance is authorized and directed to restore any deficiency in any Sinking Fund Reserve established pursuant to a revenue bond general ordinance, when such deficiency results from a decline in the market value of its investments, by charging the amount of the deficiency against available loan balances, or in the absence of available loan balances, against the appropriate operating fund balance. Within one week of taking any action authorized by this subsection (13), the Director of Finance shall provide written notice to the President and all members of Council, with a copy to the Chief Clerk of Council, detailing such action.

(14) None of the appropriations herein provided in Section 11 shall be encumbered against or expended out of the thirty eighth entitlement grant prior to the formal award thereof: Provided, that pending the receipt of all or a portion of the aforesaid grant award the Director of Finance is authorized to finance the appropriations herein provided from balances of prior entitlement grants awards. The authorization for such financing shall be transmitted by the Director of Finance to the Clerk of Council within two (2) working days of any such authorizations.

(15) In respect to the authorization amounts as set forth in Section 13 for purposes of operating the Board of Pensions and Retirement, the Director of Finance may increase each class amount by an amount not to exceed fifteen percent (15%) of the total budget for the fund for Fiscal Year 2016. The authorization for such increases shall be transmitted by the Director of Finance to the Clerk of Council within two (2) working days of any such increases.

(16) The appropriation contained in Section 9.3 of this Ordinance shall only be made available for obligation upon certification by the Director of Finance that Community Development Block Grant unexpended funds are available for Interim and Construction Assistance and that the amounts to be made available are guaranteed by an irrevocable Letter of Credit or similar security. At such time the Director of Finance may

City of Philadelphia

BILL NO. 150164 continued

authorize amounts to be provided from his/her appropriation, which amounts shall be financed by Community Development Block Grant revenues. Amounts which are repaid shall be credited as program income to finance Community Development Fund activities.

The Director of Finance and the Director of Housing, in accordance with the regulations of the Department of Housing and Urban Development (HUD), are authorized and directed to draw funds in a single lump sum from HUD's Community Development Block Grant (CDBG) to the City of Philadelphia for the appropriation contained in Section 11.1 of this Ordinance to establish a rehabilitation fund in one or more private institutions for the purpose of financing the rehabilitation of privately owned properties as part of the City's CDBG program. Funds drawn down from HUD, pursuant to this authorization, may be deposited in any private financial institution as defined by the applicable HUD regulations notwithstanding the limitations on the placement of City deposits set forth in Chapter 19-200 of The Philadelphia Code.

(17) The Director of Finance, with the concurrence of the U. S. Department of Housing and Urban Development (HUD), shall as of June 30 of the fiscal period preceding the start of this Operating Budget Ordinance, transfer all unobligated encumbrances and other available balances from the oldest Community Development Program Year not previously closed out to the next oldest Program Year as of July 1. Further, any questioned cost items from the closed out Program Year which are determined by HUD to be ineligible costs shall be transferred to the oldest open Program Year after such costs are removed. Program regulations governing such transferred funds shall be determined by HUD. The Director of Finance shall notify the Clerk of Council periodically concerning Program Year close outs and transfers.

(18) The Director of Finance is hereby authorized, at his/her discretion, to transfer the amount of the authorization and/or the obligations in respect to indemnities, advertising, insurance, telephone, postage, rental, leases, vehicle purchases, utilities, employer's share of fringe benefits and data processing services from the appropriations herein made to the appropriate offices, departments, boards, commissions or other agencies of the City.

DEPARTMENT OF BEHAVIORAL HEALTH AND INTELLECTUAL DISABILITY SERVICES
FISCAL YEAR 2016 BUDGET TESTIMONY
APRIL 29, 2015

EXECUTIVE SUMMARY

DEPARTMENT MISSION AND FUNCTION

Mission: The Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) supports a vision of recovery, resilience, and self-determination. DBHIDS continues to transition to a model of care directed by the person in recovery. Professional treatment is one component, among many, that supports people in managing their own challenges while building their own recovery resources. The recovery process is viewed as a lifetime journey.

Description of Major Services: DBHIDS provides comprehensive behavioral health and intellectual disability services through a network of provider agencies. DBHIDS is comprised of four components: the Office of Addiction Services (OAS), the Office of Mental Health (OMH), Community Behavioral Health (CBH - Philadelphia's Medicaid managed care behavioral health program), and Intellectual disAbility Services (IDS). Prior to 2003, three of the four components, OMH, OAS, and IDS, were units within the Philadelphia Department of Public Health. The fourth component, CBH, is Philadelphia's not-for-profit managed care entity. The City established CBH in 1997 to manage behavioral health care services for Philadelphia's 475,000 Medicaid recipients. The creation of CBH served as the catalyst for the development of Philadelphia's current behavioral health system. DBHIDS also partners with multiple other systems including child welfare, homeless services, criminal justice and the School District of Philadelphia to promote recovery, resilience & self-determination.

PROPOSED BUDGET HIGHLIGHTS/FUNDING REQUEST

Budget Highlights: Ninety-nine percent (99%) of DBHIDS of Behavioral Health and Intellectual disAbility Services (DBHIDS) funding comes from the State and Federal governments, including over \$960 million from the State to provide managed behavioral health care for 120,000 city residents receiving medical assistance benefits annually. The greatest challenges facing DBHIDS involve unknowns concerning State and Federal budgets. General fund support for DBHIDS is used as a match to receive nine times the investment in State and Federal funds and will remain roughly on par in FY16 with the FY15 Current Projection. The FY16 budget appropriates an additional \$112 million to DBHIDS, primarily through the HealthChoices Behavioral Health Revenue Fund, to plan for potential changes in per person allocations received. The overall FY16 Proposed Operating budget for DBHIDS is 10% higher than the FY15 Current Projection.

The FY16 DBHIDS Operating Budget request totals \$1,230,225,490: \$13,875,576 in the General Fund, \$254,797,914 in the Grants Revenue Fund, and \$961,552,000 in the HealthChoices Behavioral Health Revenue Fund. The DBHIDS FY16 Budget will support 259 positions, 16 in the General Fund and 243 in the Grants Revenue Fund. Of the \$1,230,225,490, \$61,048,663, or 5%, is for intellectual disability and early intervention services, and \$1,169,176,827, or 95%, is for behavioral health services.

Fund	Class	FY14 Actual	FY15 Current Projection	FY16 Proposed Budget	FY16-FY15 Change	FY16-FY15 Percent Change
General	100	974,425	991,846	1,000,066	8,220	0.8%
	200	12,693,482	12,975,510	12,875,510	-100,000	-0.8%
	Total	13,667,907	13,967,356	13,875,576	-91,780	-0.7%
	Positions	15	16	16	0	0.0%
Other*	100	22,396,786	22,243,030	23,142,889	899,859	4.0%
	200	1,102,835,254	1,080,027,573	1,191,223,587	111,196,014	10.3%
	300/400	277,722	457,190	407,190	-50,000	-10.9%
	800	1,760,706	1,571,553	1,576,248	4,695	0.3%
	Total	1,127,270,468	1,104,299,346	1,216,349,914	112,050,568	10.1%
	Positions	225	249	243	0	-2.5%
All	100	23,371,211	23,234,876	24,142,955	908,079	3.9%
	200	1,115,528,736	1,093,003,083	1,204,099,097	111,096,014	10.2%
	300/400	277,722	457,190	407,190	-50,000	-10.9%
	800	1,760,706	1,571,553	1,576,248	4,695	0.3%
	Total	1,140,938,375	1,118,266,702	1,230,225,490	111,958,788	10.0%
	Positions	240	265	259	-6	-2.3%

* Other Funds includes: County Liquid Fuels Tax Fund, Special Gasoline Tax Fund, HealthChoices Behavioral Health Fund, Hotel Room Rental Tax Fund, Grants Revenue Fund, Community Development Fund, Car Rental Tax Fund, Housing Trust Fund, Water Fund, Water Residual Fund, Aviation Fund, and Acute Care Hospital Assessment Fund.

Staff Demographics Summary (as of January 23, 2015)

	Total	Minority	White	Female
Full-Time Staff	243	186	57	178
Executive Staff	8	5	3	3
Average Salary - Executive Staff	\$121,605	\$135,067	\$104,490	\$119,552
Median Salary - Executive Staff	\$122,422	\$129,375	\$104,490	\$120,643

Employment Levels (as of January 23, 2015)

	Budgeted	Filled
Full-Time Positions	259	243
Part-Time Positions	2	2
Executive Positions	8	8

Contracts Summary (*as of December 2014)

	FY10	FY11	FY12	FY13	FY14	FY15*
Total amount of contracts	\$7,047,196	\$6,683,218	\$8,935,044	\$11,247,368	\$11,667,684	\$13,317,812
Total amount to M/W/DBE	\$124,000	\$398,933	\$1,521,673	\$1,609,768	\$1,587,173	\$1,395,545
Participation Rate	2%	6%	17%	14%	14%	10%

PERFORMANCE, CHALLENGES AND INITIATIVES

DEPARTMENT PERFORMANCE (OPERATIONS)

The number of unique clients served in out-patient treatment facilities decreased by 3.4% from FY13 to FY14. As of the first half of FY15, 56,174 clients have been served, a decrease of 5.99% from the same period in FY14. These recent reductions in outpatient utilization result from the expansion of other levels of care including three recently established partial hospital treatment programs. Use of out-of-state Residential Treatment Facilities (RTFs) has dropped significantly over time, from 303 individuals in FY08 to 23 individuals in FY13 and FY14. However, there are a relatively small number of people who require highly specialized services that are not available in-state and would be cost prohibitive to establish locally. Further decreases in out-of-state RTF placements are unlikely as a result. The number of new RTF admissions was introduced as a performance metric in FY14. The number of new admissions has dropped significantly since FY08 from 1,689 to 665 in FY14. Performance for this measure showed little variance from FY13 to FY14 (3.3% drop) and is on pace to meet the target of 680 new admissions in FY15. Measures for inpatient psychiatric facility discharge and readmission have a reporting window of 120 days. As a result, data is not yet available for FY15. From FY13 to FY14, the percent of follow-up within 30 days of discharge from an inpatient psychiatric facility (to help connect individuals to outpatient services and reduce recidivism) decreased by 11%, and the percentage remains below the initial FY08 benchmark. DBHIDS still expects to meet its FY15 goal of 63%. The percent of readmissions within 30 days to an inpatient facility declined from 21.4% in FY08 to 17.2% in FY14, and DBHIDS is working toward the goal of decreasing this percentage to 12% for FY15 and FY16.

Performance Measure	FY08	FY13	FY14	FY14- FY13 Change	FY14 Q1-Q2	FY15 Q1-Q2	FY15- FY14 Q1-Q2 Change	FY15 Goal	FY16 Goal
Number of unique clients served in out-patient treatment facilities	46,189	77,760	75,142	-3.4%	59,751	56,174	-5.99%	70,500	70,500
Number of unique clients served in out-of-state Residential Treatment Facilities	303	23	23	0.0%	19	25	28.9%	28	28
Number of new admissions to Residential Treatment Facilities	1,689	688	665	-3.3%	352	279	-20.7%	680	680
Percent of follow-up within 30 days of discharge from an inpatient psychiatric facility	62.4%	67.2%	59.8%	-11.0%	59.1%	N/A	N/A	63.0%	63.0%
Percent of readmission within 30 days to inpatient psychiatric facility (Substance Abuse & non-Substance Abuse)	21.4%	16.2%	17.2%	6.2%	16.7%	N/A	N/A	12.0%	12.0%

Performance Incentives: 2014 marked the fifth year that DBHIDS awarded payment bonuses to service providers based on their performance corresponding to a range of established measures. Performance incentives were available to providers across 15 levels of care. Standards required to earn Pay-for-Performance (PFP) awards were raised this year, resulting in 17% of agencies, or 73 providers, qualifying for incentives in 2014. The prior year, 45% of providers received performance awards. Continued performance improvement was observed for multiple measures including the following: 30-Day follow-up of persons discharged from Adult Inpatient Psychiatric treatment (from 71% in CY12 to 73% in CY13); the percent of appointments occurring within seven days of referral for adult mental health outpatient treatment (from 47% in CY12 to 51% in CY13); and the percentage of individuals having case management contact within two days of inpatient treatment admissions (from 87.9% in FY13 to 89.3% in FY14). A new measure is being piloted in 2015 to assess the participation of outpatient providers in public behavioral health screening events. Another new 2015 pilot measure involves gathering outcome data directly from service recipients and families via surveys. Both of these new measures will enhance efforts to comprehensively assess and improve service quality.

Performance Improvement and Accountability: In 2011, DBHIDS instituted the Network Improvement and Accountability Collaborative (NIAC) to streamline the measurement and analysis of behavioral health contract agency performance. This comprehensive approach is being progressively refined and used to promote efficiency, service quality, accessibility, as well as individualized and holistic care. Emphasis is placed on building program strengths while promoting community support and mobilization. In 2014, the monitoring team visited 66 service sites and evaluated 299 behavioral health programs.

DEPARTMENT CHALLENGES

- **Continued Impact of State Cuts:** Efforts continue to manage the fallout from the 10% behavioral health funding reduction enacted by the State FY13 combined with the elimination of General Assistance payments. The void left by the loss of these funds and entitlements continues to diminish the quality of life for thousands of local residents. The proposed FY16 state budget includes a provision for the restoration of the prior ten percent (10%) funding cut. This recommendation is encouraging; however, it is unclear if the final version of the commonwealth's budget will restore these funds.
- **School District of Philadelphia:** DBHIDS has a long history of collaboration with the School District of Philadelphia to provide medically necessary behavioral health treatment to children and families. School-based care includes behavioral health prevention, early intervention, assessment, and clinical treatment. Plans to optimize the deployment of school-based interventions will be assessed and adjusted on an on-going basis until the School District of Philadelphia's budget has been finalized.
- **Healthy PA:** Ensuring that individuals have access to behavioral health services in the wake of health reform constitutes a foremost DBHIDS priority. Under the prior State Administration, Pennsylvania opted for an alternative Medicaid reform plan, reforming the State's prior Medicaid program. "Healthy PA" significantly altered the Medicaid plan, eliminating most of the current Medical Assistance (MA) categories and creating two new benefit categories (low and high risk) as well as a private coverage option. These changes placed many people into plans that were no longer comprehensive enough to meet their health needs. In February 2015, newly elected Governor Wolf announced the intent to eliminate the Healthy PA plan and create one adult Medicaid expansion benefit package. The new State plan addresses many of the challenges posed by Healthy PA; however, it will take until the fall for all individuals to be transitioned from the Healthy PA program.

ACCOMPLISHMENTS & INITIATIVES

Transformation Decade: Over the past 10 years, DBHIDS has partnered with Mayor Michael Nutter, City Council, service recipients, family members, providers, other City Departments, and additional stakeholders to fundamentally transform the local network of care. Behavioral health and intellectual disability services have traditionally focused on symptom stability and crisis response. Over the past decade, DBHIDS has replaced these priorities with services and expectations promoting genuine recovery from behavioral health and addiction challenges, strengthening the resiliency of children, and offering individuals with intellectual disabilities opportunities to exercise choice and self-determination. Accomplishments achieved during this "Transformation Decade" have garnered local, national and international attention due the incontrovertible fact that Philadelphia's approach is working.

A major component of this transformation has involved strategic and sustained investments to foster the broad adoption of state-of-the-art approaches to treatment. The pervasive use of evidence-based treatment models has resulted in decreased use of crisis services, diminished in-patient recidivism, increased clinical stability, and enhanced cost efficiency. Simultaneously, DBHIDS has progressively increased the number of people being served and improved outcome performance across many levels of care.

Local innovations have attracted visitors from across the United States and around the world who seek to replicate Philadelphia's success. DBHIDS' achievements have been recognized by major news outlets including the New York Times, National Public Radio, and most recently the Wall Street Journal. Numerous behavioral health journals and professional organizations have cited DBHIDS' progressive, forward thinking approaches, frequently referenced as the "Philadelphia Model." Additional acknowledgments are anticipated this year as DBHIDS sponsors a series of events celebrating accomplishments achieved over the last decade that have immeasurably improved the quality of life for thousands of Philadelphians.

Public Health Approach: DBHIDS' emphasis on advancing a Public Health approach to service delivery has been a cornerstone of the aforementioned transformation. This expanded orientation transcends behavioral health and intellectual disability services to include population health promotion, community wellness, and a focus on social determinants of health. DBHIDS has instituted a number of initiatives consistent with Public Health promotion that are detailed later in this testimony. Several Public Health events and accomplishments of particular note include the following:

- The first annual “I Will Listen Day” was hosted by Philadelphia on June 3rd when hundreds of people, including the Mayor and members of City Council, recorded personal video messages vowing to listen to others without passing judgment. Thousands of additional local citizens signed pledges indicating their commitment to the “I Will Listen” campaign.
- National Depression Screening Day, October 9, 2014, involved over a dozen events across the City including college campuses, the Free Library and City Hall. This event contributed significantly to a 434% increase in the total number of online screenings last year via the DBHIDS’ public health portal, HealthyMindsPhilly.org.
- Philadelphia pioneered the widespread application of Mental Health First Aid. This innovative early intervention and public education program teaches community members how to assist individuals experiencing behavioral health challenges. Per the Thomas Scattergood Foundation, “Philadelphia is using a public health approach to organize and implement Mental Health First Aid (MHFA) in a manner that will create change and impact all levels of society.”
- The 2014 Recovery Walks event in Philadelphia attracted 23,000 participants for this annual procession through historic Old City. To date, this is believed to be the single largest recovery event worldwide.

Recovery Transformation: While behavioral health systems across the nation are now engaging in recovery-oriented care, DBHIDS was the trailblazer in transitioning away from a system primarily focused on mitigating symptoms and responding to acute distress. The “Philadelphia Model” is designed to enable individuals to recover from mental illness or addictions via enhanced access to individualized care, including an emphasis on prevention, early intervention, recovery and treatment. This work was made possible through unprecedented collaboration between City Departments, DBHIDS’ network of service providers, service recipients, and family members, as well as top innovators and thinkers in the field of behavioral health.

Public Health Strategies to Address Behavioral Health Issues: A number of DBHIDS initiatives are consistent with an emphasis on a Public Health approach to service delivery, including the following:

- **Community Wellness Coalitions:** In 2014, DBHIDS established additional Community Wellness Coalitions (CWC). At a minimum, each Coalition consists of a community-based organization, a faith-based organization, a primary health care organization, and a licensed outpatient behavioral healthcare provider. These partners work together to share their resources, relationships and expertise to meet unaddressed behavioral health care needs presented by individuals in their shared communities. DBHIDS recently expanded this project to engage several populations facing unique challenges including Males of Color, refugees/immigrants, and Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual or Ally (LGBTQIA) communities. The Philadelphia Refugee Mental Health Coalition connects immigrant and refugee children to culturally appropriate mental health care where approximately 30-50 individuals receive service per day.
- **Behavioral Health Screenings:** Free behavioral health screenings are a component of Healthy Minds Philly, a DBHIDS public health strategy to extend non-treatment services to Philadelphians while offering treatment linkages as needed. DBHIDS, in partnership with the Scattergood Foundation and Screening for Mental Health, Inc., has created the nation’s first behavioral health screening kiosk located in a retail clinic setting, called QCare, at a ShopRite in North Philadelphia. Behavioral health screenings are quick, free and anonymous; they are not diagnostic; they are available in English and in Spanish both online and via paper forms. To date, 3,630 online behavioral health screenings have taken place; 1,835 have occurred since May 2014. Screenings are available any time online at www.healthymindsphilly.org/screenings.
- **Promoting Recovery through Art (The Porch Light Program):** DBHIDS is collaborating with the City of Philadelphia’s Mural Arts Program (MAP) to create a series of themed mural projects designed to promote community wellness, de-stigmatize mental health and addiction challenges, and create supportive, recovery-focused communities. To date, 27 projects have been completed. In 2014, one large scale mural was completed that conveyed universal themes of resilience, recovery, healing, as well as collective and individual strength. Murals currently in progress include “Community Wellness,” “Southeast by Southeast,” “Finding Home,” and “My Brother’s Keeper.”
- **Cross Systems Contributions** Over the course of the past year, DBHIDS contributed funding to support other City Departments engaged in collaborative efforts to address the holistic needs of vulnerable populations. These contributions totaled over \$1 million and included the allocation of funds for services rendered to homeless persons involved with the Office of Supportive Housing (OSH).

Community Engagement Initiatives: The following initiatives are among those designed to involve and engage traditionally underserved populations:

- **Faith-based initiatives:** The DBHIDS Faith and Spiritual Affairs (FSA) Unit is dedicated to informing faith and spiritual communities regarding behavioral health care while reducing associated stigma. Recent accomplishments include multiple workshops, presentations, articles, as well as radio and television interviews promoting faith-based unity, collaboration and proactive behavioral health care. Attendance at the annual Philadelphia FSA Conference grew from 280 attendees in 2013 to 500 in 2014. Local faith-based efforts also attracted national attention resulting in an invitation for the DBHIDS FSA Director to attend a White House event acknowledging the role of this local initiative in promoting enrollment in the Affordable Care Act.
- **Mini grants:** DBHIDS issued 10 mini grants of \$5,000 each to address the issue of problem gambling. These two year grants, concluding in FY15, focus on gambling prevention, treatment, and education. Efforts were made to ensure that these resources benefitted a wide range of populations including African immigrants, Asian Americans, Vietnamese and Cambodian seniors, high school students, clergy, parents and children victimized by violence, mental health professionals, and homeless persons. To date, 6,492 individuals have participated in problem gambling prevention and education events provided by grant recipients.
- **Re:Mind:** Via this initiative, text messages are being employed to improve continuity of behavioral health care by supporting transitions to outpatient treatment following hospital stays. Specifically, this low cost mechanism issues outpatient appointment reminders via text messages to individuals who may be at risk of inpatient recidivism. 261 individuals, including adults and adolescents, have enrolled since this initiative was introduced in October 2014. Fifteen inpatient treatment providers from across the City are participating.

Creating a Stellar System – Expanding Evidence Based Practices: DBHIDS remains committed to the concept that Philadelphia residents who depend upon DBHIDS services should be afforded ample access to state of the art behavioral health interventions. Based on this commitment, DBHIDS continues to expand the availability of evidence-based treatment and technologies and is incorporating evidence-based expectations into our procurement and contracting processes. To enhance the impact of these approaches, DBHIDS has partnered with multiple internationally acclaimed originators of Evidence Based Practices (EBPs). To date, over 500 therapists from 60 programs have received EBP training. The following EBPs, promoting positive health outcomes, are supported by DBHIDS: Parent-Child Interaction Therapy, Child Parent Psychotherapy, Child Family Traumatic Stress Intervention, Trauma Focused Cognitive Behavior Therapy, Cognitive Behavior Therapy, Ecosystemic Structural Family Therapy, Functional Family Therapy, Multisystemic Therapy for Problem Sexual Behavior, Cognitive Behavior Therapy, Prolonged Exposure, Dialectical Behavior Therapy, Partners in Change Outcomes Management System, Assertive Community Treatment, and Beating the Blues Computer-based Cognitive Behavior Therapy. Detail regarding several EBPs is provided below:

- **Ecosystemic Structural Family Therapy (ESFT):** In partnership with Dr. Marion Linblad-Goldberg and the Philadelphia Child and Family Therapy Training Center, DBHIDS is currently training 24 therapists at 4 agencies to provide ESFT. Intensive training takes place twice each month over a 3 year period from January 2014-December 2016. This treatment approach is designed to assist families with children who are experiencing behavioral health problems and are at risk of out-of-home placement. Via ESFT, families learn skills needed to support their children at home and in community settings, alleviating the need for more intensive services.
- **Improving Service Outcomes (Partners in Change Outcomes Management System - PCOMS):** The Partners for Change Outcome Management System (PCOMS) is a federally recognized evidence-based, feedback-informed tool designed to improve service outcomes. This technology enhances outcomes for persons with challenging behavioral health needs through continual monitoring of achievements related to individualized recovery goals. PCOMS complements treatment by incorporating robust predictors of therapeutic success into an outcome management system that includes routine input from service recipients. To date, 21 programs across 13 local agencies have implemented this state-of-the art management system.
- **Beating the Blues (BtB):** Beating the Blues is a web-based, evidence-based, Cognitive Behavioral Therapy (CBT) program for the treatment of mild to moderate depression and anxiety. This resource is designed to benefit people who are awaiting therapy appointments and to foster increased communication and collaboration between clients and clinicians. The effectiveness of this user friendly, treatment modality has

been repeatedly confirmed via worldwide independent research studies. BtB was recently paired with peer support staff and piloted with 150 individuals who are unlikely to participate in traditional treatment options.

