COUNCIL OF THE CITY OF PHILADELPHIA

COMMITTEE OF THE WHOLE

Room 400, City Hall
Philadelphia, Pennsylvania
Tuesday, April 15, 2014
10:25 a.m.

PRESENT:
COUNCIL PRESIDENT DARRELL L. CLARKE
COUNCILWOMAN CINDY BASS
COUNCILWOMAN JANNIE BLACKWELL
COUNCILMAN W. WILSON GOODE, JR.
COUNCILMAN WILLIAM K. GREENLEE
COUNCILMAN BOBBY HENON
COUNCILMAN KENYATTA JOHNSON
COUNCILMAN CURTIS JONES, JR.
COUNCILMAN JAMES KENNEY
COUNCILMAN DENNIS O'BRIEN
COUNCILMAN DAVID OH
COUNCILMAN BRIAN J. O'NEILL
COUNCILWOMAN MARIA D. QUINONES-SANCHEZ
COUNCILWOMAN BLONDELL REYNOLDS BROWN
COUNCILWOMAN MARIAN B. TASCO

BILLS 140144, 140145, and 140146
RESOLUTION 140159

- - -

COUNCIL PRESIDENT CLARKE: Good morning, everyone. We're going to start now. This is the public hearing on the Committee of the Whole regarding Bills No. 140144, 140145, 140146, and Resolution No. 140159.

Ms. Lewis, would you please read the titles of the bills and resolution.

MS. LEWIS: Bill No. 140144, an ordinance to adopt a Capital Program for the six Fiscal Years 2015 through 2020 inclusive.

Bill No. 140145, an ordinance to adopt a Fiscal 2015 Capital Budget.

Bill No. 140146, an ordinance adopting the Operating Budget for Fiscal Year 2015.

And Resolution No. 140159, 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 2015 through 2019, and incorporating proposed

4/15/14 - WHOLE - BILL 140144, etc.

changes with respect to Fiscal Year 2014, 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 3rd, 1992 (Bill No. 1563-A) by and between the City and the Authority.

COUNCIL PRESIDENT CLARKE: Thank you.

Today we continue the public hearing on the Committee of the Whole to consider various bills read by the Clerk that constitute proposed operating and capital spending measures for Fiscal 2015, a Capital Program, and a forward-looking Capital Plan for Fiscal Year 2015 through 2020.

At this time, we will hear testimony from the Department of Behavioral Health, followed by Health Department, Department of Human Services,

4/15/14 - WHOLE - BILL 140144, etc.

Supportive Housing, and City Commissioners.

I would ask the Administration to please state your name for the record and proceed with your testimony.

DR. EVANS: Good morning, President Clarke and members of Council. My name is Dr. Arthur C. Evans. I'm the Commissioner for the Philadelphia Department of Behavioral Health and Intellectual disAbility Services and I'm here to present testimony on our FY 2015 Operating Budget. Joining me today is Deputy Commissioner David Jones as well as many senior staff who are in the audience.

The FY15 DBHIDS Operating Budget request totals $1.2 billion: 13.8 million in the General Fund, 254.9 million in the Grants Revenue Fund, and 933 million in the HealthChoices Behavioral Health Revenue Fund.

The DBHIDS FY15 budget will support 268 positions, 16 in the General

Fund and 252 in the Grants Revenue Fund. Of the $1.2 billion budget, 61 million, or 5.1 percent, is for intellectual disability and early intervention services and 1.1 billion, or 94.9 percent, is for behavioral health services.

Class 100 totals 22.6 million; Class 200 totals 1.2 billion; Class 300 totals 221,000; Class 400 totals 236,000; and Class 800 totals 1.6 million.

The mission of DBHIDS is to improve the health status of Philadelphians in need of behavioral health and intellectual disability services. This is accomplished through an emphasis on recovery and resilience-focused behavioral health services as well as an emphasis on self-determination for individuals with intellectual disabilities.

Our goal is to help individuals realize their goals and to attain the highest quality of life possible. We

work with persons recovering from mental health and/or substance use, individuals with intellectual disabilities, families, service providers, and members of the broader community to ensure that high-quality services are accessible, effective, and appropriate. We are committed to developing a system of care that is data driven, employs evidence-based practices, promotes cultural competency, and eliminates healthcare disparities.

The Behavioral Health component of the Department coordinates the City's mental health and substance use treatment system for 130,000 individuals, adults and children, annually. The Intellectual disAbility Services Division is responsible for the development, coordination, and monitoring of services for 14,000 infants, toddlers, children, and adults with intellectual disabilities.

In FY14, DBHIDS continued its

4/15/14 - WHOLE - BILL 140144, etc.

efforts to address behavioral health and intellectual disability needs of Philadelphians and to ensure that the Department employs a comprehensive person-centered approach to its service delivery.

I'll just highlight a couple of the key achievements over the last fiscal year. First of all, in the Intellectual disAbility Services area, we are serving approximately 7,700 children and adults with intellectual disabilities and 6,100 infants and toddlers who receive early intervention services. The Infant, Toddler, Early Intervention program has had a significant impact on the developmental trajectory of children from birth to age 3. As a result, many of these children enter elementary school without the need for additional supports.

In 2013, 93 percent of Philadelphia respondents to a state survey indicated that the services that they received helped them support their

child development at school and at home. Ninety-five percent of families indicated that they used the information learned from early intervention services to support their child's learning and development.

We also continue to expand our Life Sharing program. That's a program that allows people with intellectual disabilities to live in caring homes that provide an enriching, supportive environment, and as of December 2013, 236 people were enrolled in that program.

Employment is very important for people with intellectual disabilities, and we have put a lot of emphasis on that. During the first seven months of this fiscal year, 485 individuals with intellectual disabilities were employed and 784 received employment services.

In terms of some of our behavioral health initiatives, we continue to emphasize

pay-for-performance. Last year, our pay-for-performance payout was about $10 million, and we've seen some very significant improvements in service delivery as a result of that program.

In terms of our minority, women, and disabled-owned business initiatives, the Department's goal for the last fiscal year was 8 percent. We in fact came in at 14 percent. And I should note that there were several vendors who actually are minority, women-owned businesses, but have not been certified. Had they been certified, our percentage would be actually about twice what it was.

The Department is a national leader in implementing and using public health strategies to address behavioral health conditions. We are working in a lot of different domains, including using mental health screenings, both online and in the community. We're using Mental Health First Aid as a strategy to educate

the public about mental health issues. We are employing crisis response teams in the aftermath of traumatic events in the community so that we are beginning to intervene earlier when community members experience trauma. We're also now doing a pilot using an evidence-based online therapy program to expand options for people who are in need of behavioral health services.

Finally, I'll make a few comments about some of the challenges that we have currently in our system and in terms of addressing people's behavioral health and intellectual disability needs.

One of the main challenges for us right now is the lack of Medicaid expansion, which has impacted us in several ways. A couple are that because Medicaid was not expanded in the state, we have less revenue in our Medicaid managed care program than we had anticipated at the beginning of the year.

And the other issue is that it continues to put pressure on our grants, which we use to provide services for people who are uninsured.

In terms of our 2015 issues and priorities, two of the top priorities for the Department is to continue to expand to build our community-based network of services, and we will continue to improve and expand our performance evaluation system. As I mentioned, we are using pay-for-performance to drive provider performance. We found that to be a very effective way of providing -- of improving provider performance and we want to continue to expand that.

Finally, we appreciate the continuing support of Councilmembers in the ongoing effort to highlight public health issues and to secure the resources required to meet the growing demand for behavioral health and intellectual disability services. My staff and I would welcome the opportunity to meet

with any Councilmembers at your convenience to engage in further discussions regarding these issues.

I would also like to extend a personal invitation to you and your staff to enroll in our Mental Health First Aid training, and I'm happy to answer any questions that you might have this morning.

Thank you.

COUNCIL PRESIDENT CLARKE: Thank you, Doctor. A couple of quick questions.

Section 45, Page 3 of your budget detail shows a 62.9 million increase in budgeted funds for FY15, and the majority of the increase is due to a proposed increase of over 51 million in the HealthChoices Fund. Can you explain that?

DR. EVANS: Sure. So because of the way the state budget works -- remember, 99 percent of my budget comes through the State of Pennsylvania.

Because of the way the state budget works, there are changes that happen throughout the year, and to the extent that those changes happen, we want to have enough appropriation power in our budget to accommodate those. So most of the 62 million that you're looking at is not identified real dollars that we're expecting, but if we do get those dollars based on discussions that we're having with the state, we have the appropriation power.

COUNCIL PRESIDENT CLARKE: Appropriation power, okay. Do you anticipate coming close to that amount?

DR. EVANS: No, unfortunately. We don't anticipate that yet. There are a couple of things that could happen. One is that we're talking to the state right now about the captation rate that we receive for the Medicaid managed care program, and if they make some policy changes or some adjustments in that captation rate, we might see an increase.

It is also unclear where the state will end up on Medicaid expansion, and depending on that, that could also result in additional revenue to the City.

COUNCIL PRESIDENT CLARKE: Okay. On Page 4 of your testimony you state that elimination of General Assistance payments combined with the impact of state cuts continue to further weaken the safety net intended to care for people who have no alternative resources and continues to diminish.

Can you quantify the amount of people who will be affected by this gap in coverage, and also please detail the specific impacts this loss may have on the local population. And I'm representing a part of the City that has had significant challenges. I know that this is having an impact. Can you just kind of...

DR. EVANS: Sure. It's hard to quantify the actual numbers, but let me talk a little bit about what I think the

impacts are going to be.

So there are two things that have happened with regard to GA that have been challenging for us at the Department. One is that the cash benefit went away. The other is that the state has made it more difficult for people to actually enroll in Medicaid and to GA in particular.

So in terms of the cash benefit, one of the ways that that impacts us is that most of the people who are on General Assistance are adults, males, many of them are substance users, many of them historically used their cash benefit to pay for recovery housing, for example, which was enormously important, because we can provide all the treatment in the world. At the end of the day, people need a place to live and they need that kind of support to help them engage in long-term recovery. So the elimination of the cash benefit has really hurt the City's network of

recovery houses and hurt our ability to step people down out of higher levels of residential care into the community into residential -- into recovery homes. That's one way.

In terms of the enrollment issue, there are basically two types of people in the public system when it comes to financing, those who are uninsured and those who are insured. And people who have General Assistance, Medicaid, Medical Assistance, all of that are insured. What happens is that, and what has happened over the last several years, is that for the uninsured, that is a finite pot, so to speak, of dollars that has been consistently cut over the last several years. So as the numbers of people in the community have gone up in terms of uninsured, the amount of money that we've had to cover the cost of that care has actually gone down.

Medicaid, Medical Assistance, General Assistance are an entitlement, so

as those numbers have gone up, our actual revenue goes up. So what's happened is that as we receive cuts or as it's become more difficult for people to get health insurance, to get Medical Assistance, that has left those people on the uninsured side, and that's the side that has been cut. So the cuts to GA have really complicated our ability to make sure that when people show up at the door, that we have enough resources to make sure that they get the appropriate care.

So those are just some of the ways that the GA cuts continue to challenge us as a department.

COUNCIL PRESIDENT CLARKE: Lastly, the ACA. We sponsored a couple of meetings in our district, and we're a little frustrated because our good Governor hasn't figured out a way to take advantage of the potential opportunities with expanding Medicare, and unfortunately in that particular meeting,

the majority of the people there weren't actually able to take advantage of the exchanges because of the income.

Is there any hope at this point for those individuals who are not on -- have some sort of a General Assistance provision that will allow them to get some level of healthcare and don't necessarily have the income to be in an exchange because it's rather costly? Any hope for those people?

DR. EVANS: Well, there is.

COUNCIL PRESIDENT CLARKE: Or is there an option of some sort?

DR. EVANS: Well, the reality is that there's still going to be a gap of people who are not going to be insured under the ACA even if the state decided to expand Medicaid. So the way the program works, as you probably know, that for the people who are in that gap between those who have Medical Assistance and those who have private insurance is that for people who have high enough

4/15/14 - WHOLE - BILL 140144, etc.

incomes, their insurance, health insurance, would have been subsidized, making it more attainable, and then for people who have the lowest incomes, to push up eligibility so that more people could be eligible. Still going to leave a gap.

The problem with not expanding Medicaid is that there are people who today could be insured who are not insured, and obviously that presents a real challenge for us. I think there is -- the Governor actually does have a proposal in to what he characterizes as reform Medicaid and would allow Medicaid expansion. The challenge is I think twofold. Number one is, Pennsylvania has probably one of the best Medicaid managed care programs in the country. It is already a private-public partnership. It has saved the state billions of dollars. I think the actuaries show that it saved probably between $3 and $4 billion. It has improved access to care.

And so I think there are many people in the field who believe that simply expanding on this very successful program could have been -- would have been much more expedient. People would have had immediate access. What the administration chose to do is to say, Well, we need to reform Medicaid and get a federal waiver in order to make these reforms happen. That process takes a very long time, particularly the waiver that the government decided to go after. So it's probably going to take at least another year before anything would be approved and could be implemented.

So I think there is hope. There's not hope that it's going to get resolved in the near future, but in the long term, there is some hope that Medicaid will be expanded.

The other thing -- and I think this group should understand this -- is that the way the ACA works is that there's a payment called disproportionate

share payments that go to hospitals, and that's to help them cover people who are uninsured. Because it was assumed that all the state -- when the original legislation was done, it was assumed that all states would have expanded Medicaid, that those payments are going to start to go down. So hospitals that rely on those DSH payments, those disproportionate share payments, are going to feel increased financial pressure because they're not going to have those resources to cover the people who are uninsured.

So I think as -- in the course of time, it will be very difficult for the state not to expand Medicaid.

COUNCIL PRESIDENT CLARKE: Thank you, Doc.

The Chair recognizes Councilman Goode.

COUNCILMAN GOODE: Thank you, Mr. President.

Good morning, Dr. Evans.

DR. EVANS: Good morning,

4/15/14 - WHOLE - BILL 140144, etc.

Councilman.

COUNCILMAN GOODE: Could Dr. Schwarz come to the table as well.

(Witness approached witness table.)

COUNCILMAN GOODE: Good morning, Dr. Schwarz.

DR. SCHWARZ: Good morning.

COUNCILMAN GOODE: I have questions for Dr. Evans as well, but I have a series of questions for you.

Are you aware of my information request made to the Budget Director for all departments?

DR. SCHWARZ: I believe I am, yes.

COUNCILMAN GOODE: And you oversee multiple departments testifying today, correct?

DR. SCHWARZ: I do, yes.

COUNCILMAN GOODE: I'm going to outline some of those questions just not for direct response, unless you have it, but just to outline them for the record,

and I need a written response to them.

DR. SCHWARZ: I don't necessarily -- I came up not knowing what question you were going to ask, so I don't have my notes in front of me, but I'm happy to be --

COUNCILMAN GOODE: Most of these will be for written response anyway.

DR. SCHWARZ: Yes.

COUNCILMAN GOODE: What services does your department contract out that were once performed by City workers? Will you be able to provide that information?

DR. SCHWARZ: I had thought that that had been provided. I'm sorry if it hasn't. We're happy to provide it to you.

COUNCILMAN GOODE: And that includes Dr. Evans' information?

DR. SCHWARZ: All of our departments had, I believe, provided it. If you haven't received it, I apologize

and will make sure that you do.

COUNCILMAN GOODE: Okay. Are the private-sector workers who now perform these contracted services paid a living wage with benefits?

DR. SCHWARZ: So the answer to that question varies slightly by department, and I can give you an example which may be most helpful, and I believe that information was included in the response.

COUNCILMAN GOODE: Rather than example, are you going to provide a full listing?

DR. SCHWARZ: Absolutely. I believed that was done, and I again apologize if you don't have it.

COUNCILMAN GOODE: Has your department requested waivers for contractors to help them avoid paying the local living wage and benefits standard?

DR. SCHWARZ: Among the four departments, yes, there have been requests of waivers, and I believe they

were provided to you.

COUNCILMAN GOODE: And I have a listing from another source, but I look forward to your listing that information as well, and so I can expect to receive that?

DR. SCHWARZ: Absolutely.

COUNCILMAN GOODE: And the basis for the request of the waivers.

DR. SCHWARZ: Absolutely.

COUNCILMAN GOODE: Can you tell me the waiver process?

DR. SCHWARZ: Yes. So I want to make sure I understand the question. Do you mean what are the criteria used?

COUNCILMAN GOODE: How does an agency get a waiver? I know what the law says. I'm trying to figure out whether it works according to the law.

DR. SCHWARZ: I believe that it does. So an agency that has a part of its workforce where the general wage structure is such that people are paid below the living wage and there is --

COUNCILMAN GOODE: I guess my simple question is, does the agency request the waiver?

DR. SCHWARZ: Does the?

COUNCILMAN GOODE: Agency request the waiver.

DR. SCHWARZ: The contracted agency?

COUNCILMAN GOODE: Yes.

DR. SCHWARZ: Yes, they do.

COUNCILMAN GOODE: In each case the agency requested the waiver?

DR. SCHWARZ: I believe that is the case. I know it best, as you might imagine, for the Department of Public Health, but that is the process that we have intended, yes.

COUNCILMAN GOODE: And can you just verify in writing that each agency requested the waiver in whatever you're sending to me?

DR. SCHWARZ: I will do that to the best that I can, so --

COUNCILMAN GOODE: Here's the

question, and it's somewhat off the top of your head, so if you can't name an agency, fine, but if you can, that would be great.

What's the maximum amount that these contractors could have afforded to pay, the ones that got waivers?

DR. SCHWARZ: I need you to ask me that question again.

COUNCILMAN GOODE: Take an agency that got a waiver. What's the maximum amount they could have afforded to pay?

DR. SCHWARZ: They could have afforded? You mean per hour of wage or total amount for the contract?

COUNCILMAN GOODE: Per hour of wage.

DR. SCHWARZ: I would need to give you that by contract since there's so much variety in the kind of workforce and the issues. I don't -- I will go back and look.

COUNCILMAN GOODE: Do you know

by agency and contract how much each could afford to pay?

DR. SCHWARZ: I don't believe I know --

COUNCILMAN GOODE: Did you ask them how much they could afford to pay?

DR. SCHWARZ: I don't think we did precisely. I think what ability to afford --

COUNCILMAN GOODE: Dr. Evans, did you ask any of the agencies that requested waivers what they could afford to pay?

DR. EVANS: We don't ask that question specifically. What we try to understand is why is a provider asking for a waiver, and there are a variety of issues. If you want me to go into some of that, I could do that.

COUNCILMAN GOODE: I understand why waivers are given, and we can get into that a bit more. My question is, if they could not afford to pay at least 150 percent of the federal minimum wage,

which is $10.88 per hour, comparable health benefits for full-time employees, and up to 56 hours of paid sick leave, did you ask them what they could afford?

DR. EVANS: Yeah. So for providers -- so here's I think where you're going. When the ordinance was passed, we had providers who paid below the 150 percent. Our position is that we want all of our providers to be at 150 percent. And so what we've been doing is for those providers -- there's only a handful of providers that were paying some of their workers below 150 percent. We've been working with them to get them up to 150 percent, and most of them will be within the next couple years.

The instances where people are paying less than 150 percent are really special situations. Either they are people who are in training, students, so forth, or they are situations where you have workers who are sleeping overnight in a residential facility. So they're

not working all day. They're sleeping overnight. The pay structure for those organizations was such that they paid them less than the 150 percent.

COUNCILMAN GOODE: But my question, Dr. Schwarz and Dr. Evans, is, do you ask the contractors how much they can afford to pay?

DR. EVANS: Well, we don't ask --

COUNCILMAN GOODE: And if the answer is no, then the answer is no. But the law says that partial waivers are preferred to full waivers, which means that you don't offer a full waiver if you can offer a partial waiver, which means that it's important to know and to ask and to determine how much they can pay if it's less than 10.88 and for them to pay that, because the law says that the standard is what it is and there is a waiver process, but it says that partial waivers are preferred to full waivers. And so we should be doing partial waivers

where appropriate.

DR. EVANS: Absolutely. So what we're trying to -- and I clearly understand the question. So what we're trying to do is to get those providers that are less than 150 percent up to and above 150 percent as quickly as possible. So while we don't ask the question, what we do ask is for them to start moving those rates up, and all of our providers are doing that. So if they were, I don't know, say they were at 100 percent at one point. Now they might be at 125 percent today. So what we're trying to do is to move them up to that 150 percent.

The other challenge, just so you have some context, is that what this does is, it puts compression on the salary structure in some of these agencies that have a lot of low-wage workers. And so it's not just what they're doing with those workers, but then what does it do to the entire structure. So that's one of the reasons

that we're trying to help them get up to that standard in a reasonable way.

DR. SCHWARZ: I would just also say we agree with you about partial waivers. So we work with our agencies worker by worker and look at the wage structure by job title. And you will find in the information you receive -- and, if not, we can help you -- that it is the minority of workers who are receiving wages that are below living wage even within organizations.

So we agree with your idea there and have tried to operationalize that.

COUNCILMAN GOODE: I look forward to receiving the information. The information I have now actually I don't believe to be correct, which is why I made a request of each department.

DR. SCHWARZ: We're happy to work with you to make sure --

COUNCILMAN GOODE: And I'll ask further questions on the next round.

DR. SCHWARZ: Absolutely.

COUNCILMAN GOODE: Thank you, Mr. Chairman.

COUNCIL PRESIDENT CLARKE: Thank you, Councilman.

The Chair recognizes Councilman Jones.

COUNCILMAN JONES: Thank you, Mr. President.

I think before I start my question but in the process, I want to thank publicly Dr. Evans for intervening in a personal crisis, not of my own but one of my constituents. I was overwhelmed, quite frankly, with a request from a mother and a father that said, Somebody please come get my son. He is out of control. He is approaching females in an inappropriate way, and I believe if left unto his own devices, the guys and people in the neighborhood are going to hurt him.

I don't know about my colleagues, but when you get that kind of

request from a mother in panic, it helps to have a professional like yourself to be able to call and ask how do we deal with this, and I just want to thank you for intervening and possibly even saving that young man's life. So thank you.

DR. EVANS: You're certainly welcome. My staff is great at that kind of stuff, so I appreciate that.

COUNCILMAN JONES: Listen, I give credit where credit is due.

According to your budget, you have a $1.2 billion budget, which services 130,000 Philadelphians through your process. My question is similar in nature to Councilman Goode's. This process of contracting out, how much of your budget is actually contracted through subsidiary organizations?

DR. EVANS: So our department, unlike other City departments, doesn't provide services directly. We are solely a pair, with the exception of acute services. So all of the behavioral

health services that are provided in the City are done on a contractual basis, primarily with private non-profit organizations, a small handful of for-profit organizations.

So the answer to your question, when it comes to behavioral health service delivery, all of those services are contracted through private non-profits primarily.

COUNCILMAN JONES: And recently you went to a community-based model that emphasizes -- and I appreciate that you, Dr. Ambrose, and Dr. Schwarz gave a briefing last year about the interconnectivity between the three departments, and I believe together you guys represent $2.2 billion worth of our budget of social service delivery. So that was very helpful, and I would encourage you doing it again this year just to give us a refresher course.

But you also moved to a CUA system, both you and DHS, and could you

explain your rationale for doing that.

DR. EVANS: Sure. So the CUA, which is community umbrella agency, is actually a DHS construct. And I don't want to explain, but essentially what it is doing, it's moving from a highly centralized way of delivering child welfare services to those services being embedded within the community in community-based organizations. Our world, we're not a part of that per se, but because we work so closely with Commissioner Ambrose and her agency and many of the families who require child welfare services also require behavioral health services, we've worked very closely to embed and make sure that behavioral health services are embedded within them.

I think your point about moving to community-based is really important. I think the field is catching up with this idea that if we're really going to be effective with communities, we have to

be a part of the community. We just can't be in communities, but we really have to be a part of the fabric of communities. And so both DHS and my agency are moving in that direction.

COUNCILMAN JONES: And I agree in theory with that notion that you shouldn't send a child or a patient way into Hoboken when you can deliver those services here and the economic benefit here. I get that part, but some unintended consequences arise from that, like how do you monitor the outcomes of that. And I think in addition to the human capital that we pay people with, also some of the service delivery things, how do you maintain a check and balance over folk that are not quite in your department. And I don't know how it works with your department. I want to also ask DHS and also Health Department how they manage all of those contracts and what kinds of -- as important in the DHS construct, you have ten different

areas that have now subcontracted out, and the input from elected officials, community representatives, in my opinion, needs to be tweaked a bit. And so what is your observation of those outcomes thus far under that construct?

DR. EVANS: That's a very good question, and I think as a public payer, what we try to do is to make sure that every dollar that we spend is spent in the most effective and efficient way. So we have a wide range of things that we do to make sure that we are getting the best possible services for our providers and that there's accountability around the services that we provide. That includes providers having to be credentialed to be a part of our network, and we just went through a very extensive process of looking at our credentialing process really using state-of-the-art -- what we believe are state-of-the-art strategies to not just do a minimal standard, which is done typically in managed care, but to

really raise the bar on even being a part of the network.

We have a monitoring process where we have staff that go out and they spend a day or sometimes two days. They're talking to -- they're not only looking at charts, but they're talking to people who receive services or talking to management. They're looking at the service delivery in lots of different ways.

We have a consumer satisfaction team, which is an agency that is under contract with the Department. So independent of us, they go out to our provider agencies and they're talking directly to recipients of services. So unfiltered. So they're getting feedback.

I meet with the consumer satisfaction team with my senior staff on a quarterly basis, because I want them to hear what our service recipients are saying about the services that they're receiving.

We have a pay-for-performance system. For every provider in our service system and probably 80 percent now of our Medicaid managed care program, they are being evaluated usually on five to seven different metrics. We evaluate them. We rate them. We rank order those providers, and we provide incentive payments. So there are a whole host of ways --

COUNCILMAN JONES: So I'll go back to my original question. How many contracts do you oversee with how many providers -- not how many contracts. How many different providers do we --

DR. EVANS: So we have about 200 providers.

COUNCILMAN JONES: This round of questioning applies to all of them, so it's not just you.

DR. EVANS: Sure.

COUNCILMAN JONES: Because that's a lot of monitoring.

DR. EVANS: Absolutely.

COUNCILMAN JONES: And I'm more -- how long has the CUA system been in effect?

DR. EVANS: I think, again, this CUA system is really a DHS construct.

COUNCILMAN JONES: I got it. I got to ask everybody the same thing.

So to your knowledge, how long has it been?

DR. EVANS: Commissioner Ambrose has been rolling that out over the last year, and like I said, we've been working with her to do that. It's not fully implemented at this point.

COUNCILMAN JONES: So my point -- and I'll stop on this, Mr. President -- is that this is a perfect time to tweak, because we are beginning to get some concerns from the community about the new direction that they've gone in and making sure that all of the checks and balances, including wages, are in that. But more importantly

to me, service delivery impacts and outcomes. And I'll follow up on that in my next round of questioning, sir.

COUNCIL PRESIDENT CLARKE: Thank you, Councilman.

The Chair recognizes Councilwoman Tasco.

COUNCILWOMAN TASCO: Good morning.

DR. EVANS: Good morning, Councilwoman.

COUNCILWOMAN TASCO: I just want to ask a followup on the question about the waivers. Do the for-profit agencies ask for waivers?

DR. EVANS: No. These are only non-profits.

COUNCILWOMAN TASCO: Non-profits?

DR. EVANS: Right. These are agencies that are contracted directly with the Department and have grants with the Department.

COUNCILWOMAN TASCO: Okay. On

Page 4 of your testimony you discuss pay-for-performance as a way to provide incentives for contract providers to improve recovery and resilience outcomes for adults, children, and adolescents.

Can you provide some more detail for how this model improves the effectiveness and efficiency of behavioral health services in the City.

DR. EVANS: Sure. So I think this goes to Councilman Jones' question as well. So about five years ago, the Department started looking at each level of care that we pay for and developing a set of metrics to evaluate people who were providing that service. For example, level of care would be inpatient psychiatric hospitals. So what we wanted to do is to look at how could we use financial incentives to incentivize good provider performance, and what we did was, we identified things that we think are related to good outcomes and good services. We developed those metrics.

We came up with a scheme to weight those metrics and then to rank our providers based on that.

So, for example, we will look at things like the recidivism rate, the extent to which people return back to an inpatient hospitalization. We look at continuity of care, the extent to which when people leave an inpatient visit, that they are connecting to a lower level of care quickly, because we know that if people don't connect very quickly, that they're very likely to end up back in a high-cost inpatient unit, and that's just not good care for people.

So over the last several years, we've increased the number of services that are in our pay-for-performance system. Right now we have probably about 80 percent of our service system that is in pay-for-performance. We use about $10 million a year for those performance payments. It fluctuates, but around that amount. And already we started to see

some pretty significant improvements.

So, for example, one of the things that we have been working on for years was trying to get -- trying to reduce the recidivism rate back into inpatient hospital care. When we moved to pay-for-performance and providers, hospitals, were no longer getting any kind of increase outside of that performance payment, it really focused their attention on strategies to improve in that area. So for the first time in several years, we've seen a significant increase -- or decrease in recidivism in inpatient hospitals. We calculate that we've probably saved $4 million over a two-year period just by using pay-for-performance strategies in hospital level of care alone.

COUNCILWOMAN TASCO: So they work harder to provide better service.

DR. EVANS: Oh, absolutely, and I'll give you a quick example. We had one provider who -- one of the hospitals

who at the first year -- I should step back and say we have not given a cost-of-living payment to our hospitals in about five years. We've said that any increases in revenue are going to be tied to performance.

A couple years ago we had a provider who was at the very bottom of the rankings and didn't get a payment. I assumed their leadership found out that they didn't get a payment. The very next year they were at the top of the distribution. So this is a very powerful way of shaping good practices, and it's something that we are very committed to, because it actually saves us money and it gets better care for people.

COUNCILWOMAN TASCO: I noticed that you talked about sending individuals away out of the City for services on Page 3, residential treatment facilities. Do we have a number of residential facilities here and how many do you have outside of the City that you are

contracting with?

DR. EVANS: I don't know the exact number that we have outside of the City, but these are residential treatment programs for children, and a couple years ago, about three, four years ago, we as a city made a commitment that it was not in the best interest of our children, Philadelphia children, to send them to places like Utah and Colorado. We're sending them to communities where often there are no people that look like them, that understand them, and then they're coming back to the community and a lot of those kids were not doing well, and that's to be expected, because we weren't working with the families.

And so Commissioner Ambrose, Judge Kevin Dougherty, and I decided that we were really going to change that process, and over the course of about two years, we went from having over 200 kids in out-of-state residential treatment programs to now we have probably ten kids

who are in out-of-state, and all of those kids are there because those particular types of programs are not available in the state and in the City.

So we think that that's a good thing. These kids are being served closer to home, often in the community. They have the ability to have treatment services with their families, which improves the outcomes, and to the extent that these are local providers, it's obviously helping our local providers in that way.

COUNCILWOMAN TASCO: Page 4 of your testimony details the 10 percent state funding cut for behavioral health services. For the upcoming state budget, do you have any indication of additional cuts?

DR. EVANS: No. This year it looks like no cuts, surprisingly.

COUNCILWOMAN TASCO: Election year, right?

DR. EVANS: I wasn't going to

say that, but you can say that. No cuts this year.

COUNCILWOMAN TASCO: Okay. Well, we'll see what happens.

DR. EVANS: On the grant side. On the Medicaid side, there has been a challenge, because we get paid on a capitated basis, meaning we negotiate a per member per month rate with the state, and that rate has been severely, in our opinion, restricted over the last three to four years. We've actually had the same rate and we've served more people at a lower cost per person. So we've actually gotten more efficient.

The way we've been able to manage the rates not going up over the last several years is that we've become more efficient as a system, but we're just at a point now where we cannot get any more efficient. We really need to get a higher capitation rate from the state.

COUNCILWOMAN TASCO: Okay.

I'll come back.

COUNCIL PRESIDENT CLARKE: Thank you, Councilwoman.

The Chair recognizes Councilman O'Brien.

COUNCILMAN O'BRIEN: Thank you, Mr. President.

First, I would just like to commend Arthur Evans for his wonderful leadership in the City of Philadelphia on so many very, very challenging issues, and I would like to thank you for the initiative the Philadelphia Autism Project and the citywide Autism Task Force, and I'd like to give a shout-out to Valarie Oulds, who is just an extraordinary person. And we had our first leadership meeting last week, and the energy in that room, I just can't believe -- my brain just went like this, because there were so many bright people and committed people to that conversation.

And the second statement, there

are a lot of wonderful questions that preceded my interrogation on the budgetary impacts, and I would just like to echo that although there aren't any cuts on the horizon right now, they're not done until they're done. So these hearings and our advocacy are critically important to sustaining the level of service that our citizens need.

And I'd just like to again -- I understand the loss of General Assistance, Cash Assistance in 2012 combined with a failure to expand Medicaid eligibility puts a strain on the behavioral health system, but I would just like to stress the support that you provide to the organizations that provide the advocacy and the support for families who need help with a loved one with disabilities through agencies like Vision for Equality, Arc, Speaking for Ourselves, and the Mental Health Association of Southeastern Pennsylvania. Your support is critical, and we would

like, as were evidenced in these hearings, trying to support and echo those budgetary requests.

