COUNCIL OF THE CITY OF PHILADELPHIA

COMMITTEE OF THE WHOLE

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

PRESENT:

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

BILLS: 150162, 150163, 150164
RESOLUTIONS: 150179

- - -

(Councilman Jones sitting as Chair.)

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

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

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

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

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

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

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

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

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

(Witnesses approaches witness table.)

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

DR. EVANS: Okay. Good morning, Councilman Jones 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 FY2016 operating budget. Joining me today is Deputy Commissioner David Jones as well as many senior staff who are in the audience.

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

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

$185,940. And Class 800 totals $1.6 million.

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

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

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

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

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

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

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

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

Accomplishments achieved during this transformation decade have garnered local, national and international attention due to the fact that our approach is working. Local innovations have attracted visitors from across the United States and around the world who seek to replicate Philadelphia's model.

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

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

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

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

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

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

In conclusion, we appreciate the support continuing -- 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 Councilmembers at your convenience to engage in further discussion regarding these issues.

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

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

Thank you.

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

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

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

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

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

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

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

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

(Laughter)

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

DR. EVANS: Okay.

COUNCILMAN JONES: I really -- no hard

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

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

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

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

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

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

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

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

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

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

DR. EVANS: Sure.

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

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

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

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

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

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

And some schools are more challenged than others.

DR. EVANS: Sure.

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

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

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

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

number.

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

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

DR. EVANS: Sure.

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

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

DR. EVANS: Okay.

(Chairwoman Tasco now sits as Chair.)

COUNCILWOMAN TASCO: Good morning.

DR. EVANS: Good morning.

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

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

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

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

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

DR. EVANS: Sure.

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

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

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

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

behavioral health issues and having a strong partnership.

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

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

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

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

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

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

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

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

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

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

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

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

DR. EVANS: Sure, yes.

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

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

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

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

are people who really have significant issues.

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

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

COUNCILWOMAN TASCO: Would you please

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

How would you provide for additional demand?

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

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

DR. EVANS: Okay.

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

How would you provide for the additional

demand?

DR. EVANS: For the additional demand. Okay.

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

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

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

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

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

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

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

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

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

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

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

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

COUNCILWOMAN BLACKWELL: Thank you. Thank you very much.

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

DR. EVANS: Thank you.

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

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

Chair recognizes Councilwoman Sanchez.

COUNCILWOMAN QUINONES-SANCHEZ: Thank you, Madam Chair.

I also want to thank the department. I think that some of the work that they do is probably the most difficult and painstaking as it relates to working in the communities. And I appreciate we're in the process of moving a methadone clinic a hundred feet. And I'm still getting beat up because we're moving it a hundred feet, but in a more conducive environment.

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

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

provided?

DR. EVANS: Yes. So, great question.

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

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

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

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

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

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

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

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

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

DR. EVANS: Sure.

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

But no one in the Administration seems

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

DR. EVANS: Sure.

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

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

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

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

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

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

COUNCILWOMAN TASCO: Councilman Neilson.

COUNCILMAN NEILSON: Thank you, Councilwoman.

COUNCILWOMAN TASCO: I got to follow the

numbers.

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

DR. EVANS: Good morning.

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

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

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

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

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

DR. EVANS: Sure.

COUNCILMAN NEILSON: I think that's a

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

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

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

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

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

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

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

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

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

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

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

(Councilman Greenlee now sits as Chair.)

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

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

providing children services.

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

I mean --

DR. EVANS: These services --

COUNCILMAN NEILSON: That puts --

DR. EVANS: Sure.

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

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

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

DR. EVANS: I wish it was flexible.

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

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

DR. EVANS: Sure.

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

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

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

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

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

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

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

I have nothing further, Mr. Chairman.

COUNCILMAN GREENLEE: Thank you, Councilman.

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

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

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

We have created 119 initiatives that

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

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

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

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

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

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

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

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

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

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

support.

So, I just want to thank you for that. Recognize that you have really talented.

(Bell rings.)

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

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

COUNCILMAN O'BRIEN: Thank you.

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

Councilman Oh.

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

Good morning.

DR. EVANS: Morning, Councilman.

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

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

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

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

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

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

Thank you.

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

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

(Applause)

COUNCILMAN OH: Thank you, Mr. Chairman.

COUNCILMAN GREENLEE: Thank you, Councilman.

Councilwoman Sanchez.

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

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

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

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

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

DR. EVANS: Sure.

COUNCILWOMAN QUINONES-SANCHEZ: That might be helpful.

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

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

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

We have very strong --

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

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

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

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

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

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

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

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

DR. EVANS: -- each provider.

COUNCILWOMAN QUINONES-SANCHEZ: I don't

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

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

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

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

DR. EVANS: Sure. We do that all the

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

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

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

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

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

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

DR. EVANS: Sure.

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

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

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

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

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

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

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

COUNCILMAN GREENLEE: Thank you. Thank you, Councilwoman.

Councilwoman Reynolds Brown.