Addressing Community Trauma: DBHIDS is engaged in a multiyear, multifaceted, trauma transformation effort. Beginning with behavioral health practitioners and reaching out to partners across the City, DBHIDS is combining evidence-based practices and other innovative approaches to raise levels of resilience and heal the effects of trauma. The comingled impacts of trauma induced stress are often associated with chronic illness, mental health challenges, addiction, patterns of victimization, destructive relationships, as well as problems at home, work and school. DBHIDS has introduced a growing number of initiatives intended to counteract the effects of trauma and prevent repeated traumatization. The following resources are among those designed to address trauma-related symptoms and suppress trauma recurrence.

- **Early Trauma Intervention (Healing Hurt People - HHP):** Healing Hurt People is a trauma intervention program based in medical emergency departments that provides assistance to individuals and families victimized by physical violence. Youth and young adults who present in Emergency Rooms with violence precipitated injuries are screened to assess levels of need for behavioral health and social services. Licensed social workers assist young victims of intentional injury to access services intended to moderate the impact of trauma and encourage rapid recovery. Follow-up supports are provided in hospital settings and in family homes to decrease repeat victimization, prevent retaliation by victims or their families, and facilitate behavioral health service linkages. Currently these services are provided on-site at Hahnemann Hospital and St. Christopher's Hospital for Children. In 2015, HHP will expand to include Temple University Hospital. Further expansion is projected in FY16.
- **Mental Health First Aid:** Philadelphia has emerged as a national leader in the public promotion of behavioral health via the Mental Health First Aid (MHFA) initiative. MHFA is a groundbreaking early intervention, public education program that teaches community members how to identify, understand, and respond to individuals experiencing behavioral health challenges. MHFA training dispels stigma and misinformation about behavioral health challenges that impedes efforts to connect individuals with appropriate care. This training has been made available to the public, faith communities, the Police and Fire Departments, the School District, and many other organizations. This project is on track to have trained 10,000 individuals by the end of 2015.
- **Treating Post Traumatic Stress: Prolonged Exposure Trauma Training,** designed to treat Post Traumatic Stress Disorder (PTSD), has been provided for 33 therapists across 10 addiction treatment agencies that serve parenting and non-parenting women. Anticipated outcomes include increased understanding of trauma impacts and expanded public awareness of symptoms and resources. Further trainings are being targeted to key populations including faith-based organizations, LGBTQIA groups, and a range of other community stakeholders.
- **Preventing Suicide and Self-Harm (Dialectical Behavior Therapy):** This highly specialized treatment approach was conceived to help adults and adolescents who engage in very high risk behaviors including repeated attempts to harm themselves or commit suicide. Dialectical Behavior Therapy (DBT) focuses on improving emotion self-regulation skills that allow individuals to remain safe, avoid crisis events and hospitalizations, utilize less restrictive levels of care, and increase their quality of life. To date, 40 clinicians from six agencies have received intensive DBT training. DBHIDS has partnered with the Treatment Implementation Collaborative (TIC) to ensure that the delivery of DBT treatment is supported and retained in the local system of care. In 2015, TIC will tailor trainings to address areas of need identified by providers, including advanced behavioral assessments and trauma treatment. This initiative has been expanded to include the provision of this state-of-the-art treatment to high need adolescents.
- **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT):** TF-CBT is a psychotherapy model with exceptionally strong research evidence confirming its effectiveness as a treatment for children and youth who have experienced trauma. Via TF-CBT, children and families are equipped with the skills needed to manage intrusive and upsetting trauma memories; reduce or eliminate avoidance of trauma triggers, and address depression, anxiety, sexualized behaviors and dysfunctional behaviors. To date, 151 Therapists and Supervisors from 15 Behavioral Health Agencies have received TF-CBT training.
- **Child and Family Traumatic Stress Intervention (CF-TSI):** CF-TSI is a brief, intensive intervention designed to decrease the negative impact of exposure to potentially traumatic events including sexual and physical abuse, domestic violence, and motor vehicle accidents, for children ages 7 to 18. Treatment is designed to be

delivered within the first 45 days of exposure to a potentially traumatic event to prevent onset of Post-Traumatic Stress Disorder (PTSD). Treatment goals include improved screening and identification of children impacted by traumatic stress, reduced traumatic stress symptoms, improved communication between caregiver and child, enhanced skills to master trauma reactions, and assessments of need for longer-term treatment. To date, CF-TSI training has been provided to 18 clinicians from three behavioral health and two hospital-based violence intervention programs (Children Hospital Of Philadelphia's Violence Intervention Program (VIP) and St. Christopher's Hospital).

- **Promoting Safety (The Sanctuary Model):** The Sanctuary Model is a trauma-informed approach, designed to create organizational change. This model promotes creation of safe therapeutic communities for staff and service recipients. Emphasis is placed on tailoring services to respond to the varied impacts of trauma and establish organizational cultures where individuals and families are able to recover in safe therapeutic environments. To date, personnel from thirty-three agencies have received trauma-focused, evidence-based training.
- **Responding to Emergencies (Community Response Teams - CRT):** Community Response Teams provide emotional support to communities affected by disasters, emergencies, or other large scale events, including community violence, that require community support and intervention. Teams focus on reducing stress, supporting individuals and impacted communities, providing as needed service referral assistance, and following-up with individuals to track progress. All team members are trained in Psychological First Aid. Over the course of last year, teams responded to incidents of community violence involving shootings, fatal auto accidents; and fire fatalities including the active duty death of Firefighter Craig Lewis. Response Teams have also collaborated in city-wide, cross-systems planning and response efforts to insure that coordinated emergency supports and services are provided as needed.

Addressing Behavioral Health Disparities: DBHIDS seeks to encourage promising efforts designed to eliminate racial and ethnic health disparities and promote health equity and wellness for all people. The Office of the Surgeon General has documented nationwide disparities impacting minority groups including factors such as service access, availability, quality, and outcomes. To address these disparities, DBHIDS has implemented initiatives to enhance service access, engagement, and treatment retention. Recent efforts to reduce health disparities include the following:

- **Engaging Men of Color (EMOC):** Engaging Males Of Color (EMOC) is a project that seeks to promote an enhanced awareness of the behavioral health challenges experienced by males of color across the Philadelphia region. EMOC is focused on cultivating equity by addressing the impact of health, economic and educational disparities. The goal is to improve overall quality of life for this marginalized population. These efforts incorporate transformative approaches that emphasize recovery, resilience and self-determination. These measures are intended to result in the development of a continuum of engagement approaches. Target populations include African-American, African, Asian, and Latino men and boys who live in Philadelphia. To date, EMOC has served over 100 men and boys. In partnership with the Mural Arts program, EMOC is creating the first mural in the country dedicated to the lived experience of men and boys of color. In January of 2015, EMOC held its first Martin Luther King Day of Service project at the Juvenile Justice Services Center (JJSC), benefitting 30 youth and young men housed in that facility. Monthly workshops will be conducted at JJSC on a range of relevant topics including resilience, overcoming challenges, and making positive decisions.
- **Improving Access to Behavioral Health Outpatient Treatment:** In January 2014, two new outpatient programs were established in Southwest Philadelphia to expand behavioral health treatment access for adults and children living in historically underserved communities. A third outpatient facility opened in mid 2014 and a fourth program is projected to become operational in 2015. The fourth and final outpatient site is being developed in partnership with West African community stakeholders. These new resources were created to address long standing service access disparities in targeted areas of Southwest Philadelphia. These new, high quality treatment programs have a combined capacity to serve 400 individuals at a total annual cost of approximately \$400,000, reimbursed via Medical Assistance billing. Cost offsets are anticipated resulting from participants' decreased utilization of acute inpatient treatment and crisis services.

Embracing Health Care Reform: DBHIDS continues to partner with local, state and federal organizations to acquire, apply and disseminate Healthcare Reform information relevant to the local behavioral health system. These efforts

include monthly newsletters, bimonthly policy updates, the use of social media, and a regularly updated website. Technical support is being extended to internal staff and external partners regarding varied provisions of the Affordable Care Act. DBHIDS also tracks state Medicaid laws and their impact on behavioral health services. Monthly Lunch & Learn educational sessions will continue and an evaluation of these efforts will be conducted to ensure that stakeholder needs are being addressed.

Intellectual disAbilities Services: DBHIDS serves approximately 7,700 children and adults with intellectual disabilities annually. An additional 6,100 infants and toddlers receive Early Intervention Services each year. The Infant Toddler/Early Intervention program has a significant impact on the developmental trajectory of children from birth to age three. As a result, many of these children enter elementary school without the need for additional supports. Specific accomplishments include the following:

- **Philadelphia Infant Toddler Early Intervention:** This initiative served over 6,300 infants and toddlers in FY14; 200 more children than were served the prior year.
- **Employment:** In FY14, 500 individuals with intellectual disabilities were employed which marks a 3% increase in comparison to FY13.
- **Implementing Behavioral Health/Intellectual Disability Community Treatment:** A mobile service was established to provide intensive supports, including case management and psychotherapy, to people with co-occurring mental illness and intellectual disabilities. Special emphasis is placed upon decreasing hospitalizations and crisis visits, promoting recovery outcomes, and allowing individuals to remain in their homes and communities. The team accepted their first referral in 2014 and finished that year with 18 enrolled participants. It is anticipated that by the conclusion of FY15, the caseload will grow to 90 service recipients.

Intellectual disAbility Employment: In FY16, efforts to increase employment for individuals with intellectual disabilities will include the following:

- Working with schools to support transition planning that includes connections to employment and plans to facilitate transitions at earlier ages.
- Use of a peer support model to encourage families to pursue employment and employment supports.
- Collaboration with parents to help identify employment resources in their communities that may benefit their family members.
- Continued involvement in the Commonwealth's 'Futures Planning,' to promote county-based, employment strategies.

Improving Autism Services: DBHIDS continues to explore and provide person and family directed approaches for those impacted by Autism Spectrum Disorders (ASD). Interventions for this condition continue to evolve and emerge. Recent efforts by DBHIDS to provide additional ASD supports include the following:

- **Specialized ASD Services:** DBHIDS continues to expand the number of specialized autism treatment services provided to youth and families. In FY14, 4,952 unique youth accessed ASD services; this constitutes a 5.56% increase in comparison to FY13. Community-based treatment supports have increased and hospitalizations have decreased. The continuum of specialized ASD resources now includes Extended Assessment Services (EAS), Outpatient Therapy, Medication Management, Behavioral Health Rehabilitation Services, Blended Case Management, Summer Programs, After-School Programs, and Family Based Services. Provider agencies are also developing a range of educational and support groups.
- **Establishment of Autism Centers of Excellence (COEs):** Autism Centers of Excellence enhanced their treatment service continuum by implementing after school programming in 2014. They also provided opportunities for family training and support, including the establishment of a Parent Advisory Board. Furthermore, COEs have developed relationships with community stakeholders including academic centers, the School District of Philadelphia, parent and advocacy groups, and the Eastern Region Autism Services, Education, Resources and Training (ASERT) Collaborative (a statewide initiative funded by the Bureau of Autism Services, PA Department of Human Services). The provision of advocacy and psychoeducation trainings for families and community stakeholders is ongoing.

Leadership Development: DBHIDS remains committed to encouraging and equipping department personnel to acquire the skills and abilities needed to optimize productivity and advance careers. The Leadership Development

Program serves as a cornerstone of these efforts. This initiative prepares leaders and those aspiring to positions of leadership to grasp organizational challenges, embrace professional development opportunities, and implement DBHIDS' transformational vision. The Leadership Development Program is based on evidence-based research that employs comprehensive instruction, personality assessments (Myers Briggs), shadowing of senior staff and action learning projects that encourage innovation, teambuilding, and skill application. As of June 2015, 449 DBHIDS employees will have graduated from this training, including 214 supervisors/managers and 235 front line staff.

Peer Specialists: The infusion of Peer Specialists into multiple levels of care across the local, behavioral health network has served as a cornerstone for system transformation. Since the inception of the Certified Peer Specialist (CPS) program in 2006, over 700 Peer Specialists have been trained and certified in Philadelphia. In FY16, DBHIDS will continue to increase peer staff opportunities across the provider network with an emphasis upon impacting specialized populations (forensic, youth, veterans, LGBTQIA communities, etc.). Consistent with these efforts, DBHIDS is restructuring the Certified Peer Specialist training to promote better employment outcomes for these individuals and provide enhanced, ongoing support of peer staff. In FY12, DBHIDS introduced the Philadelphia Warmline, staffed by Peer Specialists, as a resource for citizens who are experiencing anxiety, depression, loss, relationship difficulties, or other life challenges. From November 1, 2013 through November 30, 2014, Peer Specialists staffing the Warmline received 812 calls.

Homelessness: DBHIDS has introduced best practices and evidence-based, data-driven strategies to better serve people confronted with behavioral health challenges who are experiencing homelessness. Partnerships with the Office of Supportive Housing, the Philadelphia Housing Authority, and other organizations have greatly expanded housing and supports, including Medical Assistance funded services, for this highly vulnerable population. More than 2,000 homeless individuals and 1,200 homeless families have benefited to date. This work has garnered praise as a national model and prompted visits from across the country.

Permanent Supported Housing (PSH): Permanent Supported Housing combines DBHIDS behavioral health services, including case management, with approximately 700 rental subsidies provided by affordable housing funding sources including the Philadelphia Housing Authority. This project is intended to promote recovery and independence via a blend of flexible supports provided to people with significant behavioral health needs who are living in stable, subsidized housing arrangements. It has been determined that participants used far less inpatient and other acute care services one year post PSH placement, in comparison to one year before entering this program. Acute care savings were estimated to total \$6.6 million across the entire population of PSH residents over a three year period.

Partnership with the School District of Philadelphia: DBHIDS continues its longstanding, strong partnership with the School District of Philadelphia to make schools safer and healthier learning environments. The investment in school-based, behavioral health services is unparalleled across the nation and specifically designed to support at-risk students before they need help. These efforts include School Therapeutic Services where clinicians are deployed to provide mental health supports for students, guided by treatment plans developed in collaboration with teachers, students, parents, and other care givers. In the FY14 academic school year, more than 37,000 students received drug and alcohol prevention services. Addiction prevention services are expected to reach 38,000 students in FY15 and 39,000 students in FY16. The goal for other school-based, behavioral health services is to maintain existing levels of support and endeavor to address emerging needs as they become evident. Efforts are currently underway to apply for a Federal System of Care cooperative agreement to expand the provision of behavioral health services to children, youth and families.

Acquisition and Application of External Resources: DBHIDS continues to explore opportunities to pursue additional funding and resources including government and foundation grants. Recent successes include the following grant awards:

- **Comprehensive Assessment for Placement and Services for the First Judicial District Mental Health Court (FJDMHC):** This federal grant funded project began in October 2014 and is scheduled to conclude in September 2016. The project seeks to improve the FJDMHC's response to justice-involved persons with severe mental illnesses in order to decrease criminal recidivism and improve behavioral-health functioning and recovery among court participants. DBHIDS plans to evaluate current FJDMHC practices and facilitate the

implementation of a more evidenced-based protocol that includes: (1) screening/assessment of both criminogenic and behavioral health risk/needs; (2) enhanced interventions that target criminogenic risk/needs and behavioral challenges; and (3) linkages to recovery-fostering supports.

- Access to Recovery Program Accomplishments: The Access to Recovery (ATR) Program was an \$11 million, four-year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). This grant provided uninsured or underinsured adults struggling with alcohol or drug challenges with an array of options and choices to obtain clinical and enhanced recovery support services. Over the course of 4 years, concluding in December 2014, this project served 11,648 people, surpassing the goal of 10,705. The ATR initiative succeeded in reducing levels of homelessness among this population by 63.1% and increasing substance use abstinence by 30%. Additionally, 30.9% of participants achieved their personal goals related to education or employment.

STAFFING

Staff Demographics (as of January 23, 2015)

Full-Time Staff			Executive Staff		
	Male	Female		Male	Female
	African-American	African-American		African-American	African-American
Total	32	136	Total	3	2
% of Total	13.0%	56.0%	% of Total	37.0%	25.0%
	White	White		White	White
Total	25	32	Total	2	1
% of Total	10.0%	13.0%	% of Total	25.0%	12.0%
	Hispanic	Hispanic		Hispanic	Hispanic
Total	5	5	Total	0	0
% of Total	2.0%	2.0%	% of Total	0.0%	0.0%
	Asian	Asian		Asian	Asian
Total	2	3	Total	0	0
% of Total	1.0%	1.0%	% of Total	0.0%	0.0%
	Other	Other		Other	Other
Total	1	2	Total	0	0
% of Total	1.0%	1.0%	% of Total	0.0%	0.0%
	Bi-lingual	Bi-lingual		Bi-lingual	Bi-lingual
Total	5	5	Total	0	0
% of Total	2.0%	2.0%	% of Total	0.0%	0.0%
	Male	Female		Male	Female
Total	65	178	Total	5	3
% of Total	27.0%	73.0%	% of Total	62.0%	38.0%

FY15 New Hires		
	Men	Women
Black	2	10
White	1	1
Hispanic	1	0
Asian	0	0
Other	0	0
Total	4	11

Two of the new hires are bilingual. The languages spoken are Spanish and Russian.

CONTRACTING

Philadelphia 21st Century Minimum Wage and Benefits Standards: DBHIDS contracts with over seventy agencies to provide a range of behavioral health services for children and adults across the City. Originally, fifteen contractors submitted requests for wage and/or benefit waivers pertaining to the new Standards. In dialogue with DBHIDS, twelve of the fifteen contractors subsequently achieved compliance and withdrew their waiver petitions. Ultimately, only three contractors pursued and were granted waivers based on rationales that included collective bargaining or training considerations. DBHIDS will continue to encourage and promote universal compliance with the new standards across our contract service network.

Minority/Women/Disability Provider Participation: Participation by minority and women in both leadership positions and workforce composition among DBHIDS non-profit contract service providers remains high. Specifically, 91.1% of the total workforce and 72.2% of executive staff of non-profit contract agencies are comprised of minority or female employees. It should also be noted that the number of contract providers with formal plans to promote diversity increased from 50% in FY13 to 65.8% in FY14.

M/W/DBE Participation on Large Contracts FY15 For Profit Contracts

Vendor	Service Provided	Amount of Contract	RFP Issue Date	Contract Start Date	Ranges in RFP	% of M/W/DBE Participation Achieved	\$ Value of M/W/DBE Participation	Total % and \$ Value Participation - All	Living Wage Compliant ?
Kids & Family	IDS/EI	\$1,325,000	4/18/14	7/1/15	MBE: 0-0%	0%	\$0	0%	Yes
					WBE: 0-0%	0%	\$0		
					DSBE: 0-0%	0%	\$0		
Goldstar Rehabilitation	IDS/EI	\$1,748,000	4/18/14	7/1/15	MBE: 20-35%	0%	\$0	0%	Yes
					WBE: 20-35%	0%	\$0		
					DSBE: 0-0%	0%	\$0		
Sunshine Therapy Club (1)	IDS/EI	\$1,208,000	4/18/14	7/1/15	MBE: 0-0%	0%	\$0	0%	Yes
					WBE: 0-0%	0%	\$0		
					DSBE: 0-0%	0%	\$0		
Sunny Days (1)	IDS/EI	\$736,000	4/18/14	7/1/15	MBE: 0-0%	0%	\$0	0%	Yes
					WBE: 0-0%	0%	\$0		
					DSBE: 0-0%	0%	\$0		
Resilient Business Solutions	Database/System Administration	\$610,000	TBD	7/1/15	MBE: 10-15%	0%	\$0	100%	Yes
					WBE: 10-15%	100%	\$610,000		
					DSBE: 0-0%	0%	\$0		

(1) Woman-owned noncertified provider

M/W/DBE Participation on Large Contracts FY15 Non Profit Contracts

Vendor	Service Provided	Amount of Contract	RFP Issue Date	Contract Start Date	Ranges in RFP	% of M/W/DBE Participation Achieved	\$ Value of M/W/DBE Participation	Total % and \$ Value Participation - All	Living Wage Compliant?
Resources for Human Development	Mental Health	\$17,623,028	N/A	7/1/15	MBE:	0%	\$0	0%	Yes
					WBE:	0%	\$0		
					DSBE:	0%	\$0		
NHS Philadelphia	Mental Health	\$11,862,179	N/A	7/1/15	MBE:	0%	\$0	0%	Yes
					WBE:	0%	\$0		
					DSBE:	0%	\$0		
Horizon House	Mental Health	\$6,050,355	N/A	7/1/15	MBE:	0%	\$0	0%	Yes
					WBE:	0%	\$0		
					DSBE:	0%	\$0		
Mental Health Association of Southeastern PA	Mental Health	\$6,404,036	N/A	7/1/15	MBE:	0%	\$0	0%	Yes
					WBE:	0%	\$0		
					DSBE:	0%	\$0		
COMHAR	Mental Health	\$4,736,002	N/A	7/1/15	MBE:	0%	\$0	0%	Yes
					WBE:	0%	\$0		
					DSBE:	0%	\$0		

Resources for Human Development:	Minority or Female	NHS Philadelphia:	Minority or Female
Workforce	84.50%	Workforce	93.20%
Executive	44.40%	Executive	61.00%
Board	60.00%	Board	17.30%
Citizens Acting Together Can Help:		Mental Health Assoc of Southeastern PA:	
Workforce	74.00%	Workforce	73.00%
Executive	65.00%	Executive	46.70%
Board	52.00%	Board	75.50%

OTHER BUDGETARY IMPACTS

FEDERAL AND STATE (WHERE APPLICABLE)

See the aforementioned detail in DBHIDS Challenges section (1st and 3rd paragraphs).

OTHER

Not applicable.

**DEPARTMENT OF PUBLIC HEALTH
FISCAL YEAR 2016 BUDGET TESTIMONY
APRIL 29, 2015**

EXECUTIVE SUMMARY

DEPARTMENT MISSION AND FUNCTION

Mission: To protect and promote the health of all Philadelphians and to provide a safety net for the most vulnerable.

Description of Major Services: The Philadelphia Department of Public Health (PDPH) is comprised of thirteen divisions that provide the infrastructure and programming for disease prevention, food safety, environmental health and health care services. PDPH also works with a broad network of community, hospital, academic and business partners throughout Philadelphia and the Delaware Valley to make Philadelphia a healthier place to live, work and play.

PROPOSED BUDGET HIGHLIGHTS/FUNDING REQUEST

Budget Highlights: The FY16 Proposed Budget for PDPH is on par with the FY15 Current Projection.

	Class	FY14 Actual	FY15 Current Projection	FY16 Proposed Budget	FY16-FY15 Change	FY16-FY15 Percent Change
General	100	43,438,286	50,107,392	50,298,254	190,862	0.4%
	200	60,457,774	60,113,510	59,953,424	(160,086)	-0.3%
	300/400	5,413,266	5,490,768	5,490,768	0	0.0%
	800	500,000	500,000	500,000	0	0.0%
	Total	109,809,327	116,211,670	116,242,446	30,776	0.0%
	Positions	659	762	781	0	0.0%
Other*	100	15,840,284	18,065,976	20,416,740	2,350,764	13.0%
	200	206,966,479	214,318,437	212,394,523	(1,923,914)	-0.9%
	300/400	2,233,976	1,670,779	1,782,279	111,500	6.7%
	800	1,628,948	2,220,355	2,865,555	645,200	29.1%
	Total	226,669,687	236,275,547	237,459,097	1,183,550	0.5%
	Positions	169	231	231	0	0.0%
All	100	59,278,570	68,173,368	70,714,994	2,541,626	3.7%
	200	267,424,254	274,431,947	272,347,947	(2,084,000)	-0.8%
	300/400	7,647,242	7,161,547	7,273,047	111,500	1.6%
	800	2,128,948	2,720,355	3,365,555	645,200	23.7%
	Total	336,479,014	352,487,217	353,701,543	1,214,326	0.3%
	Positions	828	993	993	0	0.0%

* Other Funds includes: County Liquid Fuels Tax Fund, Special Gasoline Tax Fund, Healthchoices Behavioral Health Fund, Hotel Room Rental Tax Fund, Grants Revenue Fund, Community Development Fund, Car Rental Tax Fund, Housing Trust Fund, Water Fund, Water Residual Fund, Aviation Fund, and Acute Care Hospital Assessment Fund.