The other question I would like to get to is, there recently was an article in the newspaper about Christina. I'm sure you're aware of that case. She is an adult living with autism. And there are three different areas that I've recently had meetings with people on, and I'd like your comment and advice. One is expanding the Amber Alert system, because I don't think it includes cognitive deficits like this individual is challenged with. And that would mean that I don't understand completely how the Amber Alert system works. I don't want to reinvent the wheel. What I'd like to do is take DBH, the Police Department, perhaps the DA's Office, and the media and understand how that system works and see if we can collaborate on creating a policy statement that would add this population to that important

mechanism, because this individual disappeared at 2 o'clock and unfortunately she wasn't found until 6:30 the next morning when she had froze to death. And that brings us to the second level, which is that I'm encouraging law enforcement to do an enhanced criminal investigation. And I don't say that lightly. I believe that there are three things that have to happen. You have to develop a behavioral plan. You have to have goals, and maybe those goals are expansive, more expansive than what we're doing right now. And I'm not challenged by that, but the training is critical. But also the mens rea in this case is if that individual had knowledge of this behavioral plan and in fact advocated for a one-on-one and knew the elopement issues and knew the proclivity for taking some of her clothes off and other issues, then we have to critically examine whether that behavioral plan was in effect and to what extent. And I

believe, again, that we have to bring that to the attention of our law enforcement agencies and see where that goes.

And it brings me to the third issue, and that is -- and this is, again, recognizing your advocacy. I know that cases fall through the cracks. So I would just like to know as I build these other conversations, what is it that your agency is going to respond to the elements in this case, and what are your thoughts and strategies going forward that can prevent a case like this from happening again?

DR. EVANS: So this was a really horrible case, and I think all of us felt really bad about what had happened in this case. As you probably know, the way -- unlike behavioral health care services where we contract directly with a provider, those providers are directly accountable to us for persons with intellectual disabilities. It's a

more convoluted system where the state actually has the contract with the provider. The accountability is with the state, and we play an administrative role in terms of identifying, recommending providers and some other kind of things. So it's a little more complicated when we don't have a direct contractual relationship with the provider.

So our role is to work with --

COUNCILMAN O'BRIEN: Can you just drill down into that again. So you're provided a list of providers from the state and then you work within that universe and then you select the appropriate provider.

DR. EVANS: Well, the state ultimately selects. What we do is, we can help identify providers based on criteria that the state uses, the state develops, but that is the state's criteria. We don't -- in fact, we can't change that criteria. So we're in somewhat of an awkward position in terms

of carrying out some of these tasks without the real authority to change them. We try to work with the state around that, and we'll continue to try to work with the state. And then in this particular instance, we need to work with the state to understand what happened, what were the expectations in terms of the contractual expectations with the provider in terms of the oversight of the person who was providing the care and so forth, and to ultimately make recommendations that will prevent those kinds of things from happening again.

So we're in the very early stages. I don't believe that the medical examiner has finished their process yet, but I think ultimately we need to get to a place where we can make some very strong recommendations to the state around how we prevent these kinds of things from happening again.

I actually like your idea about adding people with cognitive disabilities

to the Amber Alert system. That just to me makes a lot of sense, because you have some of the same issues as you would with someone who is a child.

COUNCILMAN O'BRIEN: If I can just comment. I know that the state is looking into this. I'm not going to step on anybody's toes in the furtherance of this investigation. I will emphasize that this case is probably two months old and that it's important that it stay up front and current in front of everybody's eyes.

There are two issues. One is what did this individual caretaker know about the behavioral plan, what should she have known, and what did she do. And I know certain things, and I'm sure you do as well, that are very troubling about that.

The second issue is that in many of these cases, the provider simply discharges this individual to avoid civil liability and then they go and work for

the next provider right down the street. That cannot happen.

DR. EVANS: Right.

COUNCILMAN O'BRIEN: That cannot happen.

DR. EVANS: I agree with that, and I think the other part of this is it's not only the individual that can move around the system, but then what is it that the provider is doing to change their policy. I mean, a big challenge often in some of our non-profit organizations can be, not all the time but can be, the issue of supervision and oversight and training. And I think these kind of issues raise that kind of issue up as well, as much as this other phenomena of people moving around.

COUNCILMAN O'BRIEN: Thank you.

DR. EVANS: That's the kind of thing that we want to get at.

COUNCIL PRESIDENT CLARKE: Thank you, Councilman.

The Chair recognizes

4/15/14 - WHOLE - BILL 140144, etc.

Councilwoman Reynolds Brown.

COUNCILWOMAN BROWN: Good morning, Mr. President.

COUNCIL PRESIDENT CLARKE: Good morning.

COUNCILWOMAN BROWN: Good morning.

DR. EVANS: Good morning, Councilwoman.

COUNCILWOMAN BROWN: First, let me echo Councilman O'Brien and say thank you very, very much for the enormously important work that you do and, more importantly, for changing the paradigm on what we do with our kids. When I came here 12 years ago, the numbers were completely reversed, where too many of our kids were leaving Philadelphia to find care. And what we know now is that we can take care of them right here in our backyard. So you're to be commended for the collaborative leadership between Dr. Schwarz and Anne Marie Ambrose around that issue. It was unacceptable how many

kids were leaving Philadelphia.

Secondly, I too have tried to follow the development of the CUAs from the bleacher in the top row, and the little I do know is that the actual thinking around that started at least four years ago, because I traveled with Judge Dougherty and Anne Marie Ambrose and Judge Dumas and others to DC to participate in a week-long conversation about this new best practice. And while we watched the rollout, I joined Councilmembers in being concerned in making sure that the mission of the CUAs is not lost in making sure that those on the front line, community-based organizations, are in the loop of opportunity for the services they already do well. And I'll look to hear from the DHS Commissioner to see how well we're doing that way.

To Councilman Jones' issue around monitoring your particular organizations, just walk through how that

happens. Do you have a unit, an evaluation unit, that hits the street and does evaluations, or what?

DR. EVANS: Sure. So we have a variety of mechanisms. We triangulate different pieces of data to try to come up with a good picture of the provider. So part of that process is, we have a unit called the NIAC Unit, which stands for Network Inclusion and Accountability Committee. So that group probably about six years ago, seven years ago, we had literally four, five different entities coming from my department going out and monitoring providers, depending on what funding stream. So if they had Medicaid, they had one group of folks, and if they had addiction services dollars, then it was another group and so forth.

So we made the commitment about five years ago that we really needed to move away from that, to put everyone on the same team, and to go out and monitor providers from a consistent framework.

In addition to pulling people together, we took a step back and we looked at our practice guidelines that we've issued to providers and said if these are the things that we believe are related to good outcomes, that we believe are related to good care, when we go out, we need to make sure that what we're looking at are those things. Because historically what happens in government is, our thinking evolves, but the mechanisms and the way we monitor programs kind of stay the same. That happens all the time. And so what we tried to do is to make sure that the current thinking was matching up with what we were actually going to look at when we went out to providers and making sure that we were looking at, again, the latest thinking around that.

So we did that. We have teams that go out to providers. Even before they leave, they will get the consumer satisfaction team report that I told you

about. They will get pay-for-performance data that I told you about. They will get information on their compliance, Medicaid compliance. So before they even get to the provider, they have a lot of information. And then while they're there, they will spend literally a day or two going through charts, talking to people, talking to staff, and then evaluating providers based on criteria that we've determined.

So it's a pretty extensive process, and that's just one of several processes that we use to provide oversight and monitoring of our providers.

COUNCILWOMAN BROWN: Well, the City has come a long way in evaluating agencies. I actually worked in the evaluation unit when I worked for the City for the Youth Services Coordinating Office, and so the thoroughness and drilling down deep has really gotten better in a big way.

And so that's on the program service delivery side of the ledger. What about on the business side of the ledger? How are these non-profits doing when it comes to MBE/WBE supplier activity?

DR. EVANS: Sure. So we also looked at the business practices as well, and so a couple of things. If you look at our contracting, so if you look at our budget and you look at the amount of dollars that go to non-profits versus for-profits, the overwhelming majority are going to non-profits, which cannot be certified. So one of the things that we did starting a few years ago was to try to characterize our non-profit agencies in terms of are they minority run, women owned.

COUNCILWOMAN BROWN: And that detail is very much appreciated, very comprehensive.

DR. EVANS: So the first thing is that a number of a large proportion of

our non-profit network are run by -- are agencies that are run by minorities and women. That's the first thing.

Secondly, a few years ago we started to look at their practices in terms of how they procure. And to give you an example of the kind of work that our finance people did, when we first went out and asked people do you have a supplier diversity plan, zero percent had a supplier diversity plan. Today about 50 percent have a supplier diversity plan.

COUNCILWOMAN BROWN: And what has been the contributing factor or factors that have led to that kind of progress?

DR. EVANS: That has been us going out and making this an issue. I mean, City Council has been clear about their --

COUNCILWOMAN BROWN: Expectation.

DR. EVANS: -- expectation

around this. We in turn have raised this with our providers. We've worked with OEO and our vendors, our top vendors, in making sure that they in fact are paying attention to this issue. As I said, a number of them, over half of them, now have a supplier diversity plan, which when we started this process, they didn't.

So, yes, we're looking on both sides of the equation, both how are they doing service delivery, but then how are they doing practices, their business practices as well.

COUNCILWOMAN BROWN: Okay. So we'll honor the clock and I'll see you on the next round.

DR. EVANS: Okay.

COUNCILWOMAN BROWN: Thank you, Mr. President.

COUNCIL PRESIDENT CLARKE: Thank you, Councilwoman.

The Chair recognizes Councilman Henon.

COUNCILMAN HENON: Thank you, Mr. Chairman and Council President.

Good morning.

DR. EVANS: Good morning, Councilman.

COUNCILMAN HENON: One, I was pleased to hear your response on a couple things. In particular, Councilman Jones', Majority Leader's, ability to have a call accepted for advice and guidance.

DR. EVANS: Yes.

COUNCILMAN HENON: I have similar experiences with the Department, but it's nice to know that somebody is acceptance of a call. Unlike I think in this budget process, we have heard that somebody who really discourages phone calls for advice and guidance. That's all public record. So thank you for that, especially when it comes to people's lives.

Also, it was nice to hear and I have known firsthand that it was nice to

hear you and Commissioner Ambrose and Administrative Judge, Judge Dougherty, working so closely together in a collaborative effort to make things work as efficiently and as safely and as economically as possible. Because I really think that's -- I mean, you can stop a lot of things. You can help a lot of the issues and what you do on a daily basis. So thank you for that.

DR. EVANS: Sure.

COUNCILMAN HENON: I have just a few couple questions. Can I ask Dr. Schwarz to please approach. Is he still here?

DR. EVANS: Yes.

(Witness approached witness table.)

DR. SCHWARZ: Donald Schwarz, Deputy Mayor for Health and Opportunity. Good morning, Councilman.

COUNCILMAN HENON: Good morning. So just a couple quick questions for you and/or folks you have

here at the table. So as Deputy Mayor, you're responsible for Department of Human Services, Public Health Department, the Health Department, and what other department? Behavioral Health and Intellectual disAbilities.

DR. SCHWARZ: And Office of Supportive Housing.

COUNCILMAN HENON: So question -- these are some infrastructure questions, and I will provide you a list. So I'm just going to give you -- I'm asking every department for all the departments that you oversee, one, where are you located, each one; do we as a city own that property; do we lease that property; what is the rent if we lease; what are the capital improvements that are in the pipeline for infrastructure, such as technology and program support; what space is being used for employees; what space is being used for storage and materials. And I have a host of other questions that I will send to you. If

you could get back to myself and the Chair, I would appreciate it.

DR. SCHWARZ: Of course.

COUNCILMAN HENON: Great. So just to recap a couple of the things. Ninety-nine percent of the budget is coming from the state. I understand that. You have a little more than 200 contractors or vendors that are working under everybody you're responsible for.

So one of the questions that I have is, you were talking about state programs and state requirements and benchmarks and things like that. Does the City -- where does the City and the state -- let me try to put it this way: So are there any instances where the state issues a license or the state has programs that the City does not have full oversight or control over?

DR. EVANS: Sure. So our relationship with providers is primarily as a payer. We at the City level do not license or regulate or develop

regulations per se for providers. So that comes from the State of Pennsylvania. They do the licensing of providers, and so you could have within the City someone who is licensed by the state but does not have a contract with us or you could have someone who is licensed and is contracted with us.

COUNCILMAN HENON: Let's start with contracted with the City. So somebody is contracted with the City. Are all contracts RFP'd?

DR. EVANS: Most of the contracts are RFP'd. We're not required to RFP for non-profit contracts, but our position has been -- actually even before the legislation with City Council, our position has been because of our desire to be as transparent as possible, to create as level a playing field for our providers as possible, that we use a competitive procurement process whenever we are trying to expand our service network.

COUNCILMAN HENON: Totally responsible and the right thing to do. Do you have any sole-source contracts?

DR. EVANS: We do. For example, with some of the academic institutions, we might have -- for example, if we're doing an evaluation on a federal grant -- that's probably the most typical kind of thing -- we will approach, say, the University of Pennsylvania or Drexel or one of the other academic institutions to go in with us on that particular project, and in that case, we don't do any kind of competitive procurement process. What we do is, we identify who we think has the best skill set for what we're trying to do and include them in that.

COUNCILMAN HENON: Okay. So in the case that a state has the authority to issue all licenses and they issue a license, where does the City weigh in or does the City weigh in on the issuance of any license or do they have any say on

any issuances of any license where it directly impacts the citizens of Philadelphia and your department, whether it's RFP'd --

DR. EVANS: Or not, right.

COUNCILMAN HENON: So two parts to that question. One, RFP'd, which would be under your -- even though you don't have the authority to license and you may not weigh in on a vendor receiving a license, how does it impact you, us in the City, through the RFP process or outside the RFP process?

DR. EVANS: Okay. So it depends -- if it is a mental health program, the Department of Public Welfare licenses the mental health programs and they have a process where they will contact my office when someone applies, and that person will have to get an endorsement from my office in order to -- as a part of that process. That's for a mental health program.

COUNCILMAN HENON: So in mental

health the state --

DR. EVANS: There is a process where they consult us.

COUNCILMAN HENON: There is a process where the state includes the City --

DR. EVANS: Right.

COUNCILMAN HENON: -- on whatever, recommendations --

DR. EVANS: Exactly.

COUNCILMAN HENON: -- or the authenticity of the contract, the standing of a company?

DR. EVANS: Sure. But on the addiction side, that is not the case. So on the addiction side, if someone wanted to open up, say, a residential addictions program, an outpatient program, a methadone program, they can go directly to the state. They can apply. The state can issue the license. We may not even know, and in fact, we've had some cases where providers have done that. They've opened up and then they've come to us

after the fact and asked to join our network, in which case we typically say no.

COUNCILMAN HENON: So what does that -- how much of a disadvantage does that have on the Department and the City on the addiction and where a license is approved and given to a provider or a company and it's not under the City's supervision?

DR. EVANS: Well, we would like for the state -- and it's actually a different state agency. It's the Department of Drug and Alcohol Programs. We would like for them to consult with the City, County. It's actually a county function, but the City on these issues. One is that we can give them feedback, number one, if we do have any kind of information about the provider who is applying. We can also give them feedback on the extent to which we think the service is actually needed in the City.

So we think it would be prudent

for the City -- for the state to have a process that included us, as we do on the mental health side.

COUNCILMAN HENON: I also like that. I think it would be responsible to include the City. So you would weigh in on different types of measures --

DR. EVANS: Sure.

COUNCILMAN HENON: -- that would conform with your department and accountability. Would that also include the community?

DR. EVANS: Right. So we --

COUNCILMAN HENON: Does the community have involvement in terms of location and to the extent of the services that are being provided in our neighborhoods?

DR. EVANS: Sure. So we think it's really important for providers to be involved, contact, engage communities as opposed to just putting programs in communities. Right now we really drive where we -- when we contract, where we

want to site programs based on what the needs are in a particular community, but even in those cases, we still think that there should be a process. The Department has had a good neighbor policy for many years. As a result of some recent interactions that we've had with City Council, we went back, we looked at our good neighbor policy. It was actually done during Estelle Richman's tenure in the City. We went back, we looked at that policy. We made some -- we updated some of the language, and in fact, I think we most recently sent it to Councilman Clarke's office, because we do want to get feedback from City Council around that issue.

So our goal is to make sure that providers are good neighbors and to do that in a way that recognizes community input.

COUNCIL PRESIDENT CLARKE: Thank you, Councilman.

The Chair recognizes Councilman

Johnson.

COUNCILMAN JOHNSON: Thank you, Council President.

Good morning.

DR. EVANS: Good morning.

COUNCILMAN JOHNSON: How you doing today?

DR. EVANS: Good morning.

COUNCILMAN JOHNSON: What is the percentage of school-age children that your particular department is servicing, specifically, one, with the Philadelphia School District; two, through Family Court working with the Youth Study Center, specifically in the area of mental health and also drug and alcohol use?

DR. EVANS: I'm sorry. Percentage of children?

COUNCILMAN JOHNSON: School-age children that your particular --

DR. EVANS: Percentage of the total people we serve?

COUNCILMAN JOHNSON: School-age

4/15/14 - WHOLE - BILL 140144, etc.

children, juveniles.

DR. EVANS: Right. I'm sorry. I just want to make sure I got the right denominator. So you're asking for the percentage of children of the total children that we serve or the total number of people that we serve?

COUNCILMAN JOHNSON: School-age children.

DR. EVANS: I'm not quite sure. What I can tell you is that the numbers are for children that we serve in our system. Probably around 50,000, 60,000 children each year are receiving services.

COUNCILMAN JOHNSON: Specifically 50,000, 60,000 children are receiving mental health services?

DR. EVANS: Any of the behavioral health services that we provide as a city.

COUNCILMAN JOHNSON: Now, in terms of specifically working with the School District and the Youth Study

Center, do you have actual numbers of students being serviced in the School District for mental health issues?

DR. EVANS: Sure. I'll get those numbers for you. Someone back there will get me those numbers. What I'll say is that we work with both the School District and Youth Study Center. With the Youth Study Center, we actually have a program embedded within the Youth Study Center, and we serve the youth mental health, behavioral health needs within that context, and we've been doing that for a long number of years.

COUNCILMAN JOHNSON: So can you give us an overview of those particular partnerships and programs --

DR. EVANS: Sure.

COUNCILMAN JOHNSON: -- with the School District as well as Family Court?

DR. EVANS: Sure.

COUNCILMAN JOHNSON: And can you break it down in two categories,

which are somewhat simultaneously the same. From the mental health aspect, one, mental health issues, but also give us an overview of the drug and alcohol therapy component as well. And I only ask that question just based upon the level of young people who self-medicate oftentimes, you know, environment. So some things that we may look at as casually maybe young people engaging in certain types of narcotics to specifically self-medicate and looking at what we are doing as a city to address those particular issues.

DR. EVANS: Sure. We can get that information for you. What I'll say is that we have a very strong relationship with the School District. We invest about $70 million a year in services that are in the School District, and those range from prevention services that are evidence-based prevention services that look at things like bullying, substance use, violence

4/15/14 - WHOLE - BILL 140144, etc.

prevention, social skills. We have a student assistance program where youth who are having mental health challenges can be assessed and connected to the right services. We have our school's therapeutic services, which is the bulk of the services, and those are very intensive services directed at kids who are at the elementary and the middle school level, and those services are for kids who have more significant behavioral health needs, as well as we have therapeutic classrooms that we support.

So we support a whole range of services. And I should mention that even at the high school level, we have three outpatient mental health clinics that are embedded in three of our high schools.

COUNCILMAN JOHNSON: Located where?

DR. EVANS: Frankford, MLK, and South Philadelphia High School.

COUNCILMAN JOHNSON: And just one last question. Out of that 70

million in services, can you give us an overview on how those services are -- the resources are distributed across the City of Philadelphia School District-wise.

DR. EVANS: Sure. So about 103 of those 103 schools have school therapeutic services. A lot more -- and I can give you the specific numbers in terms of the prevention services. The prevention services are actually much more widely distributed across the School District.

COUNCILMAN JOHNSON: That's about it for this round of questioning. Thank you.

DR. EVANS: Okay. Thank you.

COUNCIL PRESIDENT CLARKE: Thank you, Councilman.

The Chair recognizes Councilman Jones.

COUNCILMAN JONES: Thank you, Mr. President.

I want to switch gears a second and first preface my remarks with saying

that the work you do in recovery is vital to my community, but like anybody else, whether you make doughnuts or make good citizens, being a good neighbor is important to me. And I've talked to some of my colleagues about this issue of methadone clinics. Tell me your interaction with them vis-a-vis the state, you, and then the actual service provider.

DR. EVANS: "Them" being who?

COUNCILMAN JONES: Methadone recovery --

DR. EVANS: The programs?

COUNCILMAN JONES: Yes, sir.

DR. EVANS: So I should start out by saying that methadone is probably the -- no. It's not even probably. It is the most regulated treatment service that exists. It's regulated by the federal government, by the state government, the DEA, Center for Substance Abuse Treatment, and licensure within the state, as well as any of the regulations

or rules that they have to follow in terms of payment, Medicaid in particular.

So it's very heavily regulated, and we include them, as I described the process that we go through in terms of oversight of programs in general. They go through that, plus all of the additional things that they have to do as Medicaid providers.

I think the issue around good neighbor is really important for us. Just from a practical standpoint, it's in our best interest as a city and as a city department to make sure that providers that are in communities are good neighbors. It makes it a lot easier when we want to site another program in a community.

So we do a number of things with our providers to make sure that they are living up to that. When we get complaints from either the community or from City Council --

COUNCILMAN JONES: Complaint.

DR. EVANS: So we want to know what those complaints are to go back and deal with that.

But just to put it in perspective, we have 200 providers, and if you look at the number of sites that those providers are in, it's probably well over a thousand sites across the City. We don't hear a lot of complaints, so --

COUNCILMAN JONES: So here's one.

DR. EVANS: It's a small number. So I want to make sure that when there are that small number, we get to them and address them.

COUNCILMAN JONES: I admit I'm a small number. I'm going to be a vocal number, and here's why. And, again, I don't want to say anything patronizing like some of my best friends, but literally some of my best friends have had and need those kinds of services. Yet within one recovery group, within a

block there is an elementary high school. Within another block going the other side, elementary high school. And I have on more than one occasion called, written --

DR. EVANS: To?

COUNCILMAN JONES: I'm not going to say the name.

DR. EVANS: The provider?

COUNCILMAN JONES: A provider. And asked them to take a look at the numbers, the large numbers, that are outside of the facility and to question why those large numbers are allowed to congregate outside the facility. And as I dove a little deeper into the issue, some disturbing things came out, that there were certain transactions going on right there, which if you're saying that they're heavily regulated, I've said -- listen, I've reported it, and come to find out a little further that there was no -- and I asked and met with and toured the facility. And so we go through it.

And I understand the mission. I'm for the mission. I get it, even though the vast majority of people getting those services weren't from my district, even though almost 50 percent of them came from Camden and other surrounding counties. They need love and help too. So I'm not angry about that. But when listed a letter with concerns, having a meeting after a tour and nothing happens a year later, I'm at a different place in my mind.

DR. EVANS: Absolutely.

COUNCILMAN JONES: Because I'm watching parents walk their kids through that kind of traffic on their way to school. As we start to get development in the area, I'm finding developers reluctant, not because of the services in the building but the activity outside.

DR. EVANS: Absolutely. I understand.

COUNCILMAN JONES: And you know exactly where. You ride by it.

COUNCILWOMAN BROWN: Daily.

COUNCILMAN JONES: So if I say to you, neighbor, you might want to cut your grass or you might want to not put your trash out, I'm only going to say it a couple times before I start sending L&I and others to it. And I need to know what our recourse in these kinds of situations, because I'm not the only one facing that dilemma, because you want to support the mission, but I don't want to be NIMBY, but I can say that the residents, the development in that area is vital to our total community's health too.

DR. EVANS: Absolutely. So, first of all, I appreciate and I hear your belief in the need for those services, and just to be on the record, that's not always the case, so I appreciate you being very clear and strong on that issue.

In terms of the problems that -- and I know which program you're

talking about. You know, first of all, I think that when you have those kinds of issues, I think it's fine to talk to the provider, but bring us into that process so that we can work with you to try to get some kind of resolution.

Part of this is a bigger issue, which is because it is so hard to site those programs -- we have 5,000 people in 13 programs, right? So do the math. I mean, it's a very large number, and the reason that we have such large numbers is that once you get a methadone program sited, that program has to be all takers, because to try to get another program sited -- we just spent six years trying to site one program in a part of the City that has actually high rates of heroin use and opiate use. So it's very difficult, and so I think that -- we want to address the very specific issues that you're talking about there, and we will do that with you. But we also I think have to deal with the larger policy

issue, which is how does a community have a policy that allows us to distribute these kinds of programs throughout the City in a way that they don't have a large footprint.

We had a program that was on Walnut Street, middle of downtown Philadelphia, for years. No one ever knew it was there, and the reason they didn't know it was there, because we only had 200 or 300 people, it was on a busy street, people came and went every day, and there was no impact on the community. But that was a small program. If that program rose to 500, 600 people, you're going to have an impact.

And so I think that we need your help on both of those issues. Let's deal with the smaller issues, but then let's also take on some of the larger issues.

COUNCILMAN JONES: So the program in question is larger than 500.

DR. EVANS: It's larger than

500.

COUNCILMAN JONES: And it is 24 -- well, it's seven days a week. And I understand the need is to be able to deliver those services seven days a week, but, again, when you -- I don't want to threaten a license because of the services needed, but when you get ignored and when the community gets ignored, at some point, you know, I have to assert myself. And I didn't want to talk to dad. You know what I mean? I really didn't. I wanted to handle it ourselves, but at this point, my frustration level is --

DR. EVANS: I will -- we can certainly talk after this, and let's come up with a strategy. I think that just so that you know, the whole good neighbor policy that I told you about that we are reissuing and working with our providers around that, the provider that you're talking about in particular, one of the discussions we're having is can they

create a space where people can congregate -- because there's two things going on. One is, there's a bus stop there. So part of what the community is seeing is people that are waiting at the bus stop and people are not -- for whatever reason, that's an issue for people. I don't know how we resolve that issue.

COUNCILMAN JONES: No. I'm all right with that part.

DR. EVANS: But then the other part that you're saying, which is what you're describing as loitering, I think that the solution there is to have some other space that is within the confines of the building that --

COUNCILMAN JONES: Which I'm amenable to. And I really support them being able to have their smoke breaks, but it's the activities during that time. And I literally -- and I'll end on this -- sat in front of that place for hours just watching the activity. Some

people just never go, and that's because there's commerce there, and the surrounding mall gets the unintended bad consequence of folk hanging out, and it's just a deterrent to further development. And I want every citizen to be able to experience sobriety and recovery, but I want every young person to be able to walk to school without having to go through transactions. And that's what I'll say, and I look forward to working with you and I take you at your word.

DR. EVANS: We'll work together on that.

COUNCILMAN JONES: Thank you, Mr. Chairman.

COUNCILMAN GREENLEE: Thank you. Thank you, Councilman.

Councilwoman Reynolds Brown.

COUNCILWOMAN BROWN: Yes. Could I ask Deputy Mayor Schwarz to return to the table, please.

(Witness approached witness table.)

COUNCILWOMAN BROWN: Welcome back.

DR. SCHWARZ: Good morning. Don Schwarz, Deputy Mayor.

COUNCILWOMAN BROWN: And I ask that you return to the table, Deputy Mayor, principally because these departments, you are their direct link. And so again the question goes to CUAs, which we know are funded now to the tune of about 250 million annually. What I've read with interest is CBH's breakdown of the Board at CBH and pleased to say that CBH is leading by example in having a Board that's diverse and looks like Philadelphia.

So the question becomes too, in the award of CUAs, was any consideration given to or an expectation expressed -- if not now, going forward, since we know that the Mayor has signed this bill into law -- the composition of the Boards and whether or not they represent the communities that they serve? I need to

know that. And then, two, have the CUA dollars gone to vendors with minority ownership or to vendors with minorities in key management positions, again, in an effort to make sure that business is happening in Philadelphia with MBE/WBEs?

DR. SCHWARZ: So I apologize for not having the specific information on the CUAs in front of me, but the Commissioner of Human Services, who was responsible for the RFP process, will be coming this afternoon and is prepared.

COUNCILWOMAN BROWN: Terrific.

DR. SCHWARZ: Let me say that the idea of the CUAs is that agencies who are responsible for CUAs should be in neighborhoods, should be contracting with other agencies in neighborhoods, and should provide, therefore, for children and families an experience that is much more focused in neighborhood than what we've done before where we've had a central DHS that has contracted around the City but hasn't been embedded in the

neighborhood the same way the CUAs are.

COUNCILWOMAN BROWN: On the front line, yes.

DR. SCHWARZ: So I believe that we're on the same page in terms of the goal here to reflect the neighborhoods, to represent the neighborhoods, and to be embedded in the neighborhoods. It's why the partnership with the Department of Behavioral Health to assure that behavioral health services are linked to CUA services at a neighborhood level, so that children and their families can, whenever possible, remain together.

COUNCILWOMAN BROWN: Yes.

DR. SCHWARZ: And that children can be reunited with their families as soon as possible.

COUNCILWOMAN BROWN: Okay. So then we can expect Commissioner Ambrose to tell us the composition of the Boards of the CUAs?

DR. SCHWARZ: I believe so.

COUNCILWOMAN BROWN: Okay.

That will be important and revealing in terms of how those organizations seek to comply with expectations of the City on the legal side as well as moving towards a world where folks who are securing an enormous amount of dollars from the City are doing what they can to make sure they're hiring folk from the City.

DR. SCHWARZ: Absolutely. I want to emphasize that the CUA organizations are non-profit organizations.

COUNCILWOMAN BROWN: Yes.

DR. SCHWARZ: So you had mentioned ownership. They're not owned.

COUNCILWOMAN BROWN: Agreed. And even in non-profit circumstances, that expectation still exists.

DR. SCHWARZ: Absolutely. We understand that.

COUNCILWOMAN BROWN: To follow up now to -- thank you, Commissioner.

Talk a bit about what sounds very exciting, the mental health

awareness. Keep it brief, only because the clock is short, but I want to hear more details about that. And I did hear you say that that's open to the Councilmembers and staff?

DR. EVANS: Sure. So I think that one of the biggest challenges we have in our field obviously is resources, but I think a very close second is changing public perception about mental health and substance use issues.

Less than 10 percent of the people who have an addiction in the City will access treatment services. That means 90 percent of the people who are addicted in Philadelphia are not going to go into treatment, and 80 percent of them believe that they don't need treatment.

COUNCILWOMAN BROWN: And they're not going to go into treatment because?

DR. EVANS: Eighty percent of them believe that they don't need to go into treatment. So we have a big job to

do. And then half of the people who have a mental health challenge are going to access services. And, again, if you look at the 50 percent that don't, they either don't want to go or they are afraid or whatever. And so we have to pay attention to the issue of how do we change public perception so that people are willing to seek out help and that family members and people's social circles can identify when people are having problems and know how to connect them. That's what Mental Health First Aid does. Someone had a heart attack. You'd be ten people that could jump and give CPR. If someone starts to exhibit psychiatric symptoms, start to hallucinate or says that I'm going to hurt myself, most people don't know what to do. And so what Mental Health First Aid does, it's a one-day course that helps people to identify when people are having problems, learn how to support them, know how to support them, and then

know how to connect them to services.

COUNCILWOMAN BROWN: It's just a one-day course?

DR. EVANS: It's a one-day course. We have great partnerships with the School District, with Comcast, with PECO, with small community-based organizations, American Red Cross. Just across the City we've gotten really great response to this, because in all of those human service people-serving organizations, they're running into these issues. They're running into them whether they're in corporate America or they're a church or they're in the school. And so when we describe what Mental Health First Aid can do, people are more than willing to partner with us to try to educate people.

COUNCILWOMAN BROWN: So you go on site to that location?

DR. EVANS: We are doing it both ways. With the School District, what we did is, we trained 30 people --

25 people to be instructors, and now those instructors are now training teachers and faculty and security guards within the School District. In other instances what we have done is create a hub, like the National Constitution Center is the hub. The American Red Cross is a hub. Enon Tabernacle is a hub. So we have these various entities around the City who are opening up their doors and saying, We will provide training here on site, and they're pulling in people from those geographic areas.

COUNCILWOMAN BROWN: That's awesome. I have more questions, but we'll wait till the next round. Thank you.

DR. EVANS: Okay.

COUNCILMAN GREENLEE: Thank you, Councilwoman.

Councilwoman Tasco.

COUNCILWOMAN TASCO: You know, since the rules came out that you

couldn't house or institutionalize individuals with mental health problems, we now see a number of people on the street. Is there -- but you also send young people away. What happens to them when they become adults if they are entering a facility? Do you have residential facilities who may stay in that facility or do they have to leave the facility?

DR. EVANS: So for youth who are in residential facilities and then age out and become adults, that can be a challenge, mainly because we don't have a residential system for adults in the same way that we have with children. We do have some residential facilities, and particularly for people who have very high needs, we've created specialized residential programs to transition those individuals into those programs, particularly people who have both intellectual disabilities and behavioral health challenges.

The goal, though, is for people not to be in residential settings. That's always our goal. For some people they need to be in a setting where they have to have 24-hour services available, but for the most part, most people, even with the most severe forms of mental illness, can live very successfully in the community with the right set of services and supports.

So that's essentially what we've done. We worked with Dr. Schwarz on a permanent supportive housing initiative that the City has been doing actually since the Mayor has been in office. We've secured housing vouchers from the Housing Authority. Then we leverage those housing resources, those Section 8 vouchers, with Medicaid-funded treatment services, and what we've been able to do is to move both people who historically had been in residential settings into the community, supported by assertive community outreach teams or

assertive community teams, and for people who are homeless, we've been very successful in identifying those individuals who are homeless who have a mental health challenge or a substance use challenge by getting them directly into an apartment and then supporting them with, again, those Medicaid-funded services. In the cases where particularly for people who have addictions and they might not be able to go directly into a housing, we have created specialized treatment programs that people can go into specifically designed for people who are homeless. They have very long lengths of stay, and then we're able to transition them into permanent supportive housing.