Staff Demographics Summary (as of December 2014)

	Total	Minority	White	Female
Full-Time Staff	830	608	222	584
Executive Staff	23	10	13	13
Average Salary - Executive Staff	\$135,520	\$123,302	\$133,816	\$124,221
Median Salary - Executive Staff	\$107,693	\$107,587	\$107,693	\$102,477

Employment Levels (as of December 2014)

	Budgeted	Filled
Full-Time Positions	992	830
Part-Time Positions	83	49
Executive Positions	25	23

Contracts Summary (*as of December 2014)

	FY10	FY11	FY12	FY13	FY14	FY15*
Total amount of contracts	\$10,910,304	\$20,721,079	\$6,205,317	\$6,258,257	\$6,098,748	\$6,221,700
Total amount to M/W/DBE	\$100,471	\$10,983,826	\$929,425	\$1,334,834	\$2,392,181	\$2,192,162
Participation Rate	1%	53%	15%	21%	39%	35%

PERFORMANCE, CHALLENGES AND INITIATIVES

DEPARTMENT PERFORMANCE (OPERATIONS)

Uninsured clinic visits: In FY14, the percentage of uninsured visits at the City's health centers was 49.6%, slightly lower than the 52.9% reported in FY13. There was a corresponding small increase in the percent of visits covered by Medicaid and private insurance. Patients without insurance are seen by a benefits counselor to review medical insurance options, and those counselors process applications to increase the number of insured individuals visiting the City's health centers. In recent years and continuing into the first two quarters of FY15, the percentage of uninsured patient visits has been relatively stable at approximately 50%. This indicates that the initial implementation of the Affordable Care Act implementation in Pennsylvania, which expanded access to private insurance coverage under the Federal exchange program, had a minimal impact on levels of insurance coverage among PDPH patients and that potential impacts of Medicaid expansion, which went into effect in January 2015, are yet to be seen.

Restaurant inspections: PDPH aims to inspect Risk Category 1 food establishments (establishments that prepare food and serve it for immediate consumption) at intervals of 12 months and has focused efforts to reduce this interval from a high of 17.6 months in 2011 to 14.6 in FY14. In prior years, the long hiring cycle for sanitarians contributed to long-term vacancies and difficulty in meeting the interval goal for inspections. New approaches to hiring have recently reduced the number of sanitarian vacancies and the length that those vacancies are open, decreasing the time to fill sanitarian positions from 245 days in 2011 to 180 days as of the second quarter of FY15.

HIV infections: The number of case reports of newly diagnosed HIV infections dropped by 16.9% (119 fewer cases) from FY13 to FY14. The 585 cases reported in FY14 remain well below FY08 levels of 1,438, reflecting progress in preventing new HIV infections during this period. During the first half of FY15, there were 327 cases, a 3.8% increase over the same time period in FY14 which is believed to be related to fluctuations in staffing and improvements in the timeliness of reporting rather than a true increase in cases.

Medical Examiner's Office: Since FY12, the Medical Examiner's Office has focused on increasing the percentage of final reports for homicides that are completed within 60 days, both to improve its service and to comply with standards set by the National Association of Medical Examiners. In FY14, 96.5% of all homicide autopsy reports were completed within the 60 day period. This percentage dropped in the first half of FY15 due to physician vacancies in the Pathology Unit. Recruiting efforts and increased pay rates helped address this issue and new staff will start in the fourth quarter of FY15 and the first quarter of FY16.

Immunizations: The percent of children 19-35 months of age with complete immunizations was 78%. 4% higher in FY14 compared to FY13. During the first half of FY15, 85% of children had complete immunizations, a 9% increase over the same time period in FY14. For measles vaccine, 95.9% of children 19-35 months of age have received one or more doses, which is higher than both the state and national levels.

Performance Measure	FY08	FY13	FY14	FY14- FY13 Change	FY14 Q1- Q2	FY15 Q1- Q2	FY15- FY14 Q1-Q2 Change	FY15 Goal	FY16 Goal
Percentage of visits uninsured	52.1%	52.9%	49.6%	-6.2%	54.0%	51.7%	-4.4%	50.0%	48.0%
Inspection interval for category 1 food establishments (months)	N/A	17.2	14.6	-15.4%	11.9	13.5	13.5%	13.0	12.0
Total number of newly diagnosed HIV case reports	1,438	704	585	-16.9%	315	327	3.8%	600	600
Homicides having final autopsy report completed within 60 days	80.0%	95.0%	96.5%	1.6%	97.5%	90.5%	-7.2%	95.0%	95.0%
Children 19-35 months with complete immunizations 4:3:1:3:1	N/A	75.0%	78.0%	4.0%	78.0%	85.0%	9.0%	78.0%	87.0%

DEPARTMENT CHALLENGES

- **Hiring:** PDPH faces multiple challenges in filling vacant positions in a timely manner. This reflects the spectrum of capacities PDPH requires, including multiple technical specialties, a competitive hiring marketplace, dependence on federal grants, the large number of highly experienced staff retiring under the DROP program, and the length of time required to navigate internal hiring procedures. PDPH's goal is to fill positions as quickly as possible. To this end, PDPH continues to review and improve the department's hiring procedures in consultation and collaboration with OHR, promote succession planning in all divisions, and conduct various recruiting activities. In addition, as part of the work towards achieving public health accreditation, in FY14 PDPH developed a new workforce development plan. The reduction in time to fill vacant sanitarian positions and improve the competitiveness of pathologists salaries are examples of the results of these efforts.
- **Rapid evolution of health information technologies:** Advances in health information technologies present tremendous opportunities and challenges for the field of public health, in general, and for PDPH. More timely, complete, and accurate data about the health of clinic patients and, more broadly, the population of Philadelphia, will enable PDPH to improve services and programs. But, to take full advantage of this opportunity will require ongoing enhancements to PDPH's information technology infrastructure, the capacity to manage and make effective use of data in rapidly developing information technology environments, and a data-savvy workforce.
- **Health Center Appointment Availability:** As of March, 2015, all eight health centers had new and return pediatric appointments available within one month. More than half of the health centers have appointments for adult care within two months of request, and almost all have appointment availability within three months. These wait times are, on average slightly longer than wait times a year ago, and reflect reduced access due to implementation of the Electronic Health Record (EHR). This includes expected slow-downs required for physician, nursing, and clerical/administrative staff training, acclimation to new work procedures, and time needed to transfer paper records into the EHR. New adult patient appointment availability at Health Center 10 has the longest wait time, which currently averages around five months. The long wait for an adult appointment is attributed to the scarcity of other health care options in Northeast Philadelphia. As clinic staff becomes increasingly familiar with the use of the EHR, PDPH anticipates that the EHR will lead to improvements in efficiency.

ACCOMPLISHMENTS & INITIATIVES

Ebola Response: In the summer of 2014, PDPH, as the lead department responsible for the ongoing prevention and control of communicable diseases within the County, began enhancing Ebola readiness by updating preparedness plans, issuing health guidance to providers and the community, and coordinating with City agencies, hospital emergency directors, infection control specialists, the federal Centers for Disease Control & Prevention (CDC), the Pennsylvania State Health Department and other response partners. The Department also worked with the West African community in Philadelphia to educate, support, and meet the needs of newly-arriving persons.

In October 2014, at the request of the CDC, PDPH began daily monitoring of all persons newly arrived to Philadelphia from one of the affected West African countries for signs and symptoms of possible Ebola Viral Disease. Between October 2014 and March 2015, PDPH followed 453 individuals. This represents approximately 5% of the total arriving in the US. PDPH has been in daily contact with each of these individuals for 21 days following their departure from an affected country, including weekends and holidays. Each visit or phone contact involved collecting the person's temperature and a review of their health status to assure that they remained well. Nine patients required more intensive investigation, including physician evaluation and diagnostic testing, and all nine persons were determined to have other reasons for their illness; none were found to have Ebola Viral Disease. While media attention has waned, the outbreak is not over and PDPH will continue to monitor the situation.

Chronic Disease Prevention & the Decline in Smoking and Obesity Rates in Philadelphia: Smoking and obesity are the largest contributors to preventable illness and premature death in the United States. Through the *Get Healthy Philly* initiative, funded through City general funds and state and federal grants, PDPH has spearheaded an innovative citywide effort to address tobacco use, poor diet, and physical inactivity in partnership with other City agencies and non-governmental organizations. Interventions have focused on making the healthy choice the easier choice in schools, workplaces, communities, and health care settings.

Because of *Get Healthy Philly* and other initiatives at the local, state, and federal levels, smoking in Philadelphia has declined by 30% among youth since 2007 and by 15% among adults since 2008. In addition, childhood obesity rates have decreased by 6.3% since the 2006-07 school year, including substantial reductions among racial/ethnic minorities. *Get Healthy Philly* has been recognized by national and international media outlets and public health organizations as a model for how local governments can improve the health of their communities. Key *Get Healthy Philly* interventions have included:

- Creating food and fitness standards for all City-funded afterschool programs;
- Developing the largest healthy corner store network in the U.S.;
- Implementing a mass media campaign highlighting the links between sugary drink consumption, obesity, and diabetes in children;
- Extending smoke-free rules to all City parks, recreation centers, and playgrounds;
- Launching multiple rounds of hard-hitting media campaigns to encourage tobacco cessation; and
- Supporting the passage of laws to prevent tobacco sales to minors, limit sales and use of e-cigarettes, and increase the price of conventional cigarettes by \$2.00 per pack.

In 2015, *Get Healthy Philly* will assist college and universities, public housing communities, and behavioral health facilities to implement smoke-free policies. This will protect students, residents, and patients from secondhand smoke exposure, reduce asthma exacerbations and the risk of fire, and motivate more Philadelphians to quit smoking.

In 2015, *Get Healthy Philly* will launch the first-ever local media campaign to encourage physical activity by highlighting real Philadelphians exercising in free and low-cost ways. The campaign will be titled—“Make Philly Your Gym!” and will be supported through federal funds from the CDC.

Lastly, *Get Healthy Philly* will further its partnerships with hospitals and clinical providers to improve the quality of care for Philadelphia adults affected with hypertension (38%) and diabetes (16%). Through a four-year \$11.2 million grant from the Center for Disease Control, PDPH will work with 40 primary care practices that serve 350,000 patients to implement a series of quality-of-care improvement initiatives, including optimal use of electronic health records, team-based chronic disease management, aggressive identification of undiagnosed patients, home-based blood pressure monitoring, and better linkages between clinical practices and community resources.

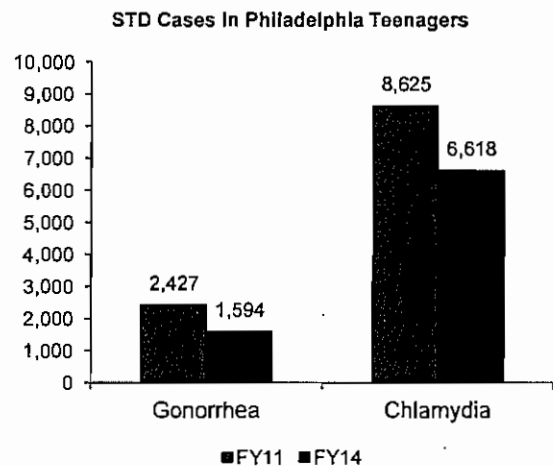
Electronic Health Records: As of March 2015, PDPH completed the installation of the practice management and medical record components of an Electronic Health Record (EHR) at all eight neighborhood health centers operated by PDPH. While the transition to the use of an EHR has resulted in temporary slow-downs in service as noted above, the use of EHR will improve clinical outcomes for patients, improve integration of health services across the City's clinics, provide a knowledge base for public health policy, and improve reporting to disease and immunization monitoring systems. Adoption of the EHR will bring PDPH into compliance with federal Medicaid and Medicare requirements. EHR program management staff is also working with the Department's Division of Disease Control to streamline and automate various functions supporting care services at the sexually transmitted diseases and tuberculosis clinics and to upgrade disease monitoring activities in accordance with national standards. The next phase of development will include implementation of service utilities, including connections to the Public Health Laboratory, development of required data-analysis utilities for performance management and quality improvement monitoring, creation of an online patient portal, and development of capacities to exchange information with area providers who provide referral, inpatient, or emergency department services for PDPH patients. The project was funded largely through hospital tax funds with supplementary grants.

Improvements in Primary Care Services: Progress continues on the joint venture between the City and the Children's Hospital of Philadelphia (CHOP) to provide health care to South Philadelphia adults and children in a unique arrangement that will allow the City to expand its provision of dental care, mammography, prenatal care and a wide range of other children's and adult health care services. The venture relocates two existing clinics: one, a pediatric primary care practice in South Philadelphia owned by CHOP, and, the other, PDPH Health Center 2. The new facility, being constructed by CHOP, will co-locate the two clinics, a City recreation center, and the South Philadelphia branch of the Free Library. The new multi-function center will allow the City and CHOP to create a complex that offers clinical care, wellness, prevention, and literacy services to improve health outcomes for children and adults. Under the

agreement, CHOP and other philanthropic sources will fully fund the construction of the complex (estimated at \$42 million), and the City will charge CHOP a nominal fee to lease the land. Outfitting City facilities (health center, library, recreation center) will be funded by the City, CHOP, and other philanthropic sources, with the City contribution consisting of \$1.8 million in the FY16 capital budget and \$2 million already budgeted in the capital budget from FY13 and FY14. CHOP and City officials hosted a ceremonial groundbreaking in September 2014. The City hopes to open the health center, library and recreation center by February 2016.

Additionally, renovation plans are underway to reconfigure space at Health Center 10 to increase capacity. The renovations include adding four additional examination rooms and an elevator to the facility, as well as replacement of windows. These renovations are expected to start later this year.

Reduced Rate of Adolescent Sexually Transmitted Diseases (STDs): In response to rising rates of STDs among adolescents in Philadelphia, in 2011, the PDPH launched a teen sexual health campaign. As a part of this campaign, PDPH promoted a custom-labeled Philadelphia condom (The Freedom Condom); expanded the number, location, and type of venues providing free condoms to teens; implemented a mail-order program for condoms; promoted condom use and access through public high schools; and developed a social media presence for the campaign. As a result of the multi-faceted adolescent STD prevention campaign, the epidemic of teen STDs in Philadelphia has waned. Cases of Chlamydia in teens, which had been steadily increasing since 2007, declined 23% from FY11 to FY14 (8,625 cases in FY11 declined to 6,618 cases in FY2014). Gonorrhea, which had shown a 52% increase in adolescent case counts from 2009 to 2011, declined by 34% among teens from FY11 to FY14 (2,427 cases in FY11 declined to 1,594 cases in FY14).



HIV Prevention and Services: Expansion of Testing, Partner Notification, Pre-Exposure Prophylaxis and Linkage to Care:

Research suggests that people infected with HIV who are unaware of their status contribute disproportionately to ongoing HIV transmission in the community. When people learn they are infected, they take steps to protect their own health and prevent HIV transmission to others. The sooner an infected individual is diagnosed and linked to care, the more quickly levels of HIV virus can be reduced through medication, decreasing the likelihood of subsequent transmission. As the national HIV/AIDS strategy has focused on ensuring high-risk individuals are tested and if HIV positive, linked to medical care, so has the work of the AIDS Activities Coordinating Office (AACO).

- **HIV Testing:** Since being designated one of 25 jurisdictions that received CDC funding for expanding HIV testing in 2007, AACO has implemented HIV testing programs in major hospital emergency departments, collaborated with the Philadelphia Prisons System to implement HIV testing of inmates at intake, and worked closely with community partner organizations to target community-based HIV testing among populations most at risk. Significant investment is also being made to encourage routine HIV testing in all clinical care settings. In calendar year 2008, AACO provided 62,295 HIV tests through its network of funded testing sites; the number of tests has nearly doubled to 115,852 in calendar year 2014 and is expected to meet or exceed that number in 2015.
- **Partner Notification:** The goal of partner services is to notify confidentially persons regarding their possible exposure to infection(s) so that they may access testing and treatment. For FY16, PDPH aims to identify 40 new cases of HIV infection through partner notification services and to link 90% of those to medical care.
- **Pre-Exposure Prophylaxis (PrEP):** is a new tool for HIV prevention. PrEP is an antiretroviral medication, which if taken daily, significantly reduces HIV infection among adult men and women who are at risk through sex or injection drug use. AACO is coordinating outreach and education to increase the number of medical care providers who prescribe PrEP and raise community and provider awareness. AACO will also be evaluating PrEP implementation. With funding from the CDC Foundation and Gilead Sciences, PDPH is currently conducting a PrEP implementation study at the Strawberry Mansion Health Center where 50 patients are currently enrolled, of whom about half are men who have had sex with men. Although any person who is a candidate for PrEP may join the study, the goal is to enroll 300 women and heterosexual men.

- **Retention in Care:** Philadelphia is one of three jurisdictions to receive funding from the CDC to demonstrate a cost-effective model for improving retention in HIV medical care for persons who have fallen out of care. This project, Philadelphia Cooperative Agreement Re-Engagement Controlled Trial (CoRECT) is expected to be funded at \$2.3 million over the 5-year project period. CoRECT is a collaboration between two PDPH divisions- AACO and the Division of Disease Control (DDC) - and will work with six HIV clinics in the City of Philadelphia, which include Ryan White-funded, private, Federally Qualified Health Center, and Veterans Administration facilities. CoRECT will evaluate whether patients who are enrolled in the active intervention arm are more likely to achieve viral load suppression within 12 months of the study compared with those receiving usual services. CoRECT is in a first year planning phase and will scale up in the second and third years.
- **HIV/STD Prevention in African American Men Who Have Sex With Men:** Based on the success of the *Take Control Philly* campaign in educating adolescents about STDs, PDPH plans to launch *Do You Philly*, a campaign for African American young men who have sex with men (YMSM) who are at increased risk of HIV/STDs. *Do You Philly* will provide resources to reduce sexual risk taking, decrease barriers to testing, combat stigma surrounding LGBT issues, and empower these young men to make healthy decisions. A major component of the *Do You Philly* program will be its website, which will include education about HIV/STDs, screening, and treatment and prevention. It will include information on pre-exposure prophylaxis (PrEP), non-occupational post-exposure prophylaxis (nPEP) and where to access free condoms. A condom mailing program and at-home testing for HIV, gonorrhea, and Chlamydia will also be offered through the website.

Achieved High Adolescent Vaccination Coverage Rates: Philadelphia's rate of vaccination coverage for adolescents has steadily increased since 2008. The CDC has presented the PDPH with the Adolescent Vaccination Coverage Award annually since inception of the award. By 2013, Philadelphia had exceeded targets established by Healthy People 2020 (national standards from the U.S. Department of Health & Human Services) by achieving immunization rates of 89% for adolescent vaccination with Tdap (tetanus-diphtheria-acellular pertussis), 95% for Varicella (chickenpox), and 91% for MenACWY (meningococcal disease) among 13-15 year olds. In addition, Philadelphia vaccination coverage with Human Papillomavirus (HPV) is one of the highest in the nation with more than three-quarters of girls 13-15 years of age having initiated the HPV vaccination series in Philadelphia, and nearly one-half having received all three doses of the series. For boys, more than 70% have received at least one dose of HPV vaccine, while 37% have completed the series.

Reduced Health and Safety Hazards in Homes of Children with Asthma: The PDPH *Healthy Homes Healthy Kids (HHHK)* Program provides comprehensive services to prevent and correct significant health and safety hazards in homes of children with difficult to control asthma who are patients at St. Christopher's Hospital for Children in Philadelphia. These children have frequent emergency room visits and hospitalizations, with attendant high medical costs, along with significant numbers of missed school days that hinder their academic progress.

The program takes a comprehensive approach that involves removing asthma triggers in the home and helping caregivers and family members adopt healthier behaviors and improve medication adherence in collaboration with their medical providers. The results have been extremely encouraging: in the first two years of the program, the 117 enrolled children reported having fewer hospitalizations, emergency room visits, and office visits, and missed school days after the HHHK interventions. The average cost per household is \$3500. In January, 2015 we expanded the program to serve asthmatic children receiving clinical care in two of the city's ambulatory health centers.

Public Health Accreditation: PDPH has been working to obtain Public Health Accreditation by 2015. Accreditation is a new national process by which local, tribal and state public health agencies assess and document their ability to provide public health services. The Public Health Accreditation Board (PHAB), an independent non-governmental agency, has developed a set of 300+ standards within ten broad categories of "essential public health functions" to serve as benchmarks for accreditation. While public health accreditation is not currently required, federal agencies, such as the CDC, will likely require accreditation within the next five years as a condition of grant awards. This will be critical for PDPH because many of its programs are made possible by grants from CDC other federal agencies.

Over the last several years, PDPH has taken a series of steps towards accreditation, including developing a citywide Community Health Assessment,¹ a department-wide five-year Strategic Plan,² and a stakeholder-driven Community

¹Community Health Assessment (http://www.phila.gov/health/pdfs/CHA%20slides_52114_revised.pdf)

Health Improvement Plan.³ These documents provide a roadmap for how governmental and non-governmental organizations will address the most pressing public health challenges of the future. PDPH submitted its final accreditation application in January 2015, is scheduled for an accreditation site visit in July 2015, and anticipates achieving accreditation by fall 2015.

Air Quality Improvements: Pending final EPA certification, Philadelphia County currently meets the National Ambient Air Quality Standards (NAAQS) set by the Environmental Protection Agency (EPA) for the most critical pollutants which affect health, with the exception of the ozone air standard.

The EPA has chosen Philadelphia as one of five recipients in the country for the Village Green Air Monitoring Station Grant award. The Village Green Air Monitoring Station is a low-cost, solar-powered modular air monitor, which will help educate Philadelphians about the impact of street-level air pollution on health. The station measures small particulate matter (PM_{2.5}) and ozone, as well as local wind speed, wind direction, temperature, and humidity, while operating on solar and wind power. It was installed on the sidewalk near Independence Mall on March 5, 2015 and formally dedicated on April 21, 2015.

Safer and More Efficient Food Standards: PDPH's Environmental Health Services (EHS) continues its efforts to become more business friendly by streamlining its business processes and standardizing practices. All of EHS's services fees are now available for payment online. Through E-pay, a payment service which allows businesses and individuals to pay departmental fees online, EHS is able to significantly reduce processing time needed for payments, which results in faster service. In addition, the division, working jointly with the Department of Licenses and inspections, has completed three manuals to help new food businesses comply with rules and regulations: Opening a Stationary Food Business; Opening a Mobile Food Business and Farmers Market Sponsor's Operating Guide.

EHS also implemented an Enhanced Uniformity training program in order to ensure that food establishment inspections are conducted in a consistent manner. The Enhance Uniformity training will increase accuracy and uniformity in inspection results; enhance food safety by ensuring sanitarians do not miss risk factor violations; improve the Department's credibility with the food businesses it regulates; reduce violations; and improve compliance at food establishments.

Measles: While much of the country has been experiencing an outbreak of measles related to a California theme park, Philadelphia has managed to remain measles-free. This is a testament to the high childhood immunization rates that are maintained among our City's children. Measles vaccination rates, measured as a single dose of MMR vaccine for children 19-35 months of age, is 95.9%, surpassing levels in the rest of Pennsylvania (92.8%) and the nation (91.9%). Receipt of the recommended two doses of MMR is 87% at the time of Kindergarten entry, and 96% at time of 7th grade entry.

Philadelphia Nursing Home: For the period of November 2014 through February 2015, The Centers for Medicare & Medicaid Services (CMS) designated the Philadelphia Nursing Home as a Five-Star Quality facility—the highest rating. CMS created the Five-Star Quality Rating System to provide consumers, their families, and caregivers with an easy way to understand nursing home quality and make meaningful distinctions between high and low performing nursing homes. The rating system features an Overall Quality Rating of one to five stars based on facility performance for three types of measures: findings from health inspections, staffing, and quality measures.

Healthier Families: In September 2014, the Health Resources Services Administration (HRSA) awarded PDPH's Maternal, Child and Family Health (MCFH) division a Level 3 Healthy Start award which is granted to selected jurisdictions to provide program services locally, as well as Healthy Start leadership and mentoring at regional level. The focus of Healthy Start is to reduce disparities in infant mortality. In 2012, the overall infant mortality rate in Philadelphia was 10.1 per 1,000 live births. For white non-Hispanic women the rate was 4.9 and for black, non-Hispanic women the rate was 15.6. Since 2007, the infant mortality rate has ranged from a high of 11.4 to a low of 9.3 in 2011. Though we are making progress in Philadelphia, the racial disparities in infant mortality are unacceptable.

²Health Department Strategic Plan (http://www.phila.gov/health/pdfs/PDPH5StrategicPlan_52114_final.pdf)

³Community Health Improvement Plan (http://www.phila.gov/health/pdfs/PhilaCommunityHealthImpPlan_52814_final.pdf)

The PDPH Healthy Start program is working to reduce disparities in infant mortality by improving women's health before, during and after pregnancy; and, strengthening family resilience by addressing the effects of early trauma that result in significant health disparities. The PDPH Healthy Start program will provide services to 1,000 pregnant women, new mothers and their infants annually for five years, in the target community of West and Lower North Philadelphia. To further strengthen family resilience, PDPH Healthy Start is developing the Healthy Start Father Initiative with a designated Men's Support Services Coordinator who will support fathers and partners of PDPH Healthy Start program participants. In addition, the PDPH Healthy Start will use its two decades of experience and expertise to further improve the capacity of providers citywide to care for women suffering from perinatal depression through the Philadelphia Perinatal Depression Institute.

STAFFING

The budget will support 781 full-time positions in the General Fund, 185 in the Grants Fund, and 17 in the Acute Care Hospital Assessment Fund. As of December 2014, 241 full or part time employees are bilingual or trilingual with fluency in 50 languages, ranging from Spanish (the most common) to Swahili to Gujarati.

The department's workforce is 732% minority (56.8% African American; 4.1% Hispanic; 9.1% Asian; and 3.2% Other race/ethnicity) and 70.4% female. Executive staff is 41.7% minority (20.7% African American and 20.7% Asian) and 56.5% female. Staff hired from 7/1/14 through 12/15/14 are 72.54 minority (47.0% African American; 7.8% Hispanic; 15.6% Asian; and 2.0% Other ethnicity) and 60.8% female. Of these new hires, 31.3% speak 10 different languages.

Staff Demographics (as of December 2014)

<i>Full-Time Staff</i>				<i>Executive Staff</i>			
		Male	Female			Male	Female
<i>Total</i>	African-American	99	373	<i>Total</i>	African-American	2	3
	% of Total	11.9%	44.9%		% of Total	8.7%	13.0%
<i>Total</i>	White	94	128	<i>Total</i>	White	6	7
	% of Total	11.3%	15.4%		% of Total	26.1%	30.4%
<i>Total</i>	Hispanic	11	23	<i>Total</i>	Hispanic	0	0
	% of Total	1.3%	2.8%		% of Total	0.0%	0.0%
<i>Total</i>	Asian	27	48	<i>Total</i>	Asian	2	3
	% of Total	3.3%	5.8%		% of Total	8.7%	13.0%
<i>Total</i>	Other	15	12	<i>Total</i>	Other	0	0
	% of Total	1.8%	1.4%		% of Total	0.0%	0.0%
<i>Total</i>	Bi-lingual	155	86	<i>Total</i>	Bi-lingual	1	3
	% of Total	18.7%	10.4%		% of Total	4.3%	13.0%
<i>Total</i>	Male	246	584	<i>Total</i>	Male	10	13
	% of Total	29.6%	70.4%		% of Total	43.5%	56.5%

CONTRACTING

M/W/DBE Participation on Large Contracts FY15 Contracts

Vendor	Service Provided	Amount of Contract	RFP Issue Date	Contract Start Date	Ranges in RFP	% of M/W/DBE Participation Achieved	\$ Value of M/W/DBE Participation	Total % and \$ Value Participation - All	Living Wage Compliant?
eClinical Works	EHR Implementation	\$8,131,873	6/29/09	3/28/11	MBE: 10-15%	100%	\$8,131,873		Yes
					WBE: 5-10%	0%	\$0	100%	
					DSBE: Best Efforts	0%	\$0	\$8,131,873	
Alpha Medical Group	Radiology Services	\$1,390,662	6/7/13	7/1/13	MBE: Best Efforts	0%	\$0		Yes
					WBE: Best Efforts	100%	\$1,390,662	100%	
					DSBE: Best Efforts	0%	\$0	\$1,390,662	
Walgreen Eastern Co., Inc.	HIV Medications	\$1,287,636	3/11/14	6/30/14	MBE: Best Efforts	0%	\$0		Yes
					WBE: Best Efforts	0%	\$0	0%	
					DSBE: Best Efforts	0%	\$0	\$0	
General Healthcare Resources	Nursing Services	\$652,311	5/30/13	7/1/13	MBE:	0%	\$0		Yes
					WBE: 1-5%	0%	\$0	0%	
					DSBE:	0%	\$0	\$0	
MEE Productions, Inc.	Media Campaign	\$415,000	8/15/12	1/20/13	MBE: 10-15%	100%	\$415,000		Yes
					WBE: 10-15%	0%	\$0	100%	
					DSBE:	0%	\$0	\$415,000	

OTHER BUDGETARY IMPACTS

FEDERAL AND STATE (WHERE APPLICABLE)

- Dependence on state and federal grants: Many of PDPH programs are dependent on external funds. This includes state and federal funds, with federal funds coming to PDPH directly or via the state depending on the funding strategy of various federal programs. This is both an opportunity and challenge. The opportunity, of course, is that these funds enable services and innovation. The challenge is that grant-funded programs operate typically on 3-5 year budget cycles, might not be sustainable for longer periods, are susceptible to cuts in federal or state budgets, or to changes in federal or state allocation strategies.

OTHER

Not applicable.

**DEPARTMENT OF HUMAN SERVICES
FISCAL YEAR 2016 BUDGET TESTIMONY
APRIL 29, 2015**

EXECUTIVE SUMMARY

DEPARTMENT MISSION AND FUNCTION

Mission: To provide and promote safety, permanency and well-being for children at risk of abuse, neglect and delinquency.

Description of Major Services: The Department of Human Services (DHS) is responsible for investigating reports of child abuse and neglect. In addition, through contracts with social service agencies, DHS provides a wide range of prevention services, in home safety and non safety services, foster care, other placement services and juvenile justice services. DHS is also responsible for operating the Philadelphia Juvenile Justice Services Center. DHS' primary goal is to strengthen and stabilize families.

PROPOSED BUDGET HIGHLIGHTS/FUNDING REQUEST

Budget Highlights: The total FY16 Proposed Operating Budget is slightly lower (0.1%) than the FY15 Current Projection. The increase since FY14 is related to the increase in the number of children in placement.

Fund	Class	FY14 Actual	FY15 Current Projection	FY16 Proposed Budget	FY16-FY15 Change	FY16-FY15 Percent Change
General	100	22,776,786	23,817,687	24,637,310	819,623	3.4%
	200	76,267,118	77,931,501	76,779,935	(1,151,566)	-1.5%
	300/400	979,940	1,027,501	1,312,076	284,575	27.7%
	Total	100,023,844	102,776,689	102,729,321	(47,368)	0.0%
	Positions	382	451	449	(2)	-0.4%
Other*	100	104,669,472	111,014,684	116,949,046	5,934,362	5.3%
	200	375,934,050	458,262,753	451,172,464	(7,090,289)	-1.5%
	300/400	2,567,388	2,015,178	2,707,544	692,366	34.4%
	Total	483,170,910	571,292,615	570,829,054	(463,561)	-0.1%
	Positions	1,182	1,390	1,390	0	0.0%
All	100	127,446,258	134,832,371	141,586,356	6,753,985	5.0%
	200	452,201,168	536,194,254	527,952,399	(8,241,855)	-1.5%
	300/400	3,547,328	3,042,679	4,019,620	976,941	32.1%
	Total	583,194,753	674,069,375	673,558,375	(510,929)	-0.1%
	Positions	1,564	1,841	1,839	(2)	-0.1%

* Other Funds includes: County Liquid Fuels Tax Fund, Special Gasoline Tax Fund, Healthchoices Behavioral Health Fund, Hotel Room Rental Tax Fund, Grants Revenue Fund, Community Development Fund, Car Rental Tax Fund, Housing Trust Fund, Water Fund, Water Residual Fund, Aviation Fund, and Acute Care Hospital Assessment Fund.

Staff Demographics Summary (as of December 2014)

	Total	Minority	White	Female
Full-Time Staff	1,535	1,290	245	1,114
Executive Staff	36	26	10	24
Average Salary - Executive Staff	\$102,551	\$102,977	\$101,445	\$102,524
Median Salary - Executive Staff	\$98,751	\$98,651	\$98,851	\$98,751

Employment Levels (as of December 2014)

	Budgeted	Filled
Full-Time Positions	1,841	1,535
Part-Time Positions	0	0
Executive Positions	37	36

Contracts Summary (*as of December 2014)

	FY10	FY11	FY12	FY13	FY14	FY15*
Total amount of contracts	\$70,502,519	\$66,736,765	\$11,675,627	\$10,981,264	\$13,075,473	\$7,361,090
Total amount to M/W/DBE	\$2,692,510	\$2,222,120	\$3,780,081	\$4,134,509	\$3,880,931	\$1,921,091
Participation Rate	4%	3%	32%	38%	30%	26%

PERFORMANCE, CHALLENGES AND INITIATIVES

DEPARTMENT PERFORMANCE (OPERATIONS)

Performance Trends: Based on the point-in-time data, the dependent placement population has been increasing since FY14, and slightly less than one third of dependent children in care have been in care for more than two years. The rise in the dependent placement population is a negative trend that DHS hopes to address through the Improving Outcomes for Children (IOC) system transformation where the primary goal is to maintain children at home in their own communities (more information on IOC can be found in the Accomplishments & Initiatives section below). The FY16 goal for the dependent placement population reflects the negative trend of a larger dependent placement population due to new child welfare laws that expand the definition of child abuse and the definition of a perpetrator, as well as increase the number of mandated reporters and the penalties for failure to report. Additionally, the number of children discharged to all types of permanency dropped when compared between the first half of FY14 to the first half of FY15, another negative trend that DHS hopes to reverse through the IOC's secondary goal to increase permanencies. The FY16 goal has been adjusted to reflect this negative trend. The percent of discharges to adoption increased slightly from the first half of FY14 compared to the first half of FY15, a positive trend that DHS hopes to maintain in FY16. The percent of permanency discharges to reunification dropped between the first half of FY14 and the first half of FY15 meaning that fewer children are returning to their families, a negative trend. DHS hopes to increase permanency discharges to reunification to 65% in FY15 and FY16. The percentage of children in congregate care placement (group or institutional level care) has decreased, a positive trend for DHS. The level of approval for new congregate care placements has been raised to ensure that the placement setting is the most appropriate. Data for the first two quarters of FY15 also shows that the number of children in out-of-state dependent placement remained stable, a positive trend for DHS. The majority of these children were in care with extended family through kinship care, and they were able to maintain familial connections instead of residing in out-of-state congregate care. The number of youth in delinquent placement decreased between the first half of FY14 compared to the first half of FY15, another positive trend. This may indicate that prevention services, alternative treatment services and diversion programs are providing resources for youth who do not pose threats to public safety.

Performance Measure	FY08	FY13	FY14	FY14- FY13 Change	FY14 Q1-Q2	FY15 Q1-Q2	FY15- FY14 Q1-Q2 Change	FY15 Goal	FY16 Goal
Dependent placement population (as of the last day of the quarter)	5,740	4,291	4,473	N/A	4,375	4,894	N/A	4,500	4,800
Number of children discharged to permanency (All Types)	2,140	1,229	1,221	-0.7%	649	478	-26.3%	1,300	1,100
Percent of permanency discharges to adoption	16.6%	28.6%	31.8%	11.3%	30.2%	32.5%	7.5%	32.0%	35.0%
Percent of permanency discharges to Reunification	66.7%	62.7%	59.7%	-4.8%	61.3%	57.4%	-6.3%	65.0%	65.0%
Percent of dependent children in care more than two years (as of the last day of the quarter)	32.3%	29.4%	31.5%	N/A	31.3%	30.0%	N/A	30.0%	35.0%
Congregate Care population: percent of children in care (as of the last day of the quarter)	25.5%	21.7%	19.1%	N/A	20.1%	14.5%	N/A	14.0%	13.0%
Dependent out-of-state population (as of the last day of the quarter)	143	51	45	N/A	44	41	N/A	45	45
Delinquent placement population (as of the last day of the quarter)	1,657	1,155	952	N/A	1,023	857	N/A	950	900

N/A - Rate of change cannot be calculated as these measures are point-in-time and some children may be counted in both periods.

DEPARTMENT CHALLENGES

FY15 was a pivotal year for the Department of Human Services. During this year, DHS opened five new Community Umbrella Agencies (CUAs). Additionally, we saw large increases in calls to the hotline, number of investigations, cases accepted for service and placements. Specifically, we saw the following growth:

- Hotline calls increased 68% when comparing February 2014 to February 2015
- Investigations are projected to be up 13% between FY14 and FY15
- The total number of active cases is up by 46% when comparing February 2014 to February 2015
- Placements are up 18% when comparing February 2014 to February 2015

DHS is continuously monitoring this growth and the potential fiscal impact. As DHS moves towards the final implementation stages of IOC, the goal is to stabilize the system. DHS is working on strengthening and expanding its hotline and investigation sections. Additionally, DHS has increased the ability to provide technical and practice assistance to the CUAs. DHS is focusing on keeping children safely in their own homes and communities and is working diligently to achieve permanency for children who have remained in the placement system.

ACCOMPLISHMENTS & INITIATIVES

Improving Outcomes for Children (IOC): The IOC system transformation is based on a belief that a community neighborhood approach with clearly defined roles between county and provider staff will positively impact safety, permanency, and well-being of the children and families that are involved with DHS. IOC is a single case management system in which a family will have one case manager who is responsible for the provision of ongoing services. Previously, several social workers may have provided services to one family and as a result, there was little coordination of those services. Under the new system, because one social worker is accountable for the entire family, needed services are expected to be better recognized, coordinated and delivered through strong community partnerships. The case manager will be employed by a Community Umbrella Agency (CUA) that is located in the community where the family lives. Under IOC, the City is divided into 10 geographic regions with one CUA assigned to each region. IOC is designed for families to receive their services in the community whenever possible.

The four goals of IOC are:

1. More children and youth maintained safely in their own homes and communities;
2. More children and youth achieving timely reunification or other permanence;
3. A reduction in the use of congregate care; and
4. Improved children, youth, and family functioning.

IOC began in July 2012 with the selection of the first two CUAs to be based in the 25th and 24th/26th police districts. During FY13, DHS began the transition of cases to the CUAs and all ten CUAs were open as of FY15. During the remainder of FY15 and the first half of FY16, DHS will focus on finalizing the full implementation of IOC with all cases expected to be transferred to the CUAs by the end of December 2015. All new cases accepted for service by the Department are currently transferred to the Community Umbrella Agencies for ongoing service delivery. As of February 2015, our CUAs are servicing over 3000 families. Our goal is to keep children in their own communities. In fact, approximately 46% of the children placed in non-kinship foster care through the CUAs, are placed within 5 miles from their home. When fully implemented, IOC is designed to decrease placement and improve the number of reunifications and other permanencies.

Reduction of Congregate Care and Out of State Placements: Since FY08, the percentage of youth in congregate care – both group homes and institution settings – has decreased from approximately 22.5% to approximately 14.5%. To reduce reliance on congregate care placements, DHS has increased the use of youth driven teamings (where youth are able to bring their support network to the table and play an active role in driving the planning process) to reconnect young people with the people in their own natural networks. DHS instituted a Commissioner approval process, which requires the Commissioner to sanction the use of congregate care placement. Additionally, between 2008 and the end of calendar year 2014, children living in non-relative out of state placements decreased approximately 90%.

Juvenile Justices Services Center: In April of 2013, DHS opened the Philadelphia Juvenile Justices Services Center, a state of the art detention center for youth in Philadelphia. At a cost of \$110 million, the new center is located at the intersection of 48th Street and Haverford Avenue. The 166,000 square foot facility is a LEED (Leadership in Energy and Environmental Design) certified building. Among its many outstanding attributes is a state-of-the art school area with ten classrooms, two full courtrooms, a fully outfitted gymnasium, a healing garden, and outdoor running track. The new center will offer an array of services to young people detained there, among them medical and dental services, education, recreational programming and court services.

Philadelphia Safety Collaborative: In August of 2013, DHS opened the Philadelphia Safety Collaborative with the Philadelphia Police Department, the District Attorney and Philadelphia Children's Alliance. The Collaborative is designed to integrate the investigative process for incidents of sexual and physical abuse. The purpose of this collaborative is to reduce the trauma for victims and their families. During calendar year 2014, the Philadelphia Safety Collaborative served 3,056 children.

Family Conferencing: In FY16, DHS will continue to implement Family Team Conferencing. These conferences are designed to provide the family with a voice in the child welfare process. Family Team Conferences occur throughout the life of a case at key decision making points, including safety and permanency decisions, child or youth placement moves, changes in service, routine review intervals, and case closings. Family Team Conferences are children and youth centered, family focused structured meetings. Attendees include: parents, youth 12 years of age or older, any supports identified by the parents or youth including family members, and friends, community resources, the CUA and DHS staff, other child, youth, and family serving agencies, and other professionals involved including counsel for parents, children and youth, if they have been identified. Since January of 2013, DHS has held over 6,000 conferences. DHS will continue to hold Family Team Conferences for all families accepted for service and assigned to the CUAs.

International Recognition: DHS was the recipient of the 2013 United Nations Public Service Award, Second Place, for improving the delivery of public services in the European and North American region. More than 600 organizations from 82 countries submitted applications for a United Nations Public Service Award. DHS is one of 47 organizations to be recognized and the only North American entity selected for the 2013 United Nations Public Service Award. The award recognized the transformation of DHS over the past six years, including the implementation of its Improving Outcomes for Children system transformation, a groundbreaking, family-centered neighborhood-based approach to child welfare. The structural and programmatic reforms by DHS have been instituted to increase accountability, improve processes and enhance child welfare and well-being.

STAFFING

DHS currently has 1,535 full time staff. Of this number, 1,290 are minority and 1,114 are female. DHS continues to maintain a very diverse workforce.

Of the full time non-executive staff, 58.2% is African American females and 19.3% is African American males. 2.5% of non-executive staff is Hispanic females and 1.1% is Hispanic males. 1.2% of the non-executive staff is Asian American females and 0.7% is Asian American males.

The DHS Executive Team is also very diverse. 47.25% of the team is African American females and 22.2% are African American males. The Executive team is also 66.7% female and 33.3% male.

DHS also has 77 bilingual employees.

Of the new hires in FY15, 26 are African American, 10 are White, 2 are Asian and 1 is bilingual.

Staff Demographics (as of December 2014)

<i>Full-Time Staff</i>				<i>Executive Staff</i>			
Male		Female		Male		Female	
	African-American		African-American		African-American		African-American
<i>Total</i>	297		894	<i>Total</i>	8		17
<i>% of Total</i>	19.3%		58.2%	<i>% of Total</i>	22.2%		47.2%
	White		White		White		White
<i>Total</i>	93		152	<i>Total</i>	3		7
<i>% of Total</i>	6.1%		9.9%	<i>% of Total</i>	8.3%		19.4%
	Hispanic		Hispanic		Hispanic		Hispanic
<i>Total</i>	17		38	<i>Total</i>	0		0
<i>% of Total</i>	1.1%		2.5%	<i>% of Total</i>	0.0%		0.0%
	Asian		Asian		Asian		Asian
<i>Total</i>	10		19	<i>Total</i>	0		0
<i>% of Total</i>	0.7%		1.2%	<i>% of Total</i>	0.0%		0.0%
	Other		Other		Other		Other
<i>Total</i>	4		11	<i>Total</i>	1		0
<i>% of Total</i>	0.3%		0.7%	<i>% of Total</i>	2.8%		0.0%
	Bi-lingual		Bi-lingual		Bi-lingual		Bi-lingual
<i>Total</i>	29		47	<i>Total</i>	1		1
<i>% of Total</i>	1.9%		3.1%	<i>% of Total</i>	2.8%		2.8%
	Male		Female		Male		Female
<i>Total</i>	421		1,114	<i>Total</i>	12		24
<i>% of Total</i>	27.4%		72.6%	<i>% of Total</i>	33.3%		66.7%

CONTRACTING

M/W/DBE Participation on Large Contracts FY15 Contracts

Vendor	Service Provided	Amount of Contract	RFP Issue Date	Contract Start Date	Ranges in RFP	% of M/W/DBE Participation Achieved	\$ Value of M/W/DBE Participation	Total % and \$ Value Participation - All	Living Wage Compliant?
Vision Quest	Placement	\$14,734,218	5/10/12	7/1/12	MBE: 20%-25%	23.60%	\$3,477,576		Yes
					WBE: 20%-25%	0.00%	\$0	23.6%	
					DSBE: 0	0.00%	\$0	\$3,477,576	
Mid-Atlantic	Placement	\$10,862,437	6/5/12	7/1/12	MBE: 20%-25%	0.00%	\$0		Yes
					WBE: 20%-25%	0.18%	\$19,600	0.18%	
					DSBE: 0	0.00%	\$0	\$19,600	
First Home Care	Placement	\$3,969,610	6/5/12	7/1/12	MBE: 20%-25%	0.57%	\$22,674		Yes
					WBE: 20%-25%	0.47%	\$18,574	1.1%	
					DSBE: 0	0.03%	\$1,278	\$42,526	
Cornell Abraxas	Placement	\$2,379,831	5/10/12	7/1/12	MBE: 20%-25%	0.00%	\$0		Yes
					WBE: 20%-25%	0.00%	\$0	0.0%	
					DSBE: 0	0.00%	\$0	\$0	
Eastern Software	Technology	\$2,093,350	4/17/12	7/1/12	MBE: 25%-30%	13.85%	\$290,000		Yes
					WBE: 20%-25%	16.00%	\$335,000	29.9%	
					DSBE: 0	0.00%	\$0	\$625,000	

OTHER BUDGETARY IMPACTS

FEDERAL AND STATE (WHERE APPLICABLE)

If funding from the federal or state government decreased, the City would be required to increase its proportionate share of dollars to purchases services. It is critical that DHS maximizes dollars from the federal and state government in light of the rising number of reports, families being accepted for services and children in placement.

DHS is continuing to monitor placement numbers as they relate to the Department's ability to draw down Title IVE dollars under the Child Welfare Demonstration Project's cap.

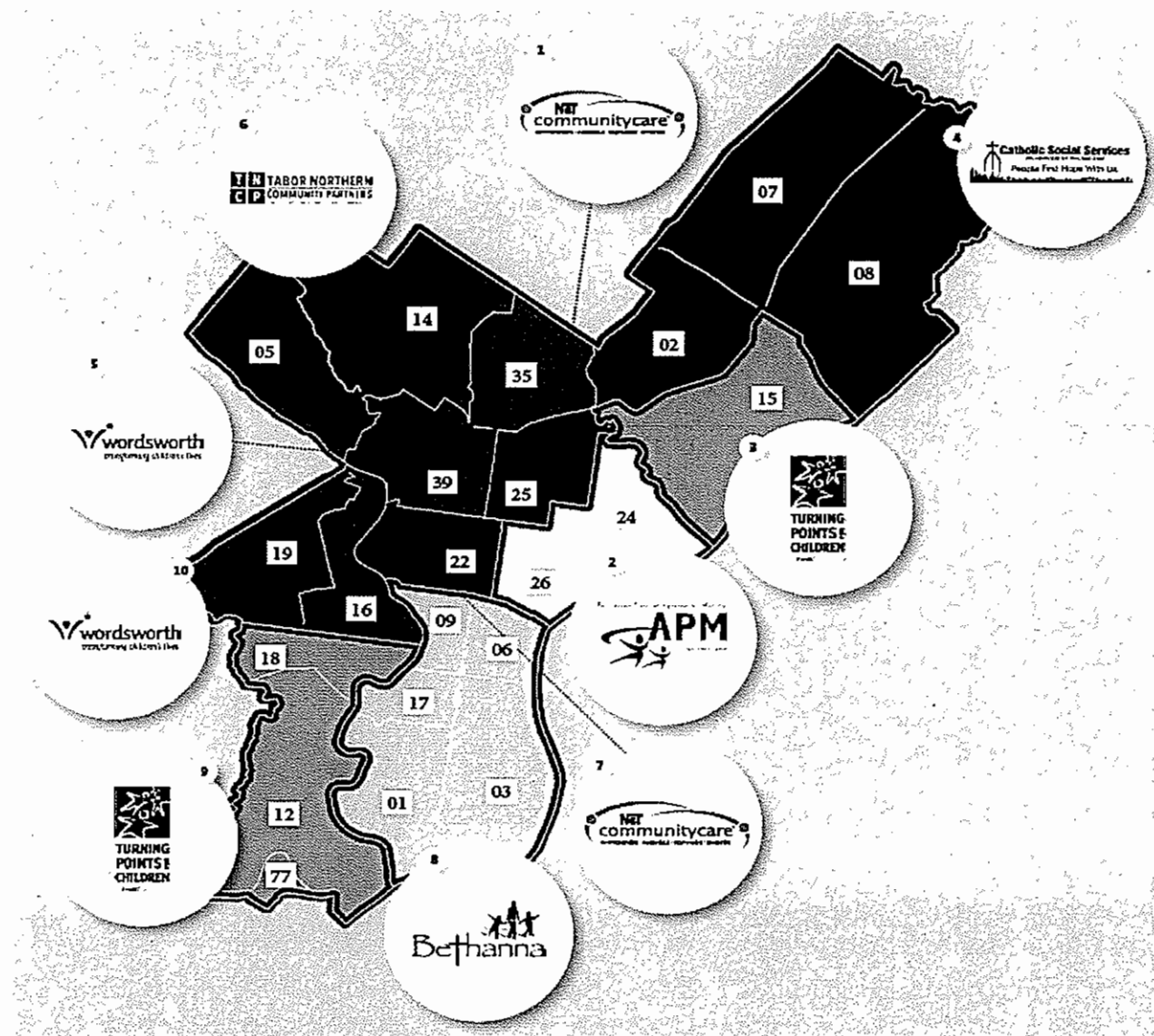
Finally, as DHS is under the Needs Based Budgeting process, DHS also continuously monitors their need for additional state dollars and will work with the Pennsylvania Department of Human Services to request additional dollars if necessary.