To date, we have, I think, around 600, 700 people who have come through that program. Ninety-three percent of them are still in the housing and they're being successful.

So the issue is, what's the

most effective model for supporting people. It is to have housing resources and then to support those individuals in the community, and that's the -- again, under Dr. Schwarz's leadership, we've been able to -- and the Mayor, frankly, who was instrumental in getting those housing resources, we've been able to successfully move people into independent living in the community, and they're doing quite well.

COUNCILWOMAN TASCO: I was just concerned about the young man who attacked the police officer on the train. I guess evidently he did have a place to stay. He just wasn't taking his medication.

DR. EVANS: Well, and I think that's why Mental Health First Aid is so important, because if you look at that case or you look -- and I don't know the specifics of that case, so I'm not speaking about his case in particular, but if you look at the high-profile cases

where you've had a person with mental illness who commits some act of violence, first of all, to put that in context, most people who have mental illnesses don't commit acts of violence, but some do. That's a reality. In almost all of those cases, when you talk to people around that person, they saw something. You hear the interviews. Well, we knew something was wrong with Bobby, or whoever, but we weren't quite sure what to do.

So what we're trying to do is to make sure that a wide range of people within our community recognize that what he's saying doesn't really make a lot of sense and it might be related to a mental health challenge and helping people understand then how to connect people, because in almost all of these instances, people knew something was wrong. They just didn't know what to do. So what we're trying to do is really equip the public to be able to intervene in those

4/15/14 - WHOLE - BILL 140144, etc.

situations.

COUNCILWOMAN TASCO: Could I please ask one more question and I'll be done and then I'll --

COUNCILMAN GREENLEE: We got a long list here.

COUNCILWOMAN TASCO: I know, but I won't be back.

COUNCILMAN GREENLEE: Okay. If you could -- yes.

COUNCILWOMAN TASCO: On Page 46 of your budget detail, CBH is scheduled to receive $851 million under their behavioral health managed care contract. Considering the recent change in leadership at CBH, have there been changes in their operations and your oversight of this provider?

DR. EVANS: Sure. So we are very, very fortunate to get Joan Erney as the CEO of CBH. Joan was the Deputy Secretary for OMHSAS at the state level. So she had responsibility for the entire state's mental health system, and we now

have her actually running CBH. So we're very fortunate. She's very accomplished and a very strong manager. So in addition to running CBH, she also sits a part of my overall management team, sits with my management team as we're making overall decisions.

So we're not changing the way we supervise, but I can tell you I have a lot of confidence in her. The team that she's been able to put together is really excellent, and so we have no -- I'm absolutely confident that we're going to see even better work coming out of that organization.

COUNCILWOMAN TASCO: Thank you.

COUNCILMAN GREENLEE: Thank you, Councilwoman.

Councilman Kenney.

COUNCILMAN KENNEY: Thank you, Mr. Chairman.

Relative to your outside contracts not only with Behavioral Health but throughout the Health Department --

and maybe Deputy Mayor Schwarz could inform us as to what goes on. Who has the utilization review and audit responsibilities for reviewing, similar to what a healthcare company would do, they have separate audit departments, separate utilization review departments, and we do it in-house or do we do it externally with a private company?

DR. EVANS: So I can speak about the Department of Behavioral Health and Dr. Schwarz can talk about the Health Department.

So within our department, as Councilwoman Tasco just noted, $851 million of our $1.2 billion budget is dollars that the City receives for the management of the Medicaid population. We do that through CBH, Community Behavioral Health. CBH is essentially an administrative services organization that performs managed care-like functions. It does utilization review. It does claims payment. It does compliance audit.

COUNCILMAN KENNEY: You're talking about national CBH, not --

DR. EVANS: I'm talking about our CBH.

COUNCILMAN KENNEY: Our CBH.

DR. EVANS: Our CBH. So to your question, we do that through our administrative services organization, which is the City-run, City-controlled Community Behavioral Health. We do utilization management. We do compliance. So they are going in, looking at charts of providers. They're making sure that they follow the Medicaid rules. If there are services that are not following those rules, we will actually take back money. We've taken back --

COUNCILMAN KENNEY: Is there interface with CMH?

DR. EVANS: I'm sorry?

COUNCILMAN KENNEY: Is there interface with CMH, I think, isn't it? The Medicaid --

DR. EVANS: Oh, CMS.

COUNCILMAN KENNEY: CMS. I'm sorry.

DR. EVANS: So the way this works is that CMS obviously controls the Medicaid program. That program is administered through DPW at the state level. DPW contracts with the City of Philadelphia, and the City uses CBH to administer the program. So that's sort of the --

COUNCILMAN KENNEY: Does CMS have much commentary? I know --

DR. EVANS: Not to us directly. They work through the state. So CMS's relationship is with the 50 states. Our relationship is with DPW.

COUNCILMAN KENNEY: And what's the level of commentary from CMS on contracts -- I know from another responsibility that I have that CMS is a difficult group to deal with, and it's a good thing that they're a difficult group to deal with, because they're looking out

for taxpayers' dollars.

So what kind of -- I mean, does it ever get to our level -- when CMS has a problem and expresses that to DPW or I guess -- to DPW, does it ever get down to us and what do we do?

DR. EVANS: Absolutely. It gets to us all the time. So DPW is constantly reviewing the state's Medicaid program and it's reviewing how the state has implemented that program. So they're looking at our practices, and they may be commenting on those practices in terms of how the state administers the program.

COUNCILMAN KENNEY: That's just on CBH, right?

DR. EVANS: I'm sorry?

COUNCILMAN KENNEY: That's just on Behavioral Health?

DR. EVANS: Just on Behavioral Health.

COUNCILMAN KENNEY: The Medicaid-funded Behavioral Health program.

DR. EVANS: That's correct.

COUNCILMAN KENNEY: So there's a straight line between CMS, DPW, and us.

DR. EVANS: That's correct.

COUNCILMAN KENNEY: Do we have any idea -- do we find out when folks are misbehaving or billing wrongly or overbilling or do we get that information? Are we told that?

DR. EVANS: So we are -- we're responsible, because we have the contract with the provider, we're responsible for making sure that the providers are eligible and are complying with Medicaid rules. When we find that they are not, then we -- if it's something that's not egregious, we will do a take-back. If it's something that we think borders on illegality, we will refer that to the state, the state's --

COUNCILMAN KENNEY: Is that information proprietary or is it public record?

DR. EVANS: Not per se. I

mean, if we do --

COUNCILMAN KENNEY: I'm not talking about the clients themselves, the patients themselves. I'm talking about the contractor. Is that information, CMS's responses or comments, DPW's actions, our take-back or whatever, is any of that public record?

DR. EVANS: I would believe that under the Sunshine Laws that it would be.

COUNCILMAN KENNEY: It would be, other than anything under HIPAA, anything dealing with HIPAA.

DR. EVAN: Yeah. Anything that was HIPAA related, no, but I would think -- I mean, we'd have to ask the Law Department in particular, but my guess would be that some of that information would be --

COUNCILMAN KENNEY: Is that something that should be reported so we know who the good actors are, the bad actors are, or the medium actors are?

DR. EVANS: Well, I think when it comes to client care, those are the kind of things that we should make more available. We have talked about a report card type of --

COUNCILMAN KENNEY: That's where I'm going. I mean, should we not know who the fine providers of service are, not only in substance abuse or behavioral health but in every other segment of outside contracting?

DR. EVANS: I think ultimately that's where we want to go.

COUNCILMAN KENNEY: Doctor, your head was shaking more vigorously under CBH as opposed to other types of contracts. I noticed the different flow.

DR. EVANS: What I'll say very quickly is that I think that that's ultimately where we want to go. The pay-for-performance system that I just told you about is probably the template for how we would do that. I think that we just -- that is a system that is

evolving, and before we put out this is a good provider and this is not a good provider, we want to make sure that that's system is reliable and valid.

COUNCILMAN KENNEY: But that's mostly state money.

DR. EVANS: That is all state -- well, state, federal.

COUNCILMAN KENNEY: State, federal money, but not Philly.

DR. EVANS: It's not local.

COUNCILMAN KENNEY: But on the other contracts, the non-CBH, non-Medicaid contracts, are there City dollars in play that need to be taken into account?

DR. SCHWARZ: So I think what may be helpful, one of the things that we've done is, we've centralized the audit functions for our four departments. So there's a central audit agency now. You know that many of the agencies that contract with one of our departments contract with more than one, and as a

result, their financial statements and their history of audit is the same across departments. It's not efficient for us to do it separately, so we've centralized that. It also means that there is an independent review, in a sense, independent of any department.

COUNCILMAN KENNEY: Independent meaning which type of audit? Is there an outside independent audit?

DR. SCHWARZ: There isn't. It's their own independent audit in the sense their financial statements, and their audit is reviewed. Every audit that comes to us, we actually get them now and we monitor them. If there is a question by an agency or there's a report in the press or we get a report from someone that there's an irregularity, that unit with the department, if it's specific to a department, otherwise if it's broader, that unit goes out and does a deeper dive on financial --

COUNCILMAN KENNEY: What

healthcare companies are required to do is not only have an internal audit division but an outside independent audit division that meets with the audit committee that compares information. Does at some point -- and I'm not saying that there's anything going wrong. You know how things are billed and things are filed and medical filings are often mistaken. Is there any need for an outside independent audit on a regular basis to kind of confirm the numbers of your own audit team?

DR. SCHWARZ: So two things I'll say that may help. One is, DBH's function as, if you will, an insurance company is unique among government. So we don't have an insurance company in the same way on the health side. The Medicaid health dollars go to other agencies under HealthChoices, the state program, and we have no control over them and we have no ability to audit those agencies. So the fee for service

high-volume collection where people talk about fraud, waste, and abuse, we, the Health Department, don't -- we're not analogous to DBH in that way, one.

Two, we have contract monitors in every department. They look at the expectations of contracts. They look at what's delivered on the contracts. They look and review every invoice based on what's in the contract and what's been done in terms of the work of that contract. And particularly for higher volume agencies where we have more contracted dollars, like the AIDS Activities Coordinating Office, there are performance measures that are broader based so we can compare.

COUNCILMAN KENNEY: I guess just the final question is, would there be a benefit to an outside independent audit firm that would confirm those findings?

DR. SCHWARZ: In a sense, we have that in the Controller's Office for

the City. I'm happy to have someone else come in.

COUNCILMAN KENNEY: My point is, the Controller is constantly -- all controllers come in here in budget season to complain about their lack of resources. I'm wondering whether or not this rises to the level of taxpayer expenditure that would call for an independent audit, not that anyone is doing anything wrong but just to confirm your numbers.

DR. SCHWARZ: So the Controller's Office looks at our procedures, and I believe that in looking at the procedures, we feel comfortable that the procedures done within the City would meet what an outside agency would do. I'm not sure what would be gained specifically based on the kinds of contracts.

COUNCILMAN KENNEY: Okay. Thank you.

DR. EVANS: I have to say for

the HealthChoices program, the City is actually required by the state to do an independent audit, and so that program is audited.

COUNCIL PRESIDENT CLARKE: Thank you, Councilman.

Quick status report. We have seven members teed up. We have four departments left after this particular department today. So no suggestions; just a simple status report.

DR. EVANS: And I'll talk fast.

COUNCIL PRESIDENT CLARKE: Thank you.

The Chair recognizes Councilman Oh.

COUNCILMAN OH: Thank you very much, Mr. President.

Good morning.

DR. EVANS: Good morning, Councilman.

COUNCILMAN OH: Thanks for all your great work. That's true, heartfelt, and also a precursor to some questions.

But these are technical questions. I'm really just exploring the answer.

So as a city, there are about a thousand licensed methadone clinics; is that correct or incorrect?

DR. EVANS: No. There are -- we have ten -- sorry; 13. Ten providers, 13 programs.

COUNCILMAN OH: Where did the number thousand come there? I just don't recall where that --

DR. EVANS: I'm not sure where a thousand came from. I'm not sure where that came from.

COUNCILMAN OH: Okay. A understanding on my part. So anyway, there's ten --

DR. EVANS: There are ten providers and 13 programs serving about 5,000 people.

COUNCILMAN OH: Okay. I apologize.

So are there metrics on success for these programs and clinics?

DR. EVANS: Sure. So as I was talking about, the pay-for-performance system. For every level of care, we develop metrics for that particular type of service. So for methadone as well as inpatient and outpatient, we are looking at various kinds of metrics.

COUNCILMAN OH: So the methadone is a replacement therapy with maintenance treatment.

DR. EVANS: Methadone is an agonist for opiates, which means that what methadone does technically is that it gets into the opiate receptors and blocks the euphoria that people will typically experience when they use opiates.

COUNCILMAN OH: So my question is, heroin addicts are opiate abusers. They get -- they go to the methadone clinic when they wake up in the morning and then they return in the evening typically. No?

DR. EVANS: No. People are

usually dosed once a day, and most people come in the morning but some people come in the evening. But a lot of people come for their daily dosing prior to going to work, and so a lot of people will be going in at 6:30, 7 o'clock in the morning.

COUNCILMAN OH: Do you know the number of people that come in in the morning and then in the evening?

DR. EVANS: I don't know -- I think that probably varies by program. The programs that have a higher proportion of people who are working probably have more people coming in in the morning and those that don't probably have more of a shift to the afternoon.

COUNCILMAN OH: My question is programs where they dose twice daily, once in the morning, once in the afternoon.

DR. EVANS: Right. But an individual is only going once, either in the morning or in the afternoon.

COUNCILMAN OH: Going twice is my question.

DR. EVANS: No. People would not go twice. People would go either in the morning or they would go in the afternoon. So the times have more to do with when people can go as opposed to people needing to go twice.

COUNCILMAN OH: So my experience is that people go twice. So that's just my personal experience where I know people who go twice, once in the morning, once in the evening. So if that is not supposed to be happening -- in other words, are you saying they're not supposed to be dosed twice a day?

DR. EVANS: Right. So if people are going twice, it could be that they're going in the morning for their medication and in the afternoon for some kind of psychotherapeutic, they might be in a group or that kind of thing, but people wouldn't be dosed twice. That would not be --

COUNCILMAN OH: So that would contradict my observation where I can say that people go twice a day for being dosed twice a day. Is that illegal? Is that improper?

DR. EVANS: Well, I can't think of any reason why someone would go twice a day. I'd be happy to talk to you about that and try to find out what that's about, but that would be highly unusual.

COUNCILMAN OH: Okay. So what is the goal of methadone replacement therapy and treatment? And I put that in the context of alcohol addiction where they try to get them off of alcohol, gambling addiction. But methadone is a substitute for heroin, and you still have people who die of overdoses and studies have shown that there hasn't been a decrease in the mortality rate or the crime for people on methadone because it can extend their whole life.

DR. EVANS: Right. So I think the thing to understand with addiction is

4/15/14 - WHOLE - BILL 140144, etc.

that --

COUNCILMAN JOHNSON: Can I get a point of information, please.

COUNCIL PRESIDENT CLARKE: Let him finish. Let him just finish answering the question.

COUNCILMAN JOHNSON: Go ahead.

DR. EVANS: So the thing with addiction is that different things work with different people and there's no one strategy that works. So some strategies are to help the person detox and to be treated, what people call, drug free or without some kind of medication. Some people find that very, very difficult, particularly people who have had a very long history of heroin addiction or opiate addiction. And so in the '60s, methadone was identified, methadone replacement therapy as you identified, as a very effective way to help people who have very long addiction careers, opiate careers, be stabilized, not feel the impact of the euphoria that is typically

felt with opiate use, and to stabilize to the point that they can get a job, that they're not engaging in criminal activity. And in fact, methadone has literally hundreds, at this point thousands of studies that show that people who use methadone decrease criminality, they increase employment, they are more engaged with their families. That's not even a question in terms of its effectiveness. Most of the opposition to methadone tends to be philosophical, that there are some people within the field that believe that, well, you're not really, quote, clean or you're not in recovery if you're using a medication to achieve your recovery. There are other medications that actually block the effects of opiates, like Naltrexone.

So there are a lot of different treatment strategies, and the thing that we try to do as a system is to make sure that all of those options are available

to people, because no one thing works for everyone.

Did I answer your question?

COUNCILMAN OH: You did, and I guess at another time, maybe not here, I'd like to explore that -- not the philosophy of it, but the -- in other words, the ones who are on methadone that actually -- methadone, Methadose that actually reunite with their families, that actually begin to live a normal life, that actually go to work, that's a success story, and the ones who don't or who relapse and come back and relapse, that's not a success story, and I'm just wondering are there measurements on those success and duplicate -- because as a prosecutor, former prosecutor, I've been familiar with the examples that I said where people go twice a day. They're high in the morning. They're high in the evening. They have great difficulty getting jobs. They don't work, and there isn't the fundamental self-esteem,

dealing with the problems type of treatment in between, maybe for insurance reasons or whatever reasons. That's my familiarity with some of the failures.

DR. EVANS: Sure.

COUNCILMAN OH: But I'm just wondering if there is a measurement of success and encouragement of successful treatment within these clinics.

DR. EVANS: Sure. So like I said, the research -- this is probably the most researched treatment methodology, addictions treatment approach, that we have. So I think the research around this is really clear. The reality is, like I started, there is no one approach that works for everyone. So even with methadone, you're going to find people that continue to struggle for a variety of reasons. One of the reasons is that many of the people who use opiates also use a lot of other substances, and programs that don't -- so if you only provide methadone, you're not

dealing with the fact that, okay, the person is using cocaine and alcohol and those other things. You're going to see the kind of pattern that you see.

So one of the things that we're doing is, in benzodiazepine use for example, is making sure the providers are using a more comprehensive way of addressing people's addiction and not just focusing on their opiate use. Our Director of Addiction Services, Roland Lamb, has done a phenomenal job of moving providers from just looking at dosing medication to really providing a comprehensive set of interventions that really are going to increase the likelihood that people are going to be successful.

What I'd offer to you is that if you'd like to sit down and talk to people in a methadone program, because I think you would be surprised at the folks who are in those programs who have their lives back, they have jobs, they have

their families back, and they're doing quite well. If they walked in this room, you would never suspect that they were a methadone client. I'd love to connect you with those folks and let you hear directly from them about what it's been for them, and I'd offer that to you and in fact anyone in Council.

COUNCILMAN OH: I appreciate and thank you very much for your answer.

COUNCIL PRESIDENT CLARKE: Thank you, Councilman.

Councilman Johnson, you had a point of order?

COUNCILMAN JOHNSON: Yeah. Just a point of information. Can you just -- and this is specifically directed toward my colleague's question. Just elaborate on the dosage per payment that the City doles out for individuals who are part of methadone programs. And I sat on the particular behavioral health board. I won't say the board, but I've always had an issue with the payment

system based upon the level of doses that you actually give to clients. Can you elaborate the City's role and how that operates?

DR. EVANS: So I think -- and Roland can back me up here -- we pay people on a per-day basis who are in those methadone programs. Again, I give a lot of credit to Roland Lamb who has -- because in a lot of places, in a lot of communities, the only thing that people are getting is the medication. They're coming to a clinic. They're getting the medication and they're essentially going home, even despite the fact that there are regulations around how much psychotherapeutic activity --

COUNCILMAN JOHNSON: How much is paid to the actual providers via the City based upon the level of doses that are doled out to the clients?

(Witness approached witness table.)

MR. LAMB: Good afternoon,

4/15/14 - WHOLE - BILL 140144, etc.

Councilman. Good afternoon, Council.

COUNCIL PRESIDENT CLARKE: Good afternoon.

MR. LAMB: The actual dosing rate is a little bit over, I think, $10.50.

COUNCILMAN JOHNSON: So just again a point of information for clarify for my colleague. So would you say -- you won't answer it that way. I'm looking at the level of an incentive of a provider who is getting paid to dole out doses of methadone to really want people to get off the methadone. At least that's what I'm trying to get an understanding. If I make money off of the number of doses that I give out to clients, I just want to make sure there's not, to be quite frank with you, an incentive to make money off the system. Because the more people stay on it and the company is getting paid, you know, when it makes the level of intervention to actually get people off the methadone.

DR. EVANS: Well, two things about what you're saying. One is that methadone is a maintenance approach, and there are people who will be on methadone for a very long period of time. Again, philosophically, some people have an issue with that. They have -- if someone is diabetic and they take diabetic medication for their diabetes, people don't seem to have a problem with that.

COUNCILMAN JOHNSON: For the record, I don't have a problem with that actual approach. I just want to clarify it, but I'm also looking at, you know, in some industries, the healthcare industry, medication is used when you're getting paid to dole out that medication in some cases as a way to make a profit. So there's less on intervention. There's less on the cognitive therapy. There's less on addressing those various social issues that will alleviate a person from being dependent upon whatever opiates that they may be addicted to as it

4/15/14 - WHOLE - BILL 140144, etc.

relates to utilizing methadone. That's all I'm backing up off the question of the Councilman, and I'll leave it there, Council President.

COUNCIL PRESIDENT CLARKE: Thank you.

DR. EVANS: I hear the question.

COUNCIL PRESIDENT CLARKE: Doctor, can you do this -- and I think you get the gist of the Councilman's question. Can you just forward in very specific terms in terms of the programmatic side of it, the contractual side of what it would be and just list dosage, times of day. I get where he's -- to determine whether or not there's some things -- there's some people out there that actually say that there is a category of providers that, frankly speaking, if people got well, they'd be out of a job. Let's call it like it is. So the question about whether or not -- thank you. So if you

could just give us very specific information on the contractual side of that.

DR. EVANS: Sure.

COUNCIL PRESIDENT CLARKE: Thank you.

The Chair recognizes Councilman Henon.

COUNCILMAN HENON: Thank you, Mr. President and Mr. Chairman.

So I have had several conversations. I've been sitting here patiently thinking to myself, listening to some of the conversations and some of the situations that we have in my district specifically. And, look, I'm glad there are treatments for people to try to turn their lives around. Everybody deserves a second chance. Some people deserve two, three, four chances. As long as they're at an advantage of turning their lives around and being a productive person in society, that's to all our benefits. That keeps the cost of

recidivism down. It keeps the cost of the numbers in our prisons down and the public safety for every community. So I get all that.

One thing -- I kind of danced around it early on because I didn't want to get into this conversation because I don't think this conversation should be here. This is just my personal thing. But there is a lack of oversight between mental health and addictions from the City perspective and the state license.

Now, if a bar -- if you have a license issued by the state, not by the City, from the state, and you have violations and violations in that bar to that license, it goes towards that license, then that license can be revoked. So what I'm going to say is, we had conversations about bad actors and everything. There are bad actors in the City of Philadelphia dealing with addictions and in exploiting the opportunity to make money. And if I find

out that they're bad actors in my district and there's no oversight from the City like mental health -- so I want to continue to work with you and your office and Dr. Schwarz in trying to have that kind of parity or that same level of oversight.

If I find bad actors, I will build up a case of them being bad neighbors and bad to society and bad to the clients that they're trying to exploit for money and bad to the community and public safety, when you have 600 people coming in and out of a day, bad for the wrong location, next to a daycare, next to a school, on a commercial corridor, in a residential neighborhood. All unacceptable if you're a bad neighbor. If they're a bad neighbor, they should be punished. They should be treated as such and their license should be revoked.

So I will work with you and your office to ensure that if you are any

of those above, I'm going to make a motion and move towards trying to have that license revoked and have them not be -- I think everybody should go through an RFP process through your office and the Department of the City of Philadelphia so we have some level of accountability.

If somebody wants to hang a shingle or a sign on a shingle and say we're open for business because somebody gave us the authority doesn't mean that you're good for the community. It doesn't mean that you have the experience. If you are buying so-called jewelry, if you think you're a jeweler, you're a pawn shop or you're somebody who buys gold for cash and now you're going to get into treatment, no. That's not good work.

So I've waited patiently to say that. I said it. And I want to continue to have conversations, because you guys do a great job and I want to make sure

that you have all the tools that you need, you have all the support that you need to make sure that people are accountable so our folks, your employees, our employees can do their job, do it effectively, do it with the tools they need, and to make sure that people are on the road to recovery, whatever that is, whatever that is, make sure that -- they can be somebody in this room. You won't even know it. I mean, I've seen people come to these places in suits in the morning, and I've seen them not. But when you see 400, 500 of them or 50 of them hanging outside and then a single mom has to walk through with their kid to get to daycare or school or after-school program or to pick them up because she's working, that puts everybody at risk and in danger. So the message is clear.

DR. EVANS: Sure.

COUNCILMAN HENON: We need oversight, and if you're bad, I want to move to revoke their license.

Thank you.

DR. EVANS: Thank you.

COUNCIL PRESIDENT CLARKE: Thank you, Councilman.

The Chair recognizes Councilwoman Quinones-Sanchez.

COUNCILWOMAN SANCHEZ: Thank you.

Good afternoon, gentlemen.

DR. EVANS: Good afternoon.

COUNCILWOMAN SANCHEZ: I really appreciate your working and providing the tours and some of the information related to the clinics so that folks kind of get an idea of the complexity of this situation.

One of the things that has arisen from these very necessary kind of tensions is what Councilman Henon was alluding to, is the accountability and how do we work to ensure that people on methadone or people seeking mental health services treatment that there is a monitoring so that the product doesn't

4/15/14 - WHOLE - BILL 140144, etc.

become a profit-making arm for the non-profits.

With that, I've noticed an abundance of pharmacies popping up located near a lot of the mental health services providers, and so I wanted to ask, because you fund a lot of these organizations and then they do the fee for services, is there any way that we monitor the level -- and you mentioned that some folks on methadone have other medical issues. Is there any way for us to monitor the prescriptions that are being issued to clients, and how do we hold folks accountable to that? And the reason I say that, from Broad Street to Kensington on Lehigh Avenue that I share with President Clarke, there are 12 pharmacies, and some of them only open certain hours during the day, and it's becoming a -- so I need to know what's going on.

DR. EVANS: So that's a complex question, in that there are parts of that

that touch the behavioral health system and then there are parts of that that don't. As you can imagine, there are a lot of primary care physicians. There are pain clinics in communities that are dispensing a lot of benzodiazepines, a lot of opiates and has nothing to do with behavioral health care other than once they get addicted, they end up in our system and we have to treat them.

What we're seeing is increasingly the number of people who are on prescription medications who start out on those prescription medications. The physician determines that the person is now addicted, cuts them off of that medication. Those people convert over to heroin, which is a lot cheaper, to continue their habit, because without the medication, they're going to go into withdrawal. So a lot of those people end up in our treatment system.

In terms of providers within our treatment system who are contributing

to the problem because they are dispensing benzodiazepines or whatever the medication is, when we identify those folks, we do make a referral to the state around their practices, if we identify a physician that is not -- their prescribing pattern is questionable and problematic.

The challenge is -- and we're trying to get better on this, because we're caught a little bit off guard on this -- is that you might be at Clinic A today. You get identified. Three weeks later you might be at Clinic B, and we may not know that until we catch up.

So we're looking internally now about at how we can, when we find these prescribers that do have these questionable prescribing patterns, to identify and track them and make sure that we get them out of our network. Obviously we don't have authority over where they might end up if they have a valid license from the state, but we can

try to make sure that they're not continuing the practice within our network. But it's a big issue for us as really a society right now.

COUNCILWOMAN SANCHEZ: So we have no -- so there's no systematic way right now that we're monitoring the scripts for some of the providers? Are we looking at that? I mean, if a person --

DR. EVANS: I think we do.

COUNCILWOMAN SANCHEZ: -- is being reimbursed from CBH, are we monitoring the scripts?

DR. EVANS: We do. We actually get some of the prescription data, and that allows us to look at certain kinds of patterns.

(Witness approached witness table.)

DR. HURFORD: Good afternoon. Matt Hurford, Chief Medical Officer, Department of behavioral Health.

So we are fortunate in that we

have, via the relationship the City has through the state, access to the prescription data for Medicaid recipients in Philadelphia, and we use that information in a number of ways to ensure that our members and the people that are served in the behavioral health system are receiving optimal care. That happens at an individual level during the utilization review process. It happens at an agency level when we, for example, have coordination meetings with the medication assisted treatment providers. Roland Lamb meets regularly with those providers, and there are opportunities to ensure that if there are individuals who are receiving high rates of medications that should not be used in conjunction with each other, that those providers are able to work with those individual members to have and receive appropriate care.

COUNCILWOMAN SANCHEZ: So you would be able to see, for instance, if I

said to you, I'm concerned about these pharmacies, you would be able to see who is writing scripts from your system that go to that particular pharmacy?

So here's what's happening: People claim they lose their prescription, say we have, you know, folks getting -- we know they're selling it. They say they lose it. But in particular I'm interested from a pharmacy perspective and seeing if there's a tie-in with a mental health organization and a pharmacist.

DR. HURFORD: That would be more difficult. The data that we receive is for paid claims that Medicaid actually pays. So the information that we generally receive is the patient, the medication dose, quantity dispensed, the prescriber, but not necessarily the pharmacy itself.

The other issue I should mention is that both for individuals who see providers that are not in our network

and pay cash either for the clinical visit itself or for the medication itself, we will have no way of tracking that information. It will not be reported via Medicaid, and there is no way that we will have an ability to access that, other than by individual report.

COUNCILWOMAN SANCHEZ: Okay. So the state -- we would have to get that information from the state in terms of tying it back into the pharmacies?

DR. HURFORD: That's correct.

COUNCILWOMAN SANCHEZ: And then we're going to be like we are with the recovery houses. The state chooses what information it wants to give us and not give us, and, therefore, we have a problem.

I'll go back. I know -- I'll come back to that point.

COUNCIL PRESIDENT CLARKE: Thank you, Councilwoman.

The Chair recognizes Councilman

Jones.

COUNCILMAN JONES: Thank you, Mr. President.

And I almost have to apologize for starting the methadone clinic discussion.

DR. EVANS: I want to talk to you after this about that.

COUNCILMAN JONES: I mean, really I will work better to do things in writing.

DR. EVANS: Not a problem.

COUNCILMAN JONES: But one of the more disturbing things I found out is that one of the directors makes 892,000 each clinic that they supervise or is that is a sum total?

DR. EVANS: No, I don't think that that -- there may be -- the methadone providers or programs are part of usually larger organizations.

COUNCILMAN JONES: Can you provide that --

DR. EVANS: You're probably

talking about someone who is at the --

COUNCILMAN JONES: I was told --

DR. EVANS: -- at the agency level, not at the actual program level.

COUNCILMAN JONES: How much does the President of the United States make today?

COUNCIL PRESIDENT CLARKE: Not that much.

COUNCILMAN JONES: Not that much. I'm just saying. To my colleague's question, is it about the money? I don't know, but it seems to me it's not a vow of poverty either.

So I want to change gears and get you out of that.

DR. EVANS: I appreciate that.

COUNCILMAN JONES: And I appreciate your willingness to have your staff work with us on the issue.

What I want to talk about at this point is, in my neighborhood and in a lot of neighborhoods, what happens is

as a result of gun violence, you have trauma, and I want to know how do you approach that problem, particularly for youth. One of the most disturbing things in my tenure as a Councilperson is riding by those teddy bear memorials, but worse than the teddy bear memorial is kids playing jump rope almost as a desensitized new normal, and I wanted to know what role you guys play in cooperation maybe with DHS or others. How do you intervene on that?

DR. EVANS: So that's a really great question, because it's something that we're spending a lot of time and energy on, the issue of untreated trauma in our communities.

So the best way to describe it is, we have a three-pronged strategy. One is to make sure that we have evidence-based treatment options available to people. You cannot assume that if you go to a generic mental health clinic that people there are trained to

treat trauma, and in fact, most clinicians, whether psychiatrists, psychologists, social workers, whatever, are not trained to actually deal with trauma. So one of the things we've done is to bring in people who have created the most effective trauma treatments and have them work within our system to train our providers. We've trained a network of both children's providers and a network of adult providers to do that.

Secondly, our second strategy is to make sure that we are intervening early. So in those communities where we have gun violence, particularly when it's witnessed by children or by the community; for example, a community center, we will send what we call our crisis response teams into those communities to work, not necessarily to do interventions but to provide information to people. So these are people that have been trained in psychological first aid, and the idea is

that they're going in, they are a lot of times at those memorials that they have in the community. They're handing out information, and they're just making sure that people -- part of it is to send the message that it's not okay for this to happen in the communities and that people are going to sometimes have a --

COUNCILMAN JONES: Could you provide to members of Council the contact person?

DR. EVANS: Sure.

COUNCILMAN JONES: Because all too often we're dealing with that, and it's like you're lost for words of what to truly -- we're not trained.

DR. EVANS: That's right. And these people are trained to go into those kind of situations and provide support for people. So it's our way of not waiting until people develop PTSD, but going into the community immediately after these kinds of things happen, getting information to people, and then

being that face so that if people do have problems, they know someone down the street is there that can help.

And then the third strategy is to work with our systems partners, police, for example. We've trained 2,000 police officers on crisis intervention training, because police officers are often going into situations where people may have a trauma history, psychological distress, and we want them and the Police Commissioner wants them to be able to respond appropriately in those situations. We're doing similar work with DHS in terms of helping that system in terms of dealing with trauma.

COUNCILMAN JONES: Like Pavlov's dog, I've learned to respond to the bell, and I just want to end with particularly dealing with public schools, there are more and more occasions -- and I've had a reason to talk to educators more often with the school mergers and the lack of counselors and this, that,

and the other. How closely do you work when a child has an episode in a class and do you train personnel in the schools to know how to deal with that first aid, if you would?

DR. EVANS: Sure. So --

COUNCILMAN JONES: Thank you, Mr. President.