OTHER

DHS continues to monitor the impact of the sweeping reforms to the Child Protective Services Law that went into effect in January of 2015. These new laws expanded the definition of child abuse as well as widened the definition of who can be a perpetrator. In addition, the new laws increased the number of mandated reporters and the penalty for not reporting. DHS has begun to and expects to see further increases in the number of reports and investigations as a result of this widened definition of child abuse and who can be a perpetrator. As part of IOC, DHS is strengthening and expanding its investigative sections. In order to ensure quality practice for those cases that are accepted for service, DHS has increased focus on providing technical assistance to the CUAs. DHS placed DHS staff on site at the CUAs to work with and mentor the CUA case managers and supervisors. Additionally, DHS continues to monitor and evaluate providers to ensure quality practice for the children and families that DHS serves.

OTHER RELEVANT DATA AND CHARTS

Below is a map of all ten CUA locations throughout the city.



Region	Community Umbrella Agency (CUA)
Eastern North Philadelphia: 25 th Police District	NorthEast Treatment Centers (NET)
Eastern North Philadelphia: 24 th and 26 th Police Districts	Asociación Puertorriqueños en Marcha (APM)
Lower Northeast: 15 th Police District	Turning Points for Children
Far Northeast: 2 nd , 7 th , and 8 th Police Districts	Catholic Social Services
Logan/Olney: 35 th and 39 th Police Districts	Wordsworth
Northwest Philadelphia: 5 th and 14 th Police Districts	Tabor Northern Community Partners
North Central Philadelphia: 22 nd Police District	NorthEast Treatment Centers
South Philadelphia: 1 st , 3 rd , 6 th , 9 th , 17 th Police Districts	Bethanna
Southwest Philadelphia: 12 th , 18 th , and 77 th Police Districts	Turning Points for Children
Mantua, Overbrook, Wynnefield: 16 th , 19 th Police Districts	Wordsworth

**OFFICE OF SUPPORTIVE HOUSING
FISCAL YEAR 2016 BUDGET TESTIMONY
APRIL 29, 2015**

EXECUTIVE SUMMARY

DEPARTMENT MISSION AND FUNCTION

Mission: To help individuals and families move towards independent living and self-sufficiency in safe and stable housing. The Office of Supportive Housing fulfills this mission through Philadelphia's Homeless Continuum of Care and the Riverview Home, which is a state, licensed Personal Care Home that provides housing to low income elderly and disabled persons. OSH is also responsible for the policy, planning and coordination of the City's response to homelessness.

Description of Major Services: The Office of Supportive Housing (OSH) is charged with planning and implementing the City of Philadelphia's support and services to residents who are experiencing homelessness and whenever possible to prevent homelessness. OSH balances diverse needs, capturing as many resources and tools as possible and directing them to multiple subpopulations. OSH does its work always in partnership with other city departments, the Commonwealth and the Federal government, as well as over 50 non-profit corporations and advocacy groups. OSH provides direct support to emergency housing, as well as a wide array of services including transitional and supportive housing to individuals, couples and families.

PROPOSED BUDGET HIGHLIGHTS/FUNDING REQUEST

Budget Highlights: The FY16 General Fund proposed allocation is slightly higher than the FY15 Current Projection to account for employee salary increases as a result of union contract settlements. The total FY16 Proposed Operating budget for OSH is on par with the FY15 Current Projection.

Fund	Class	FY14 Actual	FY15 Current Projection	FY16 Proposed Budget	FY16-FY15 Change	FY16-FY15 Percent Change
General	100	7,877,851	8,263,759	8,281,213	17,454	0.2%
	200	36,866,677	36,586,621	36,586,621	0	0.0%
	300/400	340,878	344,127	344,127	0	0.0%
	500	30,899	32,421	32,421	0	0.0%
	Total	45,116,305	45,226,928	45,244,382	17,454	0.0%
	Positions	154	159	159	0	0.0%
Other*	100	395,640	614,129	710,423	96,294	15.7%
	200	28,501,815	45,022,629	44,956,142	(66,487)	-0.1%
	300/400	976,701	887,489	887,489	0	0.0%
	Total	29,874,156	46,524,247	46,554,054	29,807	0.1%
	Positions	9	12	12	0	0.0%
All	100	8,273,491	8,877,888	8,991,636	113,748	1.3%
	200	65,368,492	81,609,250	81,542,763	(66,487)	-0.1%
	300/400	1,317,579	1,231,616	1,231,616	0	0.0%
	500	30,899	32,421	32,421	0	0.0%
	Total	74,990,461	91,751,175	91,798,436	47,261	0.1%
	Positions	163	171	171	0	0.0%

* Other Funds includes: County Liquid Fuels Tax Fund, Special Gasoline Tax Fund, Healthchoices Behavioral Health Fund, Hotel Room Rental Tax Fund, Grants Revenue Fund, Community Development Fund, Car Rental Tax Fund, Housing Trust Fund, Water Fund, Water Residual Fund, Aviation Fund, and Acute Care Hospital Assessment Fund.

Staff Demographics Summary (as of December 2014)

	Total	Minority	White	Female
Full-Time Staff	164	138	26	119
Executive Staff	16	13	3	9
Average Salary - Executive Staff	\$88,427	\$87,366	\$93,027	\$93,554
Median Salary - Executive Staff	\$86,111	\$83,600	\$97,731	\$93,150

Employment Levels (as of December 2014)

	Budgeted	Filled
Full-Time Positions	171	164
Part-Time Positions	0	0
Executive Positions	16	16

Contracts Summary (*as of December 2014)

	FY10	FY11	FY12	FY13	FY14	FY15*
Total amount of contracts	\$2,854,086	\$4,276,757	\$4,026,492	\$4,518,015	\$4,183,400	\$3,629,928
Total amount to M/W/DBE	\$472,260	\$880,773	\$1,469,777	\$1,709,346	\$1,167,480	\$1,092,480
Participation Rate	17%	21%	37%	38%	28%	30%

PERFORMANCE, CHALLENGES AND INITIATIVES

DEPARTMENT PERFORMANCE (OPERATIONS) Emergency housing (shelter) served an average of 1,500 single individuals and 450 families every night in FY15. During the winter months of December 1 through March 31 an average of 450 additional emergency housing beds were available. This support is critical to persons who might otherwise be on the streets.

The number of households receiving financial assistance to prevent homelessness increased from 610 to 676 (10.8%) from FY13 to FY14. Starting in the second quarter of FY14, OSH used Housing Trust Funds and also received Community Services Block Grant (CSBG) Funds from the Mayor's Office of Community Empowerment and Opportunity to provide prevention services. In the second quarter of FY15, OSH received additional CSBG funds and is already serving more than twice the number of households in the first half of FY15 relative to the same period in FY14. Through the second quarter of FY15, 374 persons have received assistance to prevent them from experiencing homelessness.

In concert with the City's 10 Year Plan to End Homelessness, a plan created in 2005, OSH implemented the Mayor's Homeless Housing Strategy, which included a commitment to provide housing opportunities for homeless individuals and families. Since the end of the Federal American Recovery and Reinvestment Act (ARRA) funding of \$23.million from 2009 – 2012, to provide Prevention, Rapid Re-Housing and Housing Stabilization services there has been a dramatic decrease in the numbers of families and persons assisted to prevent homelessness and to move out of homelessness into permanent housing. The ARRA funding was approximately \$7 million per year whereas the FY14 Federal allocation was \$2.8 million. Rapid re-housing is the practice of focusing resources to help households (individuals and families) to quickly move out of homelessness and into permanent housing and reduce the amount of time experiencing homelessness. Participants receive financial assistance to move back into the community and housing stabilization services which is a type of case management focused on helping participants to maintain their housing, such as managing the household budget, making timely rent and utility payments and being a good tenant and neighbor. OSH continues to seek and utilize all available local, state and federal homeless rapid re-housing funding and assure that residents in Emergency and Transitional Housing are able to connect with all mainstream benefits for which they qualify and connect them to resources and opportunities to increase their skills, education and income. The number of households receiving assistance is lower for the first two quarters of FY14 because the performance measures only represent new households whereas the majority of recipients of rapid re-housing assistance at that time were already housed and receiving ongoing rental assistance. In the first two quarters of FY15, OSH was able to move 272 households out of emergency housing into transitional housing and end homelessness for 174 households. In FY16, OSH will continue to provide short to medium term financial assistance and housing stabilization services to households residing in emergency or transitional housing. The goals and service for upcoming rapid re-housing and prevention services are contingent on expected grant funding and capturing of other supportive housing resources in FY16.

In addition to rapid re-housing, OSH provides Continuum of Care permanent supportive housing units. OSH serves as the collaborative applicant for Continuum of Care funding through HUD. The Continuum of Care (CoC) program is designed to focus community commitment on the goal of ending homelessness and providing funding for new and ongoing efforts to quickly re-house homeless individuals and families and promote self-sufficiency among individuals and families experiencing homelessness. In FY14, OSH completed 509 Transitional Housing Placements. Placements for the first and second quarters of FY15 are slightly higher than those quarters in FY14 (265 in FY14 and 272 in FY15). More than 80% of those who leave Transitional Housing enter permanent housing. OSH is on track to meet the FY15 placement goal of 505.

Performance Measure	FY08	FY13	FY14	FY14- FY13 Change	FY14 Q1- Q2	FY15 Q1- Q2	FY15- FY14 Q1-Q2 Change	FY15 Goal	FY16 Goal
Households provided financial assistance to prevent homelessness	336	610	676	10.8%	181	374	106.6%	675	N/A*
Households provided financial assistance to end homelessness	N/A	291	135	-53.6%	59	174	194.9%	155	N/A*
New permanent supportive housing units for people experiencing homelessness (Non-Philadelphia Housing Authority)	76	180	59	-67.2%	0**	0**	N/A	100	100
Number of transitional housing placements	435	539	509	-5.6%	265	272	2.6%	505	520

*Dependent on grant funding received during year.

** Per HUD, numbers are reported 1x/year at the end of the fiscal year

DEPARTMENT CHALLENGES

- Philadelphia's homeless strategies are recognized nationally as very productive and effective. However, the need for affordable housing, coupled with high levels of poverty and unemployment continue to have a direct impact on the numbers of individuals and families in particular that consistently present at our front door. More and more low-income and poor citizens turn to the homeless system to meet their housing needs. On any given day, OSH is operating at or near full capacity. On average, 30 families present daily at the Appletree Family Intake Center. The OSH front door is the safety net for these families.
- The number of young mothers with one or two children is significant. Many of these young families are not characteristically homeless; many of them have never had a home, meaning they have never lived independently. They became a parent and/or young adult living with family, friends and "couch surfing" with a child in tow. These families thrive when there are supportive services and a healthy environment that builds accountability and key life skills of child care, healthy food and job skills. OSH is currently developing ways to provide appropriate housing options with increased collaboration.

ACCOMPLISHMENTS & INITIATIVES

Increased Homeless Housing: Between 2008 and 2014, the overall Philadelphia homeless housing inventory increased by 80% (from 3,047 to 5,500) through local and federal McKinney-Vento Act-funded construction, rehabilitation and leased units, including units through the City's partnership with the Philadelphia Housing Authority. To date, through this partnership, 2,103 individuals and 1,601 families have moved into permanent housing. In addition, through the 2013 HUD Continuum of Care Program, the City was awarded \$29.8 million for continuing and new housing for individuals and families experiencing homelessness, including 80 newly funded permanent housing units. The decrease in non-PHA permanent supportive housing units in FY14 was due to delays in the receipt of grant funding and in agencies securing development funding. The FY15 Quarter 1 and 2 numbers are not available at this time as per HUD, they are reported once per year at the end of the fiscal year. OSH expects to meet the FY 15 goal of 100 new units.

Homelessness Prevention: OSH will continue to work to prevent homelessness of individuals and families already housed by providing financial assistance with delinquent rent and/or utilities or security deposits to re-locate to more affordable housing and providing financial assistance to prevent mortgage foreclosure. The FY16 goal is contingent upon the amount of funding received from federal and/or state sources.

Expansion of Beds for Victims of Domestic Violence: The number of beds for women and children experiencing domestic violence were expanded, as well as community-based services for Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual (LGBTQIA) and gender minority individuals experiencing domestic violence. In FY14, the City provided \$3 million for Domestic Violence services to double the number of emergency housing beds (from 100 to 200) for women and children experiencing domestic violence. In addition, OSH expanded community-based services to serve LGBTQIA and gender minority victims of domestic violence.

In FY15 to date, Carol's Place (the new 100 bed shelter operated by Women Against Abuse (WAA)) has served 349 people (151 adults and 198 children). An additional \$200,000 provided through transfer ordinance will support child

care/children's programming onsite. A Domestic Violence (DV) specialist funded to assist at OSH intake has provided support and services to 223 unique adult consumers during FY15 to date. The DV hotline collaboration between Congreso, Lutheran Settlement House, Women in Transition and WAA, funded in part through OSH, has fielded more than 9,000 calls from victims in FY15. In FY16, OSH will support the implementation of the Citywide Coordinated Response to Domestic Violence, which builds on the successful efforts of law enforcement to increase and improve efforts to address DV by engaging the City's social service departments and other key stakeholders in the collaborative effort.

Ending Veteran Homelessness: In Philadelphia, 9% of adults experiencing homelessness were Veterans per the 2014 U S Conference of Mayor's Hunger and Homelessness Report. Since August 2013 through March 2015, the City and partners, including the Veterans Administration (VA), the Public Housing Authority (PHA) and non-profits, ended homelessness for 862 veterans. Philadelphia has been designated one of 10 Dedicating Opportunities to End Homelessness (DOEH) communities by HUD and the US Interagency Council on Homelessness. Philadelphia used a diversity of housing strategies, as well as data-based analytic tools to project gaps and identify housing resources to close the gaps and end chronic and veteran homelessness. In addition, Philadelphia participated in the Rapid Results Institute sponsored by Community Solutions to build a local team to end veteran homelessness. This is leading to new housing commitments and processes to ensure that veterans are identified, targeted, and offered housing solutions more quickly. OSH is now developing a new partnership with HUD/VA with new resources to Support Service for Veterans Families (SSVF) and a total of 460 rental subsidies.

With an estimated 500 veterans in need of housing, adequate resources from the VA, and the continuing commitment from the partners to collaborate, OSH is now working with the Philly Vets Home team for a final push to meet Mayor Nutter's goal to end veteran homelessness in 2015.

Permanent Supportive Housing Clearinghouse: In 2012, OSH, in concert with Health & Opportunity, developed an initiative to consolidate the housing resources of the social service departments in the City. With this effort, there is a streamlined, single point of access to permanent supportive housing. This eliminates duplicative efforts and the cost of maintaining multiple access points, promotes coordination between housing and services, and assures that all available housing resources and partnerships for supportive housing are captured and not lost. Resources are dedicated to households served by the Health & Opportunity social service cluster who have both a services and a housing need, including individuals and families with mental illness, chronic substance abuse and related health disabilities, as well as those who are homeless or at the highest risk of homelessness. This initiative now includes access to 8 programs and to date 3,055 individuals and families have been housed.

Infant Screening Protocol: Mothers who reside in emergency housing with infants 0-4 months of age are now supported to develop strong, healthy babies with the development of new infant protocols and services. An Infant care nurse weighs infants 0-4 months every two weeks for up to 16 weeks to track growth and development and parents receive assistance with locating and connecting to a primary care provider for regularly scheduled well child appointments. In FY14, 39 infants were screened, and to date, 59 infants were screened in FY15. In addition, all children in Emergency Housing receive an immunization screening.

Facility Improvements: In the FY16 OSH proposed Capital Budget, \$1.0 million is recommended for capital improvements at the Woodstock Family Residence, Stenton Family Manor, Our Brother's Place (single males) and the Riverview Home. This funding is for infrastructure improvements such as fire alarm system upgrades, door replacements, installation of emergency generators, HVAC upgrades and facade and shower room renovations

Development of New Permanent Supportive Housing Resources: OSH is now in a feasibility stage of initiating new partnerships at a local and national level to create 100 units of permanent supportive housing annually. These would be new units in addition to other permanent supportive housing unit creation. Potential strategies to accomplish this goal include providing incentives to improve the housing stock owned by small and minority landlords and property owners, as well as, faith-based partners, to join OSH with a commitment to supportive housing units. A specific partnership with private and other City agencies is assessing the potential for building new models of supportive housing for veterans and young families.

STAFFING

OSH has hired 4 new employees since the beginning of FY15: 3 are African-American males and one is and Asian female.

Staff Demographics (as of December 2014)

<i>Full-Time Staff</i>			<i>Executive Staff</i>		
	Male	Female		Male	Female
	African-American	African-American		African-American	African-American
<i>Total</i>	34	84	<i>Total</i>	6	4
<i>% of Total</i>	20.7%	51.2%	<i>% of Total</i>	37.5%	25.0%
	White	White		White	White
<i>Total</i>	8	18	<i>Total</i>	1	2
<i>% of Total</i>	4.9%	11.0%	<i>% of Total</i>	6.3%	12.5%
	Hispanic	Hispanic		Hispanic	Hispanic
<i>Total</i>	1	9	<i>Total</i>	0	3
<i>% of Total</i>	0.6%	5.5%	<i>% of Total</i>	0.0%	18.8%
	Asian	Asian		Asian	Asian
<i>Total</i>	1	2	<i>Total</i>	0	0
<i>% of Total</i>	0.6%	1.2%	<i>% of Total</i>	0.0%	0.0%
	Other	Other		Other	Other
<i>Total</i>	1	6	<i>Total</i>	0	0
<i>% of Total</i>	0.6%	3.7%	<i>% of Total</i>	0.0%	0.0%
	Bi-lingual	Bi-lingual		Bi-lingual	Bi-lingual
<i>Total</i>	3	11	<i>Total</i>	0	3
<i>% of Total</i>	1.8%	6.7%	<i>% of Total</i>	0.0%	18.8%
	Male	Female		Male	Female
<i>Total</i>	45	119	<i>Total</i>	7	9
<i>% of Total</i>	27.4%	72.6%	<i>% of Total</i>	43.8%	56.3%

CONTRACTING

M/W/DBE Participation on Large Contracts FY15 Contracts

Vendor	Service Provided	Amount of Contract	RFP Issue Date	Contract Start Date	Ranges in RFP	% of M/W/DBE Participation Achieved	\$ Value of M/W/DBE Participation	Total % and \$ Value Participation - All	Living Wage Compliant?
Food Management Services d/b/a Linton's Management	Food service for the Riverview Home	\$712,527	4/20/12	7/1/12	MBE: 10-15%	0%	\$0	0	Yes
					WBE: 10-15%	0%	\$0	0%	
					DSBE:	0%	\$0	\$0	
US Facilities	Maintenance services at 6 City-Supported Emergency Housing Facilities	\$663,250	4/19/13	7/1/13	MBE: 5-10%	100%	\$663,250	\$663,250	Yes
					WBE: 5-10%	0%	\$0	100%	
					DSBE:	0%	\$0	\$0	
Core Care Food Services	Food service Families Foreward/Phila/Kirkbride Campus	\$600,334	4/9/13	7/1/13	MBE: 5-15%	0%	\$0	0	Yes
					WBE: 5-15%	0%	\$0	0%	
					DSBE:	0%	\$0	\$0	
Darlene Morris	Emergency Housing & Support Services to homeless families	\$415,000	3/17/14	7/1/14	MBE:	0%	\$0	\$415,00	Yes
					WBE:	100%	\$415,00	100%	
					DSBE:	0%	\$0	\$0	
Social Solution Global Inc.	Customization/ ongoing support for HUD mandated HMIS database	\$400,000	1/29/13	10/1/13	MBE: 10-15%	8%	\$32,000	\$32,000	Yes
					WBE: 10-15%	0%	\$0	8%	
					DSBE:	0%	\$0	\$0	

OTHER BUDGETARY IMPACTS

FEDERAL AND STATE (WHERE APPLICABLE)

Philadelphia will receive a small increase in Emergency Solutions Grant (ESG) funds (\$250K) to support rapid re-housing rental assistance. Nationally, there are increases in the Continuum of Care Homeless Assistance Program funding. However locally, there is a \$ 3.5M reduction in HOME, CDBG and HOPWA funds that are critical HUD funding that supports housing development and rehabilitation.

The proposed State funding is favorable in the Homeless Assistance Program (HAP), Human Services Development Program (HSDP), State Food Purchase Program (SFPP), resulting in as much as a \$ 600K increase overall if passed by the legislature.

OTHER IMPACTS

Per the December 2014 U S Conference of Mayor's Report on Hunger and Homelessness, the main causes of homelessness in Philadelphia among families with children are: lack of affordable housing; eviction; and, poverty. Among unaccompanied individuals, the main causes of homelessness are: lack of affordable housing; substance abuse and lack of needed services; and, poverty.



City Council of
Philadelphia

Philadelphia School-Based Family Service Centers

A Roadmap to Support Academic
and Economic Outcomes for
Philadelphia Students & Families



City Council of
Philadelphia

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Letter From Philadelphia City Council

Education is one of the fundamental components of helping children reach their full potential. Yet, a child's ability to succeed academically is not solely determined by access to quality teachers and plentiful books. Research continues to show that academic performance is linked to one's health, income, safety, and other social factors. Communities around the country have embraced this notion and transformed schools into places that both educate and promote healthy students, families, and communities.

School-Based Family Service Centers (SBFSCs) are based on full-service community school models that are currently supporting 1.5 million students in 3,000 schools across 150 municipalities nationwide. Full-service community schools are built on partnerships between school and communities that integrate academics, youth development, family support, and health care. These community schools are designed to remove barriers to student academic and socioeconomic success.

This innovative model for education also seeks to strengthen families by customizing the services offered at each school to match the specific needs of each neighborhood.

Through listening to each neighborhood about the services that would most help them, SBFSCs will become far better equipped to promote comprehensive child and family wellness.

School-Based Family Service Centers in Philadelphia will adopt an innovative approach to education by integrating health and social services for children and their families within schools themselves, and in so doing align the interrelated goals of providing quality education, nutrition, healthcare and other services essential for student, family, and community wellness.

By enabling Philadelphia schools to coordinate multiple services in one location, essential care will become far easier to access, thereby increasing the likelihood that children and parents will have the tools they need to reach their full academic and economic potential.

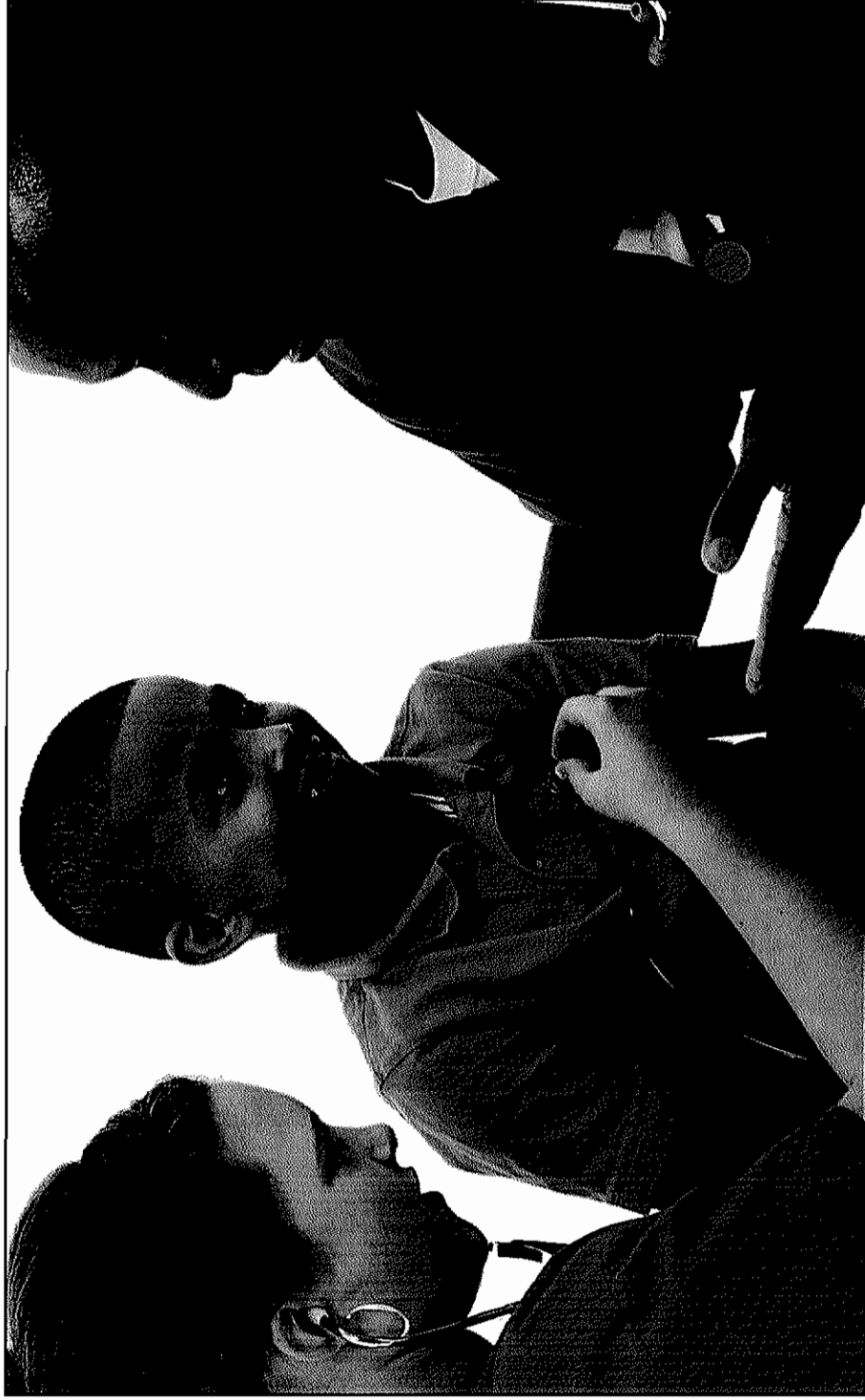
Introduction

Over the last decade, research on full-service community school outcomes has consistently shown:

- Strong increases in academic performance, college enrollment rates, access to preventative health services, and parental involvement; and
- Substantial decreases in dropout rates, chronic absenteeism, and disciplinary actions.