DR. EVANS: -- the relationship that we have with the School District, that we have with Dr. Hite and his staff, is the best it's been in my tenure, and I've been in my position for nine years now. We're working with them in multiple levels. We have the school therapeutic services that are in schools. So for those kids that are likely to have those kinds of challenges, there are behavioral health professionals in the schools that are working directly with them. Those behavioral health professionals are also working with the staff, the administration, the faculty on how to better handle those kind of situations.

We have a protocol worked out with the School District so that when a situation exceeds what they can handle in the school, that we will deploy our crisis response -- I'm sorry; our mobile crisis teams to the school to help manage those situations. And when there are particular issues that come up, Dr. Hite will call me directly or I might call him, and we will collaborate and we'll deploy staff.

So we have both routine protocols that we have in place and we have the kind of relationship that they will call and we will work out those kinds of situations directly.

COUNCILMAN JONES: Thank you, Mr. President.

COUNCIL PRESIDENT CLARKE: Thank you, Councilman.

The Chair recognizes Councilwoman Reynolds Brown.

COUNCILWOMAN BROWN: My line of questioning also includes what we're

doing in our schools, so I'd like some further information on that, particularly around violence in schools.

You currently fund several programs that have proven successful in reducing youth violence and recidivism amongst juvenile offenders. The Functional Family Therapy is one such program. How many FFT programs are you currently funding? How many of them have established programs in the public schools? What youth violence reduction programs are you currently funding within the public schools, and some detail around those in particular. Is there room to do more? Are there dollars available to do more?

DR. EVANS: So FFT is -- we have three providers of FFT.

COUNCILWOMAN BROWN: You said three?

DR. EVANS: Three providers. It's not an intervention that you do in the school. The whole idea is to do it

in the family setting. So it's not a school-based service. It's a family-based service.

Our capacity to do more? Yes, we have some capacity. In fact, one of the conversations we are having with Dr. Hite right now is around how we deploy the current resources in the schools. So I said we have a $70 million investment in the schools. A lot of where those services are delivered is a historical artifact, and what we're doing now is we're looking at essentially re-procuring those services and how would we distribute those services in the areas that the School District is identifying as having the highest need.

So that's part of our capacity, is to try to shuffle the deck so that we are targeting services in the areas of the greatest need, but part of it is, we do have some capacity and we're working with the School District to identify what those services might look like.

COUNCILWOMAN BROWN: And so coupled with that, might DHS be at that table as well as -- is DHS at the table?

DR. EVANS: DHS, us, and the School District. For example, a few months ago we did a joint event that included the School District, DHS, and my department all coming together and then looking at how do we better address the social, emotional needs of children.

COUNCILWOMAN BROWN: And maximize those resources. The other agency I was trying to remember is the DA's Office, because in having a meeting with the District Attorney, he also has a strong interest on the prevention side of the ledger. So having him at the table as well, he has some great ideas about how well they do this in San Francisco. So know that as an FYI, he has an interest in that area as well.

DR. EVANS: Be happy to work with him on that.

COUNCILWOMAN BROWN: Okay.

4/15/14 - WHOLE - BILL 140144, etc.

Community-based providers -- no. One second.

The inclement weather, we know it wreaked havoc on everybody, and community-based organizations providing behavioral health services were closed as a result on many of those days. Since those agencies were not able to provide services and, therefore, unable to bill CBH, what was the fiscal impact of such closures on those agencies? Can you discuss that, please.

DR. EVANS: We know --

COUNCILWOMAN BROWN: In the past you made attempts to reimburse agencies for some portion.

DR. EVANS: Sure. We know that some agencies experienced a financial impact because of all of the snow that we had this year. This year we are not in a position -- historically we have worked with those providers to try to figure out strategies to help compensate them for that loss in revenue. We're just not in

that position this year. We're going to be very, very tight this year, and we might even have a deficit in the Medicaid managed care program. So we're not in a position to help the providers out this year as we have in the past.

COUNCILWOMAN BROWN: And I would imagine that's been shared uniformly across the system?

DR. EVANS: The providers know that. We've let them know.

COUNCILWOMAN BROWN: Okay. We talked about the Mental Health First Aid.

I thank you very, very much. I will look forward to hearing more about the agencies that you contract with and where they are with regards to Board composition and engagement on the procurement side of the ledger.

DR. EVANS: Sure. We'd be happy to tell you that. I can tell you that 75 percent of the staffing at our non-profit agencies are minorities, women, and disabled, and 65 percent of

their executive staff are minority, women, and disabled. So I think we have a good representation in our private non-profit world.

COUNCILWOMAN BROWN: So it suggests that it's possible.

DR. EVANS: I definitely believe it's possible.

COUNCILWOMAN BROWN: Leadership that moves the needle. Thank you very much.

COUNCIL PRESIDENT CLARKE: Thank you, Councilwoman.

COUNCILWOMAN BROWN: Thank you.

COUNCIL PRESIDENT CLARKE: The Chair recognizes Councilwoman Tasco.

COUNCILWOMAN TASCO: Just very briefly along with that. In looking on Page 13 of your budget, I noticed that the Northwest Human Services, one of your largest contracts, has no minorities or women on their executive staff and only 16 percent of their Board are people of color or women.

DR. EVANS: Yeah.

COUNCILWOMAN TASCO: How can we correct that?

DR. EVANS: I don't know about that provider specifically. I think we've given the message that we think this is important. In that particular case, we can certainly raise it, because they are one of our larger providers. So that's an issue that we certainly can raise with their leadership, which is actually about to change in the next couple of months.

COUNCILWOMAN TASCO: Okay. Thank you.

COUNCIL PRESIDENT CLARKE: Thank you, Councilwoman.

The Chair recognizes Councilman Kenney.

COUNCILMAN KENNEY: Mr. President, as an early Easter gift to you, I yield my time.

DR. EVANS: I think that's an early Easter gift to me, Councilman.

COUNCIL PRESIDENT CLARKE: Thank you.

The Chair recognizes Councilman Oh.

COUNCILMAN OH: Thank you very much, Mr. President.

My last comment, which I stopped because of the time, was that my interest was in addition to my colleague's about bad neighbors, bad actors, but just if there are alternative payment methods that reward the successful treatment as opposed to the continued maintenance. And I understand continued maintenance may just have to be the way it is, but I just wonder about kind of in the overall cost of things kind of rewarding successful treatment over continued treatment.

Thank you.

DR. EVANS: Okay.

COUNCIL PRESIDENT CLARKE: You're good, Councilman?

COUNCILMAN OH: Thank you.

COUNCIL PRESIDENT CLARKE: Thank you.

The Chair recognizes Councilwoman Quinones-Sanchez.

COUNCILWOMAN SANCHEZ: Thank you.

To the issue of diversity, I noticed that in your demographic information, you have a zero percent in terms of language, bilingualism. Can you speak to that in terms of services.

DR. EVANS: I'm not sure what you mean.

COUNCILWOMAN SANCHEZ: In your report out on minority and staff demographics, you put that you have out of your staff six Hispanic males, four Hispanic females, but you put that in terms of language, bilingualism, zero percent.

DR. EVANS: I don't think that would be correct. I think the people --

COUNCILWOMAN SANCHEZ: I would hope not.

DR. EVANS: Yeah. The people who self-identify are bilingual. We actually have several bilingual staff, multiple languages.

COUNCILWOMAN SANCHEZ: According to your numbers, it's 2 percent. So I wanted to speak to language access and cultural competency given that number.

DR. EVANS: So language access, the preferred way to have language access in our field is to have providers that speak the language who are trained as psychologists, psychiatrists, social workers. When it comes to Spanish, we have lots of providers who can provide services in Spanish. When we have other languages, often we have to use interpreters. We do have some Southeast Asian capacity and some of those languages. We also have providers who have Russian-speaking staff, particularly up in the Northeast. So we do have around our system people who are

bilingual, bicultural, and can work directly with people. In the instances when we don't have that, we use an interpreter service. We actually have two contracts for interpreters, and there is no language to date that we've not been able to find an interpreter for in those cases where we don't have trained professionals in a person's language.

COUNCILWOMAN SANCHEZ: It would be great for maybe next year if we can report that out by provider, just to see it.

I want to go back to accountability as providers. I know that on the recovery side, you guys have been very proactive in helping us identify good actors, bad actors, closing down folks, helping us close down even those houses that are not funded by the City. In the last couple of years, we've talked about the multiple providers who may have multiple members living in a particular address. How have you guys -- how have

your providers been working to ensure that people living in these residency houses -- I know part of what we asked for was where we saw consistency in multiple folks, that there be some sort of site visit or other things. How are you guys doing on that?

DR. EVANS: Are you talking about recovery houses in particular?

COUNCILWOMAN SANCHEZ: Yes. Recovery houses, yes.

DR. EVANS: Okay. I might need Roland Lamb's help on some of this, but we have, as you may recall, a set of standards that we have issued and we've encouraged our providers to -- well, for our providers who we directly fund, they have to follow those. We've used our bully pulpit, so to speak, for those providers that are not funded by us to also adopt those standards, and I think we've done a pretty good job. Roland's staff and he have done I think an excellent job of really getting providers

to adopt those.

We recently got a federal grant that allows us to pay fee for service as opposed to a grant for people to identify a recovery house that they want to go to. All of those providers now have to adopt our standards. So I think our penetration rate in terms of people adopting those standards has gone way up, especially with the federal grant that we got.

And then the other piece is that providers know that if they want to be a part of our network, whether they're funded by us or not, that that's something that we are going to be looking to.

COUNCILWOMAN SANCHEZ: I'd like to get an executive summary of that federal grant and how you're going to pay folks for that, because that becomes -- I know that's sort of a replacement to the cash assistance that was provided for people for recovery. So I'd like to know

how that's going to be applied and how people are going to get paid for those services.

DR. EVANS: Sure. Absolutely. In fact, if we didn't have the federal grant, the cuts that we received in GA would have a much greater impact than they've had, but we've been able to compensate a little bit by using that grant to give people those resources to access recovery housing and other recovery support services.

COUNCILWOMAN SANCHEZ: Okay. I don't know, Roland, you want to report any progress?

MR. LAMB: Well, the progress that we've made is fourfold. Remember, we have about 300 entities in the City of Philadelphia that call themselves recovery houses. Out of those 300 entities, we directly contract with 17, and then under ATR, Access to Recovery, which is the federal grant that Dr. Evans mentioned, we have another 14. All of

those have to meet the standards of our recovery house network or our housing network.

We are also supporting the Pennsylvania Association of Recovery Residences, which is working with the state to enact legislation to put everyone that calls themselves a recovery house under a set of standards. If you're going to call yourself a recovery house, you're going to have to adhere to the standards.

We've actually taken two of our recovery houses that we had under contract and have removed them from our system because of just that issue, that we found that people were -- there were too many people in a facility, and we shut that facility down as far as we were concerned.

COUNCILWOMAN SANCHEZ: Okay. Just one last thing. When new providers are coming into the system or people are setting up new fee for services who

expect to be reimbursed by CBH, are they getting a packet about how they locate? And the reason I say that is because one of the things that becomes problematic is when people go into a facility that is not zoned yet, set up, expend money, then we're the bad guys because we don't let them site.

What are you guys doing to providers, current providers, who want to expand? What are you telling them before they go and set up anywhere else? Is there something -- I want to know if there's something in writing, because what I don't want is for someone to say to me, We're a good provider and all this other stuff and call Roland Lamb and call Dr. Evans. No. What are the rules -- what do we tell folks when they want to move into somebody else's neighborhood around expanding without all the pre stuff done?

DR. EVANS: So we tell them two things. One is that if they are going to

expand and we're doing some kind of program expansion, we do it through a competitive procurement process. And, two, if they are going to expand, our expectation is that they follow the good neighbor policy.

One of the things that we've done recently because of all of the interactions we've had with Council around this in the last several months is, we've gone back and looked at that policy and we will be reissuing that. We actually want Council's feedback. We sent it to Councilman Clarke. And so hopefully all of you will have a chance to take a look at that and give us feedback, because what we'd like to do is that before we do -- or as we do a competitive procurement, that one of the things that we'll get issued with that or at least be referenced is, here's our good neighbor policy and that is what we expect you to adhere to.

COUNCILWOMAN SANCHEZ: I

haven't seen that information, but in there, do you --

DR. EVANS: It just came out.

COUNCILWOMAN SANCHEZ: Have you mapped out where the current services are?

DR. EVANS: Yeah. One of the things we do is, we look at both where we identify need and where we have providers and where people are. So what we're trying to do nowadays is -- in the old days, people basically set up a program and we funded it based on other criteria. Nowadays we are much more focused on targeting areas of the City that don't have access to services or areas where we've identified high need and not enough services.

COUNCILWOMAN SANCHEZ: So you haven't done any new RFPs? I know folks were waiting for that.

DR. EVANS: It's unlikely that we're going to do any RFPs this year because of the tight financial situation

we're in. There may be some very special things that we do, but for the most part, there are no major expansions this year.

COUNCILWOMAN SANCHEZ: Okay.

Thank you, Mr. President.

COUNCIL PRESIDENT CLARKE: You're good?

COUNCILWOMAN SANCHEZ: I was going to ask one more, but...

COUNCIL PRESIDENT CLARKE: Go ahead.

COUNCILWOMAN SANCHEZ: In terms of the information provided around the policies, in terms of mapping that out, if it's not included, can that be mapped out for us?

DR. EVANS: Oh, sure.

COUNCILWOMAN SANCHEZ: I think the visual, it becomes very important for folks as you make these decisions. I think siting these places -- I'd like to see what those policies consist of and I'd like to see you articulate what a good -- without looking at the financial

part of it, what is a good model. I think what you see is the hesitancy of folks because when the number becomes outrageous, then -- I have, for instance, two methadone clinics within a mile radius of each other. So what's an ideal model? Is it a 200-person model?

DR. EVANS: I see.

COUNCILWOMAN SANCHEZ: What is the best practice so that as you're giving that to us and you're asking us to help input on a policy, that we have that information. What's the best model -- because I think at some point, if we want to be proactive, we got to fund this appropriately. And so your reliance is solely on CBH, but some of us would say, Hey, maybe we need to put general operating money at the table to ensure that we are not disrupting neighborhoods, but at the same time, we're providing the treatment.

I think too many times we look at it from a financial perspective as

opposed to what's the best practice, and I think if we're going to review any policy, I think we need that. We need to be able to say what makes sense. I know for Council President, he has a huge one in his district, and no one should be subjected to that kind of volume because we haven't said this is the model that is best. It's a hospital setting. It's 200 visits a day, whatever that is, and then how do we ensure that we're putting those models with other programs and services, the co-location, so that the model works financially for the provider but, more importantly, for the neighborhood.

DR. EVANS: Right. Those are excellent points, and we'd be happy to both share what our best thinking is now but also get your input, because ultimately this has to work both from a treatment service delivery standpoint but also from a community standpoint.

COUNCILWOMAN SANCHEZ: So we just need that model. We want to know

what that looks like.

COUNCIL PRESIDENT CLARKE: Right.

COUNCILWOMAN SANCHEZ: So we're not the bad guys all the time.

COUNCIL PRESIDENT CLARKE: Right. Exactly.

COUNCILWOMAN SANCHEZ: Thank you, Mr. President.

COUNCIL PRESIDENT CLARKE: Thank you, Councilwoman.

Can we agree to have a followup and call it a working session, because too often every year we have these debates, and CBH tends to be one of the longer departments and we don't address it again until the following budget year in realtime. So if we could agree -- and I'll ask a couple of members of Council to participate in a task force or some sort of working group so we can go over these different issues and to actually come up with a set of recommendations, if need be some changes in legislation, some

changes in direction or whatever we need. Then we can actually have a report that we can issue, so next year's budget hearings won't be as long. All right?

DR. EVANS: I'm enjoying myself, sir.

COUNCIL PRESIDENT CLARKE: Well, you get to leave, right?

DR. EVANS: Right.

COUNCIL PRESIDENT CLARKE: We got four more departments.

DR. EVANS: I think I just did the rope-a-dope. I don't think you have anything left for them.

COUNCIL PRESIDENT CLARKE: I know. Seasoned veteran.

Thank you. I just want to thank you so much for your testimony, and we'll reach out and we'll set something up.

DR. EVANS: Thank you.

COUNCIL PRESIDENT CLARKE: Thank you so much.

We need to take a five-minute

break and then we'll come back and hopefully we can get through the Health Department relatively soon and then we'll break for lunch.

(Short recess.)

COUNCIL PRESIDENT CLARKE: We're going to start. Next up we have the Health Department.

(Witnesses approached witness table.)

COUNCIL PRESIDENT CLARKE: Good afternoon.

DR. SCHWARZ: Good afternoon.

COUNCIL PRESIDENT CLARKE: Good afternoon. You can proceed.

DR. SCHWARZ: Good afternoon, Council President Clarke, members of City Council. I'm Donald Schwarz here for this session as Health Commissioner. With me today are Tara Mohr, Deputy Commissioner for Finance; Kevin Vaughan, Deputy Commissioner for Administration; and Karla Hill, Director of Human Resources for the Department. Thank you

for the opportunity to present the Department of Public Health's Operating Budget request for Fiscal Year 2015.

The FY15 budget will continue to support services basic to the Department of Public Health's core mission, to protect and promote the health of all Philadelphians and provide a healthcare safety net for those most at risk.

The Department's Fiscal Year '15 budget request totals about $356 million, which represents an increase of $10,086 over the Fiscal Year '14 estimated obligations due to an incentive award under the City's Energy Efficiency Savings Program bestowed upon the Department for lowering its overall energy usage.

You have my full written testimony, so I'll summarize.

COUNCIL PRESIDENT CLARKE: Thank you.

DR. SCHWARZ: It includes a

summary of the great progress that we're making in many areas of public health in collaboration with Council: Reducing the rate of smoking in the City by more than 15 percent, lowering the amount of sodium in Chinese takeout restaurant food by 20 percent, stopping the increase in rates of obesity for our children and adults, reducing rates of sexually transmitted diseases in our young people, lowering our infant mortality rates, reducing the level of toxins in our air, improving home environments for children, reducing the horrible toll that AIDS and HIV take on our communities, and improving the care we provide to vulnerable Philadelphians in our health centers.

Let me briefly highlight for you two particularly important initiatives for the Department. We're in the process of seeking public health accreditation. Accreditation is a new national process by which local, tribal, and state public health agencies assess

and document their ability to provide the ten essential public health services. The National Public Health Accreditation Board, an independent non-governmental agency, has developed a set of more than 300 standards and measures to serve as benchmarks for accreditation. Through accreditation, the Board strives to advance quality and performance within public health departments all across the country.

While public health accreditation is not currently required, federal agencies such as the U.S. Centers for Disease Control and Prevention have indicated that they will likely require accreditation within the next five years as a condition of grant awards.

Through this effort, we've developed a required community health assessment, which is now available online for everyone at our website, phila.gov/health, and I encourage everyone to explore it. It includes 62

health indicators for Philadelphia, looking at them over time by population subgroups, by neighborhood, and it provides comparative today to other U.S. cities and counties. We're using the assessment to develop a new strategic plan for the Department, also as part of accreditation, and have shared that plan and -- have shared the data widely in Philadelphia neighborhoods with Philadelphians, both through our website and through community and organization stakeholder meetings with a range of public health partners.

In addition, since 2012, the Department has focused formally on performance management activities under leadership from the Commissioner's office. Some of the stars of performance improvement are here with me today. We began by improving the infrastructure parts of our department, but we're now moving on to improve the core operations work of the Department. In this regard,

I am particularly proud of the work of the Office of Food Protection, or the OFP. This effort has been led by Dr. Palak Raval-Nelson, Director of our Division of Environmental Health; Nan Feyler, my Chief of Staff; and Bernard Finkel, the Director of the Office of Food Protection.

At Council's request, we strive to become more business friendly. The office recently released a guidebook for starting a new stationary food business and has provided our customers; that is, the businesses, with the ability to pay plan review and enforcement fees online, which is revolutionary, as you know, for our part of City government. As a result of the electronic payment system, revenue has increased for the Department and the ease of payment has improved for our consumers.

Currently, customers can pay only two types of fees online, but the Office of Food Protection is working to

4/15/14 - WHOLE - BILL 140144, etc.

address programming and firewall issues and hopes to have the system operating for all types of fees by the end of this year.

I thank you, Council President and the members of Council, for your continuing support of public health in Philadelphia, and I'm happy to answer your questions.

COUNCIL PRESIDENT CLARKE: Thank you very much, Doc.

I actually just have one question for you at this point. In your testimony, Page 2, it talks about currently having 135 unfilled budgeted full-time positions for FY14 and it also states on Page 4 of your testimony that many of your divisions face challenges in maintaining staffing. One, is that number accurate? And I know it was in your testimony. And, two, can you talk to us about the likelihood that you will be able to fill those positions and the challenges associated with filling those

positions if that in fact is the only basis for having 139 unfilled positions? Because I know our government works -- sometimes we appropriate money. We do certain things as we move throughout the process. And I saw Rebecca sit up as I said that. She thought I was getting ready to ask questions about the money. But can you talk to me about the 139, please.

DR. SCHWARZ: So we have worked very hard in the Department on improving our hiring processes. And as you know from your years in the City and you know from talking to departments, that is a difficult process. Hiring in the City is precise, often it's difficult because there are a lot of job classes, and it takes a long time for certification and testing to happen, and there are a lot of moving parts, as government I think on this issue needs to have to assure that the work of the Civil Service system isn't violated and to assure that all

Philadelphians have an opportunity to apply through the merit-based Civil Service system.

We have worked diligently, and I highlight our Director of Human Resources, Karla Hill, to reduce the time for hiring, and what you see in the number of vacancies in the Department is the output of that work.

What I have to say is that at the same time, we are a relatively old department in terms of our workforce, and many people are retiring. We are doing a lot for succession planning, but keeping up with retirements and keeping up with staff turnover is equally difficult. So to bring down the number of vacancies means that not only do we have to fill the vacancies each year, but we have to fill the new openings that happen because of retirements or people leaving. And that is an ongoing challenge for us, particularly since about 40 percent of our workforce is delivering healthcare

services in our health centers, and that kind of staffing is highly competitive in Philadelphia.

So we have a lot of staff turnover, although I have to say our staff turnover rates in our ambulatory health centers are comparable to other healthcare institutions in Philadelphia, but given the number of people, that still creates vacancies throughout the year.

COUNCIL PRESIDENT CLARKE: Okay. So 40 percent are directly related to healthcare service delivery.

DR. SCHWARZ: Yes, sir.

COUNCIL PRESIDENT CLARKE: And you would acknowledge that the City of Philadelphia has some of the best healthcare schools. Is there a reason why we cannot recruit those employees, those potential employees, from those schools?

DR. SCHWARZ: No. We do, but --

COUNCIL PRESIDENT CLARKE: Is there a reason why they opt not to go our direction?

DR. SCHWARZ: The demand for those folks is substantial, and salary is often the deciding issue. You all know that in the last year, with Council's approval, we increased, for instance, salaries for our physicians. That has made a huge difference in our ability to fill unfilled vacancies for positions and retain physicians.

COUNCIL PRESIDENT CLARKE: Right.

DR. SCHWARZ: That took us three years. So we have to keep up on salaries. Council and the Administration I think have worked well to try to do that, but it's a very competitive environment, particularly with the Affordable Care Act. Demand for personnel has changed and is changing. It's, I think, part of the beast. All healthcare institutions in Philadelphia,

not just us, have the same issue.

COUNCIL PRESIDENT CLARKE:

Right. So this is unrelated, the question that I will put forth to the School District, but related in a sense that you basically are making our case that one of the concerns that we consistently raise with the School District is, for whatever reason, not having a very significant curriculum based on the job opportunity. I always like to say we spend too much time teaching to pass the test, but we don't teach to get a job. And I talk about the fact that in the City of Philadelphia, we're probably surpassed by maybe two other cities in terms of healthcare careers and opportunities and why we need to start refocusing some of our curriculum so these young people in the public school system have a real opportunity to ultimately be in probably one of the only growth industries and it will, in the foreseeable future, continue

to be a growth industry, why we need to focus on having some serious curriculum changes in the Philadelphia School District to make sure that we can take advantage of that.

But that's not a question for you today. But I just want to say thank you for possibly giving me an opportunity to reference this conversation when the School District comes in.

I want to thank you for your good work, and I'd like to recognize Councilman O'Brien.

COUNCILMAN O'BRIEN: Thank you, Mr. President.

Dr. Schwarz, welcome.

DR. SCHWARZ: Thank you.

COUNCILMAN O'BRIEN: I know that the AIDS Activity Coordinating Office's Preventative Planning Project has experienced some significant budget cuts. As a result, the HIV/AIDS program for people with disabilities run by Vision for Equality lost their $62,000

funding for this program in the year 2013.

One, I know that reducing the toll of HIV/AIDS through surveillance, prevention, education, and health is one of the Department's goals. However, I'm concerned about the need to do outreach to individuals with disabilities. I'm sure you're aware that people with intellectual disabilities, autism are often sexually active, but they have little access to information regarding how to have safe sex, where to seek testing or the means to protect themselves. So I'm concerned why this sole program offered to people with intellectual disabilities and autism in Philadelphia was ended, and I have a two-part question.

Are you familiar with this program, the HIV/AIDS program for people with disabilities, and, two, is there any possibility of restoring some or all of that funding at some point during the

Year 2014 and '15?

DR. SCHWARZ: I appreciate your question. I can give you some good news for the clientele that you're most concerned about, and I agree with your concern. And I can say that for any agency, as with Behavioral Health and Human Services, actually the money the AIDS Activities Coordinating Office, which is largely state and federal funding, is bid out through request for proposal processes. So with the next round of RFPs, every agency will have an opportunity to bid. Our priorities, therefore, are heavily set by the agencies that give us money or cut our money, as you can see. That's issue one.

Issue two is, what has changed dramatically in the last, I would say, year and a half nationally around outreach, testing, and education for HIV is that the Centers for Disease Control has pushed very hard, and we agree with them, that HIV testing and education

should be routine in healthcare settings. So that when you go to the doctor or I go to the doctor or anybody goes to the doctor, that provider needs to address issues around sexual behavior and needs to make sure that everyone has had at least one HIV test. And if someone has had an HIV test that's negative but they continue to have risky behaviors, to continue to educate and test. And we are working now with all of the healthcare providing agencies in Philadelphia to routinize that.

So for clients who have intellectual disabilities who generally have another healthcare provider, we want that healthcare provider routinely to test those folks and talk to those folks about HIV. That is a new strategy. It's a federal strategy, and we have embraced it wholeheartedly here in Philadelphia. And we hope what that will do is allow populations that we've not been able to reach through contracting out with

individual agencies to more globally and comprehensively reach everybody in Philadelphia, because we have a substantial number of folks who have HIV and don't know about it and yet they may be receiving regular medical care. So through regular medical care for all populations, we hope we will better identify those who have HIV.

COUNCILMAN O'BRIEN: Thank you. I'll try to sneak this under the wire. I want to congratulate you on your work on Get Healthy Philadelphia, and I know that by reading your testimony that the rates of smoking have dropped by 15 percent over the last four years and the level of childhood obesity has declined by 5 percent, and these are just some of the many successes this program has experienced.

DR. SCHWARZ: Thank you.

COUNCILMAN O'BRIEN: But we also -- again, my proclivity for protection and advocacy for my guys, we

know that individuals with disabilities experience co-morbid conditions. They often have higher rates of sedentary behaviors and higher rates of obesity. These higher rates of obesity can be attributed to accessibility issues, stigma, which can isolate individuals with disability, the lack of knowledge and information regarding what is available, and the lack of accessibility to playgrounds.

We know the side effects of medications can result in secondary health conditions like diabetes and that individuals with disabilities often have shorter life expectancies.

My first question is, to my knowledge, there hasn't been a concerted effort to target families impacted with disabilities, and if that's correct, I would love to work with the Health Department to include a focus on individuals with disabilities as part of Get Healthy Philadelphia.

We established through my office and Katy Kaplan some wonderful relationships with our institutions of higher learning that are eager to address some of these issues and can really serve as a wonderful resource for this important initiative.

DR. SCHWARZ: We'd be happy to work with you. Absolutely. I think it's an important population.

One thing I want to say is about smoking.

COUNCILMAN O'BRIEN: Please elaborate.

DR. SCHWARZ: So for populations who have mental health issues, nationally, not in Philadelphia but nationally, 50 percent of people who smoke nationally are part of the behavioral health system. And what we know is, for instance, about 90 percent of people with schizophrenia smoke. So one group that we have worked with really well is the behavioral health system, and

having Dr. Evans and his people as our colleagues has meant that here in Philadelphia, we are bringing together public health and behavioral health to address those issues and, at the same time, helping to educate providers about the issues of obesity. Because people with behavioral health issues generally don't die from their behavioral health issue. They die from chronic illness.

You are completely on target. Obesity and tobacco are killing people who have disabilities and particularly behavioral health issues. So we believe it's a critical need to partner and reach those individuals and offer them prevention help, guidance, resources and so forth, because they should live -- everybody should live a long life, and if either lack of knowledge, lack of access or lifestyle is impacting people's length of life, in the Health Department we believe we need to address it.

COUNCILMAN O'BRIEN: I'd just

like to comment that it was so evident how well you work with Arthur Evans, and that also part of that grouping and excellence of integration and blending and braiding of service include Anne Marie Ambrose at DHS and Joan Erney at CBH. So thank you very much. It's wonderful to see that level of cooperation.

DR. SCHWARZ: Thank you.

COUNCIL PRESIDENT CLARKE: Thank you, Councilman.

The Chair recognizes Councilman Jones.

COUNCILMAN JONES: Thank you, Mr. President.

I too want to commend you for the cooperation that you've had and again reiterate the briefing that you had last year with all three major stakeholders within Health, Human Services, and Behavioral Health. I thought it was excellent for us to see the interaction and helped me a great deal to kind of

understand what you guys go through and how you -- the teamwork approach to taking and providing services.

Another issue that you are paying attention to is alternate forms of service delivery, such as telemedicine. We had a hearing. I was delighted to hear that you guys have used that, and is there further areas that it can be expanded to was the question during the hearing.

DR. SCHWARZ: Yeah. I think we are very open, as you heard, to exploring. Part of the challenge for us has to do with professional licensure, and you heard that I think loud and clear in the hearing. So there are regulatory issues by both the state and the federal government, although heavily by the state, that impact the ability to expand in many areas of telemedicine, and those are being addressed. It may seem like a slow pace to us locally when we see need, but I have to say looking at the

challenges in changing the regulation, both at the state and federal level, progress is being made.

COUNCILMAN JONES: I was told you would develop a task force to look at that.

DR. SCHWARZ: So we have not yet. Part of it is through inquiry to see who would be the expert helpers. We're still trying to figure that out. So where are the opportunities, because we could develop a task force report that's not based in reality, but I think you want and you're going to want something that can be actionable. So that's the first step.

COUNCILMAN JONES: I appreciate that, and a wise Councilperson told me act in haste and repent in your leisure. I always remembered that. One of these days. I'm paraphrasing.

How has sequestration and the loss of stimulus dollars impacted your service delivery, and are there options

to replace those dollars that you may have lost?

DR. SCHWARZ: So I don't think we're going to see anything of the magnitude of stimulus again. And remember that, in a sense, stimulus was supposed to tide us over as tax dollars rebounded, and to some extent, this Council has worked with us to replace some dollars. Probably the biggest area has to do with obesity and tobacco prevention. We were the number one rated entity nationally for those dollars. So we received a good amount of dollars in Philadelphia, which we've used to build infrastructure, as you know, and we have results which are pretty gratifying.

What is more concerning that isn't exactly sequestration and isn't the loss of stimulus is a federal policy change that dollars which may have gone to large cities are now increasingly being directed back to states. Those dollars originally went to cities to

reflect the fact that state governments often didn't appreciate or politically wouldn't acknowledge the needs in cities. By redirecting those dollars to states, what we're seeing is the reallocation in formula changes for dollars that have come to Philadelphia in the past and instead they're going here and there around the state, without a direct tie to need, because if you look at need, Philadelphia has the lion's share of need in Pennsylvania, and if you look at proportionate dollars, federal formulas that included us generally were more proportionate.

So what's happening now I believe is disadvantageous to the City and isn't disadvantageous based on rationale. It's based on a change in policy.

COUNCILMAN JONES: And, finally, because Pavlov's dog is salivating at the sound of the bell, two fiscal notes. Payments to Alpha Medical

Group for reading x-rays and mammogram films was reduced substantially, but purchases of pharmaceutical care increased 33 percent, from 2.9 million to 4.25 million. Can you explain, A, the reduction and, B, the increase.

DR. SCHWARZ: So the increases and decreases have to do in part with demand and have to do with adjusting the contracts to what we've seen in past years as need. So it's rightsizing the dollars and in part the appropriation. You and we both know that for health services where there is a question of use, if we don't err on the sign of generosity, we have to come back to you again.

COUNCILMAN JONES: We don't want that.

DR. SCHWARZ: And the goal was to estimate within a range of error that was reasonable. If we don't spend it all, it will go to the rest of the City for other things that have been

4/15/14 - WHOLE - BILL 140144, etc.

appropriated.

COUNCILMAN JONES: One other reduction was prenatal care issues, resulting in the loss of 750,000 to fund prenatal services. You gave a scenario where prenatal premature deaths a couple years back that was frightening and alarming. You talked about a study that was done in inner city neighborhoods why particularly minority women were having premature births, and you could only, after you peeled the layer of the onion off, talk about it was stress, similar to people growing up in a war zone area, that the day-to-day pressures of living in the hood were actually causing this, and that struck me and I never forgot it. So when I see the $750,000 reduction, tell me what's going on with that.

DR. SCHWARZ: I need to see the exact line. I think, but I'm not sure, that it may represent a movement of dollars -- oh, wait. Different issue. What you're seeing is in the last year,

in keeping with both the wish of this Council and the wish of the Administration, as you know -- I hope you know -- we moved a substantial number of physicians who had worked with the Department through contract into Civil Service, and what you're seeing is the contract that's labeled that way, but actually represents the purchased physician services moving into Civil Service.

COUNCILMAN JONES: So the funding level -- service level has not been reduced.

DR. SCHWARZ: It has not.

COUNCILMAN JONES: I'm good. Thank you, Mr. President.

COUNCIL PRESIDENT CLARKE: Thank you, Councilman.

The Chair recognizes Councilwoman Tasco.

COUNCILWOMAN TASCO: Thank you.

Dr. Schwarz, thank you and certainly thank you for your leadership

in the Health Department.

On Pages 3 and 4 of your budget testimony, you discuss Medicaid expansion under the Affordable Care Act. According to various news accounts, it does not appear that Governor Corbett's Healthy PA plan will be approved by the federal government as an acceptable means of Medicaid expansion in Pennsylvania.

Do you have any new updates on this issue? Also, how has the expansion delay impacted Philadelphia, and if the Healthy PA plan is rejected, how will this outcome impact Philadelphia going forward?

DR. SCHWARZ: I appreciate your question. So we are not part of the conversation between the state and the Department of Health and Human Services. The period for comment on the Healthy PA plan, public comment, ended I think it's last Thursday. City commented, Behavioral Health, and Health commented separately, because there are both

4/15/14 - WHOLE - BILL 140144, etc.

behavioral health issues on Medicaid expansion and physical health issues. We commented on both.

We are hopeful that the Department of Health and Human Services and the Governor's Office will be able to come to some accommodation. We would prefer that that accommodation not unnecessarily burden Philadelphians and that the closer we get to simple Medicaid expansion using existing mechanisms that have been shown to be effective, as Dr. Evans talked about, to simply increase by a hundred thousand the number of Philadelphians with health insurance, which could be done with the stroke of a pen tomorrow, we're hopeful that this negotiation ends positively and quickly so that we can get more Philadelphians insured.

In the meantime, I want to assure you and all of Council and all people in Philadelphia that our health centers continue to provide care for

people without health insurance. We are the provider of last resort. We will be the provider of last resort. What you see in this budget reflects, I think, efficiency and operation of those health centers. So we're trying to use our dollars wisely. But we are committed to providing care for those people who are not insured in Philadelphia to assure that everybody has access to healthcare.

COUNCILWOMAN TASCO: Well, I appreciate that, and I know that you'll do all you can to make sure to give us some assurances that our citizens will be taken care of. I have no doubt about that.

Have you had or has there been any attempt by the state Health Department to bring not only you from Philadelphia but other health directors from across the state together to sit down and talk about what's going on? Has that dialogue taken place?

DR. SCHWARZ: Around Medicaid?

COUNCILWOMAN TASCO: Medicaid or anything in terms of the health issues of the state.

DR. SCHWARZ: So something very exciting. There are 16 local health agencies, ten of which are recognized by the state through a funding stream. It's been longer than anyone's memory since they all came together, and the Secretary of Health convened us all. So there was a meeting in Harrisburg. People got to see each other for the first time in many cases. We had talked on the phone a couple of times, but now we have faces, and we're now doing regular conference calls.

So the state is trying, particularly around public health issues, to do better in coordinating the local agencies and the state, which is very exciting. Medicaid is not a topic for that conversation, because that's DPW, not the Health Department. So while you and I might wish that there could be

conversation, there has not been.

COUNCILWOMAN TASCO: On Page 4 of your testimony details the federal funding cuts for lead poisoning, infant mortality, and STD programs. Over the past years, the Health Department has made great strides in these areas. How do we maintain these success in light of the federal cuts?

DR. SCHWARZ: So we're worried, let me say that. What happened around lead in particular is that we took a 90 percent cut, and those dollars have now been distributed throughout Pennsylvania independent of need in terms of lead poisoning. So we have taken this as a stimulus to become as efficient as possible and to go for any grant dollars that are available and to figure out partnerships with other City agencies, state agencies to try to both maintain and expand what we're able to do. It's a challenge.

I'm happy to say that our

numbers on lead poisoning, our numbers on infant mortality look good this year. We have the lowest infant mortality rate in the City's history. And the issue that I raised last year about problems with access to prenatal care persist, but the rate of inadequate prenatal care looks like it's finally coming down. So I have good news. We've had great partnerships from other parts of the healthcare sector, both insurers and providers. I think it's the best we can do at the moment.

COUNCILWOMAN TASCO: Okay. Thank you. I got one more question before the bell rings. On Page 5, you describe capital improvements for Health Department facilities. Can you provide some more detail with regards to capital improvements at the health centers and particularly are we making improvements at technology at our facilities?

DR. SCHWARZ: So I can provide you offline, if you want, detail, but I

can say that yes, we are. The biggest investment has to do with electronic health records. So we have just finished implementing the practice management part of electronic health records at seven of our eight. The eighth one will go live in June. It will be the second of our full clinical suite as well, and by the end of this calendar year, we should have all of our health centers electronic in terms of health records, which is pretty exciting.

In addition, we are moving more and more toward digital radiography, so state-of-the-art x-ray, both the equipment piece and the ability to send images through computer to people interpreting them. The Alpha Medical Group is not located in our health centers. We can now send images and get excellent review and answers in realtime.

We are committed to assuring that Philadelphians have access to state-of-the-art care, and as is in my

testimony, the partnership with the Children's Hospital, building a new Health Center 2 in South Philadelphia with a rec center and library and a health center from CHOP, will mean -- I can say we're pretty far into the planning process now and people will be dazzled by the new health center.

COUNCILWOMAN TASCO: What about our health center in the Northeast?

DR. SCHWARZ: So the good news is the waiting times for healthcare now -- I have been -- this is my seventh time to City Council, and for every one of them, I have had to say at Health Center 10 the waiting time for a new adult patient appointment is 235 days or more. We're now down below 150 days waiting for a new patient appointment at Health Center 10. So I'd like to sort of celebrate that moment.

Now, part of -- that's the good news. Part of the issue is, we've had increased waiting times at some of the

other health centers. Nothing to the extent that we had at 10, but I think it's great news. So particularly for those folks who had to wait the longest amount of time, the reduction in waiting time in the Northeast is important. That does not reflect -- I want to be really clear -- that does not reflect a reduction in demand or need. We need more healthcare in the Northeast.

COUNCILWOMAN TASCO: Aren't we supposed to get federally funded healthcare?

DR. SCHWARZ: We're hoping that we'll get what -- the first step in expanding federally qualified health centers is that the area has to be designated as one of medical need or shortage. That process was undertaken by the Department, and we finally in 2014 got approval from both the state and the federal government, so there is a new health shortage area in the Northeast. That will stimulate, I hope, more

federally qualified health centers in that area.

I worry that as we look at need, need keeps moving further out, and the only health center located relatively far out in the Northeast is our own Health Center 10. So we're going to see a lot of demand at Health Center 10 I think for a long time and we need another health center or we need expanded health center, and that is both a capital and operating expense issue. As I said to Council last year, we wait to see what the impact of the Affordable Care Act will be. If the Affordable Care Act brings new revenue to the Department, I would propose that that revenue be used for the operation of either a new or an expanded Health Center 10.

COUNCILWOMAN TASCO: Thank you.

I've asked all my questions.

COUNCIL PRESIDENT CLARKE: Thank you, Councilwoman.

The Chair recognizes

4/15/14 - WHOLE - BILL 140144, etc.

Councilwoman Quinones-Sanchez.

COUNCILWOMAN SANCHEZ: Thank you.

So we can keep that conversation going around the health center. What are the possibilities -- I realize that this designation was hugely important for the need in the Lower Northeast. What are the possibilities and have you explored with the co-location of any other need that we're exploring in the Northeast as a way of incentivizing potentially a federally certified medical center from locating there as opposed to the City having to build its own?

DR. SCHWARZ: So the answer to that question is yes and no. We've met with all of the currently federally qualified provider agencies and have talked pretty clearly with them and shared our information about need, and we're hopeful that folks will begin to think about new sites. The problem with

relocation as opposed to new location is that, in general, the current centers are located in places of need. So they can't move very easily without leaving somebody behind. What we need is an additional federally qualified provider, and co-locating them would be terrific. We need to figure out what either new site or existing site has capacity of the size required for a new federally qualified center and what provider agency would like to open. All of that will be much better if Medicaid is expanded.

The financials in the Northeast are very difficult because of the proportion of people who are currently uninsured and will likely continue to be uninsured until Medicaid is expanded. So I think what we'll see in the marketplace in general when Medicaid expands, we'll see much more interest, and I hope we'll see better access, particularly in the Northeast.

COUNCILWOMAN SANCHEZ: I agree

with all of that. We need the Medicare expansion. I just think that when I talk to the great providers that I have in my district, there's an issue of capital and building capacity. And so what I don't want is for us to only look at it from it has to be our center and we have to manage it, and really look at, okay, if we can't do all of these things, how do we incentivize it. Because I agree with you, it has to be an expansion. They're all overcapacity in all of their current sites. But it's sort of like how do we create that incentive so that we're looking at it.

Now, I know there's controversy around where it gets located also in terms of the neighborhood because of the changing kind of demographic. And so I want to be part of those discussions.

DR. SCHWARZ: Sure.

COUNCILWOMAN SANCHEZ: Because it will probably -- I'll probably end up having to take the hit for wherever we

put it, and I'm okay with that, because I think strategically it makes sense. I just want to look at a model that allows us to speak to the community about how that enhances. So the location is key and potentially the provider is key.

So I just want to be kept in the loop, because I get asked the question all the time, because I think people want me to say, No, I wouldn't locate it in my district, which I'm not going to say it. But I do want to figure out -- again, it's a potential for a good partnership and a good co-location potentially, so to deal with some of the fears and the concerns when you talk about a publicly subsidized health center over there. So I want to be part of that conversation early on.

DR. SCHWARZ: Thank you.

COUNCILWOMAN SANCHEZ: Real quickly, and you can submit this to the Chair, because I know our Council President, we have other stuff going. If

you can give me one, two, three bullet points of where we are with the Philadelphia Nursing Home. I notice that there is an increase allocation for it. Where are we in terms of some of the quality assurance, the financial reporting? There's been controversies around the subcontractors. You can give me one, two, three update and then submit everything else to the Chair.

DR. SCHWARZ: Be happy to. One, two, three update?

COUNCILWOMAN SANCHEZ: Yeah. Some good news?

DR. SCHWARZ: Let's see. We are in great shape in terms of quality assurance from the point of view of the inspections by the state, which are, as you know, the most comprehensive. We're doing incredibly well there. The state is, I think, very pleased with the operation of the nursing home and how we're doing on standards.

What else can I say? The

4/15/14 - WHOLE - BILL 140144, etc.

increase has to do with spending authority mostly actually and the ability to spend if revenues go up, because we match fairly well. And --

COUNCILWOMAN SANCHEZ: On the contracting, particularly some of the living wage provisions with their contractors.

DR. SCHWARZ: So we have worked very closely with the nursing home. As you may know -- I don't know if you know actually -- their issues with living wage have to do with security guards, and they started at a point where they were way behind. They have increased on an annual basis, I would say, generously from the point of view if you look at percentage increase. So that on January 1st, 2015, all of their security guards will be above living wage. So this issue will go away in less than a year and -- that's the answer.

COUNCILWOMAN SANCHEZ: Awesome. Good to hear. If you could submit that

just as a kind of report, update on those issues since we get calls.

DR. SCHWARZ: Be happy to.

COUNCILWOMAN SANCHEZ: Thank you.

Thank you, Mr. Chair.

COUNCIL PRESIDENT CLARKE: Thank you, Councilwoman.

The Chair recognizes Councilwoman Reynolds Brown.

COUNCILWOMAN BROWN: Thank you.

I'd like to continue the line of questioning around nursing homes and ask that you include in the information that the Council Lady has asked the demographics of the nursing home by age and race. What is the average age? Would that be -- average age of nursing home.

DR. SCHWARZ: The residents of the nursing home?

COUNCILWOMAN BROWN: Yes.

DR. SCHWARZ: Sure. Absolutely.

COUNCILWOMAN BROWN: Might you know now as you sit here? I'm just curious.

DR. SCHWARZ: It's low compared to other nursing homes.

COUNCILWOMAN BROWN: Low meaning lower than 60?

DR. SCHWARZ: Yes.

COUNCILWOMAN BROWN: So you have young people, you have citizens there that are 60 and under?

DR. SCHWARZ: Yes.

COUNCILWOMAN BROWN: So --

DR. SCHWARZ: That is the particular niche that our nursing home as a county nursing home in Philadelphia fills, because there are a substantial number, as you may know, of younger people in Philadelphia who particularly have traumatic brain injury.

COUNCILWOMAN BROWN: Brain injury?

DR. SCHWARZ: Brain injury. So they have gunshots. They have overdosed

and had anoxic brain damage. They have other reasons for brain trauma. And those folks are Medicaid covered and they can't often get into private nursing homes because of the rules on Medicare.

COUNCILWOMAN BROWN: Amazing.

DR. SCHWARZ: So our county nursing home provides them with a place to go for the kind of ongoing care that they need, and it is a particular and important role for our county nursing home. And so we have been very careful in how we have thought about and worked with the nursing home in order to not damage that ability to care for those younger people.

COUNCILWOMAN BROWN: To capture that particular group.

How much money does the City of Philadelphia spend per year on the nursing home, approximately?

So different question would be, do we generate any revenue from owning --

DR. SCHWARZ: Do you mean

revenue -- you mean the expenditure after --

COUNCILWOMAN BROWN: Yes, yes, yes. Expenditure per year.

DR. SCHWARZ: We put about $3.5 million in in terms of operating.

COUNCILWOMAN BROWN: Does the City generate any revenue from owning -- and the operative word here is "owning" -- the nursing home?

DR. SCHWARZ: We do, and it's reflected in the budget.

COUNCILWOMAN BROWN: Okay. So to the question, scenario, factual, Montgomery County actually sold their nursing home for 41 million and netted 28 million.

DR. SCHWARZ: Yeah.

COUNCILWOMAN BROWN: And so the question becomes, can, should we be in the business of running, owning a nursing home given the prospect that we stand to net X number of millions of dollars by placing it in the hands of professionals

who live and do that every day?

DR. SCHWARZ: So you know I'm a pediatrician.

COUNCILWOMAN BROWN: I know that you are?

DR. SCHWARZ: I'm a pediatrician.

COUNCILWOMAN BROWN: Yes, yes, yes, I do. I knew that before --

DR. SCHWARZ: So you can imagine when I started in this job how much I knew about nursing homes. So I've had a steep learning curve, and I started off just where you are with the question of why does Philadelphia continue to have the license and run a nursing home. And it is the patient population and the need to guarantee those folks a place to go that is the reason and the justification that I would give you for Philadelphia continuing to manage that nursing home.

The issue is that we could sell the license to our beds.

COUNCILWOMAN BROWN: We could

sell the license to?

DR. SCHWARZ: Our beds, which is how this would happen. If that happens, we don't have a guarantee that those beds would be filled with all those people who have gunshot wounds to their head and traumatic brain injury, and I don't know where they would go. There is no incentive for private providers to care for them in the way we are.

COUNCILWOMAN BROWN: Wow. And so you've done the homework and research on that that says that private providers who do this for a business are less inclined to capture, care for, be concerned with that population?

DR. SCHWARZ: It's the reason we continue to have demand for our services.

COUNCILWOMAN BROWN: Really?

DR. SCHWARZ: Yes. So populations that you care a lot about and I care a lot about and this Council cares a lot about --

COUNCILWOMAN BROWN: Would be castaways.

DR. SCHWARZ: -- are critical patients to the nursing home.

COUNCILWOMAN BROWN: Wow. That's troubling. Okay. I think we've adequately covered that topic, at least for now. So you'll make sure that the President gets that breakdown, if you will.

DR. SCHWARZ: Yes.

COUNCILWOMAN BROWN: And there's no place in the country that does what we currently do for our Philadelphia Nursing Home in a private enterprise?

DR. SCHWARZ: I'm not aware and I will do my best to answer the question of nowhere, but none that I'm aware of or have found. I think that's the answers.

COUNCILWOMAN BROWN: And reflecting on this book, Getting to Yes, and folks who are extremely expert negotiators, I would bet that given your expertise that you could persuade --

first of all, we agree on the positive yield of wanting to move in that direction. You just never know until you have the conversation. You know what I mean?

DR. SCHWARZ: Yeah. I'd be happy to talk with you more about the issue.

COUNCILWOMAN BROWN: Let's explore that.

DR. SCHWARZ: Good. Thank you.

COUNCILWOMAN BROWN: Thank you.

Thank you, Mr. President.

COUNCIL PRESIDENT CLARKE: Thank you, Councilwoman.

The Chair recognizes --

COUNCILWOMAN BROWN: I'll come back on the next round.

I get that. So I'm not on the next round.

COUNCIL PRESIDENT CLARKE: We have to do lunch and then we got three more after that.

COUNCILWOMAN BROWN: Okay.

COUNCIL PRESIDENT CLARKE: The Chair recognizes Councilwoman Quinones-Sanchez.

COUNCILWOMAN SANCHEZ: So I'm going to ask you to submit this stuff to the Chair. I wanted to give you a heads-up. We're going to be doing a hearing around language access. I notice that the Department gives the Health Federation $261,000 for translation services at health district centers. So I'll save those questions for that hearing and maybe I'll just give you one of the things we're going to be looking at is the creation of bilingual positions throughout the different departments, and your department is one of the places where we think we have some room to grow.

I wanted to ask you who collects student data on disease, pregnancy, and others? I can't seem to get the District to give me answers.

DR. SCHWARZ: I missed the -- did you say student data?

COUNCILWOMAN SANCHEZ: Yeah, the data of our young people. Who tracks data around diseases, pregnancy and other things?

DR. SCHWARZ: So I'm going to answer you in two ways so that it's clear to you, because I'm not sure what you want exactly, but --

COUNCILWOMAN SANCHEZ: I want to know who tracks it. So I want to know -- I've been trying to get pregnancy data and some other data related to schools as we look at holistic approaches, syphilis, herpes.

DR. SCHWARZ: So we track it for all young people in Philadelphia.

COUNCILWOMAN SANCHEZ: For all?

DR. SCHWARZ: But we don't have a way to track it for those people who are students. It's not reported that way. We don't have any access under FERPA --

COUNCILWOMAN SANCHEZ: HIPAA?

DR. SCHWARZ: -- to the list of

kids, where they're in school and so forth. So I can tell you by all of the census tracts around the school, but we know that particularly as kids get to the age of pregnancy, they don't necessarily go to their neighborhood high school.

COUNCILWOMAN SANCHEZ: Right.

DR. SCHWARZ: And certainly for charter schools, I have no way to do it. So we can track for you the general rates, but we have no information on the rates for pregnancy, for instance, by school. What we do have is, we now screen for sexually transmitted infection in all of the public high schools and some of the charter schools. And we can array the rates of positivity or the numbers of positivity. That depends on kids coming forward to be tested. So I would caution you that you don't really want our data if what you want is a systematic exploration.

COUNCILWOMAN SANCHEZ: I think we need to have a conversation. As we're

dealing with school climate and issues that are going on in the schools, we're going to need to figure out how we interface that data and not violate HIPAA to get that, because it's very hard to address an issue if we can't track it, particularly as it relates to syphilis, herpes and other things that are going on in the school building.

DR. SCHWARZ: Okay.

COUNCILWOMAN SANCHEZ: Thank you.

That's it, Council President.

COUNCILMAN JONES: The Chair recognizes Councilwoman Brown.

COUNCILWOMAN BROWN: I want to simply put these questions on the record. Forward the information to the Chair and/or I can meet with your designee as directed by the issue.

So an update on our great lead activity. And kudos again to Nan for working closely with my office for over a year and for Councilwoman Sanchez helping

me from the sidelines to get that through. I would like an update on that and then the progress we've seen with childhood obesity and what the next steps might be that we can do as a city. I know there's been great improvements for little people, 3 to 5 year olds, but what can we do better to capture teenagers, the high school students.

DR. SCHWARZ: We're doing it.

COUNCILWOMAN BROWN: So if we could maybe just have a meeting about that --

DR. SCHWARZ: Absolutely.

COUNCILWOMAN BROWN: -- to get a huge update on that.

DR. SCHWARZ: We appreciate your leadership on that issue.

COUNCILWOMAN BROWN: I remain excited about it, because it's still a national crisis.

DR. SCHWARZ: Absolutely.

COUNCILWOMAN BROWN: We're doing better in Philly, but we're unlike

a lot of municipalities. So we will get that. Send that to the Chair and we'll have a meeting on the other.

DR. SCHWARZ: Be happy to.

COUNCILWOMAN BROWN: Thank you very much, Commissioner.

Thank you, Mr. President.

COUNCILWOMAN SANCHEZ: Council President, I just have one issue, but I'm going to ask that maybe we consider doing it on the briefing, which is environmental services. I wanted to tie in one of the things that we've learned with this L&I around inspections and the proactivity, I wanted to get a briefing or have a discussion around environmental services and health inspections, particularly its impact on small businesses, but maybe we can do that in a briefing versus this. But I want to put it on the radar, because I think we need to schedule that.

COUNCIL PRESIDENT CLARKE: Thanks, Councilwoman, because I actually

was thinking about asking that question about the rotation of inspections, because we have some, particularly in these restaurants, some real challenges.

DR. SCHWARZ: We would welcome hearing your concerns.

COUNCIL PRESIDENT CLARKE: Thank you. Thank you, Councilwoman.

Okay. We're going to break until 3 o'clock, at which time we will do the City Commissioners and then we'll follow up with --

COUNCILWOMAN BROWN: Don't we have DHS?

COUNCIL PRESIDENT CLARKE: Yeah. I think that will be an extended version, so we'll probably do the Commissioners first.

(Short recess.)

COUNCILMAN GREENLEE: Good afternoon again. We're going to continue our hearings now. The next department up is City Commissioners. Welcome, everyone. Please identify yourself for

the record. If you could summarize your statements and then we'll have questions.

COMMISSIONER SCHMIDT: My name is Al Schmidt and I have the honor of serving as Vice Chairman of the City Commissioners. Our Chairman, Commissioner Anthony Clark, has come down with the flu and can't join us today, and Commissioner Stephanie Singer has a personal commitment, but we are joined by Carla Moss, Chief Deputy Commissioner to Commissioner Clark, and Dennis Lee, Chief Deputy Commissioner to Commissioner Singer. We're also joined by our Department Administrator, Greg Irving, and our Budget Officer, Valerie Crawford Keith.

Thank you for the opportunity to testify before you today and to give a brief summary of our budget for the coming fiscal year, our budget request.

Our total proposal for FY15 General Fund budget request is $9.4 million, which is 514,000 higher than our

4/15/14 - WHOLE - BILL 140144, etc.

FY14 current estimates due to the new need for a voting machine parts warranty and an electronic voting machine maintenance contract. These services were previously covered under the Department's ten-year warranty contract that began with the purchase of our current voting technology in 2002.

During our current fiscal year, the Department has had several important achievements. I'd like to quickly highlight a few of them now.

COUNCILMAN GREENLEE: Sure.

COMMISSIONER SCHMIDT: The Department launched a new website, www.philadelphiavotes.com and continually adds features to this site, making it the best county election site in the nation. We've revamped our Election Board training by creating improved and updated election guides and providing all of our training material online. The Department made copies and filed nomination petitions, made them available

electronically for free for the first time. Beginning this coming election, Election Board workers will receive a modest $5 increase for attending Election Board training. This is the first increase in 19 years.

The Department will strive to increase the Election Board worker pay by making modest incremental increases where possible. We hope these increases will begin to help mitigate the challenge of filling vacancies on Election Boards and contribute to better trained Election Boards.

And, lastly, last year the Department assigned our new Budget Officer, Valerie Crawford Keith, with the responsibility of performing outreach to minority, women, and disabled business enterprises. Val met with the African American Chamber of Commerce and Hispanic Chamber of Commerce. Both organizations publish business opportunities with our department in their newsletters, and Val

is in contact with them throughout the year to provide them with updates. In the coming weeks, Val will be meeting with the Asian American Chamber of Commerce and Women Business Associations to foster relationships with both groups. The Department hopes that these outreach efforts will yield more opportunities to disadvantaged business enterprises to do business with the Department.

I'm now going to provide an overview of the Department's minority, women, and disabled business enterprise levels and the demographics of our staff.

Our current M/W/DBE participation rate goal has been set by OEO at 30 percent. Our department is currently at 43 percent. Our new voting machine hauling contract is subcontracted to a WBE. This makes up 42 percent of the 43 percent participation rate.

The Department's full-time staff is composed of 44 percent minority employees, 56 percent white, and 34

percent female. The Department's executive staff consists of 38 percent minority employees, 63 percent white, and 38 percent female.

We have six full-time bilingual speakers in the Department, five of whom speak English and Spanish and one who speaks English and Arabic.

In closing, I'd like to thank the dedicated staff of our department for their hard work and again thank City Council for the opportunity to testify today. We welcome any questions.

COUNCILMAN GREENLEE: Thank you, Commissioner. Thank you for your time and for all you do. I know something about having trouble getting Election Board officials, and I'm glad to see any increase that happens. I understand the first two elections, that money will come from a HAVA grant; is that correct?

COMMISSIONER SCHMIDT: That's correct. We have some "use it or lose

it" money in HAVA that's dedicated for Election Board training issues and --

COUNCILMAN GREENLEE: We never want to lose it.

COMMISSIONER SCHMIDT: No, we don't.

COUNCILMAN GREENLEE: All right. Now, I know you referenced that there will be savings. Can you detail what you think the savings will be in the future or is it a little too early to tell, to make up that money?

COMMISSIONER SCHMIDT: Well, this past year, for example, we had increased expenditures to our budget by roughly $700,000 beyond what was budgeted for. Because we were in an off year, so-called off year, election cycle with lower turnout, fewer voter registrations and things like that, we were able to save resources through fewer temporary full-time employees, only because it was a lower turnout election. Now, with the gubernatorial election coming up and

municipal election for Mayor and City Council and all the rest, we won't have that opportunity right around the corner, but we were able to close the $700,000 gap this year.

COUNCILMAN GREENLEE: Great. And you talk about in your testimony about a proposed budget increase of 514,000 plus for voting machine maintenance. Can you detail that a little bit more? I know the machines have been around a little bit.

COMMISSIONER SCHMIDT: They have. The machines have been around for some time and the cost of maintaining the machines has been increasing, not only because of parts and other issues, but we had a ten-year warranty for the machines that is now expired. That accounted for the $700,000 increase in the form of a parts warranty and a software maintenance contract. We were able to cover that this last year. We'll be able to cover $200,000 of the 7 in the next year's

4/15/14 - WHOLE - BILL 140144, etc.

budget. That's why the request for the additional 500,000, to cover those expenditures until we acquire new voting technology.

COUNCILMAN GREENLEE: And is the plan to get different machines at some point, actually new machines?

COMMISSIONER SCHMIDT: It is. When we came in, we didn't have the benefit of previous data for machine malfunctions or other sorts of issues, but it's something that we've begun to track and is of concern, because the machines are now older. We have a good number of calls on Election Day from Election Boards about problems. Most of those are revolved over the phone. A lot of them are not. Whether they're machine malfunctions or all the rest -- I'm sure you've seen it in 15.

COUNCILMAN GREENLEE: And have they increased the concerns or the problems with the machines?

COMMISSIONER SCHMIDT: The

anecdotal evidence we have points to an increase both in terms of smaller mechanical malfunctions and greater issues with, as we understand the voting machine -- this doesn't affect the vote totals, but the voting machine turning off and has to be reset and restarted. Again, it doesn't affect votes that are cast before or after that happens, but it results in a call to our department with a concern.

COUNCILMAN GREENLEE: Okay. Well, we want everything to run as smoothly as possible out there.

COMMISSIONER SCHMIDT: Our vendor has been working on that.

COUNCILMAN GREENLEE: And we have a really keen interest in that next year, don't we?

COMMISSIONER SCHMIDT: Yes. Certainly.

COUNCILMAN GREENLEE: Councilman Jones, you have questions? That's a rhetorical question, do you have

questions, Councilman.

COUNCILMAN JONES: More of a statement than a question. I wanted to thank your offices and all of the Commissioners for working with us on issues related to elections, whether it's polling places or whether it's complicated issues like voter ID and dealing with that. I want to particularly thank you for your outreach efforts with Dennis Lee, who is the Deputy, and Tracey Gordon and Craig McLaurin, who I see at community functions teaching people how to use the machines. And all I can tell you is that we appreciate it and want to make sure that we support you in the pay increases for those people who work for just about minimum wage for --

COUNCILMAN GREENLEE: Maybe sub-minimum wage.

COUNCILMAN JONES: It might be. You might be in violation of Councilman Goode's labor law here.

So I just want to say thank you. I see your staff in the community whenever there's a question about who is registered. There's not a long answer to come after that, and we appreciate that as we go about our business of trying to service the people. So thank you.

COMMISSIONER SCHMIDT: Thank you for your kind words, Councilman.

COUNCILMAN GREENLEE: And I certainly second that. The Commissioners Office does a great job. I have to throw in a plug for Carla Moss, who is my election expert, as far as I'm concerned, who gives great service, and I know it's a tough job and actually I think considering everything, the elections run very well every year, and I think all you, the Commissioners and the staff, need to be congratulated.

COMMISSIONER SCHMIDT: Thank you, Councilman.

COUNCILMAN GREENLEE: Thank you, sir.

4/15/14 - WHOLE - BILL 140144, etc.

Any other questions?

(No response.)

COUNCILMAN GREENLEE: See, this is good. This shows you're doing a good job because the board is not lit up. Again, thank you for your time.

COMMISSIONER SCHMIDT: Thank you, sir.

COUNCILMAN GREENLEE: We'll be seeing you.

The next department is Department of Human Services, and I'm going to go out on a limb and say this will not be as short as the City Commissioners.

(Witnesses approached witness table.)

COUNCILMAN GREENLEE: Commissioner, how are you?

COMMISSIONER AMBROSE: Good afternoon. How are you, Councilman?

COUNCILMAN GREENLEE: Good. Very good.

Please identify yourself for

4/15/14 - WHOLE - BILL 140144, etc.

the record and proceed.

COMMISSIONER AMBROSE: Anne Marie Ambrose, Commissioner, Department of Human Services.

COUNCILMAN GREENLEE: Please proceed.

MS. HANNS: Chanell Hanns, Chief of Staff, Finance, Department of Human Services.

DEPUTY COMMISSIONER HARLEY: Vanessa Garrett Harley, Deputy Commissioner, Children and Youth Division, Department of Human Services.

COUNCILMAN GREENLEE: Welcome.

COMMISSIONER AMBROSE: Good afternoon, members of City Council. I'm Anne Marie Ambrose, Commissioner of the Department of Human Services. DHS's FY15 General/Grants Revenue budget request is $657,450,812. Our general obligation budget request is $98,338,951. This is the same as the FY14 estimated obligation level. DHS's Grants Revenue Fund request is $559,111,861.

I would like to highlight two of DHS's many accomplishments this year. DHS is currently fully engaged in a major system transformation called Improving Outcomes for Children. IOC is based on a belief that a community neighborhood approach with clearly defined rules between county and provider staff will positively impact safety, permanency, and well-being. Under IOC, families will have one case manager and one plan to guide them through their child welfare system. Services will be delivered in ten geographic regions by lead agencies called Community Umbrella Agencies.

Currently, DHS is on schedule to have all ten Community Umbrella Agencies fully operational by January of 2015. CUAs I and II began receiving in-home and placement referrals in January and April of 2013. CUA-III and CUA-IV each began receiving in-house and family foster care referrals in January of 2014. CUA-V is scheduled to begin

receiving cases next week, and CUA-VI through VIII will begin to receive cases in July of 2014. The remaining CUAs will begin to receive cases in November of 2014.

Additionally, I am pleased to report that on August 5th of 2013, DHS sex abuse investigation staff began working with staff from the Philadelphia Police Department, the Philadelphia Children's Alliance, and the District Attorney's Office at the new co-located site called the Philadelphia Safety Collaborative at 300 East Hunting Park. The co-located facility was created to better coordinate investigations and services to child victims of sexual abuse. This new larger facility will help lessen the trauma of the investigative process by offering a comfortable child-friendly place for children to receive services and by allowing partner agencies to effectively and efficiently coordinate their efforts

in a single location.

Our commitment to this process is evident by the fact that we have increased funding for the Philadelphia Children's Alliance by 442 percent since FY08. I would like to say a special thanks to Councilwoman Quinones-Sanchez for her leadership and support in moving this project forward to completion.

My staff and I are available to answer any questions you may have regarding my testimony today or the formal testimony I submitted previously.

Thank you for the opportunity to appear before you today.

COUNCILMAN GREENLEE: Thank you, Commissioner.

On Page 2 of the testimony, you talk about 251, which I believe is 14 percent, of the staff force unfilled positions; is that correct? What are the particular challenges in having those unfilled positions and is there a particular plan to get those filled?

COMMISSIONER AMBROSE: So the challenges for us are transitioning to Improving Outcomes for Children. So we don't want to fill positions that ultimately might be direct case management positions in the community. So we've been very conservative and actually have used our data to inform.

Recently, we decided that we needed to fill some of the positions because caseloads were creeping up and we were getting more investigations coming in. So we recently filled about 119 positions.

COUNCILMAN GREENLEE: Okay. All right. So they're being filled as kind of almost as we speak, right?

COMMISSIONER AMBROSE: That's correct.

COUNCILMAN GREENLEE: Great. Let me go to the Councilmembers.

Councilman Jones.