The inspiration for launching School-Based Family Service Centers (SBFSC) is simple: we can better prepare Philadelphia's children for academic success by simultaneously improving their physical, emotional, and social well-being.

School-Based Family Service Centers are a more efficient and effective use of taxpayer money than traditional schools. Children will have better educational outcomes because their health, nutrition, and behavioral needs are all being addressed simultaneously.



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Family Resources & Continuing Education

Social workers, knowledgeable about community-based resources, will link students and their families to relevant programs and services. Referrals will be based on needs identified during the student/family need assessment. Social workers will serve as case managers, not only making appropriate service referrals, but providing follow-up to ensure the student and the family are connected with service agents.

Services should include general social service assessment, referral, and guidance to access eligible public assistance and other programs that provide basic needs. These include: psychosocial risk assessments; nutrition counseling and assistance; housing placement; utilities subsidies; medical insurance; legal services; continuing education; tax benefits; employment services; child day care and elder care services; and substance abuse services.

Nonprofits and other non-governmental organizations can also use SBFSCs as a delivery vehicle for services that support students and families. For example, local community colleges and universities can help improve socioeconomic outcomes for families by offering English as a Second Language (ESL), GED, job training, and college readiness programs.

Providence, RI students who were in schools that were integrated with School-Based Family Service Centers in 2009 exhibited 55% fewer incidents of chronic absenteeism. The same students had a 97% attendance rate where their parents attended Family Literacy classes.

Why Does Philadelphia Need School-Based Family Service Centers?

In Philadelphia, 40% of school-age children (age 17 or younger) live in poverty—one of the highest rates in the nation. An estimated 30% of Philadelphia children live with a chronic disease like asthma – a statistic that does not include children who receive little or no medical care and therefore go undiagnosed or untreated. Many disadvantaged children are unable to learn because they lack essentials such as adequate food and basic healthcare. We cannot declare that we have fulfilled our moral duty by simply providing our City’s children with desks, pencils, books, and teachers. These children need far more in order to have positive academic outcomes. Their families often also require support in order to have positive socioeconomic outcomes. We cannot declare that we have fulfilled our moral duty by simply providing our City’s children with desks, pencils, books, and teachers. These children need far more in order to have positive academic outcomes. Their families often require support in order to have positive socioeconomic outcomes.

School-Based Family Service Centers will not only focus on the needs of students inside the school, they will also address their needs outside the school. Naturally, success will not be possible without active engagement from community groups that are already making important contributions inside many of our City’s schools.

Between 2006 and 2011, all 51 Cincinnati Public Schools were transformed into School-Based Family Service Centers. Graduation rates soaring from 51% in 2000 to 82% in 2010. (details page 9)

Demographic Context

More than half of Philadelphia’s residents are racial and ethnic minorities, with Blacks comprising 44%, Hispanics making up 13% and Asians comprising 7% of the total population. Twelve percent are foreign born, and 21% speak a language other than English in the home. Seven percent of Philadelphia households are linguistically isolated. Linguistic isolation refers to a household in which all members over the age of 13 speak a non-English language and have difficulty with English. This demographic composition highlights the need to utilize culturally-competent, linguistically-appropriate providers in the delivery of health and social services to our city’s diverse population.



students and their families face is impossible without ongoing community engagement happening at each SBFSC. Only then can we design comprehensive programs that effectively address the unique needs of every neighborhood’s families. The proposed School-Based Family Service Centers (SBFSCs) will ensure Philadelphia students and families can access a full array of health and social services in the city in the most convenient, affordable manner possible.

Economic Indicators

While trends in unemployment mirror that of Pennsylvania over the past decade, Philadelphia’s unemployment rate has consistently surpassed that of the state. The median income (\$35,386) is a fraction of the state’s average (\$51,230). Consistent with national trends, ethnic and minority groups have lower median incomes than whites. Families affected by unemployment and low wages are less likely to have health insurance, which compromises their access to healthcare services, places them at risk for poor health status, and increases the chances of chronic absenteeism.

More than one quarter of our residents (26.9%) live below the federal poverty line. The proportion of children 17 years and younger living in poverty is nearly 40%. Children raised in poverty face daily overwhelming challenges that undermine academic performance. Data from the National Assessment of Educational Progress show that more than 46% of average math scores and 40% of average reading scores across states are associated with child poverty rates.

Disparities in socioeconomic status are evident across the School District of Philadelphia (SDP). The proportion of SDP children who qualify for free lunch far surpasses the state average. Nearly three out of four children were eligible for free lunch in 2013. A growing body of data suggests less advantaged students are more likely to have behavioral problems at school and lower academic achievements than their more advantaged peers.

cleanings, oral health education and referrals to local dental treatment and specialty services off-site.

Early Childhood Programs

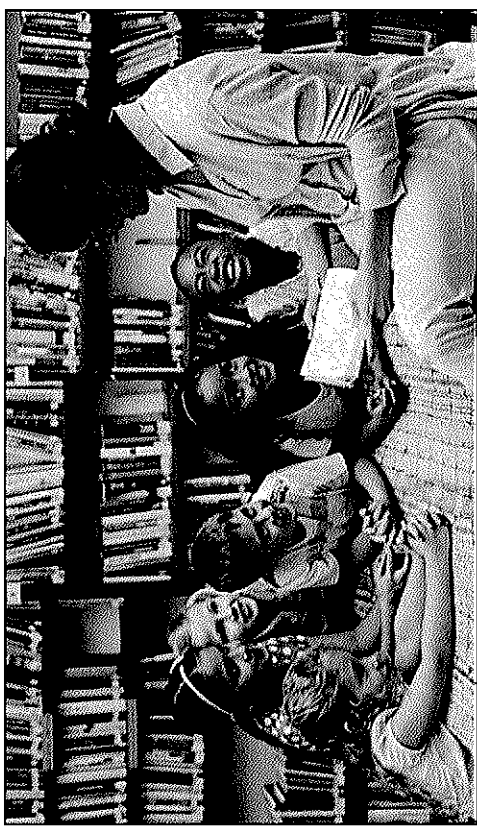
Early childhood education and Head Start preschool programs prepare children for transitioning into elementary school by building confidence and skills

in each child. Parents benefit from the same programs as they help develop education readiness skills that support the child in preparation for their primary education experience. Further, when a preschool program is located in the school building, transition to kindergarten and primary grades is easier. The benefits to both children and families are long lasting

Before and After School Programs

Because there is not enough time in the school day for many children to acquire all the skills they need to succeed in today’s educational system, before- and after-school programs provide an ideal space for extended learning opportunities. Schools that are open for longer hours before and after the school day, and where creative enrichment

programs are provided, can help children achieve significant academic gains. Further, where the extended learning opportunities are integrated into the school’s academic curriculum, after-school activities can reinforce and enrich what children learn each day. When the programs are extended over the summer, remediation and preparation learning can prepare the child for the following school year. These same programs also help children gain social skills and cultural experiences that lead to strong youth development.



Philadelphia’s Shaw Middle School, which partners with the University of Pennsylvania to provide School-Based Family Services, saw suspensions decrease from 464 to 163 over a span of six years.

Services Provided Through School-Based Family Service Centers

All SBFSCs, through guidance from the Community Advisory Board (CAB), should perform needs assessments to determine medical and social services that families may be eligible for and to assist in accessing them through education and enrollment. Baseline services, which will be available either through direct service delivery or referral, are outlined below.

Medical & Health Education Services

Healthcare services should include services comparable to that provided by primary care providers (PCPs). Services will include wellness exams; episodic acute care, including diagnosis and treatment of illness and injury; immunizations; basic laboratory tests; and follow-up and coordination of care whenever appropriate. Additional services should also include education related to nutrition and physical activity, chronic disease management, pregnancy tests and counseling as appropriate, testing and treatment for sexually transmitted infections as clinically indicated, and referrals for specialty care or other needed services not provided onsite.

Behavioral Health Services

Behavioral health services should include age-appropriate, culturally competent screening and assessment to facilitate early identification of substance abuse, domestic/dating violence, and mental health disorders. Additional services should include mental health and substance abuse awareness and prevention education; individual, family and/or group therapy/counseling provided by a qualified staff person; crisis intervention/counseling; and case management/client advocacy. Clients will be referred to a continuum of mental health

services for medications, emergency psychiatric care, community support programs, substance abuse services, and inpatient and outpatient mental health programs.

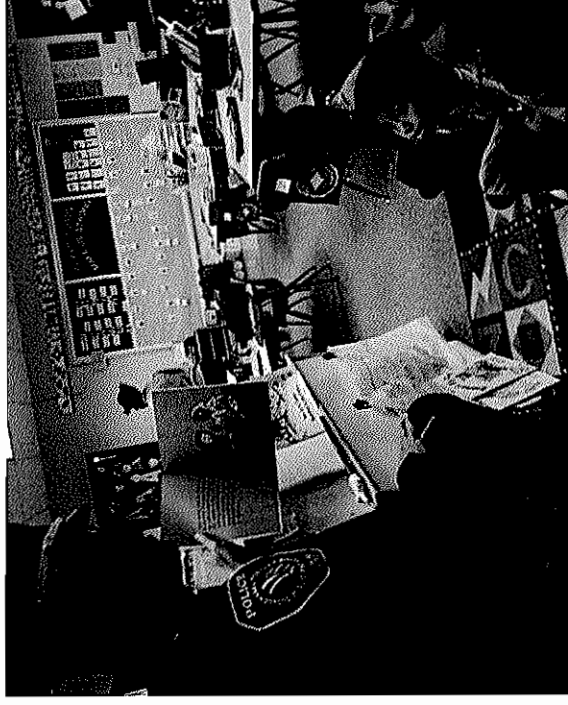
Vision, Oral and Auditory Health Services

Oral health services should include oral health screenings, fluoride varnish, sealants, dental



Safety Indicators

Crime rates in Philadelphia are trending downward—a promising sign for our city's residents. Unfortunately, Philadelphia's crime rate still far surpasses the U.S. average, and violence is highly concentrated in a number of our neighborhoods. The effects of concentrated violence on youth can be seen in our schools every day.



According to the 2013 Youth Risk Behavior Survey (YRBS), more than one third of Philadelphia youth were in a physical fight one or more times in the 12-month period preceding the survey. The proportion of youth who were in a physical fight on school property at least once during the year was double that of the U.S. average (16.2% versus 8.1%). A reported 2,756 violent incidents were reported at schools during the 2012-2013 academic year. Exposure to violence, including peer victimization and family and community violence, are damaging to our youth. Some studies suggest exposure to violence, directly or as witnesses, may be linked to poorer academic outcomes.

Health Indicators

More than 30% of our children who receive some form of medical care are living with a chronic disease. More than 30% of these children live with asthma. There is evidence that indicates access to school-based health programs reduces hospitalization rates and increases the number of days in school among children with asthma. One fifth of Philadelphia youth experience childhood obesity. School-based health services have been associated with increased physical activity and better nutrition.

Reproductive health indicators among Philadelphia youth are also cause for concern. The rates of chlamydia and gonorrhea among 15-19 year olds are 3.5 times and 3 times the national rate, respectively. Compared with the U.S. average, Philadelphia youth are more likely to report: having had sexual

intercourse prior to age 13 years; having had sexual intercourse with four or more persons during their lifetime; and not using any methods to prevent pregnancy during their last sexual encounter. Early and age-appropriate education, prevention and intervention programs can help mitigate the social and economic impact of sexually transmitted infections and teenage pregnancy.



In Philadelphia, the Sayre High School Class of 2007, whose students were provided school-based family services, achieved a 90% on-time graduation rate. Between 2007 and 2009, the rate of graduates enrolling in two-year or four-year college grew from 68% to 84%.
(details page 12)

Program Development

Community Advisory Boards

Each School-Based Family Service Center will establish, and receive guidance from, a local Community Advisory Board (CAB) that manages the ongoing community engagement process to identify the unique needs of the students and families at each SBFSC school. Additionally, CAB responsibilities include: managing community engagement; overseeing site-based coordination of activities; publishing a report card on service outcomes; and providing governing oversight. The CAB's membership should include representatives from the school staff, parents, students (if middle or high school), and community stakeholders. The CAB should also include healthcare and social service providers that support the school center, public agencies, post-secondary institutions, and local community-based organizations.



An Organizational Structure that Listens and Evolves

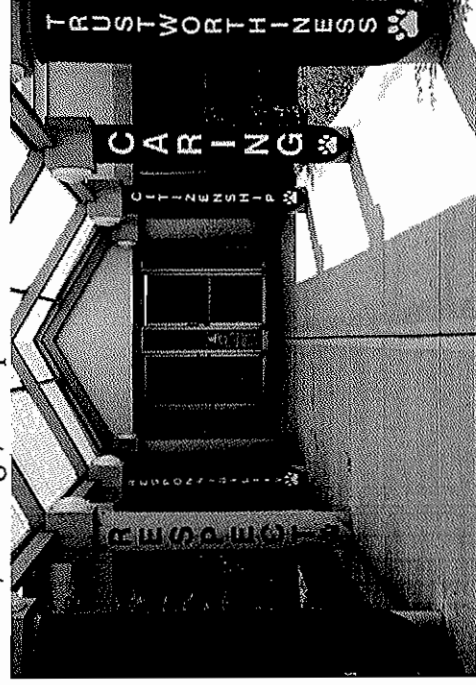
A Cabinet will be constituted with the purpose of establishing citywide programmatic policies and strategies to support operations of SBFSCs. The Cabinet will provide implementation guidance and interface with each Community Advisory Board to ensure the improvement of: student well-being, academic achievement, and family socioeconomic outcomes. Cabinet members will include representatives from the leadership team of participating groups including:

- Parents
- Educators & School Staff
- School District of Philadelphia
- Community Service Providers
- Philadelphia Department of Human Services
- Philadelphia Department of Public Health
- Philadelphia Housing Authority
- Philadelphia Office of Supportive Housing
- Philadelphia Mayor's Office
- Philadelphia City Council

Locating Services Where They Are Most Impactful

All services must be delivered in collaboration with Philadelphia public schools, parents, health and service providers, and appropriate community partners. Schools are the center of the community and shared resources lead to improved student learning, stronger families, and healthier communities. It is essential that SBFSCs be convenient to the students, siblings, and parents. This can

best be achieved by establishing strong partnerships between communities and schools. When a service cannot be placed inside the school itself, it must be placed conveniently within the community or at another nearby SBFSC so transport does not create an additional barrier to access or utilization.



Alcohol and Substance Abuse

According to data from the National Survey on Drug Use and Health (NSDUH) for the Metropolitan Statistical Area (MSA) that includes Philadelphia, 16.6% of individuals aged 12 years or older used an illicit drug in the past year—surpassing both the state (13.6%) and national rates (14.7%). One tenth of the MSA residents were classified as having substance use disorder, and more than 25% of people in the MSA participated in binge alcohol use at least once during the past month. Data from Philadelphia's YRBS confirm alcohol and illicit drug use is a concern among Philadelphia's youth. One in four youth in our city report current alcohol or current marijuana use. One third of youth (33%) reported they had at least one drink of alcohol or had used marijuana at least once during the 30 days before the survey. Almost one fifth of youth (18.9%) had tried alcohol for the first time before age 13 years. One in four youth (25.1%) reported they had used marijuana at least once during the 30 days before the survey; 8% had tried marijuana for the first time before age 13 years.

Research has established an association between poor grades and substance use among young people. There is also compelling evidence demonstrating that parental substance or alcohol abuse increases a student's risk for drug and alcohol abuse and low educational attainment. Programs addressing both parental and youth substance-using behaviors are imperative for the academic success of our city's youth.



Academic Indicators

Philadelphia ranks first in the state for public school dropouts, with a rate that is more than triple that of the state average. One fifth of our city's residents do not have a high school diploma or its equivalent.

Less than half of students scored proficient or above on math and reading—falling short of the 78% and 81% federal No Child Left Behind targets, respectively. Minority students and students from economically disadvantaged backgrounds fared worse.

At Carlin Springs Elementary School in Arlington, VA, 95% of parents are taking adult ESL (English as a Second Language) courses.



The design of community schools vary depending on the resources and needs of the local community. What Sayre and more robust community schools elsewhere in the country have in common are “broad participation by a wide range of providers, intensive coordination and collaboration between the school, its teachers and leaders, and outside partners, and the active engagement of the surrounding community.”

Bundling City Services Under One Roof

Philadelphia has always had the tools necessary for transforming every district school into vibrant School-Based Family Service Centers. Now we have the will to make this a reality. Our City can reasonably achieve this ambitious goal through grouping together existing City services for children and families; service contributions from our City's world-class health and higher education institutions; and an experienced third-party responsible for coordinating care and measuring outcomes so we can track each student's wellness needs in real-time.

Philadelphians already contribute their tax dollars to countless child and family services each year. The question is not whether they should be giving more, but whether their tax dollars are being spent in the most intelligent way—and in a manner that reaches the largest percentage of those in need. Below are a handful of the ways in which local tax dollars are already enhancing the quality of life for children and families. School-Based Family Service Centers would simply bundle the high-quality work being done across the City and provide it in the most convenient location possible—schools.

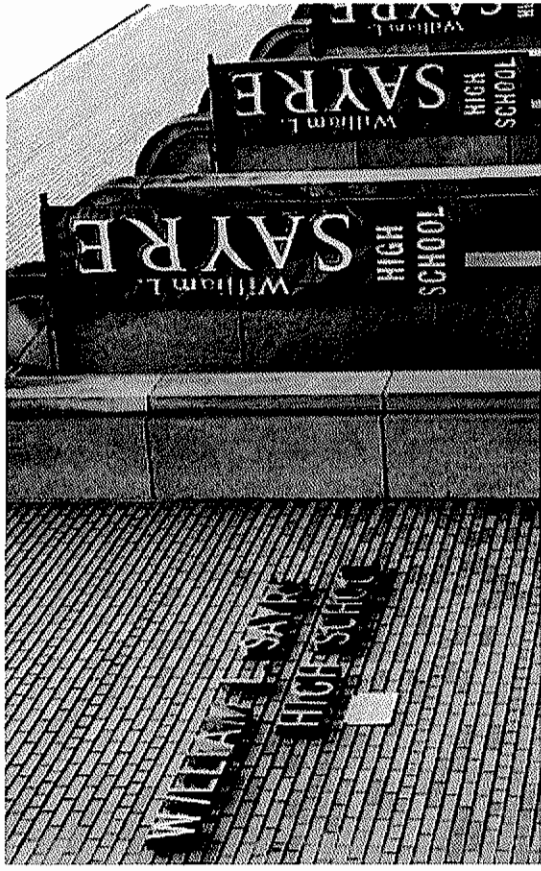
- | | |
|--|--|
| • Arts & Culture Programming | • Juvenile Offender Support Services |
| • Behavioral Health and Intellectual disAbility Services | • Language Access Training |
| • Child Care Funding | • Parks & Recreation Department |
| • Community College of Philadelphia Tuition Subsidies | • Public Defender's Office & Legal Services |
| • Youth Aid Diversion Panels | • Public Health Clinics - Maternal, Child, and Family Healthcare |
| • Empowerment Zones | • School District of Philadelphia (Direct Funding) |
| • Family Court | • Social Services |
| • Financial Literacy | • Supportive Housing Programs |
| • Free Library of Philadelphia | • University Scholarships |
| • GED & Job Training | |

A Case Study in Community Partnerships: Sayre High School

Philadelphia's Sayre High School is a living example of how engaged community stakeholders can transform the learning experience for public school students. While far from complete, the Sayre High School experience comes closest to reaching the ambitious goals of School-Based Family Service Centers.

Through a long-lasting partnership with the University of Pennsylvania, the public school offers an enhanced health sciences curriculum which features cross-collaboration with prominent university science faculty. In 2011, over 350 University of Pennsylvania students gained vital work experience at Sayre as 'co-learners' under the supervision of highly experienced, licensed care providers.

After listening to the needs of Sayre parents, the high school now stays open until 8 p.m. and offers free after-school mentoring and intensive support for college and career readiness.



A health center opened within Sayre High School in 2007. Funded through federal grants and a sustainable funding model, students and community members are provided convenient access to world-class doctors

from the University of Pennsylvania. In addition, the school has a nutrition and garden program that offers job experience, healthy eating classes and more.

The work has paid off. According to the Annenberg Institute for School Reform at Brown University, "Sayre's first senior class of 80 students had a 90% graduation rate, and 56% enrolled in post-secondary education."

Sayre's science curriculum, a main focus of the partnership, focuses on hands-on inquiry and small group learning. A cohort of 10th graders from Sayre travel to the University of Pennsylvania's School of Medicine to gain real-world medical certifications, opening the door to immediate employment opportunities in various medical services professions.

Common Characteristics of Successful Community Schools

- Physically located in the school or proximate to school grounds
- Offer a comprehensive range of services that are customizable to meet specific needs of students and families
- Multidisciplinary team of care providers who work with educators, school nurses and social workers to deliver quality care that can be integrated with learning experience
- Offer services available to members of community in which school is located
- Have an advisory board consisting of community representatives, parents, service providers and school staff to provide planning and oversight to ensure services meet needs

The Cincinnati Story: How A Struggling School District Became A National Model

Experts consistently point to Cincinnati Public Schools' nationally recognized "Community Learning Centers" as one of the best models for community schools.

Key Components & Program Structure

The Community Learning Center Institute is a non-profit that manages the administrative responsibilities of a citywide network of community schools "each with a set of financially self-sustaining, co-located community partnerships responsive to the vision and needs of each school and its neighborhood." The five core components of the Cincinnati model are:

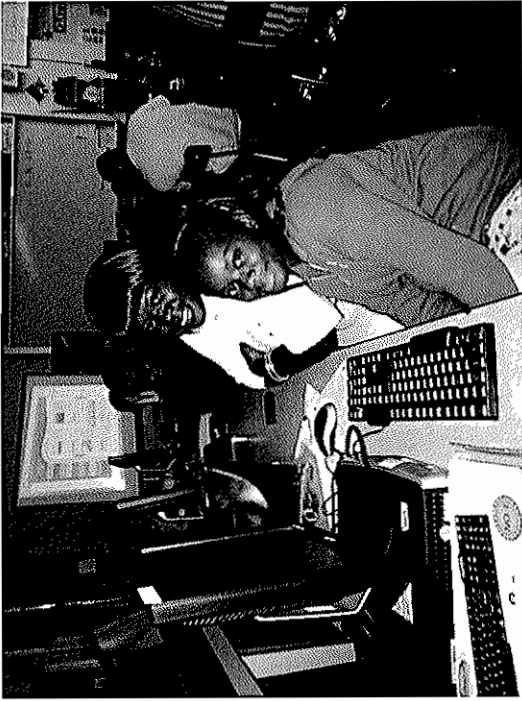


1. A commitment to comprehensive, sustained community engagement to ensure service partnerships remain responsive.
2. Site-based governance that includes parents, educators, and community leaders that is charged with: establishing the unique vision for each school; steering the selection of community partners and care providers; and evaluating their performance.

3. Partnership networks comprised of care providers that provide equitable access to quality services in a manner that is financially sustainable and ensures district dollars remain dedicated to education.

4. Cross Boundary Leadership that knits together the partnership network leaders as a collaborative team to provide coordination and integration of interdisciplinary resources.