COUNCILMAN JONES: Thank you very much, Mr. Chairman, and

Commissioner, good afternoon. Thank you for the work you do and to your very competent staff, many of whom I've gotten to know on case specifics and recognize, in doing so, the hard task, the often challenging and almost impossible task you guys face. I want you to know sincerely that I -- I could not do your job, and I've said that to members of your staff. My heart is way on my sleeve and I know it is in your staff persons too, but you guys have developed a tougher skin than I ever could dealing with some of the not so pretty parts of our society. So, again, sincerely thank you for the work you guys do.

COMMISSIONER AMBROSE: Thank you.

COUNCILMAN JONES: I want to say before I even get started that the questions that I'm asking -- and I wanted to put that on the record -- aren't designed to come at the Department. It is designed to get clarity for me so that

I can help you, and whether it's through legislation or budget or whether it's through the ability to provide you resources that you may need, that's the spirit of what I'm asking about.

So with that said, can you help me to understand your CUA process. And I remember early on when you were kind enough to orientate me and my staff members how your interest was to create a localized service delivery product, but for the record, can you tell us how that started.

COMMISSIONER AMBROSE: Sure. Well, Improving Outcomes for Children actually comes directly out of the Child Welfare Review Panel recommendations related to the Danieal Kelly death. All of those 37 recommendations were related to safety and the need for the Department to focus more clearly, in a laser-like fashion on the safety of the children that we're responsible for. And the specific recommendation that IOC actually

addresses is the need to provide clarity between what the provider worker does and what the DHS staff do. So if you remember from the Danieal Kelly death, there were caseworkers that the Department paid to go out and visit Danieal Kelly through a private provider and there were DHS staff who were supposed to go out and check on the safety of her and her siblings. And unfortunately what I've come to say, when everybody is responsible, nobody is responsible. So we had a dual case management system that was inefficient and ineffective in keeping children safe.

And so the history behind this is about 20 years ago, DHS sort of privatized services and they started having private providers go out and deliver services direct case management, but they never redefined what DHS staff were supposed to do. So IOC is an attempt to fix that structural problem.

So through IOC, we have direct

case management through provider workers that are paid by the Department. They are the single case manager responsible for those families. And we also knew that we were one big building at 1515 Arch in the middle of the City where none of our children and families lived, and we believed this was an opportunity to use neighborhood providers who had a history of providing services to really gain the trust of the children and families that we serve so that they would go to those Community Umbrella Agencies for help.

And so we have -- I've actually talked about IOC since 2011 in my testimony. We've had a four-year planning process with the benefit of over 150 stakeholders, including providers, advocates, the courts, DHS leadership and staff, and the launch of IOC was actually last year as a result of that planning process. We also have the two leading national child welfare foundations

supporting the work of IOC. So Casey Family Programs has been providing guidance from the very beginning, and more recently, about two years ago, the Annie E. Casey Foundation started providing us with support and guidance.

COUNCILMAN JONES: And I appreciate all of the due diligence that went into this directional change. However and nevertheless, you could build a rocket to go to Mars and if folk on the ground find issues with it, you should adjust and maybe even take that into account.

Having said that, my wheelhouse of information will never be in the social work area, but from time to time, I get concerns from stakeholders, end users, your clients that prompt me to want to take a look at, well, how are we doing things a certain way, and one of my concerns is regulations, monitoring, oversight of those CUAs.

It's become very popular for

folk to kind of, whether it's zoning or other things, to kind of cut out the Councilpersons in that, and one of the good things about us is that we don't know a whole lot about a whole lot of things, but we know a whole lot of things that people and other people have information and expertise on.

And so to be able to get that check and balance I think is very important from an oversight kind of way. Your department represents 2.2 billion if you include Health and Behavioral Health. It makes up a massive part of our appropriations.

So with this system, I have some concerns about how we make sure and assure -- and I know it's still early. I'm going to say that again. I know it's still early, but with an eye towards not having conflicts of interest, meaning that if I'm a subcontractor and my job is to self-police or monitor myself, I'm never going to find issue with myself,

ever. I'm perfect. Ask my staff. They'll tell you. I will never -- but also the good thing about me is that I have to go every four years before the voters, and then they may correct me a little bit and say, Well, yeah, you're all right, but here's some things you can improve on.

So one of the things I'm very concerned about is whether or not it is structured to be able to look at itself and say, We need to do things this way, and what happens in issues maybe of conflict of interest, that it is -- I'm throwing the ball and my sub-recipients are catching it, so, therefore, I'm not going to be as discriminating against taking people out of the process because of failure to execute your mission.

How do you circumvent or safeguard that against in the CUA system?

COMMISSIONER AMBROSE: So not a day goes by that we don't get one or several complaints about what we do at

DHS. So I'm not unfamiliar to the complaints that you probably receive about my agency, and I know that we try to address those when you bring them to our attention.

Another criticism of the agency that played out in the Child Welfare Review Panel is that we weren't monitoring our providers, and so the provider in the Danieal Kelly death had never provided children services before and probably shouldn't have been providing the services that they were providing. And so when I came in as Commissioner in 2008, one of the first things that I did was create a Division of Performance Management and Accountability, and I think we presented some of the work that we started when you came to our office for the orientation. That division has actually evolved, and there is a very arduous quality assurance process that we have for monitoring the CUAs, because we also share your

concerns. Despite the fact that the direct case management will be done by Community Umbrella Agencies, the responsibility for children and families still rests with the Department of Human Services. And so we've built structured monitoring functions into Improving Outcomes for Children for all of the CUA agencies and the subcontracting agencies. And I'll just go over briefly some of those quality assurance functions.

COUNCILMAN JONES: Wait a minute. Rather than do that, because my Chairman is a strict timekeeper, I've sent you a letter and having you in advance -- we'll argue about whether it was to be provided in writing. We won't argue about it, but some of the questions I wanted submitted for the record were, what is your processing chart for ordinary placement?

COMMISSIONER AMBROSE: I have answered all of those questions. I'm happy to go over them today or I can

present them in writing.

COUNCILMAN JONES: So I don't have to keep talking. You can just answer.

COMMISSIONER AMBROSE: Okay. So when calls come into the hotline, we answer those calls and we have -- I have all the questions and answers. I'm good.

We answer all of those calls and we have something that we've created called Hotline-Guided Decision-Making. In other jurisdictions and in child welfare in general, it's called Differential Response, because every call is not the same. So based on the allegations that are brought to our attention, we have specially trained hotline staff who handle those calls and they have a script that they use, and we prioritize those calls based on the vulnerability of the children and the issues that are brought to our attention. And so sometimes there's a two-hour response that we have to go out for.

Sometimes it's not a priority and we sort of triage those cases. And Gary Williams, who is my Director, and Vanessa know these things much more explicitly. But we have a safety assessment process, and Gary can talk through all of those things if you want the specifics, but based on those issues, we make a determination of whether there's an immediate safety threat.

If there's an immediate safety threat to a child, we have a responsibility to remove them from an unsafe environment. And so that's what the hotline workers do immediately. And then there's an entire process that we use to make decisions about what's the most appropriate placement for that child. If they can't remain in their home, we look for family first, and we're proud of our kinship care rates. DHS does a good job in keeping children with their families whenever possible, and if that can't be done, then we move them to

foster care settings. So we use a least restrictive set of criteria that's laid out in the child protection services law to make those decisions.

COUNCILMAN JONES: So we're going to skip down some of those, because what it calls for is a process chart, which you will provide the Chair so that every Councilperson can have that, and it also talks about a process chart when complaints happen, and you will provide that to the Chair for all members of Council. But let me -- how many children are under your care?

COUNCILMAN GREENLEE: I think you're breaking -- you said I was going to stick to the five minute.

COUNCILMAN JONES: But she was going to answer all these. I was going to skip down for you.

COUNCILMAN GREENLEE: Okay.

COUNCILMAN JONES: So that she doesn't have to answer each --

COUNCILMAN GREENLEE: You must

be a politician. Okay.

COUNCILMAN JONES: I am. No doubt.

So how many children are under your care?

COMMISSIONER AMBROSE: So under our care as far as cases that have been accepted for service, we have about 4,500 children in placement, which is out of home care, and accept-for-service cases where families need some services but the children can remain in the home, we have about 1,500 cases right now.

COUNCILMAN JONES: So how many children -- and these are hard questions -- have been fatally injured under the last three years? Let's go with that.

COMMISSIONER AMBROSE: So in the last year, there were seven near fatalities and six fatalities. And I don't have the other two years with me.

COUNCILMAN JONES: You said seven fatalities?

COMMISSIONER AMBROSE: Seven near fatalities and six fatalities.

COUNCILMAN JONES: And these are children that were in foster care?

COMMISSIONER AMBROSE: No. No. They were on active DHS cases. That's what the law provides for. Act 33 provides for active DHS cases.

COUNCILMAN JONES: How many incidents of child abuse were reported to your agency in the last three years? And while you're getting --

COMMISSIONER AMBROSE: Reports coming in?

COUNCILMAN JONES: Yeah. And then how many while in your care?

COMMISSIONER AMBROSE: You're talking about reports. So that's about 1,200 reports a month that come through the hotline as I described it.

COUNCILMAN JONES: How many are while in your care, where you get -- whether through a foster parent or through direct care? How many complaints

of abuse do you get over the last three years?

COMMISSIONER AMBROSE: I don't have that figure with me today.

COUNCILMAN JONES: That was in here. That was Question No. 3. Under the documents then comes the questions. That was No. 3.

COMMISSIONER AMBROSE: Yeah. So No. 3 there were 18 indicated reports in FY13, which was July 30th to June 30th of 2013.

COUNCILMAN JONES: Say that again.

COMMISSIONER AMBROSE: Eighteen.

COUNCILMAN JONES: Eighteen for the year?

COMMISSIONER AMBROSE: Correct.

COUNCILMAN JONES: How many for the past three years?

COMMISSIONER AMBROSE: I don't have that with me.

COUNCILMAN JONES: All right.

COMMISSIONER AMBROSE: But I can get that to you.

COUNCILMAN JONES: You can get it to the Chair.

COMMISSIONER AMBROSE: Sure.

COUNCILMAN JONES: I'm going to ask one other. So explain the followups once you get a complaint of abuse -- and I don't want to get into the types of it and I want to maintain all of the confidences I can. What happens once you get a complaint? What is that process?

COMMISSIONER AMBROSE: So if it's a complaint of --

COUNCILMAN JONES: And I'll stop, Mr. Chair. Look.

COMMISSIONER AMBROSE: If it's a complaint of a child that's in our care, those investigations are actually handled by the Department of Public Welfare. So they handle all of those investigations through their southeast regional office, and then they provide us with a finding based on their

investigation of the cases. If it's a general complaint where there isn't a report that's called in, we handle those complaints through a number of ways through the Commissioner's Action Response Office, which is managed in my office where I have staff who look into those complaints, and sometimes we do those independent of our staff and sometimes we do them in consultation with our staff. And then there's also in our Provider Relations and Evaluations of Programs staff, which is where we look at our provider agencies, sometimes it's a concern about a provider. And so if that comes up, then we handle -- there's special analysts within that unit who go out and investigate that complaint.

COUNCILMAN JONES:

Mr. Chairman, again, this process will continue on the next round.

COUNCILMAN GREENLEE: I'm sure of it. Okay. Thank you, sir.

Councilman Goode.

COUNCILMAN GOODE: Thank you, Mr. Chairman.

Good afternoon, Commissioner.

COMMISSIONER AMBROSE: Good afternoon.

COUNCILMAN GOODE: Are you familiar with the information request I made to the Budget Director for all departments?

COMMISSIONER AMBROSE: Yes, sir.

COUNCILMAN GOODE: I'm really looking at those services that were once performed by City workers, now are performed by contractors, whether they are local firms, whether there's a diversity of local firms, whether the workers there are paid a living wage and benefits. And so I'm going to focus on just two areas within my timeframe.

First is waivers that were requested with regard to living wage and benefits standard. In Fiscal Year '12, you requested 16 waivers, I believe. In

Fiscal Year '13, you requested ten waivers. In Fiscal Year '14, you requested 11 waivers. I want to focus on one waiver in particular. I'm not going to call the name of the agency, but it's a $25 million contract, and the reason given by the Managing Director's Office in the documentation that I see here says it was in the best interest of the City. It doesn't say financial hardship. It doesn't say it was collective bargaining agreement. It simply says it was in the best interest of the City.

COMMISSIONER AMBROSE: Yeah. I'm sorry, Councilman. I don't actually have that on my list of waivers that we gave this year. My list has eight different providers and PHMC is not one of them. So I might be confused about the list that I have and the one that you received, so I apologize.

COUNCILMAN GOODE: That's part of the reason why I asked departments for the information, because I don't think

this information is necessarily accurate. So I prefer to receive it from the departments.

COMMISSIONER AMBROSE: I think --

COUNCILMAN GOODE: So I'll just shift in questions.

In terms of the waivers that you requested -- or I should say I should start here, were there waivers as requested by the agencies? Because that's the actual protocol.

COMMISSIONER AMBROSE: Yes. Yes, sir.

COUNCILMAN GOODE: And when the waivers were requested by the agencies, did you ask them how much they could afford to pay?

COMMISSIONER AMBROSE: It looks like only on one of them we did ask, and in fact, the agency -- for Adelphoi Village, we denied their waiver because they had a lot of cash in reserve, and so it appeared that they could easily pay a

4/15/14 - WHOLE - BILL 140144, etc.

living wage. And so that was the one that we denied. I can't speak to whether -- I don't know if we did that routinely, but on this one we did.

COUNCILMAN GOODE: And you are aware that the law says that partial waivers are preferred to full waivers. In other words, if they can't pay $10.88 per hour, which is 150 percent of the federal minimum wage, and offer comparable health benefits for full-time employees and up to 56 hours of paid sick leave, whatever portion of that they can offer, they should offer. We should not be subsidizing poverty wages, and particularly in this line of work, it's important. And the number of waivers may not seem like a lot of money, but if that $25 million contract does not exist, there's still some mighty big contracts there.

COMMISSIONER AMBROSE: I agree with you, and I think we could do a better job on doing the partial waiver.

COUNCILMAN GOODE: Okay. I'll be satisfied with that. And you are still forwarding or that information has been forward in terms of the information request?

COMMISSIONER AMBROSE: Yes, and I'll make sure the chart I have is consistent with the information you have.

COUNCILMAN GOODE: The other concern I have, of course, is whether there is a diversity of opportunities being offered once this stuff is contracted out, and when I look at the Fiscal Year '13 and the fact that the Department was responsible for about $53 million in contracting, I see that $47 million in contract dollars were excluded because there was supposedly little to no opportunities related to businesses owned by women and people of color. Can you explain that to me? That's 81 percent of the contract dollars being excluded from opportunities.

COMMISSIONER AMBROSE: I think

that change -- and I know that Angela Dowd-Burton couldn't be here today. She had a prior commitment. I think some of that was done in consultation with DHS regarding our numbers because of the fact that so many of our contracts are court-ordered placements, and so the Department sometimes doesn't have a say in where the court decides some of those children go. And so we have lots of conversations with Judge Dougherty, and he's an amazing partner, but he has a little bit more power over some of these decisions than I do.

We've done a really good job of trying to look at things creatively and, in fact, have brought some of our bigger providers into the City to provide services, and I think we've talked about that before. We've also seen some increases with some of our bigger providers. And so we've been hammering home the message with them around the supplier diversity plans.

COUNCILMAN GOODE: So the question is, are there goals set for supplier diversity?

COMMISSIONER AMBROSE: Yes.

COUNCILMAN GOODE: And if not, why?

Then why is $47 million in contracts excluded if there are actual goals for supplier diversity?

COMMISSIONER AMBROSE: So on some of the -- I have both calculations. So the way the law is written, we've seen progress. We're still below the 25 percent, and we have to do better.

COUNCILMAN GOODE: That's not the question I'm asking. The question I'm asking is, why was $47 million in contracting excluded?

COMMISSIONER AMBROSE: I think you'd have to ask the Office of Economic Opportunity. We did the calculations both ways.

COUNCILMAN GOODE: You did not request for that $47 million to be

4/15/14 - WHOLE - BILL 140144, etc.

excluded?

COMMISSIONER AMBROSE: We had conversations with the Office of Economic Opportunity about the difficulty in reaching the goals based on the array of service providers that we have.

COUNCILMAN GOODE: Did you request that the $47 million dollars -- did you request that 81 percent of your contract dollars be excluded?

COMMISSIONER AMBROSE: No. I don't recall making that request.

COUNCILMAN GOODE: Thank you.

COUNCILMAN GREENLEE: Thank you, Councilman.

Councilwoman Bass.

COUNCILWOMAN BASS: Thank you. Thank you, Mr. Chairman.

Good afternoon.

COMMISSIONER AMBROSE: Good afternoon.

COUNCILWOMAN BASS: So I have a couple of questions for you, and just in keeping in mind what everyone else said

and really has summed up here is that there's really nothing more important than the future and the focus on our young people. And as the mother of a 4-year-old, I know that if I mess up, you can't do it back. You can't take it back. You can't do over. Once you mess up with a child, that's it, you know. So the work that DHS does is critical to our future, to our young people, to our communities. It's so very important. So I just feel that this is one of the City's departments that deserves the attention and spotlight, if you will, during budget season, and we want to do that appropriately and ask the harder, more difficult questions.

So I just want to ask a few questions and I want to start out with questions about the CUA, and I wanted to talk about the CUA in the sense that as I understand it -- and I always look at nationally what are other cities doing, how does Philadelphia fit in with what

other folks are doing, are we doing things sort of ahead of the curve, are we behind the ball, are we looking at what succeeded elsewhere or are we just trying to something brand new. And so my question regarding the CUAs is really how they're managed, how that has worked thus far. I know that it's relatively new, but I was wondering if you would speak to the fact that it seems as if we're the only ones who are on this sort of arrangement on a national level that I know of, unless you can speak to that and know of others who are doing this sort of arrangement.

COMMISSIONER AMBROSE: Sure. So as I indicated earlier, we actually spend about two years researching Improving Outcomes for Children and we had the support of Casey Family Programs during the initial piece of that research. What we did is scan a national best practice, and so there are many systems that are doing, quote,

"privatized" service delivery. However, they're not doing it the neighborhood level that we are. And so we visited New York City, which is actually doing the direct case management through the providers, not through the agency. We visited Florida where the whole state is privatized and they created lead agencies that are very similar to the CUAs. We talked and continue to talk to Kansas, which has been one of the most successful privatized systems that's out there.

And so we've done a lot of research, but nothing is like Philadelphia, and so we wanted to make sure that whatever we did was going to be best for the children and families that we serve, which is why as we learned about what was happening, we brought together the 150 different stakeholders that I referenced earlier. We broke ourselves out into six groups to look at things like practice. And so we have a new safety model of practice that's

consistent with the values that we established. We had a contracting and finance subcommittee. We had a legal and legislative subcommittee. We had a data. And we went over different systems. We talked through lots of --

COUNCILWOMAN BASS: I guess what I'm asking is, what other cities are similar to Philadelphia in terms of the scope of services that we're offering and also the numbers of children. So I think you said it was about 4,500 children in placement and then another 1,500 who are at home under DHS or the CUA supervision.

So who else is doing what we are doing; that is, at this size and in a similar fashion?

COMMISSIONER AMBROSE: So New York City is probably the system that's most similar to what we're doing, and as I indicated, they're doing the direct case management. Now, they do that in their boroughs. So we went out and visited those community centers in their

4/15/14 - WHOLE - BILL 140144, etc.

boroughs.

COUNCILWOMAN BASS: How many children are they serving? Because New York City is considerably larger.

COMMISSIONER AMBROSE: Way more than we are. I can get that number for you.

And the other thing that we took from New York City was their teaming model of practice.

COUNCILWOMAN BASS: Their what?

COMMISSIONER AMBROSE: Teaming. We call it family team conferencing. So while DHS has given the direct case management responsibility to the CUAs, we continue to monitor every single case. Initially we do a safety conference within 20 days of us getting that case, but then every three months DHS staff, what we call facilitators, are actually out in the Community Umbrella Agencies teaming the case with the family and anybody that the family wants to bring and any service provider, including our

behavioral health partners who sit in on those teamings so that we can monitor how things are going for that family based on the plan that's been developed.

COUNCILWOMAN BASS: I still don't think that we have the answer here, because as I said, New York City is a population of 8, 9 million people. We're 1.5. And, you know, with the five boroughs, I'm sure that they serve a larger population. And so it's not really comparable to Philadelphia and our issues, even though geographically we're both very close by and East Coast cities and all that, but in terms of the scope of services that they're providing in their boroughs, in their areas and the numbers of folks that they have in terms of providers and actually out and about doing this work, it would be great to get some idea of who else is nearby. Is Baltimore? Which is a city that's probably a little closer in scope and size. What are they doing? What about

Boston? What about other cities that are similar that are doing this?

COMMISSIONER AMBROSE: So there's no other city that's doing what Philadelphia is doing. We do have collaborations with Boston. They're a state-run system, though, so it's difficult to compare them, because we're a state-administered county -- county-administered state oversight state and Massachusetts is not.

I think you're exactly right. When we compare ourselves to cities and looking at child welfare issues, we compare mostly with places like Cleveland and Baltimore based on our poverty rates, based on our number of single-headed households. And so those similarities are much more clear with the cities that you've mentioned.

COUNCILWOMAN BASS: And you said that the CUA system came out of the Danieal Kelly case or it came out of the Improving Outcomes for Children?

COMMISSIONER AMBROSE: The recommendation that we addressed was one of the recommendations in the Danieal Kelly death, yes.

COUNCILWOMAN BASS: Okay. And I know that the bell rung, so I'll come back around for my next set of questions, Mr. President.

COUNCIL PRESIDENT CLARKE: Thank you, Councilwoman.

The Chair recognizes Councilwoman Tasco.

COUNCILWOMAN TASCO: Good afternoon.

COMMISSIONER AMBROSE: Good afternoon.

COUNCILWOMAN TASCO: On Page 1 of your testimony you stated that one of the goals of this system transformation entitled Improving Outcomes for Children, which uses ten regional providers called Community Umbrella Agencies, or CUAs, since they have more children and youth maintained safely in their homes and

communities. In this regard, can you describe the CUA selection process and state the number of CUAs that are based inside the City or outside of the City.

COMMISSIONER AMBROSE: So what we recognize -- and I was able to watch the testimony of Dr. Evans and heard him talk about the goal that he and Judge Dougherty and I had to bring kids closer to home, and in fact, we have too many kids in congregate care settings and most times those congregate care settings are outside of the City, and so the goal was really to provide supportive services in the communities where our children and families live and make those services easily accessible.

And so the selection process was looking at the RFP that we developed, and that was after all of the work we did with the stakeholders, and the selection process was the response to the RFP as well as looking at a financial audit of the agencies that applied, looking at

past performance of those agencies based on the services that they were delivering to DHS or elsewhere, and then doing a presentation. What was their vision for improving outcomes for children in the neighborhoods where they were applying. And so that was a presentation to me and my executive staff, and the decisions were made based on that criteria.

COUNCILWOMAN TASCO: Well, do the Boards of the CUAs reflect the community from where they are?

COMMISSIONER AMBROSE: So some of them do better than others, and so I can go through of the ones --

COUNCILWOMAN TASCO: Do you require them to have a diverse Board?

COMMISSIONER AMBROSE: Absolutely.

COUNCILWOMAN TASCO: And does it include the community where they are?

COMMISSIONER AMBROSE: Absolutely.

COUNCILWOMAN TASCO: You say

some of them are doing better. So those who are not doing better, what do you do to make them comply?

COMMISSIONER AMBROSE: Well, for instance, one of the requirements of the Community Umbrella Agencies is that they have a Community Advisory Board. So that Community Advisory Board is made up of community members who would advise the CUA and DHS about how things are going for the children and families that are being served in their neighborhood. One of the members of that Community Advisory Board must sit on the Board of Directors of the CUA. So there's an accountability issue that happens there.

With a couple of the CUAs in the first round of selections, they did not get selected because they didn't have a diverse Board of Directors for their agency. The second time around they had actually done much, much better, and so they ended up being a successful applicant the second time around.

So it is something that we've taken very seriously, because we believe that the people delivering the services to the children and families that we serve should be culturally appropriate and relate to them in a way that helps them address the issues that brought them to the agency's attention.

COUNCILWOMAN TASCO: Have all the CUAs been set up?

COMMISSIONER AMBROSE: They have all been selected.

COUNCILWOMAN TASCO: All contracts have been let?

COMMISSIONER AMBROSE: Correct.

COUNCILWOMAN TASCO: Throughout the City?

COMMISSIONER AMBROSE: Correct.

COUNCILWOMAN TASCO: Now, we just talked a little bit about the role that you would play once they're all up and running, but I heard you say that you're going to have clear monitoring oversight. I mean, how much are you

going to be involved, and does that call duplicates service?

COMMISSIONER AMBROSE: So we've tried to intentionally and deliberately eliminate the duplication of service, which is why the model is for a single case management role. But the way that DHS is going to be involved primarily is through the teaming process, and Vanessa can walk through that teaming process, where we have a DHS staff person monitoring and looking at how the plan is working for that family every 90 days. So we'll be checking in every 90 days and, more importantly, through our Division of Performance Management and Accountability, we have several monitoring functions that we'll be doing, which are quality assurance functions where we're randomly looking at cases on a weekly basis to check the safety assessment of those cases, quarterly basis we're randomly pulling cases and reviewing those cases to make sure things

are going well with the case, and then we also have established over a number of years our child stat process and our quality service review process where we regularly review cases. With the quality service review process, we randomly pull cases, 12 cases every quarter for the CUAs. We spend two days with a team of folks that includes all stakeholders. So we have advocates that participate, people from CHOP, people from the court. Two-people teams review those cases. They interview the child, they interview the family, they interview service providers, they interview teachers, and they then rate that case. They look at how is this child doing and they rate that case, and then they rate the system performance on the case with certain measures that we've established.

With child stat, that's an even -- we take cases from the quality service review and then we look at performance measures for those providers,

and we review those cases every quarter for each of the CUAs. So there's a pretty rigorous monitoring function.

The other thing that we've added is something that we called quality visitation review, where we go out randomly and select cases, and I think we're going to be doing 20 or 30 a month where we go out and we interview the family and we say, you know, have you been receiving services, who was here, how long did they stay, did they come in the house and look at things and make sure kids were safe or did they just sit on the porch and ask you five questions and leave. And that quality visitation review is a really important way to check on how kids and families are doing and how families perceive the services that we're delivering. And so we have a pretty rigorous monitoring function that we've established.

COUNCILWOMAN TASCO: I have one more question while he's talking.

When the CUAs were organized, when the agencies presented a proposal to you and -- I guess you had sent out an RFP, and in the RFP they had to respond to how you thought the CUAs would work, right?

COMMISSIONER AMBROSE: Correct.

COUNCILWOMAN TASCO: So they responded. Now, a lot of these agencies have to hire additional people. Are they going to train these people or the retiring staff, individuals who may have already been in service to families before?

COMMISSIONER AMBROSE: So we actually assisted with the training, with the support of the state. So the Office of Children, Youth and Families has been supportive of Improving Outcomes for Children from the very beginning. We actually meet with them every other week to ensure things are going well. We have used their child welfare training program and their charting the course training,

which is how workers who do direct service in child welfare get certified, and our training -- I don't know how many people we've trained over the last -- 398 staff from the CUAs, with more coming. We actually had a new class that started. I think we have 114 people being trained.

So this has been a pretty gigantic effort, but essential for us to do to make sure that all of the work that we've done over the last six years to ensure that children in the City are safe gets transferred to the CUAs and the agencies that are doing the work at the neighborhood level.

COUNCILWOMAN TASCO:

Mr. President, I have a lot of questions, but what I'm going to do a just ask a couple when my turn comes around, key questions, but I would submit questions to Ms. Ambrose and ask her to respond, and then we will share the questions and answers.

COUNCIL PRESIDENT CLARKE:

Thank you, Councilwoman.

COUNCILWOMAN TASCO: Because we could be here all afternoon.

COUNCIL PRESIDENT CLARKE: Thank you.

Councilman Jones, you said you were going to do the same thing?

COUNCILMAN JONES: No. No. I mean, some of them -- to be honest, I already submitted mine in writing, and there was a miscommunications about providing it back in writing. So while we're here --

COUNCIL PRESIDENT CLARKE: I thought I heard you say "me too" when the Councilwoman was saying it.

COUNCILMAN JONES: No.

COUNCIL PRESIDENT CLARKE: All right. Thank you.

Thank you, Councilwoman.

The Chair recognizes Councilwoman Reynolds Brown.

COUNCILWOMAN BROWN: Thank you.

Good afternoon, Commissioner.

COMMISSIONER AMBROSE: Good afternoon.

COUNCILWOMAN BROWN: As you can see with this new paradigm shift, there are a lot of questions, and it's not unusual. We're adjusting to a different way of trying to provide services to children and families in what we hope to be a better way.

Now, you've given a lot of explanation on the accountability on the case management side. Speak to us about accountability and how we're going to monitor those CPOs that are trench warfare at ground level who will be working with the CUAs.

COMMISSIONER AMBROSE: So it's actually the same way. Because of the way that we're going to be reviewing the cases, we're going to be digging deep, and so any service -- so right now the CUAs have subcontracts with foster care agencies, let's say, and so that foster care agency is going to be required to

submit case notes. And so we have access to those case notes. We'll be reviewing those case notes and then verifying the activity that's reflected in the case notes through the teaming process and through the other quality assurance functions that I've mentioned.

COUNCILWOMAN BROWN: And how will that differ from the pre-Danieal case?

COMMISSIONER AMBROSE: So before we had our case managers doing some of the work. So let's say we're supposed to do monthly visits of children and supervised visits for parents. Their children are in placement and there needs to be a supervised visit so we can work toward reunification. Many times, despite the fact that we were paying a provider agency to do that supervised visit, they just didn't show up and then we would have to come. Now we don't have that confusion. There's one person who is responsible, one person who can be

held accountable, and we'll be monitoring that process.

COUNCILWOMAN BROWN: Okay. You said that the court-ordered placements -- Councilman Goode raised a question around this chart that he and I keep, and one of the explanations was the fact that the court-ordered placements then disqualify them from being held to the same standards around MBE/WBE activity. So share an example of a court-ordered placement that would not be treated the same way as those in this $47 million contract number.

COMMISSIONER AMBROSE: So when the court -- and probably the best example of these cases are the juvenile justice cases where the court has authority to make decisions based on their concern regarding community protection. So with youth who are arrested through the delinquent system, if there's a community protection issue and they can't find a placement that's

close to Philadelphia, they might want to send a kid to -- we use Summit Academy --

COUNCILWOMAN BROWN: Roanoke, Virginia.

COMMISSIONER AMBROSE: Well, we don't do that anymore, thank God. We've gotten better with out-of-state placements. We still send, in my opinion, our children too far away from home where we can't do the kind of family work that we should be doing.

COUNCILWOMAN BROWN: Agreed.

COMMISSIONER AMBROSE: But if there's a court order for a placement, even if I don't have a contract, I'm required to get a contract.

COUNCILWOMAN BROWN: The reason why I say Roanoke, Virginia, I actually when I worked for the state court unit at Philadelphia Family Court was responsible for taking a 6 foot 15-year-old to Roanoke, Virginia because our area did not have the skill set capability agency that could adequately meet his need.

COMMISSIONER AMBROSE: That was the Pines, wasn't it?

COUNCILWOMAN BROWN: Yes. So as we said to Dr. Evans this morning, it's been a dramatic paradigm shift in figuring out how we can keep kids closer to home, and that's a good thing.

COMMISSIONER AMBROSE: Yes.

COUNCILWOMAN BROWN: That's a good thing.

Back to the CUAs. We're well aware that there's an expectation that Boards look like Philadelphia. And so with the CUAs, does the composition of the Boards of the CUA operators represent the communities that they serve? Was that a part of the RFP process in this review?

COMMISSIONER AMBROSE: The 25 percent requirement was part of the RFP process, absolutely. And traditionally with the non-profits that we have in Philadelphia, we're pretty lucky that many of the Boards and staff reflect the

population that's being served. And so with the selections that we've made, some of the providers do better than others, and one in particular we're not satisfied with the Board composition and we've talked to them about that, and in the next 30 days, they'll be appointing two more African American women to their Board based on our concerns regarding the composition of the current Board.

And so this to us is a new opportunity for us to be clear with the Community Umbrella Agencies what our expectations are and to work with them to make sure that they meet those expectations, including the law requiring the 25 percent. And so I meet with the CUAs directly every Monday and we talk about these issues, and we've seen improvements in the small amount of time that we've been meeting with them, and we continue.

COUNCILWOMAN BROWN: So they get it that this is not optional, it is

required, and in cases where they're having difficulty in meeting this new requirement, the consequence is what?

COMMISSIONER AMBROSE: Well, the consequence could be, if it was necessary, that we award the contract to somebody else. They've actually understood this. I think that they've worked hard and they've worked together. So, for instance, they identified a computer supplier on their own together that's a minority contract. And so what we're seeing is a lot of partnership and a lot of thinking together, which is not something that we usually see among the provider community. So it's a positive, and we need to continue to push for them to do that kind of work, and we make suggestions to them as well. So, for instance, at our CUA meeting this week, we brought in Congreso and the Attic as potential subcontracts for the CUAs. And so the Department has a role in this too. It's not just abdicating the

responsibility to the CUAs. It's something that we need to monitor and we need to continue to push.

COUNCILWOMAN BROWN: The bell has run. I'll get to my next set of questions on the next round.

Thank you, Mr. President.

COUNCIL PRESIDENT CLARKE: Thank you, Councilwoman.

The Chair recognizes Councilman Jones.

COUNCILMAN JONES: Mr. President, when you give a hint, I try my best, to the degree that I can, to accommodate it.

So Councilwoman Tasco and myself have submitted a bill for consideration that looks at the community-based oversight board. So during that hearing, a lot of these questions and concerns will come up, because we do have some questions and some of them were raised in these Chambers about composition, about

4/15/14 - WHOLE - BILL 140144, etc.

possible conflicts of interest, service providers being on those oversight boards which might have a reluctance to kind of report some of these things, which --

COMMISSIONER AMBROSE: Are you talking about the Community Oversight Board that monitors DHS or the Community Umbrella Agencies? I'm sorry. I'm just confused.

COUNCILMAN JONES: All of the above. So we're talking about the Community Oversight Boards that deal with you and you deal with the sub-providers and the CUAs. So my point is, and simply put, is that we're talking about a lot of money. Each of these agencies that we've developed, CUAs, how much are they contracted with the City for on average? About $7 million?

COMMISSIONER AMBROSE: No. It's more than that.

COUNCILMAN JONES: How much is it?

COMMISSIONER AMBROSE: It's

about -- it's a total of $40 million.

COUNCILMAN JONES: So divided by ten. So my point is, Councilwoman Bass has not met with her CUA. I have not -- maybe you have, but I haven't, and I'm concerned that we need to. And usually when there's a contract over a year, it has to come before this body. We're talking about a considerable amount of money that is not going to get the oversight that it needs.

So my concern is that, yes, in the effort of it being more efficient, well, it kind of usurps our responsibility here. So we're going to take a look at that and we'll send you a copy of it, so there's plenty of time for us to have these longer discussions, but three things that concern me. Diversity, monitoring, and self-monitoring possibly within the CUAs. And at the end of the day, it's about these kids and making sure that they're given the best environment, which I think we share that

concern. No doubt in my mind that you and your staff do, but sometimes in order to do an efficient thing, we're not doing also an effective thing, and I want to make sure that that happens. And the jury is still out. It's very new, but this is the best time to start to take a strong look at it when we're talking about this much money and impact on that many folks.

COUNCIL PRESIDENT CLARKE: Thank you. Thank you, Councilman.

The Chair recognizes Councilwoman Bass.

COUNCILWOMAN BASS: Thank you, Mr. President. Had to think about it, huh?

COUNCIL PRESIDENT CLARKE: Well, we're trying to make sure during the rotation that people that haven't asked questions in this particular round gets an opportunity. The board is a little more challenging than meets the eye.

COUNCILWOMAN BASS: That's all right. That's all right. So thank you.

A couple more questions. I just want to pick up where Councilmember Jones just left off in terms of concern about the CUAs and the system that we have in place, because it seems that this again came out of the Danieal Kelly case and the idea was that, you know, this would be somewhat more effective or reduce the City's liability by having it sort of -- having these CUAs which would do something very similar to what was in place before, because you said that during the Danieal Kelly case, there was an outside provider and then it was sort of monitored by the City, and that fell apart, and it seems like we're actually right back at the same system almost again, maybe with a different name, but it does seem like we're kind of doing the same thing over and over again. And I just wanted to ask a couple of questions about the CUAs and the way we monitor

them, because, again, in some ways, as Councilman Jones just said, we talk about effectiveness and efficiency, and my question is what is the real goal here? And I would assume that we're really trying to be effective, effective in the lives of these children that we're serving.

So when it comes to the high turnover at provider agencies, can you talk about -- let me ask you, what is the turnover at these agencies and how are you made aware of it? What do you think of it? What is your thoughts behind the agencies and the turnover that they see?

COMMISSIONER AMBROSE: So I just want to be clear that this isn't about being more effective. It's about doing our best that we can to take care of the children that we're responsible for. So that was the only goal that we had in mind in moving forward with Improving Outcomes for Children. And in fact, we haven't recreated the dual case

management system model that existed before. We're not even out of that, because we're doing a phased implementation approach. So only two of the CUAs have been fully implemented.

But in regard to the turnover question, we actually meet with the CUAs, as I said, every week. We monitor their staffing at those meetings and we address turnover issues. There have been some turnover issues.

COUNCILWOMAN BASS: What kind of issues are they?

COMMISSIONER AMBROSE: So the issues are that the staff before in the provider agencies could have relied on DHS. So if they couldn't do the work, they always knew that there was somebody at DHS who was going to pick up the slack. That doesn't exist anymore. And so I think the children and families that we serve, the cases are very complicated. The poverty issues can be devastating. The abuse and neglect issues are

difficult to see, and this is very hard work and so --

COUNCILWOMAN BASS: Absolutely.

COMMISSIONER AMBROSE: -- I think the heavy lift that the provider agencies have experienced, particularly since the first cases they took were the safety-related cases where you see the more difficult issues were sometimes more than the staff were able to handle. And so I think that the CUAs have done a very responsible job of trying to weed out the staff who can't do this work, because some people just aren't made to do the kind of work that my staff do every day.

COUNCILWOMAN BASS: I agree. This is not for everybody. That is not for anybody and everybody.

COMMISSIONER AMBROSE: What we've done is had Khalid Asad and the DHS University go out to each of the CUAs, talk through some of the turnover issues, try to provide some technical assistance and additional training to those CUAs to

make sure that they could be fully staffed.

COUNCILWOMAN BASS: So what would you say on average the turnover has been at the agencies?

COMMISSIONER AMBROSE: I mean, it's hard to say because only two of them have been fully operational.

COUNCILWOMAN BASS: For those two, what's the turnover been?

COMMISSIONER AMBROSE: I don't know. I can get you that number.

COUNCILWOMAN BASS: Okay. I think that's important information to have, just so that we can have a sense of what's going on with the CUAs who are handling this.

And also one of the things you mentioned was the caseload and that -- again, everybody is not meant for this kind of work. It's very difficult. It's very challenging, very complicated. And so can you talk about the caseloads that these folks are expected to carry and

what happens. So is my caseload 20 cases or 50 cases. What is the caseload that is on the average? And if I am not keeping up with my caseload, what does that mean? How does that affect the service that I provide, that I offer, the care that we offer? What happens then?

COMMISSIONER AMBROSE: So the caseload sizes for the CUAs are ten families per worker. The state regulations go up to 30, but we know that that would be nearly impossible and not a good thing for kids and families. So we did a lot of research. We looked at our caseload sizes. We looked at other systems, and we came up with ten, and that is the caseload size. We think that's a manageable caseload size, but as we continue to learn more about the challenges of the work from the CUAs' perspective, that's something that we'd be open to changing either up or down based on the monitoring that we're doing and the conversations that we're having

4/15/14 - WHOLE - BILL 140144, etc.

with the CUAs.

COUNCILWOMAN BASS: Okay. And I know that the bell rung, so I'll come back.

Thank you, Mr. President.

COUNCIL PRESIDENT CLARKE: Thank you, Councilwoman.

The Chair recognizes Councilwoman Quinones-Sanchez.

COUNCILWOMAN SANCHEZ: Thank you.

Let me continue that line of questioning. It wasn't where I was going to start.

You spoke about the CUA caseload. What is your staff's caseload in comparison to what we're asking CUAs to do?

COMMISSIONER AMBROSE: So our caseloads range -- our average right now is probably around 17. It depends on where you are in the agency. So our intake at the front end, the staff that do the investigations, the caseloads are

a little bit lower there. At the back end of the system, our caseloads are too high right now, and part of that is because we're working through Improving Outcomes for Children and transitioning those cases to the CUAs. So the instability in the agency right now is actually with the back end, because those are the cases that are being transferred over to the CUAs.

In our Adoptions Unit, I think our average caseload size is about 15 right now. So it varies, and I can actually send you -- we monitor the caseloads at DHS on a monthly basis, and we often hear from our staff that the caseload size is too much and they're not able to do the kind of work that they need to do with the families, which is why we arrived at ten. So we did a lot of discussion with staff as part of our due diligence in moving forward with the model.

COUNCILWOMAN SANCHEZ: And

obviously we've been working on this CUA stuff and I have a lot of just kind of generic questions, because I think there's been some positives and some negatives, but I just wanted to state in this kind of framework because I want to talk about -- or I want you to talk about we're creating kind of an external unit, and I want to make sure that the rules of engagement for them is one where you want them to be successful, but I also want us to internally also be looking at how do we make our internal system successful. And so looking -- when you see the disparity, you know ten is ideal, yet our folks are being asked to do 17. When are we going to level that out so that folks feel like this is not just about them being successful but it's also internally, in light of the fact -- because I think on the staffing issue we've learned with all the CUAs, it's hard to staff.

COMMISSIONER AMBROSE:

Absolutely. So we're working towards transitioning that whole back end out, which is the difficulty in stabilizing the caseload sizes now. What I'll say to you is that the design is for us to build resources at the front end. We'd actually like to have much lower caseloads at the intake section so that our workers can feel good about the investigations they're doing. We have amazing staff in our multidisciplinary team, sections that have too many cases right now, and so the idea is to make sure that we're able to put the resources at the front end so the staff can feel better about the work that they're doing. We're going to be increasing their responsibilities with their participation in the teaming, and so we need to give them the time not only to manage those investigations but to participate in the teaming that's going to be the handoff of the case from DHS once there's an accept-for-service decision to the CUA.

So we agree with you.

COUNCILWOMAN SANCHEZ: Okay. So do you have a plan that you are already articulating about what that number is that gets you there, how many years is it going to take us to get there?

COMMISSIONER AMBROSE: So we have a plan. The plan is to hopefully get to -- right now all of our new investigation workers get about nine cases a month. We'd like to get that down to six cases a month. And so we have a staffing plan post IOC that would get us there. And so we're thinking about those things, and we meet with those -- Vanessa responsible for pulling that plan together with the support of the other staff at DHS and the leadership team.

COUNCILWOMAN SANCHEZ: Okay. I wanted to ask you in terms of -- and we'll get into some of the CUA discussion, but I wanted to talk about

4/15/14 - WHOLE - BILL 140144, etc.

internally.

So what are the things that you're doing internally for your system around building capacity, morale and all of the issues related? Because, again, we'll get to the CUA piece of it. Internally what are some of the things that are going on to help with training and all of those other things?

COMMISSIONER AMBROSE: So training is a big piece of what we're trying to do. It occupies a lot of our time. I think those staff who are now on the CUA side are very excited and happy, and so morale is very different. On the -- still in the old DHS system, staff are really struggling because they don't know what it's going to mean for them. So what we've tried to do is, we do a monthly newsletter. We've done a series of all staff meetings. We did one for all staff. We had to do it over the course of four days because we have a lot of staff, where they're able to come

together and we answer questions. We're getting ready to do one next month as well, where we're not going to talk as a leadership team, but we're going to actually have the CUAs come and present on what's happening in the neighborhoods, and we're also going to have our DHS staff who have transitioned to the new positions in IOC to come and talk about what that looks like and give them a sense of what their future is.

So those are constant issues. We have a lot of communication campaigns. We have our Crusaders Award next month, and last month we had our breakfast for all of our DHS staff who have been in the agency for over 20 years. So those kinds of things we try to do routinely. It was Social Work Month last month, so we gave out goodies and treats. We had someone come in and do massages and we set up a photo booth.

So we try to do lots of things for staff morale, but these are hard

jobs, and I think when you're in the midst of transformation the way that we're in the midst of a transformation, staff morale can be low, and so we've been trying to work on that.

We've also recently established an employee recognition program where every month we're honoring a DHS employee, giving them like free parking for a month and a card. And then we do a kudos corner, because I think every day the staff at DHS do very heroic work that no one ever talks about, and so we acknowledge that internally by putting up signs and posters honoring the staff at DHS who have done something exceptional.

COUNCILWOMAN SANCHEZ: On the next round we'll talk a little bit about long-term sustainability. One of the things that I don't want to see us is in a situation where we shift all of our resources and capacity externally and we don't keep some internally. And so I want to talk a little bit about long term

how that looks.

COMMISSIONER AMBROSE: Sure.

COUNCILWOMAN SANCHEZ: Okay.

Thank you, Mr. President.

COUNCIL PRESIDENT CLARKE: Thank you, Councilwoman.

The Chair recognizes Councilwoman Reynolds Brown.

COUNCILWOMAN BROWN: Thank you.

Continuing with the discussions and inquiries around CUAs, so we've spoken about Board composition, and we'll look to hear how that is progressing in a way that makes sense so that all of us are aware. The next question deals with how CUA dollars go to vendors with minority ownership and/or to vendors with minorities in key management positions, what that process looks like, what the status is to date, what are the procedures to keep you informed on how they're doing in this area.

COMMISSIONER AMBROSE: So our contract with the CUAs requires me to

approve every subcontract.

COUNCILWOMAN BROWN: Oh, really?

COMMISSIONER AMBROSE: Yes. So we'll be able to monitor who the CUAs are subcontracting with in a way that's consistent with the vision for IOC, that children and families are receiving grassroots, neighborhood-based services that can respond to their well-being needs as well as their safety needs. And so through that subcontracting approval process, DHS will remain responsible to ensure that diverse continuum of services at the neighborhood level.

COUNCILWOMAN BROWN: Wow, that's encouraging, to repeat what was said over here, to know that there's another layer of oversight. So for CUAs who don't get it, they know that you're looking.

COMMISSIONER AMBROSE: That's right. And we've already had to have some difficult conversations with some of

4/15/14 - WHOLE - BILL 140144, etc.

the CUAs.

COUNCILWOMAN BROWN: We wouldn't be surprised with that.

COMMISSIONER AMBROSE: In Florida, you know, one of the systems that we learned a lot from, they actually put a cap on the number of contracts the lead agency could have at 30 percent, and 70 percent of the contracts had to be subcontracted out. We're getting dangerously close to having to do that based on some of the CUAs not really moving forward in subcontracting the way we need them to. And so if we need to do that, we certainly have the authority and discretion to do that.

COUNCILWOMAN BROWN: Okay. So that speaks to the program management social service side. Now let's look to the business side of the ledger. What are the expectations with regards to supplier diversity and who those CUAs do business with, catering to uniform to et cetera, et cetera, et cetera.

COMMISSIONER AMBROSE: So all of the subcontractors will be required to have a supplier diversity plan. That will be part of the review process that the CUA does and part of our internal review process that we have at DHS.

COUNCILWOMAN BROWN: Is that a new requirement piece for DHS?

COMMISSIONER AMBROSE: So it's a new requirement for us. All of our contractors over the last two years have been required to have a supplier diversity contract. So if it's an existing DHS provider, it shouldn't come as a surprise. But our numbers aren't always that good, and so we need to use this as an opportunity to reinforce that expectation.

COUNCILWOMAN BROWN: What are some of the excuses given to those who can't figure out how you can look at the Greater Philadelphia Chamber or the African American Chamber or the Latino Chamber to find businesses in this town

that have what it takes to do business with these larger non-profits?

COMMISSIONER AMBROSE: I think some of the excuses we get is that they're not certified, but we've already set up a webinar with Angela Dowd-Burton for just the CUAs to walk through and do a meet-and-greet with some of these Philadelphia-based providers who are certified. So Angela is being very proactive in assisting us in making sure that we're doing a better job.

COUNCILWOMAN BROWN: Okay. Well, know we'll be looking to see what the progress and status of that is next year when you report.

Since launching the Improving Outcomes for Children program, what are some of the significant changes your office has noted thus far related to delivery of services?

COMMISSIONER AMBROSE: I think the most promising change is the teaming process, where we've actually created a

philosophy and values that really value the voice of families in that teaming process. And so we have supports at the CUA with parent advocates. If it's a youth case, any youth 13 or older participates in the teamings. And I think we try to facilitate the teaming in a way that provides them with the supports necessary to work through their plan, and I think they feel more valued in the process. And so we've gotten very positive responses. Our teaming director, Tyrone Harvey, is here, and I think that's been one of the more positive developments. And so we're seeing a change at the neighborhood level where families feel that their voice is something that we value in trying to help heal the issues that brought them to the Department's attention, and that's very promising, and staff feel good about that too.

COUNCILWOMAN BROWN: Okay. Thank you. I'll see you on the next

4/15/14 - WHOLE - BILL 140144, etc.

round.

Thank you, Mr. President.

COUNCIL PRESIDENT CLARKE: You're welcome, Councilwoman.

The Chair recognizes Councilwoman Tasco.

COUNCILWOMAN TASCO: Thank you.

How does this new program impact on your budget? So you're running the show. It's $15 million and now you're contracting out to all these agencies. What is the budget impact?

COMMISSIONER AMBROSE: So there is no budget increase. It's a budget neutral proposal. We knew that there was no new money, and this really wasn't about money. It was streamlining a process and making sure that we got better outcomes for kids and families because the accountability was clear.

So what we've done is actually just looked at, based on each CUA, the number of children and families being served, did a lot of work on coming up

with case rates, and we now have a case rate for each of the CUAs. And we're going to implement that case rate July 1st, but up until now, we've been paying the actual costs. And we're actually doing fine financially right now, but we also have a financial audit piece, because we need to make sure we keep doing fine, because there is no additional money and we need to make sure that we're using the taxpayer dollars effectively.

COUNCILWOMAN TASCO: So now are you transitioning out some of the caseworkers that worked for DHS that --

COMMISSIONER AMBROSE: No. We made a commitment to our staff that there would be no layoffs. And so through attrition we've lost some staff, but we recently hired some staff. We have identified new functions. And so what used to be the social work supervisors on the back end of the system in our ongoing service regions are now practice

specialists, and they actually conduct the teamings that I've been talking about. And then our workers who provided the direct case management system in the ongoing service regions are now called team coordinators. So what they do is they really get prepared and get families prepared for the teamings. They gather all the paperwork. They invite all the people who need to be there, and they participate in those teamings as well.

We've also --

COUNCILWOMAN TASCO: What's a teaming?

COMMISSIONER AMBROSE: A teaming is a family team conference that we're going to be doing at key decision points. There's four different teaming conferences that Vanessa can -- she's the expert and Tyrone is really the expert, but she can talk through all of those teamings and what happens at each of those teamings and how we remain accountable.

COUNCILWOMAN TASCO: Now, these are the teamings that you're teaming with the CUA?

COMMISSIONER AMBROSE: In the neighborhood. In the neighborhood, yes.

DEPUTY COMMISSIONER HARLEY: So what we have is four different types of teamings. Primarily they're conducted in the neighborhood, because we found that if you can bring services closer to the home of someone, if I only have to walk three blocks as opposed to take two buses, I'm more inclined to go. So we do them in the community at various places, and the CUAs are responsible for identifying sites that are appropriate. Sometimes they're in -- they may have a partnership with a religious place or a rec center or wherever, but we do them in the neighborhood.

At the table is the family primarily. They are the most important ones, and the facilitator, who is the DHS social worker who is facilitating the

meeting, the team coordinator of DHS social worker as well that Anne Marie just talked about. But also at the table is any of the other providers who are giving services, usually CBH or the Department of Behavioral Health is there, because many of our cases involve that, and anybody else who may -- our Education Support Center, because we have found that we're really trying to work on improving the educational outcomes for our kids, particularly given the status of the school system right now. So we have an Education Support Center liaison there and anybody else that may be able to add to the family in what's going on.

Ultimately at that table, things are discussed at key decision-making points, but usually around every 90 days. And we do that because we now have court hearings around every 90 days. So it's also a check-in point in terms of whatever court orders to make sure that things were done so

that everyone can come to a consensus in terms of when you present in court.

At the table in the initial conferences, which are the child safety conferences, if we are removing a child from a home or trying to figure out if we could stabilize a child in their home, you would have a DHS worker, because our front-end investigators do the initial investigations, but also the CUA may have a representative. The conferences moving forward would have the CUA worker or case manager who is assigned to the case present at the table. And so --

COUNCILWOMAN TASCO: Let me just ask about that. Families are experiencing problems. DHS intervenes, and then at some point, you assign them to a CUA. Is that the way they get to the CUA?

DEPUTY COMMISSIONER HARLEY: Yes. The way --

COUNCILWOMAN TASCO: They get to the CUA through DHS or through the

courts?

DEPUTY COMMISSIONER HARLEY: Through DHS, because primarily how it would flow is, we would get a call into our hotline. We would investigate. Based on that investigation and the safety assessment that we do, we make a determination as to whether or not there is a safety threat that exists or whether or not this family needs services. We accept a family services. It's after the investigation is completed and we have made a determination and accepted them for services that the case is actually handed off at one of the team meets to the CUA so that the family can, you know, meet that new CUA worker and it is transitioned from DHS to the CUA. That's when it's handed off.

COUNCILWOMAN TASCO: Okay. Thank you.

COUNCIL PRESIDENT CLARKE: The Chair recognizes Councilman Jones.

COUNCILMAN JONES: So yesterday

the Community Oversight Board released a report, and as Councilwoman Sanchez said, there have been some improvements, yet there's still some challenges. I think one of the areas of improvement is the visitation portion that they stressed that in '13 that --

COMMISSIONER AMBROSE: It's one of the challenges, not improvements.

COUNCILMAN JONES: So that's one of the challenges. And that brings to mind one of the issues that we shared with the staff, and they've been working on it diligently.

So it's also my understanding that this Board was created under the Street Administration?

COMMISSIONER AMBROSE: That's correct.

COUNCILMAN JONES: And that there is at least a recommendation or a feeling that they may be out of useful life, that they're ready to disband?

COMMISSIONER AMBROSE: No.

What happened is about a year and a half ago, the Community Oversight Board -- they report to the Mayor. They don't report to me. They reported to the Mayor that we had substantially completed most of the 37 recommendations that were made by the Child Welfare Review Panel, and they felt that they didn't need to do that anymore. Dr. Schwarz and the Mayor felt that they were so beneficial to the improvements of the agency and that we still had so much more work to do, that they needed to stay, and at that time, we added some -- we had lost a couple of members. We added some additional members. We added former Mayor Goode. We added Shelly Yanoff. We added a youth advocate who had aged out of the foster care system, and we added a parent advocate who had lost her children to DHS and had children in placement. And so we also decided that while we may have had a stabilization around how we were handling safety cases. We really needed to move

on to well-being issues. And so -- I'm sorry.

COUNCILMAN JONES: I know. It's just this is my clock. I just -- what I wanted to say was that to me a lot of the questions that are being brought up are found within this report and that President Clarke did his due diligence and realizes that we may have some further input on this, which I think is important. Councilwoman Tasco's bill and ours is looking into this relationship, and I think specifically Councilwoman Bass around the question of the newborn CUAs, that we need to monitor this a while to -- it's like anything, you need beta testing. You need to take it out on the road and see what works real well, reinforce that, and see what needs a little tweaking that might better improve what is our common goal, which is service for these kids.

So we've seen some inherent conflicts. We think maybe if we talk

about it a little more -- and I heard you say that the CUAs are coming in to talk to your staff about what's going on in the real world, because all of us are sitting in these Chambers, but these babies are out there in these homes. Well, it might be good to have a couple of members from Council go to that too to be able to ask questions and get some concerns raised about it. And I trust my leader, Councilwoman Tasco, who runs that committee, who has put a lot of time in on this, as at least someone who has a wheelhouse of information about it.

So that's up to you, Council President, but I think this board is raising some of the issues. When we talk about this type of money and this amount of responsibility, we do need to have some input.

COUNCIL PRESIDENT CLARKE: I agree, Councilman. Thank you so much.

The Chair recognizes Councilwoman Bass.

COUNCILWOMAN BASS: Thank you, Mr. President.

Councilman Jones, I agree with you. The more input, the better. And so, you know, I could agree with myself all day long, but it's important to hear what other people think and what other input can be provided to really perfect the system. And so just a couple more questions.

Can you talk about if a CUA is not performing up to par, what is the formal process for the City ending a relationship or breaking an agreement with a CUA?

COMMISSIONER AMBROSE: So our contract allows us to get out of any contract with 30 days' notice.

COUNCILWOMAN BASS: Thirty days' notice, okay. And --

COUNCILWOMAN BROWN: I'm sorry. What was the answer?

COMMISSIONER AMBROSE: I'm sorry. We have to give 30 days' notice

to the CUA if they're not performing consistently with our expectations.

COUNCILWOMAN BROWN: Thank you.

COUNCILWOMAN BASS: And what would bring a CUA to that point, that you would determine that they're not performing up to your expectations?

COMMISSIONER AMBROSE: There could be lots of issues. So the most obvious would be repeated patterns of not taking care of the children and families that they're required to serve. I've been doing this work long enough to know that one incident shouldn't determine an outcome, but if we are monitoring the CUAs the way we expect to monitor them and, that is, on a weekly meeting with them and looking at their safety assessments and digging into their files, we're going to know pretty soon whether there's a pattern of children not being properly served, and we're going to have to take some urgent action if we see that. And we've had to do that since

I've been Commissioner, and we don't hesitate to do that when we need to.

COUNCILWOMAN BASS: Okay. As you said, I mean, this is not new to you. You've been around. How long have you been in this line of work?

COMMISSIONER AMBROSE: Twenty-seven years.

COUNCILWOMAN BASS: So you know or know the signs of a provider who should not be in place.

COMMISSIONER AMBROSE: Absolutely.

COUNCILWOMAN BASS: Okay. And the other question I have for you is in terms of DHS workers that move into CUAs -- that's correct?

COMMISSIONER AMBROSE: Correct.

COUNCILWOMAN BASS: So what's the process there in terms of moving an employee with the Department of Human Services into a CUA?

COMMISSIONER AMBROSE: So they're actually still DHS staff. They

just have a new job title and their location changes. And I talked about this before when social work supervisors transitioning into practice specialists lead the teamings and social work service managers transitioning into team coordinator roles. Also social work supervisors transitioning into practice coaches, which sort of work within our DHS University. When we're noticing a problem based on our case reviews that we're doing with the CUAs, we don't want to just say, Oh, they're not doing well. We want to go in there, sit down with them, talk through what our findings are, and help them get better. So that's the role of the practice coaches.

COUNCILWOMAN BASS: And so if you're taking a DHS worker, who is still a DHS worker, you're taking them and you're moving them to a new location and with a new job title and responsibility. What happens with their old caseload?

COMMISSIONER AMBROSE: So their

old caseload has transitioned over already.

COUNCILWOMAN BASS: So it goes with them as well?

COMMISSIONER AMBROSE: No. No. So this has been a very complicated and difficult to task for us to transition these cases. So we review all the cases before they transfer over. As staff get freed up because cases are transitioning to the CUAs, those staff are the ones who can apply -- it's not a one-for-one. It's staff apply as caseloads shrink. Staff apply for the new positions. They get interviewed and then they move into those roles.

COUNCILWOMAN BASS: So, again, if I'm a DHS worker and I move over to a CUA and I had a caseload of, say, 20 cases and then those 20 cases are not coming specifically with me, the person who has been familiar with those cases, knows those families, has been intimately involved with the care of those children,

those cases are now going elsewhere?

COMMISSIONER AMBROSE: So that's also done very carefully. So if cases -- because we've been involved with the family for a long time and the case is getting ready to close out in the next couple of months, those cases won't get transitioned. So Kimberly Ali, who is our Operations Director on the ongoing service region side, actually personally has herself and a unit that reviews all those cases before the transition takes place. So the cases --

COUNCILWOMAN BASS: But I guess what I'm saying is, it seems as if there's a gap in care and it seems as if -- like I said, if I'm a DHS caseworker and now someone else has my cases or actually I leave and no one else is immediately assigned, it seems -- and there might be what you figure, okay, out of the 20 cases that I have, maybe five of them are sort of on the tail end, they seem as if it's going to be okay, it's

going to be a situation where we can close particular cases, and then the other five, ten, 15, whatever, cases kind of sit and wait for someone to pick them up.

COMMISSIONER AMBROSE: So they wouldn't sit and wait. I mean, I think you're laying out one of the challenges of moving to Improving Outcomes for Children, which is running a dual case management system and transitioning those cases over. And so there's -- obviously we're not letting cases languish. I mean, the whole --

COUNCILWOMAN BASS: But I guess I'm still not clear. So if I have 20 case and say five of them are about to drop off, so there's another 15 cases. I've moved over to a CUA. Who is immediately picking up my 15 cases and handling them?

COMMISSIONER AMBROSE: There's a redistribution of the cases through a floater unit. I can let Vanessa talk

about it.

DEPUTY COMMISSIONER HARLEY: Basically what happens is that your remaining caseload, whether it be the 15 or the 20, is redistributed amongst other social workers within your unit, section, whatever. There are floaters units in every section. We call floaters because they pick up caseloads for just such a time as this. When somebody leaves, there is a worker that can fill in that gap.

If the floaters unit has already sort of reached their maximum capacity, which does happen at times, and certainly while we're running this dual system, moving cases into the new system under IOC and trying to work our old system, what you have described has happened, but we do make provisions --

COUNCILWOMAN BASS: So it has happened that cases have been kind of just left hanging?

DEPUTY COMMISSIONER HARLEY:

Not left hanging. They're reassigned to another worker, is what happens to that case. That entire caseload, whether it's 20 cases, to use your example, would be redistributed. So two might go to one worker in this unit, two go to another, but they're redistributed so that they are all reassigned.

COUNCILWOMAN BASS: Is there a particular -- do you have a timeline for when someone should be in touch to say, you know, I'm going to be helping you now, I'm going to be working with you now, Cindy Bass is somewhere else now? I guess an initial contact. Do you have a timeline for when that has to happen when a caseload is redistributed?

DEPUTY COMMISSIONER HARLEY: So, yes. So when a case is redistributed, the new worker is actually required -- usually we try to get them out within like seven days of getting the case to meet the family so that they will know I am now your new worker,

particularly the young people, because we want as much continuity as possible for them to go out, hopefully meet the family and to say that I'm the new worker.

We also -- it's a little bit easier for us to manage it in this situation because we know the worker that is leaving and when they're leaving, so we're already trying to prepare for that transition. So that worker is already working with her families and letting them know I'm going to be transitioning into a new position, and if she knows who the worker is going to be, so-and-so is going to be your new worker. Sometimes they're going out together and meeting the family so that the transition piece occurs.

The other thing is, sometimes we have to stagger when they move. While I may have wanted them to go into their new position on May 1st, I may have to hold it up until I have an opportunity -- because we have to make sure that all of

the cases are accounted for and all of the families are getting the services that they need. So sometimes you have to stagger when you allow people to move into their new positions.

COUNCILWOMAN BASS: Okay. Is there any internal -- this is my last question, real quick question.

Is there any internal quality control in terms of ensuring that that initial contact has happened?

DEPUTY COMMISSIONER HARLEY: We do get reports on whether or not the initial contact happens.

COUNCILWOMAN BASS: I'm sorry. Within seven days. Is there --

DEPUTY COMMISSIONER HARLEY: We monitor visitation. So there is a hierarchy. There's a worker, a supervisor, an administrator, a director assigned to every case. So that that's the team assigned. So that supervisor or administrative team tries to make sure it happens. Now, in some cases -- I'm

giving you best-case scenario, but to be honest, there are cases where it's the supervisor for a short period of time who is intervening until the case is reassigned to someone else. So the contact with the family may be made by the supervisor on the case.

COUNCILWOMAN BASS: Okay. All right. Thank you.

COUNCIL PRESIDENT CLARKE: Thank you, Councilwoman.

The Chair recognizes Councilwoman Quinones-Sanchez.

COUNCILWOMAN SANCHEZ: Thank you.

So I want to talk now a little bit around the CUAs. I know some of the issues as this was rolling out was the issue of these being a geographic overlay with the Police Department. Have you guys readdressed that and looked at a better geography versus just the Police Department for service areas, and how have you dealt when there might be

multiple children in a family and they cross the street, Lehigh Avenue, they're in a different police district?

COMMISSIONER AMBROSE: I think on the police district side -- and, remember, the reason we did that is because that's traditionally the way we assigned cases. And so there's been a huge community engagement strategy that not only DHS is engaged in, but really the CUAs are responsible for. And so now they're viewing it as the neighborhoods. So they're able to articulate the neighborhoods they're in instead of just the police districts that they're in.

On the issue of children moving or living with a relative across lines, we do an assessment of that family and make a decision based on the family composition and the service array as to which CUA that case belongs to. And, you know, those are sticky situations, but our families often are transient and so that's not an uncommon occurrence. You

know, they have family members throughout the City and sometimes they move from one family to another, and some of those arrangements are informal and some of those arrangements are formal or court ordered, and so we have to pay close attention to that issue, but it is a real issue.

COUNCILWOMAN SANCHEZ: When there are disputes around the handling of a CUA, does the family have the ability to appeal that back to DHS directly?

COMMISSIONER AMBROSE: Yes. Not only every CUA has our Commissioner's Action Response phone number on their letterhead, but also anybody, including the family, can request a teaming at any time. So it doesn't have to be just the intervals that Vanessa talked about. And the family -- this is explained to them. If they're not happy with something that's happening, they can say, I want to have a teaming, and they can call for a teaming. Anybody in the sort of team as

we define it can ask for that, but they also have very clear directions on the letterhead of the CUAs that they can call DHS directly.

COUNCILWOMAN SANCHEZ: Going back to -- and you said this, and I heard it, and you weren't affirming it as strongly as I know you meant it when you said it around the contracting and the subcontracting. One of the things that we've seen over the course of the last six years, in particular during this transition, there were a lot of services all over the City. There was a robust provider system, and there's many reasons. Cultural competency was an issue. Some people don't cross Broad Street for services, all the things that you talked about.

Have you done an analysis of the providers by area and looked at who has been de-funded as a result of this shift in terms of who's still in the game, who is not in the game, who has

made the decision and -- because in some cases you have providers that provided very unique services because that's all they wanted to do, which was a good thing, but because they're small, and we talked a little bit last year around capacity, that I didn't want a CUA to say, I'm not contracting with this person because I don't think they have the capacity, that they not be responsible for building the capacity so that they could play in this new reformed arena.