5. On-site Resource Coordinators in every school that interface with teachers and staff to provide the critical infrastructure at the site level to develop, integrate, and manage the community partnerships.



Highlighted Outcomes

With community learning centers as a central strategy for school and neighborhood improvement, Cincinnati Public Schools have:

- Become the highest performing urban district in Ohio for five consecutive years;
- Narrowed the achievement gap between black students and white students from 14.5% in 2003 to 1.2% by 2010;
- Raised high school graduation rates from 51% in 2000 to 81.9% in 2010;
- Established two co-located early childhood education centers, 20 school-based health centers, two dental clinics, and the first school-based vision center in the United States;
- Surpassed enrollment projections, in part because of middle class families returning to neighborhood schools; and
- Provided positive conditions for learning through hundreds of community partnerships, which brought millions of dollars in additional resources to the students and their families.

The Proposed Philadelphia Model

The proposed Philadelphia Model for School-Based Family Service Centers draws from the decades of experience in communities across the country where measurements of the effects on student's academic performance and wellness continue to inspire an increasing number of cities to follow their lead.

School-Based Family Service Centers (SBFSC) will adopt the major tenets of full-service community schools drawing from the best models from across the country. Additionally, a Community Advisory Board (CAB) will be formed at each SBFSC location to ensure every student and family member receives the high-quality services they need. Each CAB should include representation from that school's own parents, educators, school staff, service providers, and other community stakeholders. The Philadelphia model for SBFSCs aims to eventually provide convenient, affordable access to the following services at every District school across the City and include:



- Primary Health Clinics – Facilities that operate in school buildings, on school grounds or in the neighborhood using a multidisciplinary team of providers to care for the students, which will provide primary healthcare, dental care, vision care, behavioral health, counseling, and health education.
- Early Childhood Development Programs – Programs that provide services including all-day childcare, after-school care, family guidance, and similar means-tested programs.
- After School Programs – Programs that build on the effectiveness of schools by providing school-age children with academic and nonacademic support.
- Youth Development Programs – Youth programming that provides purpose-driven activities including mentoring, substance abuse counseling, physical activities, community service learning, and pre-employment training.
- Family Resources & Continuing Education Programs – Services for parents and guardians that help support the home on an ad hoc basis or through case management and can include: parenting education; literacy; career counseling and employment programs; tax education; General Education Development (GED) preparation; college readiness support; immigration information; housing, food, and clothing assistance; health services; and early child care.

PUBLIC TESTIMONY ON APRIL 29th

Name	Company	Phone #
Bob Previdi	Bicycle Coalition of Greater Philadelphia	267-235-8523
Waffiyah Murry	Safe Routes Philly, Coordinator	
Sarah Stuart	Deputy Director Bicycle Coalition of Greater Philadelphia	
Hans Kersten	St. Christopher Hospital	215-765-9500
Judith Robinson	Citizen	215-386-1280 ext. 105
Jeannine Lisitski	Women Against Abuse, Executive Director	215-732-5829 x110
Beth McConnell	PACDC	267-787-5344
Margaret Cukoski	Pa Council of Children Youth and Family Svs.	267-528-9053
Charles Younger		215-300-7886
David Fair	Turning Point for Children	267-317-2298
Angel Rodriguez	APM	215-266-9436
Kelly Davis	Lutheran Settlement House	

~~Bob~~ Andy Martino
 Bob Harrison Stenton Family

Testimony : Reduction in Funding of Safe Routes Program 4/29

"This is the decision I regret the most of my mayoral service". Mayor Nutter

These words were spoken by Mayor Nutter at the beginning of March in his last budget address. He was referring to libraries. In an attempt to reduce spending across the government he attempted to close 11 libraries based on incomplete information by well meaning members of his administration.

As we come into 2016 with the expectation of internal budget cuts at the Philadelphia Department of Public Health which will affect Safe Routes the words ring true for this program. The effect of \$50,000 in cuts will be devastating to programming which will create hardship for those who can least afford it. As was found with the decision to close libraries there are nuances which are not being looked at with this decision.

- This cut in safe routes will also cost the lost of matching NHTSA funding.
- The communities that most need these services have no recourse to replace them

If we look at the Community Health Improvement Plan for 2014 - 2018, increasing physical activity is one of the priorities, specifically Chronic Disease related to Poor Diet and Physical Inactivity. Physical activity without parameters of safety is as unsafe as no physical activity.

Community Health Improvement Plan 2014-2018

Philadelphia Community Health Improvement Plan Summary of Priorities and Goals

Priority 3: Chronic Disease related to Poor Diet and Physical Inactivity

Goal 1 Increase access to healthy foods

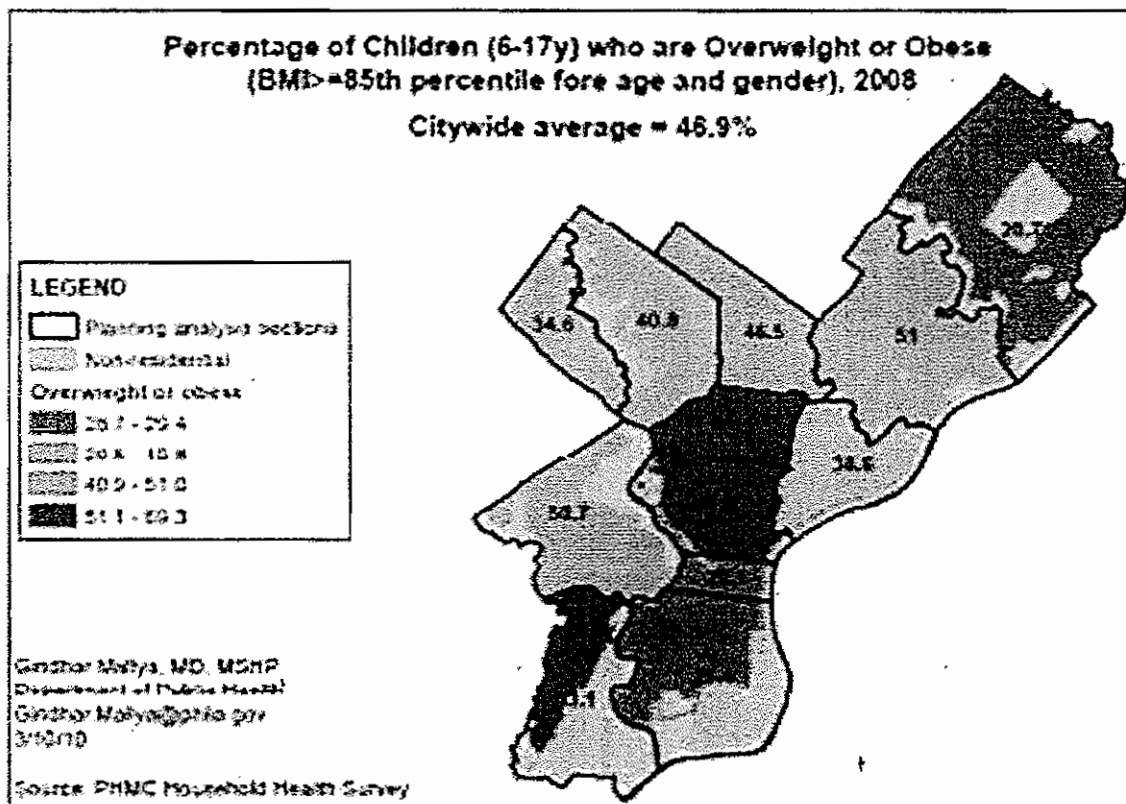
Goal 2 Increase physical activity among children and adults

Goal 3 Further the integration of nutrition and physical activity promotion with clinical practice

Goal 4 Improve knowledge of and access to evidence-based community resources

Although violent crime in the city has gone down over the years there still are dangers and concerns with children traveling to school. In the last few years 24 schools were closed which created additional travel in some communities. Safe Routes was a resource which was geared toward making that travel safer. Lea was one of the schools affected by those closings by having the Wilson school merge with it. Children had to travel past extremely busy streets and across some of the top 10 most traveled Septa routes. This created a danger for students and increased stress for parents. Safe Routes is a program whose mission is to lessen the safety issues with students traveling to school. It is also geared toward helping to train them in best practices of walking and riding which in turn directly affects their physical being.

Considering the fact that 54% of Philadelphia children aged 6 – 11 are overweight or obese with an outstanding 70% in North Philadelphia, this is more than just an issue but in fact a crisis. To take away a program which could directly affect change in those numbers is ill conceived especially considering the nominal cost of the program.



So as we look at budgets and what is important or not important, we must set priorities. With the Philadelphia Department of Public Health making children physical activity one of its priorities for 2014 - 2018 that is a great start. To cut a program from the budget which could economically facilitate this could be a decision which will in the future be called *"the decision I regret the most"*.

So I ask for the health and safety of the children of Philadelphia that this funding be restored.

HENRY C. LEA & ALEXANDER WILSON MERGER

Student Travel and Safety Analysis



Student Safety Report

ANAYLYSIS OF STUDENT SAFETY

Safety Report

Introduction	2
Crossing Guard Locations	2
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PENNDOT Data	4
SEPTA Data	5
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INTRODUCTION

Due to budget cuts the School District of Philadelphia has determined that a number of schools had to be closed. Because of a number of factors the Alexander Wilson School was placed on this list and subsequently voted to be closed by the School Reform Commission. Many of the population of Wilson does not meet the criteria for transportation services; determined by the district to be those students living 1.5 miles from the prospective school location. There are a total of 76 students who currently live beyond this cut off of 1.5 miles and are eligible for transportation services out of the 239 current population. Wilson is located exactly 1.02 miles from Lea with most of the current population living Southwest of the school and above Woodland Ave. This will require those who do not receive transportation services to walk a route which includes many busy thoroughfares and highly trafficked streets. Wilson's population consists of grades K through 6, and due to the age of students who will be required to walk or find other means of transportation this report will examine any factors which will lead to safety concerns for parents and students.

Current Locations of Crossing Guards



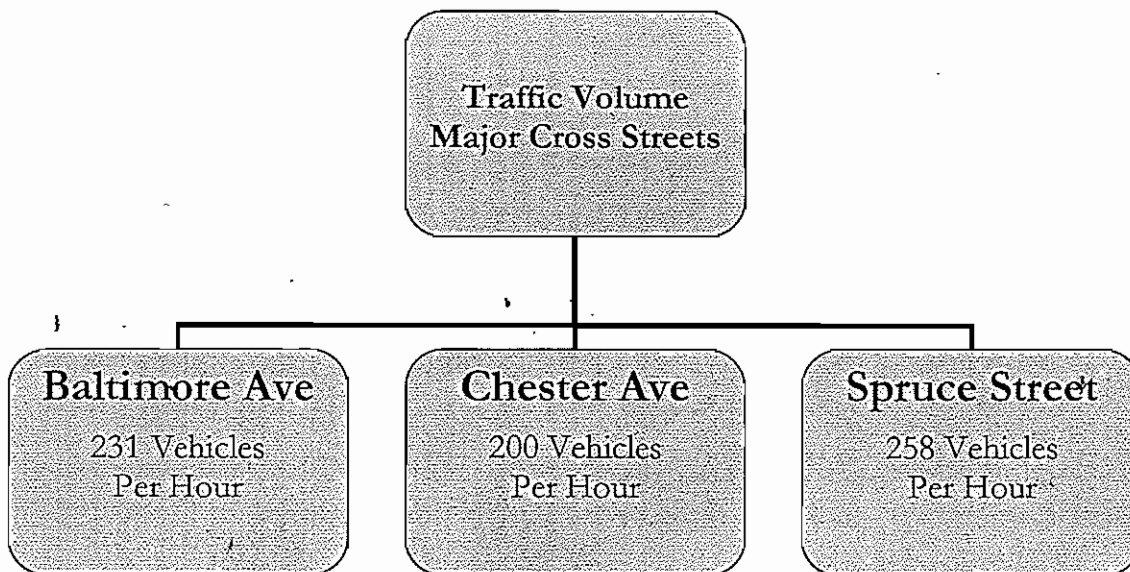
- The 18th Police Department was contacted to report on locations for Crossing Guards
- According to Officer Porter who oversees the guard force all crossing guards will continue at the same locations during the 2013 - 2014 school years. An analysis was requested to determine need for additional locations for Crossing Guards in area of Wilson School

High Traffic 2 Lane Thoroughfares - Wilson to Lea

- Woodland Ave
- Kingsessing Ave
- Chester Ave
- Springfield Ave
- Baltimore Ave
- Spruce Street

Low Traffic 2 Lane Thoroughfares - Wilson to Lea

- Cedar Ave
- Hazel Ave
- Larchwood Ave
- Osage Ave
- Pine Street



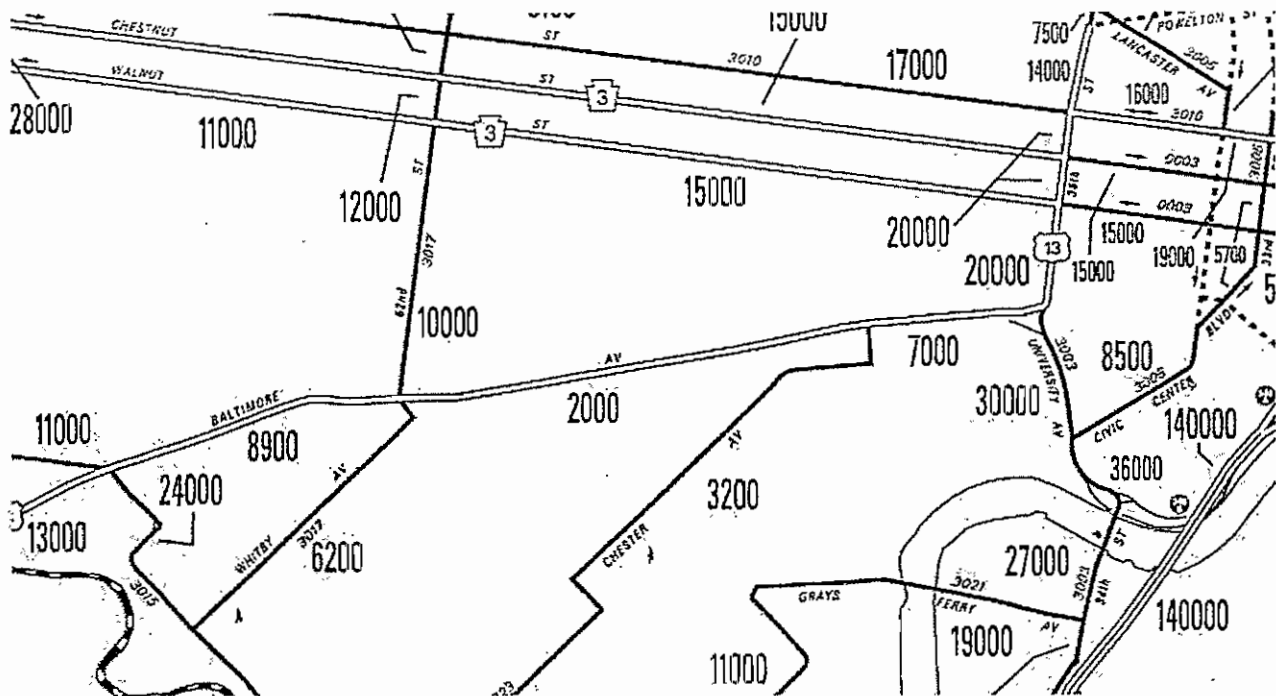
PENNDOT Data



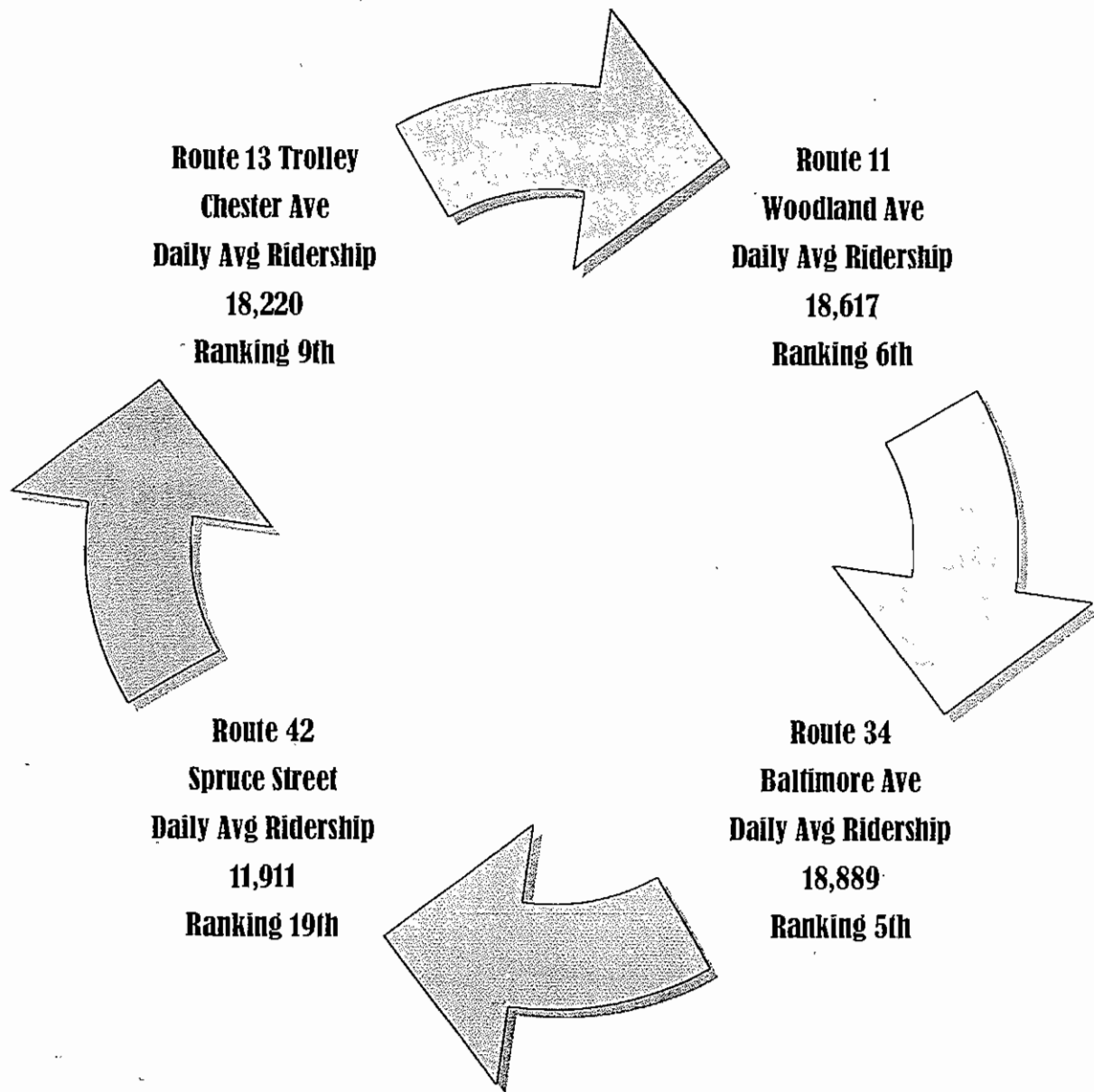
2011
TRAFFIC VOLUME MAP
PUBLISHED NOVEMBER 2012

PHILADELPHIA COUNTY PENNSYLVANIA

PREPARED BY THE
PENNSYLVANIA DEPARTMENT OF TRANSPORTATION
BUREAU OF PLANNING AND RESEARCH



- Traffic Volumes vary along route of travel for students but the average remains high for this region
- Four Trolley or Bus Routes will need to be crossed by students traveling to Lea from Wilson area
- Per Septa Data these routes are rated in their top 10 for usage by public transit customers



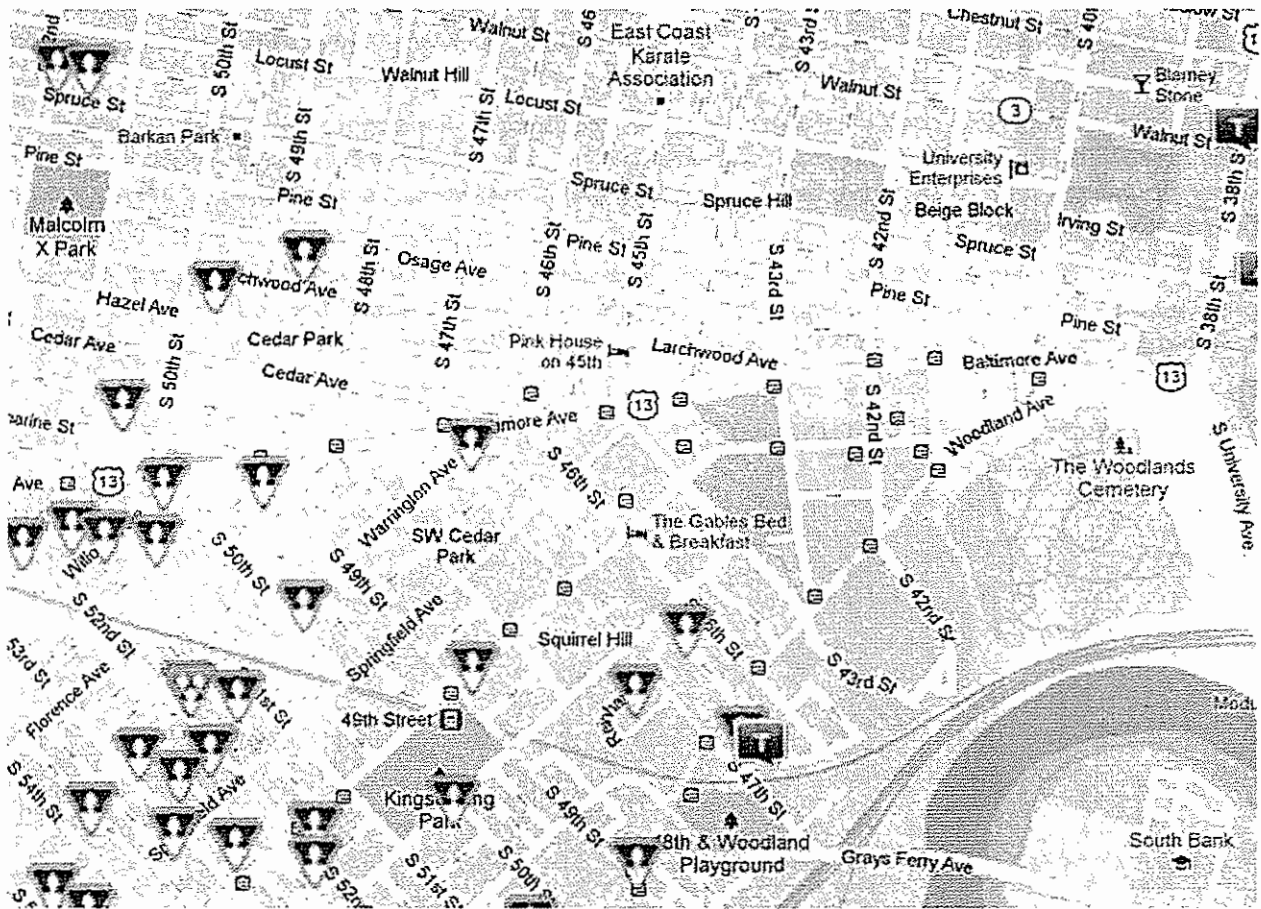
Public Transportation Volume - Cross Streets

Three of the top 10 Septa lines, based on volume, transverse the route that students will travel to Lea from their current residences near the Wilson School. This creates a safety hazard for children traveling



SEPTA Data

Crime Data



Map listed above represents crime data for the region that encompasses Lea and Wilson.

LEGEND :

- Red Markers Represent Sex Offender Locations
- Orange Markers with multiple figures represent multiple Sex Offenders
- Blue Markers with a T represent Thefts

Steps Taken

1. **University City District:** Representatives from UCD were contacted to develop a plan* for September 2013 to have Bicycle Ambassadors patrol the route determined most safe for travel by students.
2. **University of Pennsylvania Police:** Captain Fisher of Penn Police was requested to devise a plan for the coming school year to add patrols along the favored route to Lea to insure safety.
3. **Philadelphia Police 18th District:** Officer Porter was reported to concerning availability of additional Crossing Guards for Woodland Ave and Kingsessing Ave. Additional patrols were requested to insure safety of children, especially during the Winter when daylight declines, and periods when after school programs release students.
4. **Philadelphia Bicycle Coalition:** Safe Routes Walkability Survey was recently conducted of Lea population to determine routes students currently travel and a grant was procured to have PENNDOT do a complete analysis of travel routes for all students in September 2013.