COMMISSIONER AMBROSE: So this is a really important issue. That's why I retain the authority to approve any subcontract. So that's probably the biggest piece of this.

COUNCILWOMAN SANCHEZ: But have you done an analysis? Can you see who is in the game?

COMMISSIONER AMBROSE: So what we've done is -- we haven't done an analysis, a formal analysis. What we've done is, we've met individually with many

of the providers who we still continue to believe are very valuable pieces of the work that we're going to do with IOC and paired them up with the CUAs in their area. So there's many of those relationships and partnerships that are forming.

Additionally, what we've decided to do was really pull back on the prevention contracts, because when we asked the CUAs to be able to articulate a prevention plan, they really weren't able to do that in the comprehensive way we need them to do it. And so there's going to have to be a whole lot more work that's done between the current prevention providers and the CUAs in order for us to get to that place. And I think there's also going to need to be some of those community engagement strategies evidenced in a different array of contracted services than we've traditionally had. Some more of the grassroots providers that have never had

a contract with the City now have an opportunity to really be supports in the neighborhoods that they can do good work in.

COUNCILWOMAN SANCHEZ: For me, having that analysis is important. So one of the things that I've tried to do is ask people to willingly talk to other folks, and I've gotten a lot of resistance. And so I'm glad that you're pulling back on the prevention side, because I think a lot of those services given what's going on particularly at the school-based level, there's a real need for a real hands-on kind of intervention. And so there's some resistance from the providers to even meet with folks to make a decision about whether that's a service that they need, even though their own agency capacity demonstrates their lack of knowledge in a particular area.

COMMISSIONER AMBROSE: You're right on target, and I think it's interesting that initially I think the

CUAs haven't been as proactive as they need to be, and some of the other providers are just scared of the unknown. And so --

COUNCILWOMAN SANCHEZ: Well, they don't want pushback. So we're all trying to place nice in the sandbox, but you have to be hammer.

COMMISSIONER AMBROSE: That's right.

COUNCILWOMAN SANCHEZ: So you have to say to folks, You have an organizational capacity that's A, B, C, D. You do not know X, Y, and Z. So you have to force that, because it's not going to happen. And so what you have is this tension around the smaller groups saying, I don't want to complain because then I'm going to be -- the little that I have is going to be taken from me, as opposed to how do we provide that kind of intervention.

COMMISSIONER AMBROSE: I think you're right, and some of these providers

actually have done such a good job, the community-based providers, they need to expand what they're doing now. And so there's a couple of providers that are more tentative about doing that, and we're facilitating those meetings and those partnerships.

COUNCILWOMAN SANCHEZ: Can you put someone in charge within your team of the CUA piece that maybe can serve as the entry point for these groups to say, These are some of the services. Because you're doing the capacity kind of analysis, that you can say to a service provider, These are some of the gaps and here are two or three people that we've pre-assessed that are in your geography.

COMMISSIONER AMBROSE: Yes.

COUNCILWOMAN SANCHEZ: You would need to put someone in charge of that, because as you and I both suspected, it's a problem.

COMMISSIONER AMBROSE: We're actually getting ready to hire somebody

who is just in charge of resource development, and some of that is connected to our child welfare demonstration project, but the bigger piece of that is where are the gaps in services and how do we fill those gaps in services with community-based providers.

COUNCILWOMAN SANCHEZ: And that that be written into their renewals. I mean, I really just feel like people will linger and use up the clock.

Thank you, Mr. President.

COUNCIL PRESIDENT CLARKE: Thank you.

Okay. We still have one department left, just a status report.

Thank you. The Chair recognizes Councilwoman Reynolds Brown.

COUNCILWOMAN BROWN: So having heard that caution, Commissioner, this report is issued annually --

COMMISSIONER AMBROSE: Yes.

COUNCILWOMAN BROWN: -- the report on progress on the Community

Oversight Board? So the next time we'll see an update is April 2015?

COMMISSIONER AMBROSE: Correct. Well, there's going to be an interim report here, because Dr. Linda Morrow and Judy Silver, Dr. Silver, who are members of the Community Oversight Board, did a ton of work on older youth as one of the well-being issues that they wanted to dig into. And so we're going to issue an interim report just on what's happening with older youth. So you'll be able to see that.

Part of the issue was that they -- it was so comprehensive that they hadn't had a chance to crosswalk it with the CUAs, and we've done so much work under the leadership of Margarita Davis-Boyer, who is our older youth coordinator, that in some ways they wouldn't keep up with the progress that was being made at the Achieving Independence Center and a lot of the enhancements that Margarita has tried to

4/15/14 - WHOLE - BILL 140144, etc.

bring to the agency.

COUNCILWOMAN BROWN: Well, that's a segue to my last and final question. I have many more on the CUA, briefly because the clock has actually rung. An update on that population. Because we know they're least likely to go to college. They're most likely to end up in homelessness, et cetera, et cetera.

COMMISSIONER AMBROSE: I could talk about that for a very long time. It is a huge area of focus for us. I can submit something in writing --

COUNCILWOMAN BROWN: Could you, please.

COMMISSIONER AMBROSE: -- that gives you an update on the way we've changed what we're doing at the Achieving Independence Center and the work that we're doing with the School District, which we think is really essential and urgent right now. And those are the two areas where we've really expanded what

we're doing in areas of well-being, particularly with education given the crisis at the District and with our older youth and the issues that they have on the behavioral health side, and great partnership with Dr. Evans and Judge Dougherty on all of those issues.

COUNCILWOMAN BROWN: Please do that.

COMMISSIONER AMBROSE: I will do that, because the Council President wants to not have me talk for a long time.

COUNCILWOMAN BROWN: Thank you very much.

Thank you, Mr. President.

COUNCIL PRESIDENT CLARKE: Thank you, Councilwoman.

The Chair recognizes Councilman Jones.

COUNCILMAN JONES: Thank you again, Mr. President, for your patience.

We're going to get another bite at the apple when we talk about the

legislation examining the Community Oversight Board, but I want to transition very quickly to talk about your relationships in schools, particularly your truancy division that was eliminated. It's not eliminated?

COMMISSIONER AMBROSE: No.

COUNCILMAN JONES: Is it under the IOC model now?

COMMISSIONER AMBROSE: So we have truancy units at DHS. In 2009, we started an Education Support Center, and we've consolidated the truancy work from the education -- that used to be in Prevention into the Education Support Center. In fact, we've enhanced those services. We just decided to hire 27 additional staff to put in the Education Support Center. Many of the focuses will be on truancy, but we're actually assigning two workers per CUA in --

COUNCILMAN JONES: Those are your employees?

COMMISSIONER AMBROSE: They'll

be DHS staff.

(Continued) -- in schools that have been identified as having more DHS kids and by the District as having leadership that are receptive to us working in those schools and actually identifying prevention issues in a very proactive way.

In addition, per CUA, we're going to have one DHS staff who is going to be working on little kids, so kids zero to 5 who we really need to make sure are making the right connections to early intervention and Head Start and are ready to learn by the time they get into kindergarten. And then for older youth, we're going to have one staff per two CUAs that are really focusing on the very concerning educational outcomes for older youth who are part of the DHS system.

COUNCILMAN JONES: I'm glad to hear that, because with shrinking staff at the schools, it was very disturbing to see that that --

COMMISSIONER AMBROSE: Exactly why we did it.

COUNCILMAN JONES: I appreciate it.

And if you could provide to the Chair and other members of Council how many truancy cases do you get from K to 3rd grade? You don't have to answer it now. But also from 4th grade to 12th grade. And I would be interested in seeing that collation with trouble at home or other issues that may be factors in dealing with that.

COMMISSIONER AMBROSE: I will say that the truancy issues are very difficult to arrive at right now, because the District no longer has the staff to identify truant children. So we're going to have to think very differently about how we use our truancy providers and really have them go into the schools and in some ways try to get those cases for us, because the process that we created two years ago no longer works because the

District truly does not have the staff necessary to identify those children. And it's really important for us to be able to identify those kids and provide a really prompt intervention.

COUNCILMAN JONES: Well, one final point is that I would encourage you along with the Department of Health, along with Behavioral Health to do the briefing that you did a year ago.

COMMISSIONER AMBROSE: Sure.

COUNCILMAN JONES: I thought that was helpful to members to get a better understanding of the interlocking relationship of that, but just like with this truancy, it flips over into the schools. So there's a lot of interlocking relationships and, quite frankly, why I'm concerned about CUAs, because I know how important your staff are to all of these other agencies, and I don't know if I'm going to get that same quality from some person -- and I know they have good reputations, but I know

that you're the -- I don't want to use the term devil, but you're the devil I know as opposed to trying to get to know the other ones.

COMMISSIONER AMBROSE: Well, you know them now. They're just doing the same work my staff are doing. So many of them are the same workers who have been working in the system for 20 years. They've just been doing duplicate functions of what DHS staff were doing.

COUNCILMAN JONES: Thank you, Mr. Chairman.

COUNCIL PRESIDENT CLARKE: Thank you, Councilman.

The Chair recognizes Councilwoman Bass.

COUNCILWOMAN BASS: Thank you, Mr. President.

And just last couple of questions. A review of the budget shows that your fringe benefits costs were going to increase about 6.7 million, and I'm wondering if you have an explanation

as to why that's increasing so much. One would think that it was actually decreasing.

COMMISSIONER AMBROSE: Marcia Dixon is our fiscal officer. She's going to come up to answer the question.

(Witness approached witness table.)

MS. DIXON: Good afternoon. My name is Marcia Dixon. I'm the fiscal officer at DHS.

What that reflects is, we were allowed to get reimbursed more money from the state for fringe benefits. Our fringe benefit rate went up about 10 percent. It's been at like 43 percent for about maybe five or six years. They finally released the bulletin that allowed us to draw down more funding for our fringe benefits. So what you were seeing before was only 43 percent reimbursement.

COUNCILWOMAN BASS: So you weren't getting reimbursed the full

amount basically?

MS. DIXON: Right.

COUNCILWOMAN BASS: And now you're being reimbursed the full amount?

MS. DIXON: We're being reimbursed 53 percent. But from prior years, I know that the City's fringe benefit rate with the unfunded liability was more upwards of 60, 65 percent. So we're getting closer.

COUNCILWOMAN BASS: Okay. Thank you.

And the other question I had is if you could discuss, Commissioner, your internal -- when it comes your employees within DHS. And I know that that covers a wide spectrum of folks, but can you talk about your hiring and termination processes.

COMMISSIONER AMBROSE: So we actually hadn't done hiring for a while. We recently hired over the last eight months 119 new staff. And so the hiring process is that we get a list and we look

at that list and try to interview and select the best candidates as part of that process.

COUNCILWOMAN BASS: If an employee has a grievance, what's the process?

COMMISSIONER AMBROSE: Based on not getting hired?

COUNCILWOMAN BASS: No, no. An employee.

COMMISSIONER AMBROSE: We work through our Human Resources Department and try to address whatever grievance that they have. The union is pretty instrumental in working with them to address those grievances. When there's a grievance that comes to my attention, it's usually assigned to one of the Deputy Commissioners. So if it's in children and youth, Vanessa would sit down and try to mediate that grievance and come up to a resolution.

COUNCILWOMAN BASS: I would assume that everything is done in

writing, that there is a paper trail?

COMMISSIONER AMBROSE: Yes.

COUNCILWOMAN BASS: So if there was an issue that -- if there was an investigation, if there was a problem, then I would be informed in writing and provided a copy of whatever in writing and if there's an appeal process; is that correct?

COMMISSIONER AMBROSE: Yes. There's an employee violation report that's issued as a result of discipline and then there's an appeal process to that. If there's an investigation, there's a written report that --

COUNCILWOMAN BASS: That's provided?

COMMISSIONER AMBROSE: It depends on the nature of the investigation. So we usually consult with Law depending on what the investigation is.

COUNCILWOMAN BASS: So if there's an investigation into an

4/15/14 - WHOLE - BILL 140144, etc.

employee --

COMMISSIONER AMBROSE: Many of the cases where we have investigations are related to the integrity officers. So those cases are usually handled in consultation with the Inspector General's Office and the Law Department. And so depending on whatever the finding is, we would turn it over if they advised us to turn it over and in some instances we would not turn it over.

COUNCILWOMAN BASS: So if I am under your employ and terminated at that point --

COMMISSIONER AMBROSE: Those are employee violation reports, and there's a due process that accompanies all of the employee violation reports where there's a preliminary hearing, and then if it can't be resolved at the preliminary hearing level, we have a hearing where there's a panel that there's --

COUNCILWOMAN BASS: So there

should be a hearing?

COMMISSIONER AMBROSE: Correct.

COUNCILWOMAN BASS: Does that matter regardless of the rank of the employee?

COMMISSIONER AMBROSE: No. No. Every employee, if they want to have a hearing, has a right to have a hearing.

COUNCILWOMAN BASS: So every employee --

COMMISSIONER AMBROSE: Unless they're an exempt employee.

COUNCILWOMAN BASS: Unless they're an exempt employee. And who would be considered an exempt employee?

COMMISSIONER AMBROSE: The Deputy Commissioners. I'm an exempt employee. So the leadership team of DHS.

COUNCILWOMAN BASS: And what would be the process for them?

COMMISSIONER AMBROSE: For discipline?

COUNCILWOMAN BASS: Right. For discipline or termination.

COMMISSIONER AMBROSE: There would be a hearing. I mean --

COUNCILWOMAN BASS: There would be a hearing for --

COMMISSIONER AMBROSE: Well, there could be a hearing.

COUNCILWOMAN BASS: -- an exempt employee?

COMMISSIONER AMBROSE: There could be a hearing for an exempt employee, but usually it's in the discretion of the appointing authority whether they want to have a hearing or not. It depends on what the nature of the concern is.

COUNCILWOMAN BASS: Back up for one second. You said there could be a hearing at the discretion of who?

COMMISSIONER AMBROSE: The appointing authority. That would be me.

COUNCILWOMAN BASS: So you would determine if there is a hearing for an employee that was going to be terminated?

COMMISSIONER AMBROSE: It depends on whether --

COUNCILWOMAN BASS: An exempt employee.

COMMISSIONER AMBROSE: It depends on whether termination is an issue. So there are different rules with exempt employees.

COUNCILWOMAN BASS: Right. So I'm saying specifically if you were going to terminate an exempt employee, you could determine if they had a hearing or not?

COMMISSIONER AMBROSE: If I wanted to terminate them?

COUNCILWOMAN BASS: Yes.

COMMISSIONER AMBROSE: No, because I don't need to have a hearing for an exempt employee.

COUNCILWOMAN BASS: Okay. So if they're an exempt employee, there's no hearing that's required?

COMMISSIONER AMBROSE: There have been issues where we have had formal

discipline per exempt employees.

COUNCILWOMAN BASS: But I'm asking about specifically what's required.

COMMISSIONER AMBROSE: I don't want to misspeak, so let me make sure -- I always consult with my HR Department, and in areas where there is an exempt employee, I would consult with the Law Department as well, Suzanne Reilly.

COUNCILWOMAN BASS: So before you terminate an employee who is exempt, you would have consulted with the Law Department and HR?

COMMISSIONER AMBROSE: Correct.

COUNCILWOMAN BASS: Okay. Thank you.

COUNCIL PRESIDENT CLARKE: Thank you, Councilwoman.

Councilman Jones.

COUNCILMAN JONES: That's for the next one.

COUNCIL PRESIDENT CLARKE: Mistake?

COUNCILMAN JONES: Thank you.

COUNCIL PRESIDENT CLARKE: Thank you, sir.

Thank you very much for your testimony.

COMMISSIONER AMBROSE: Thank you.

(Witnesses approached witness table.)

COUNCIL PRESIDENT CLARKE: Good evening.

MS. MINTZ: Good evening.

COUNCIL PRESIDENT CLARKE: Please proceed.

MS. MINTZ: Good evening, Council President Clarke and distinguished members of City Council. My name is Dainette Mintz. I am the Director of the Office of Supportive Housing. I am joined today by OSH Chief of Staff Joye Presson and OSH Deputy Director Roberta Cancellier and OSH Deputy Director Letty Egea-Hinton.

The mission of OSH is to plan

and coordinate Philadelphia's response to homelessness and assist individuals and families experiencing homelessness to achieve greater self-sufficiency in long-term housing. In addition, OSH administers Riverview Home, a state-licensed personal care home that provides housing to low-income elderly and disabled persons. I am pleased to offer this testimony outlining the OSH budget request for Fiscal Year 2015.

The proposed Fiscal Year 2015 budget is $91,838,358 and includes an allocation of $43,613,802 in general funds, which represents 47 percent of our budget, and $48,224,530 in grant funds, which represents 53 percent of our budget.

The Fiscal Year 2014 General Fund budget -- I'm sorry; '15 General Fund budget is $45,052,630 and includes additional funding requested by City Council in Fiscal Year '13 to increase the supply of emergency housing for

victims of domestic violence by 100 beds.

OSH is the Collaborative Applicant and coordinates the federal HUD Continuum of Care for homeless assistance in Philadelphia. OSH operates centralized intake into the City-funded emergency housing system. We oversee more than 2,500 contracted emergency housing beds; provide financial assistance to prevent homelessness and mortgage foreclosure, and rapidly rehouse homeless households in private rental units; manage state and federal support for food for shelter, food pantries, and food cupboards; coordinate entry into and oversight of 550 contracted transitional housing units and contract for 950 permanent supportive housing units, which represents 1,800 beds of housing for homeless persons.

OSH manages the HUD-required Homeless Management Information System, which is an electronic system to collect data regarding the characteristics and

needs of individuals experiencing homelessness in Philadelphia, and operates Riverview Home. More than 25,000 individuals are served annually through OSH.

This year Philadelphia endured the second snowiest winter in its history, with more than 75 days in which a Code Blue was activated by OSH to provide additional resources for individuals and families experiencing homelessness. Our city was well equipped and deeply committed to making extraordinary efforts to provide emergency shelter for people experiencing homelessness in the cold, especially those who are living outdoors. I am pleased to report that we had sufficient capacity to address our winter emergency housing needs and that there was not a single homeless death due to hypothermia.

Despite the continued desperate need for affordable housing in Philadelphia, the City is a leader among

cities in addressing homelessness, as demonstrated through collaboration, innovation, and results. Of 25 cities that participated in the 2013 U.S. Conference of Mayors Hunger and Homelessness survey, including Chicago, Los Angeles, Phoenix, and DC, Philadelphia saw a small decrease in the overall number of homeless individuals on average. Participating cities saw a 4 percent increase.

In 2013, Philadelphia added 462 new affordable housing beds for people experiencing homelessness, more than twice the number in other cities on average. In addition, OSH and partners are making progress towards the national goal of the United States Interagency Council on Homelessness, which includes HUD and the Veterans Administration, to end homelessness for chronically street homeless individuals and veterans by the end of 2015 and setting a path to end homelessness for families and young

people by 2020.

That represents a brief summary of the more detailed testimony that was submitted by the Administration. I'd be happy to answer any questions any members of Council may have.

Thank you.

COUNCIL PRESIDENT CLARKE: Thank you. Good evening. A couple of quick questions. In your testimony you referenced the City's need for more affordable housing.

MS. MINTZ: Yes.

COUNCIL PRESIDENT CLARKE: But yet I think you suggested that you met the needs of the homeless population in this past year.

MS. MINTZ: We met the needs of the homeless this winter, and that basically means trying to get people off the street who live on the street so that no one would freeze to death. That by no means indicates that we have a housing placement for everyone.

COUNCIL PRESIDENT CLARKE: So you meant the short-term needs?

MS. MINTZ: Yes.

COUNCIL PRESIDENT CLARKE: Which was the winter.

MS. MINTZ: Get people off the streets into short-term housing. But for everyone who goes into short-term housing, they need a long-term house, and therein lines the rub.

COUNCIL PRESIDENT CLARKE: And are you and your department involved in the intermediate or the longer term housing strategy?

MS. MINTZ: We collaborate with the Office of Housing and Community Development and we attempt to leverage the federal grants that we receive to develop more housing specifically for the homeless, and we've tried to work through some trials and issues that they've had with reductions anticipated to CDBG and HOME funds in the past. We also have the unfortunate issue of there being some

community oppositions to the siting of homeless projects, and so we are actually in a deficit position this year, in that for the last couple years which there's been no new housing development identified for homeless persons.

COUNCIL PRESIDENT CLARKE: Okay. So I understand you have a number of transitional houses in the City of Philadelphia.

MS. MINTZ: Yes.

COUNCIL PRESIDENT CLARKE: And that basically prepares people to move into traditional long-term housing.

MS. MINTZ: Exactly.

COUNCIL PRESIDENT CLARKE: So is there a shortage in the traditional long-term housing --

MS. MINTZ: Yes.

COUNCIL PRESIDENT CLARKE: -- that would not afford you an opportunity to move folks from transitional into long-term and then freeing up spaces for people that are going through the

4/15/14 - WHOLE - BILL 140144, etc.

process, going from homeless to transitional and then to long term?

MS. MINTZ: Yes. So our continuum sees recruitment of engagement of people on the street who would typically go into short-term housing, and from there they would move to long-term housing. Likewise for families who are struggling to find housing they can afford, right now the only door open to them is emergency shelters. So they come to our intake centers for placement in emergency housing. We are basically in a -- across a spectrum of housing. We are being asked to provide more emergency housing to meet that immediate need, but in responding to that, that means we have an increase need of people who need to move out of that housing into long-term housing.

COUNCIL PRESIDENT CLARKE: Right.

MS. MINTZ: The rule of thumb across the nation is that not everyone

needs to go into emergency housing. Primarily because people are poor is the only reason why they're asking for shelter placement. If we had long-term housing available to them, we could make that connection at the front door, but because we have an unlimited supply of -- a limited supply of housing, we're not able to make that connection.

COUNCIL PRESIDENT CLARKE: Right. So if we were able to tell you that we had a strategy that would put a thousand units of affordable housing on the table within the next year or so, you'd be in a position to move a whole lot of people off the street, because you have more transitional housing available because the people that are currently in the transitional housing can move into the longer term housing?

MS. MINTZ: Yes.

COUNCIL PRESIDENT CLARKE: Would that be --

MS. MINTZ: I've heard a rumor,

and what we typically would do would be to ask if there could be a seta-side for homeless families, because in our experience, our families don't compete as well as non-homeless low-income families. So we really do need a set-aside to be able to have a fair opportunity to get homeless folks into housing.

COUNCIL PRESIDENT CLARKE: Particularly affordable, below 60 percent median income. Sixty to 30 --

MS. MINTZ: Exactly.

COUNCIL PRESIDENT CLARKE: -- is really our target population.

MS. MINTZ: Yes. Yes. But that would be very helpful.

COUNCIL PRESIDENT CLARKE: I'll probably be asking you to come testify at a hearing shortly at some point in time.

MS. MINTZ: Okay. Before December.

COUNCIL PRESIDENT CLARKE: We all kind of know the need, but we just want to document --

MS. MINTZ: I'm here until December.

COUNCIL PRESIDENT CLARKE: We look forward having you at that public hearing.

I just had another quick question. Page 13, 14, and 15 of your budget details, it proposes an allocation for specialized services, family shelter, single shelters, Mayor's homeless initiative and winter initiative, but the specifics are yet to be determined.

MS. MINTZ: Yes.

COUNCIL PRESIDENT CLARKE: Is there a reason?

MS. MINTZ: We typically wait until after the budget has been passed before we do the allocations. We indicate to our providers we're looking at level funding, but if there is the need for us to do a shift of a few dollars, we typically just wait to make those allocations. And what we try to do is ensure that what we present in the

budget is the amount we've allocated for that activity, so that what you see reflected there is the amount that's allocated for that activity and that we then make the final allocations once the budget has been passed.

COUNCIL PRESIDENT CLARKE: Okay. And I ask this particularly because I know a couple of Councilmembers that are not here and some that are here are very interested in the commitment to providing housing short term for domestic violence.

MS. MINTZ: Yes.

COUNCIL PRESIDENT CLARKE: And we just wanted to make sure that as the priorities get established, that that's right up top.

MS. MINTZ: Sure. Understood. And you'll see that we've been consistent in our budget in which we have not completed that 2015 column, because, again, just depending upon whether or not there is any change in our state and

federal grants that would also impact whether or not we're able to provide the same amount of funding to some of our providers. But in the case of the domestic violence, those are all general funded, and so I think we can reflect what we would be providing, and that's based on the funding that's been specifically allocated for that activity.

COUNCIL PRESIDENT CLARKE: Okay. All right. Thank you. Thank you very much.

The Chair recognizes Councilman Jones.

COUNCILMAN JONES: Thank you, Mr. President.

It is my understanding this is your last budget.

MS. MINTZ: Yes.

COUNCILMAN JONES: After how many years?

MS. MINTZ: In October it will be 32 years of service.

COUNCILMAN JONES: And I would

say that I think, without fear of successful contradiction, this department has been a national model on the continuum of homelessness to self-sufficiency; is that correct?

MS. MINTZ: That is correct.

COUNCILMAN JONES: How long were you the Director of this?

MS. MINTZ: Eight years next month.

COUNCILMAN JONES: So I don't know if we want to let you go. I mean, quite frankly. We may have to introduce some legislation.

MS. MINTZ: I'm running.

COUNCIL PRESIDENT CLARKE: Councilman, you weren't supposed to let it out today.

COUNCILMAN JONES: Oh, all right. Okay.

I don't know. And I say that in gest, but I say it in true, because, you know, you deal with the fact that because you're so good, you become a

regional magnet for homeless. People know if I can get to Philly, I can get some help, and that is an additional challenge.

I think when you start looking at your transitional housing program or your rapid rehousing program or your benefit connection dealing with particular groups that have challenges with disabilities, when I look at the demographics you serve -- my colleagues often ask for those kinds of figures -- you deal with 28 percent males, 72 percent females, which is interesting, 72 percent of whom are African American or black, 15 percent are white, 5 percent are Hispanic, and 1.8 percent are Asian Americans. So you have a United Nations of services there, and I just want to say -- and it's been a long day for all of us, but I wanted to let you smell your roses --

MS. MINTZ: Thank you.

COUNCILMAN JONES: -- a bit and

say the true honor to you is on my first day, Mr. President, we had just gotten sworn in '08. It was January '08. We had a nice little party in the hallway. You know, you were part of it. And it was a lot of people wishing us well, and we had food and entertainment out there, a little band, and everybody had a wonderful time. And then I remember at the conclusion of the dinner, there was a family sitting on my chairs, the chairs I still have out there, and I said, Did you enjoy yourself.

Yes.

Are you okay?

No.

And the response was, Well, why aren't you okay?

They said, We're homeless.

And if you understand sheer panic hit me, because now I have to really be a Councilperson and provide some real service. All the pomp and circumstances are all over. Well, the

phone call I made was a fortuitous one. It was to you. And within about an hour, a gentleman came up. And these particular folk had specific needs, because they were mentally challenged, some of them in the family. And a van pulled up, and you could have been sent by an angel in my eyes, because I sincerely believe that your first constituent service request, you'd better get it right, because it's like your first dollar bill you get when you -- your first sale, you'd better make it. And I felt that way, and I've felt that way each and every year. Whenever I call your office or your staff, I get a real live person with a real live answer. It isn't always the one that I'd like to have, but it's a real live answer that I can count on, and I appreciate that.

MS. MINTZ: Thank you.

COUNCILMAN JONES: I have no other questions, Mr. President.

MS. MINTZ: Thank you.

COUNCIL PRESIDENT CLARKE: Wow, she really did make an impact on you, sir. Thank you. Thank you so much, Councilman.

The Chair recognizes Councilwoman Reynolds Brown.

COUNCILWOMAN BROWN: Okay. It goes without saying the work you do enormously important, and the domino effect of those that you take care of, you can't even measure.

MS. MINTZ: Thank you.

COUNCILWOMAN BROWN: So it certainly does not go unrecognized in the time you put in with your career.

School District of Philadelphia, what measures and programs does your department take to ensure that the many children that are in shelters are still able to pursue their elementary and secondary education? Just speak briefly to the connectedness to the School District and how and what's done.

MS. MINTZ: We work very

closely with the School District. As a result of the Homeless Act, there are specific funding that is made available to the School District to assist homeless children, assistance for transportation to cover the cost of tokens, assistance to help those kids with uniforms, acquisition, et cetera. So we work very closely with their office to make that happen.

We also work closely with the office in terms of trying to identify how many of our kids are in their system who may not be identified as being homeless but are in need of assistance. And so we work very closely to continue to have an open dialogue in regards to the number of our kids in their system and who might be having some challenges, et cetera.

COUNCILWOMAN BROWN: What's the number to date of young people that are in your system in the Philadelphia School District? I'm curious.

MS. MINTZ: So according to the

Pennsylvania Department of Education, there were 3,011 homeless students in school year 2012 through '13 in Philadelphia, and that's through 12th grade. A task force was established to examine the educational needs of Pennsylvania's homeless children and youth, and so as a result of that, the statewide survey was to parents experiencing homelessness so that they could report, and the state tried to gather that number.

COUNCILWOMAN BROWN: This past winter was tough for everyone. During the -- what type of -- we know that homeless individuals are encouraged to seek shelter, particularly during Code Blue. What effects did the increased number -- and I'm being presumptuous. We would assume that there was an increased number in those who went in because of Code Blue. What effects did that have on your budget?

MS. MINTZ: We actually had a

fortunate circumstance this year. As you may recall, the agency has been working for the past couple years to replace the beds due to the close of the Ridge Avenue shelter, which was our largest single male facility.

COUNCILWOMAN BROWN: Is that right?

MS. MINTZ: And we closed that in 2012. And so for the last couple of years, we've been looking for locations and sites, and as a result of looking at sites, as we approached this winter we had more sites than we've ever had access to because of that active work to try to replace the Ridge beds, and we took advantage of that. Without knowing that we were going to have a horrific winter, we just took advantage of the fact that we had access to these properties and we asked the Administration for additional money to cover the cost and we received an additional 347,000 from the Administration for us to be able to

increase our winter beds and, boy, are we glad we did, and then we had the winter that we had.

COUNCILWOMAN BROWN: What properties?

MS. MINTZ: They are scattered throughout the City. They might be properties that someone -- one was a correctional facility and they moved out, and they are still in the midst of trying to find a long-term tenant. So we do a winter program. We only operate from December through the end of March. So we could use it for four months while they're still trying to find a long-term leaser.

We work with a couple of homeless providers who actually own their own properties and they don't have annual programming in them. So if they're vacant during the winter months, we'll utilize those properties. Again, it's dependent on whether you have properties that you can use and whether you have

funds to pay for them. And so we were very fortunate that we had a couple of extra properties and got additional funding from the Administration this year, and it resulted in us being able to have our outreach teams offer people a placement off of the street this winter. So there was never an issue where we didn't have a bed for a single person on the street this winter if they were willing to come in.

COUNCILWOMAN BROWN: So it's fair to say that the impact was nominal.

MS. MINTZ: The impact was -- I mean, we had the funding within our budget because we got the additional 347,000. Had we not gotten that, we would have been in a deficit position for that amount of money.

COUNCILWOMAN BROWN: I just have one final question, Mr. President.

COUNCIL PRESIDENT CLARKE: Go ahead, Councilwoman.

COUNCILWOMAN BROWN: The rapid

housing program, my office worked as well as we felt we could with a circumstance regarding a woman that had been a part of rapid housing. And so the question is, what oversight is done for this program and what regulations are in place to prevent a person from falling through the cracks? What kind of triggers do you have?

MS. MINTZ: We have standard review. That particular case had some extenuating circumstances.

COUNCILWOMAN BROWN: Yes, it did.

MS. MINTZ: Typically the program is trying to help someone who has the resources to be able to pay their rent on an ongoing manner, and in that particular case, we provided that person with some money to get caught up on their rent.

COUNCILWOMAN BROWN: Yes. From what I can tell, your office did everything, including walk water.

MS. MINTZ: Exactly. And unfortunately it is still dependent on folks assuming their responsibility in paying their rent going forward.

COUNCILWOMAN BROWN: Indeed.

MS. MINTZ: And there's always oftentimes or more often than we'd like, there are folks who will believe that they can come back to the well whenever they get behind. Our standard policy is that you can only be served once in any 12-month period to provide as an opportunity to serve another Philadelphian who might be in need. And so in this particular case, we had assisted this person and we were still in the 12-month period in which she could not be served again. We attempted to connect her to housing counseling. She declined, as well as your office did as well.

COUNCILWOMAN BROWN: Yes.

MS. MINTZ: So the resource there is, again, trying to connect her to

some behavioral health services to change her pattern of activity, but beyond that, there really is very little that we can do. What she is eligible for is, if she comes back in after the 12 months, we can assist her again, but part of what we attempt to determine is if this is someone who is going to be an abuser of our services, we try to tag that.

COUNCILWOMAN BROWN: Thank you for helping us try to figure that out.

MS. MINTZ: Sure.

COUNCILWOMAN BROWN: Thank you very much.

Thank you, Mr. President.

COUNCIL PRESIDENT CLARKE: Thank you, Councilwoman.

And with that, I want to thank you very much for your testimony and thank you for your years of service.

MS. MINTZ: Thank you. Thank you very much.

COUNCIL PRESIDENT CLARKE: This Committee will stand in recess until

4/15/14 - WHOLE - BILL 140144, etc.

Wednesday, April 16th at 10:00 a.m. in Room 400, City Hall.

Thank you.

(Committee of the Whole recessed at 5:35 p.m.)

- - -

CERTIFICATE

I HEREBY CERTIFY that the proceedings, evidence and objections are contained fully and accurately in the stenographic notes taken by me upon the foregoing matter, and that this is a true and correct transcript of same.

MICHELE L. MURPHY
RPR-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.)

D

J

P

S