West Philadelphia Students Should Not Have to Resort to Third World Conditions to Get to School

Conclusions

- Based on data accumulated of traffic volumes, and public mass transit route ridership numbers, there appears to be an imminent risk to the population of students who will be traveling to Lea from the Wilson vicinity. Steps must be taken to provide at the minimum a mode of safe transit from Woodland Ave and 46th Street; Wilson's current location, to Locust Street and 47th, Lea's address.

The safest walking route has been determined to be from 46th and Woodland Ave, North to Kinsessing Ave, Southwest to 47th Street, and taking 47th Street the remainder of the route to Lea. Due to the number of multiple intersections along Baltimore Ave this proves to be the most critical area for safety concerns on this path. It appears that 47th and Baltimore Ave is the safest location to cross Baltimore Ave due to a crossing guard being stationed there.

Photos of High Traffic Intersections



Woodland Ave looking East with 47th running North and South

No Crossing Guard at this Intersection Crossing Guard at 46th and Woodland (Leanne)

Trolley Route 11 Runs along Woodland Ave - Septa's 6th Busiest Route



47th Street facing North with Kingsessing running across East to West

No Crossing Guard at this Intersection

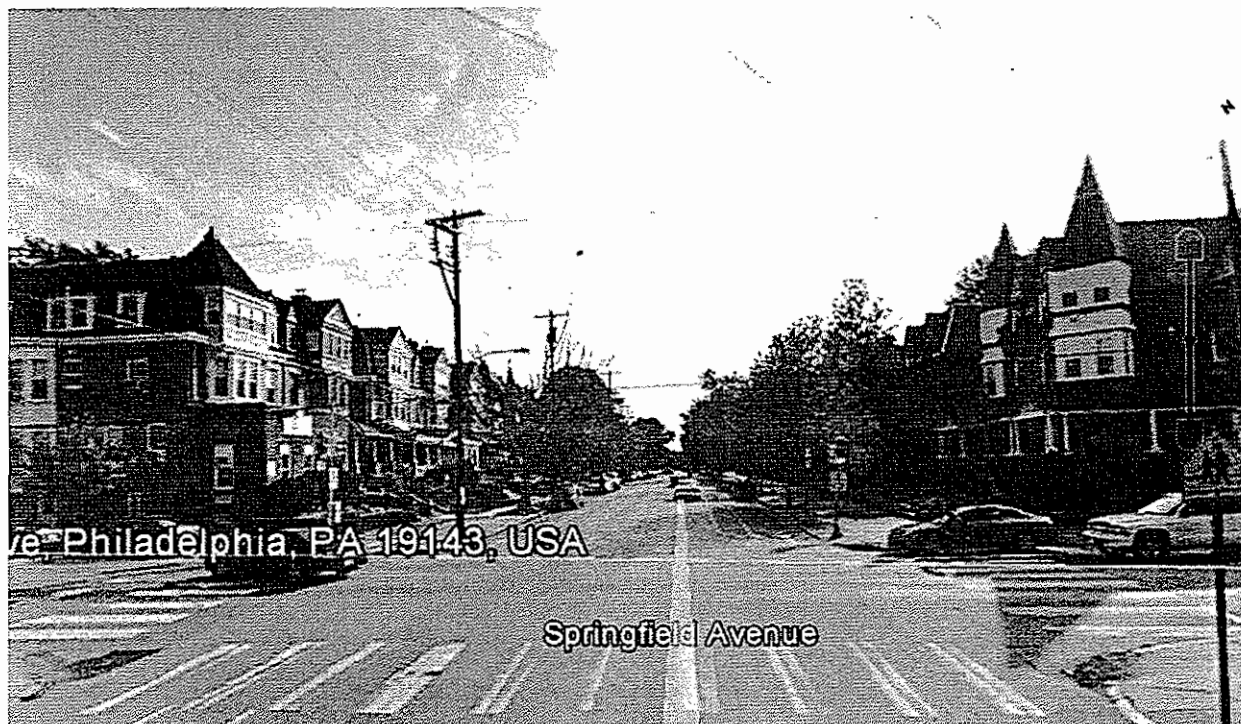


47th Street facing North with Chester Ave running across East to West

No Crossing Guard at this Intersection

200 Vehicles per hour travel this section of Chester Ave

Trolley Route 13 Travels along Chester Ave - Septa's 9th Busiest Route



Springfield Ave facing West with 47th Street running across North to South

Crossing Guard Located at this Intersection (April)

Francis de Sales Parochial School Located on this corner



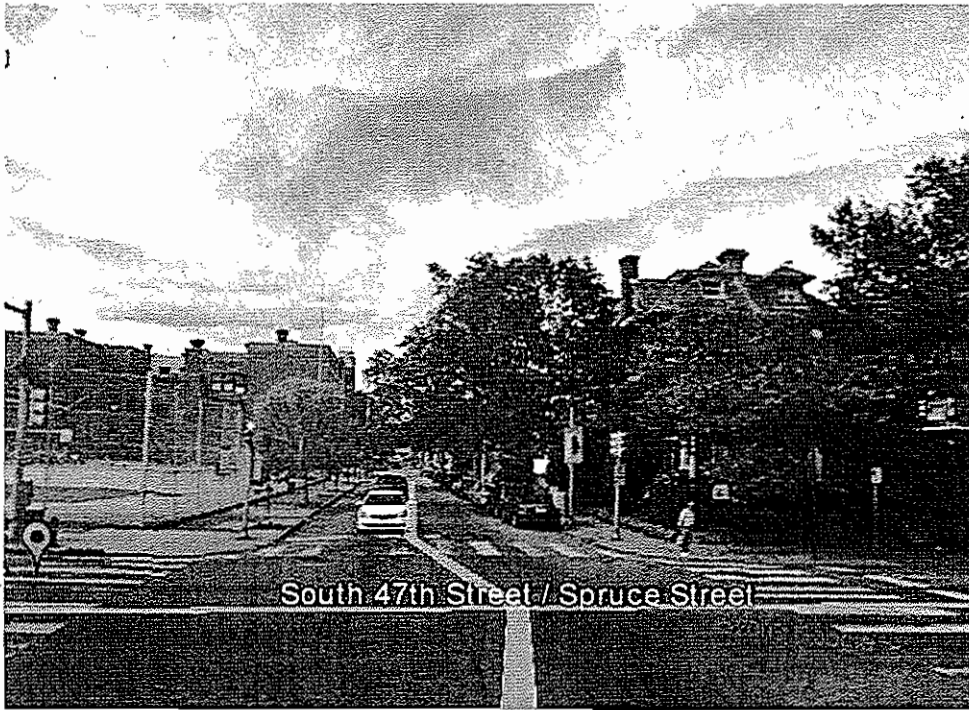
Baltimore Ave facing East with 47th running across North to South

Crossing Guard Located at this Intersection (Renee)

Intersection has a Island with creates traffic multiple traffic patterns

231 Vehicles per hour travel this section of Baltimore Ave

Trolley Route 34 Runs along Baltimore Ave - Septa's 5th Busiest Route

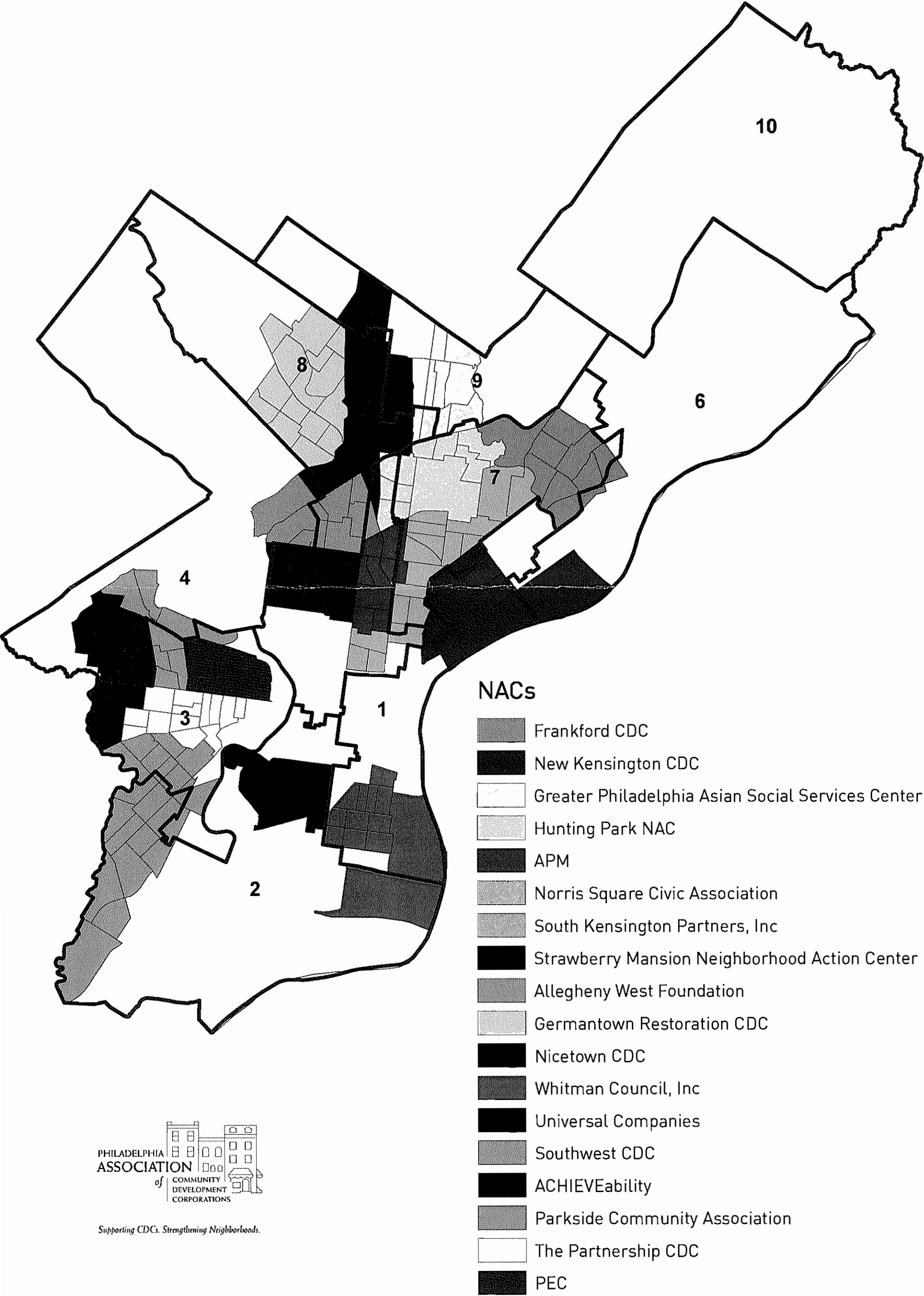


47th Street facing North with Spruce Street running across East to West

Crossing Guard located at this Intersection (Edna)

Bus Route 42 Runs along Spruce Street - Septa's 19th Busiest Route

Philadelphia's Neighborhood Advisory Committees by 2016 City Council District



Supporting CDCs. Strengthening Neighborhoods.



1315 Walnut Street, Suite 1600 | Philadelphia, PA 19107

www.pacdc.org PHONE 215.732.5829 FAX 215.732.5725

Supporting CDCs. Strengthening Neighborhoods.

**Testimony on Bill No. 150164, FY16 Operating Budget of the City of Philadelphia
Presented to City Council's Committee of the Whole
April 29, 2015**

Beth McConnell, Policy Director, Philadelphia Association of Community Development Corporations

Good evening and thank you for the opportunity to testify. My name is Beth McConnell, and I'm the Policy Director for the Philadelphia Association of Community Development Corporations (PACDC). PACDC is a membership association of more than 100 organizations, including 50 CDCs, which work to advance equitable development, revitalize Philadelphia's neighborhoods and improve quality of life for residents.

We are here to urge City Council to work with the Nutter Administration to allocate an additional **\$1 million in General Funds in the FY16 City Budget to support neighborhood small businesses and commercial corridors including the Storefront Improvement Program (SIP), which would also free up \$500,000 in federal funds to strengthen the NAC program.**

\$535,000 in General Fund dollars are needed to fund the Storefront Improvement Program (SIP), which was transforming our neighborhood commercial corridors and boosting small businesses. SIP is an excellent example of how modest investments in our neighborhood corridors make a big impact. SIP provides matching grants to small businesses to help them fix up the facades of the properties they rent or own. Since 2009, more than 382 unsightly, outdated, blighted or uninviting storefronts have been transformed with new windows, doors, signs, paint, lighting or other features in every single Council district. These improvements have led to increases in foot traffic and sales, helped leverage other private investment on our corridors, and helped new small businesses just starting out achieve immediate success. This generates returns to the City in increases in sales, wage and business tax payments.

Unfortunately, the Philadelphia Department of Commerce was forced to unveil new guidelines for the program in December to comply with federal prevailing wage rules and related complex regulations. These new guidelines are threatening this dynamic, successful program: This month, the Tacony CDC had to cancel plans to improve 11 storefronts, other PACDC members report that contractors are declining to bid, and small business owners who wanted to access the program are not applying because of the impact of these new restrictions. In fact, SIP applications have dropped by more than half. While PACDC supports policies that ensure contractors are paid a fair wage for their work, the federal rules are overly burdensome for small businesses that are only spending a few thousand dollars, as well as neighborhood-based contractors that are losing out on potential work.

The only way to avoid the federal rules that threaten the program is to use another source of funding. ***If SIP were to be funded with local dollars and kept at level funding for the grants and support services, \$535,000 in General Funds is needed.*** This would give the Commerce Department the flexibility to design rules for SIP that make sense for Philadelphia, as well as the flexibility to consider funding SIP projects on corridors that may not be eligible for CDBG funding but still face challenges and would benefit from a modest public investment. ***It would also free up CDBG funds that were devoted to SIP to be re-directed to the Neighborhood Advisory Committee (NAC) program.*** We want to thank Councilman Henon for leading the charge advocating to save SIP, and encourage other members of Council to join him.

We advocate that another \$465,000 in General Funds be made available for the corridor management and corridor cleaning programs. Our commercial corridors are strongest when they have three ingredients: corridor managers that serve as advocates, organizers, marketers, planners and problem solvers; cleaning staff that keep the corridors free of litter and illegal dumping; and physical improvements that make the corridors attractive to potential shoppers and new businesses. In fact, many SIP applications come as a result of corridor managers recruiting multiple small businesses to participate, helping them find qualified contractors and fill out applications. Private investment is more likely to flow to our corridors if they are kept clean, and have staff dedicated to implementing a comprehensive revitalization strategy. But also due to federal funding cuts and restrictions on where CDBG funds can be spent, far too many of our neighborhood corridors lack managers and cleaning staff: only 19 out of more than 70 that are targeted for

support. ***An additional \$465,000 in General Funds would allow the Commerce Department to boost investment in these critical programs to achieve more comprehensive revitalization of our corridors, and reach neighborhoods that are not CDBG eligible, yet still sorely lacking in investment.***

\$500,000 is needed to stabilize the Neighborhood Advisory Committee (NAC) program, which is a critical community outreach tool. Neighborhood-based community organizations are absolutely vital in implementing strategies to attack poverty and improve the conditions of our neighborhoods. The NAC program provides a form of constituent service right in our neighborhoods, connecting residents with help to save their home from foreclosure or find an affordable home, keep the heat on, address food insecurity, find employment, and a myriad of other services. The NAC program also serves as a forum for resident engagement in planning and development decisions, and for organizing community clean-ups and neighborhood festivals to improve quality of life and connect neighbors with each other.

Resources from OHCD for the NAC program are among the only source of public or private funding for neighborhood-based organizing and outreach. Unfortunately, cuts in Philadelphia's federal CDBG allocation from Washington D.C. have led to significant cuts in the NAC program. The overall number of NACs has been reduced, leaving those that remain to do more with less: expand their service territories, serve more residents, and do it with less funding and less capacity. In 2014, OHCD funded 19 NACs with just over \$1 million in CDBG funds to serve more than half a million residents. The NAC program is underfunded, under-capacity and unable to keep up with the growing demand for help from residents struggling with economic insecurity.

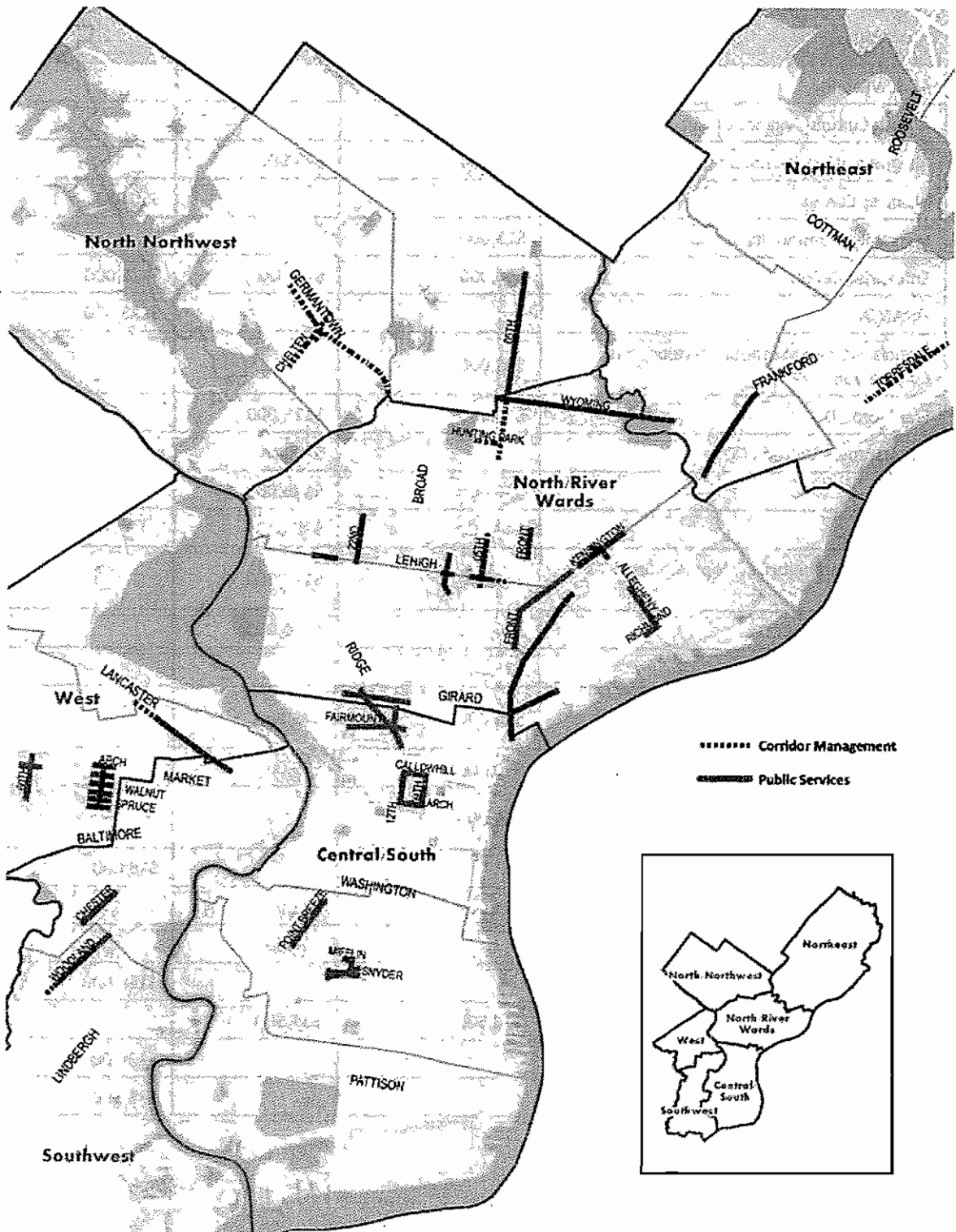
In the long run, the NAC program and other community groups need a total of \$4 million annually to truly "scale up" and meet the needs of our residents. But just to meet the program's basic needs in FY16, \$500,000 is needed to provide more adequate support to cover the program's basic costs, expand the program modestly to add a few more NAC programs, to provide training and technical support to NAC staff to help them share and implement best practices, and create a small pool of funds for innovative projects or services to support our neighborhoods. ***If General Fund Revenue was made available to fund the Storefront Improvement Program, then \$500,000 of the federal***

CDBG funds freed up should be re-directed to stabilize the NAC program. We also want to thank Councilman Jones and Councilwoman Blackwell for hosting a briefing on the NAC program, which will be held next Thursday, May 7th at noon after Council's Stated Meeting, in the Caucus room, where you will hear from NAC leaders about their work.

In closing, I'd like to thank Council President Clarke and Councilwoman Blackwell for the recent and upcoming hearings to examine how Philadelphia can better meet the needs for affordable homes. We look forward to working with you over the summer to consider potential revenue sources to at least double resources for the Philadelphia Housing Trust Fund.

Thank you for the opportunity to testify.

Targeted Corridor Management and Public Services



Commerce Department Program Allocations for Year 41			
Organization	Public Services in Commercial Corridors	Targeted Corridor Management	Business Technical Assistance Program
ACHIEVEability	\$27,500		
African Cultural Alliance of North America	\$35,000		
Allegheny West Foundation	\$30,000	\$75,000	
Business Center			\$50,000
Diversified Community Services	\$25,000		
Enterprise Center	\$50,000	\$75,000	\$125,000
FINANTA			\$125,000
Francisville Neighborhood Development Corporation	\$30,000		
Frankford CDC	\$50,000	\$125,000	
Germantown United CDC		\$75,000	
HACE	\$50,000	\$125,000	
Impact CDC	\$40,000	\$75,000	
Korean Community Development Services Center	\$40,000	\$120,000	
New Kensington CDC	\$75,000	\$175,000	
Newbold CDC	\$25,000		
Nueva Esperanza Housing & Economic Development Corp.	\$35,000	\$75,000	
People's Emergency Center CDC	\$30,000	\$75,000	
Philadelphia Chinatown Development Corporation	\$56,000		
SCORE			\$75,000
Southwest CDC	\$35,000	\$75,000	
Tacony CDC		\$37,500	
UAC/Entrepreneur Works			\$125,000
Village of Arts and Humanities	\$28,500	\$37,500	
Welcoming Center for New Pennsylvanians			\$125,000
Women's Opportunities Resource Center			\$75,000



Luz E. Lopez, M.S.
Board Chair

Nilda I. Ruiz
President & CEO

Good Evening esteemed Council Members,

I am Angel Rodriguez Vice President of Asociación Puertorriqueños En Marcha (APM). I am before you today in support of the allocation of an additional \$1 million dollars in General Funds in the FY16 budget to support neighborhood small businesses and commercial corridors, which would also free up federal funds to strengthen the NAC program.

It is well documented that due to cuts to CDBG funds from Washington D.C. these successful programs are struggling and that complicated federal rules that restrict how and when the funds can be spent.

With \$1 million dollars of General Fund revenue would allow these programs to continue to serve our neighborhood small businesses, commercial corridors and disadvantaged residents.

In particular the \$500,000 dollars needed to stabilize a vital community outreach tool, the Neighborhood Advisory Committees is critical.

- The Neighborhood Advisory Committee program (NAC) provides a form of constituent service in our neighborhoods,
 - Connecting residents with help to save their homes from foreclosure
 - Find an affordable home,
 - Keep the heat on,
 - Address food insecurity and,
 - Find employment.
- The NAC programs are a forum for resident engagement:
 - In planning and development decisions,
 - For organizing community clean-ups and neighborhood festivals
 - And improve quality of life in our City of Neighborhoods.
- Our NAC program has also been a vehicle to leverage additional resources for our community residents such as:
 - Crime Prevention Programming
 - Lead & Healthy Homes Services
 - Energy Saving Initiatives
 - Basic Systems Repairs and,
 - Numerous Health initiatives addressing Asthma, Obesity, and Diabetes to name a few

Unfortunately, cuts in Philadelphia's federal CDBG allocation from Washington D.C. have led to significant cuts in the NAC program. The overall number of NACs has been reduced, leaving those that remain to do more with less: expand their service territories, serve more residents, and do it with less funding and less capacity. In 2014, OHCD funded 19 NACs with just over \$1 million in CDBG funds to serve more than half a million residents.

The NAC program is underfunded, under-capacity and unable to keep up with the growing demand for help from residents struggling with economic insecurity.

In the long run, the NAC program and other neighborhood groups need \$4 million to scale up, but \$500,000 is needed for FY16 to restore some of the recent federal cuts. This would provide:

- More adequate support to cover the program's basic costs,
- Expand the program modestly to add a few more NAC programs,
- Provide training and technical support to NAC staff to help them share and implement best practices, and
- Create a small pool of funds for innovative projects or services to support our neighborhoods.

If General Fund Revenue was made available to fund the Storefront Improvement Program, then \$500,000 of the federal CDBG funds freed up should be re-directed to stabilize the NAC program.

APM stands ready to work alongside City Council, the Administration, PACDC, and various intermediaries in this endeavor to improve the quality of life for the citizens of Philadelphia.