COUNCILWOMAN REYNOLDS BROWN: Good morning, gentleman.

DR. EVANS: Good morning.

DEPUTY COMMISSIONER JONES: Good morning.

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

DEPUTY COMMISSIONER JONES: Actually, my second.

COUNCILWOMAN REYNOLDS BROWN: Oh, okay.

DEPUTY COMMISSIONER JONES: But thank you.

COUNCILWOMAN REYNOLDS BROWN: Welcome back. You survived it.

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

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

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

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

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

COUNCILWOMAN REYNOLDS BROWN: Right.

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

appropriate services are -- are --

COUNCILWOMAN REYNOLDS BROWN: Rendered.

DR. EVANS: Are rendered for those -- for those children. But, you know as I was mentioning earlier, that -- that in the best case scenarios, the providers that are providing those services are really doing that in collaboration, close coordination with the schools and with parents to make sure that as people, as you hit those milestones, if there are challenges, that those are being addressed through a -- through a refining of the treatment approach.

COUNCILWOMAN REYNOLDS BROWN: What point does your agency say enough is enough, we're not doing -- operating the best interest of this kid, let's do something else?

I mean, at what point is the plug pulled to say we're not meeting the needs of this child?

DR. EVANS: Right. That's a hard question. I mean, I think that's a question that we would -- we would try to answer in

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

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

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

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

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

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

COUNCILWOMAN REYNOLDS BROWN: Okay.

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

DEPUTY COMMISSIONER JONES: Actually -- David Jones.

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

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

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

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

to be more sophisticated then you might imagine.

COUNCILWOMAN REYNOLDS BROWN: Okay.

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

COUNCILWOMAN REYNOLDS BROWN: Okay. I have one more.

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

COUNCILWOMAN REYNOLDS BROWN: Okay. Now problem.

COUNCILMAN GREENLEE: Okay.

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

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

COUNCILWOMAN REYNOLDS BROWN: I see.

DR. EVANS: -- the loss of counselors.

COUNCILWOMAN REYNOLDS BROWN: Okay.

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

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

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

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

COUNCILWOMAN REYNOLDS BROWN: Yes.

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

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

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

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

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

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

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

DR. EVANS: Oh, absolutely.

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

district what the new structure looks like.

DR. EVANS: Okay. We appreciate that.

COUNCILWOMAN REYNOLDS BROWN: Thank you. Thank you, Mr. Chair.

COUNCILMAN GREENLEE: Thank you, councilwoman.

Councilwoman Sanchez, do you? Okay.

COUNCILWOMAN QUINONES-SANCHEZ: Yes.

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

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

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

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

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

COUNCILWOMAN QUINONES-SANCHEZ: While

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

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

DR. EVANS: Reducing the budget for?

COUNCILWOMAN QUINONES-SANCHEZ: For Prevention Point.

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

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

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

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

COUNCILWOMAN QUINONES-SANCHEZ: Right.

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

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

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

COUNCILWOMAN QUINONES-SANCHEZ: Okay. I

will make sure that before the end of the budget.

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

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

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

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

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

be receiving.

COUNCILWOMAN QUINONES-SANCHEZ: Okay. So, you leave that up to the --

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

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

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

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

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

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

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

DR. EVANS: What do you mean multiple addresses?

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

DR. EVANS: Right.

COUNCILWOMAN QUINONES-SANCHEZ: The one provider.

DR. EVANS: Right.

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

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

Just as a way of background, you know,

that there are recovery houses that we directly fund.

COUNCILWOMAN QUINONES-SANCHEZ: I get that.

DR. EVANS: Okay.

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

DR. EVANS: Sure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. LAMB: Right.

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

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

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

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

COUNCILWOMAN QUINONES-SANCHEZ: All

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

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

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

DR. EVANS: Good morning.

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

DR. EVANS: You heard that? Of course.

COUNCIL PRESIDENT CLARKE: Councilman te -- okay.

DR. EVANS: It's a done deal.

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

DR. EVANS: Sure.

COUNCIL PRESIDENT CLARKE: We had a

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

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

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

DR. EVANS: Sure.

COUNCIL PRESIDENT CLARKE: Thank you.

Chair recognizes Councilman Jones.

COUNCILMAN JONES: Thank you from all my

constituents to look out for us like that.

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

DR. EVANS: Sure.

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

DR. EVANS: Sure.

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

DR. EVANS: Sure.

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

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

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

So, if you can share that again.

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

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

We do Pay For Performance where we look

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

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

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

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

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

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

If you achieve really highly, you will

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

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

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

COUNCILMAN JONES: So, we have over the

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

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

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

DR. EVANS: Sure.

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

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

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

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

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

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

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

COUNCIL PRESIDENT CLARKE: Thank you, Councilman.

Chair recognizes Councilman Neilson.

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

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

DR. EVANS: Right. No, I understand.

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

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

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

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

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

COUNCILMAN NEILSON: I know.

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

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

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

DR. EVANS: Absolutely.

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

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

We would welcome those conversations.

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

I have nothing further, Mr. President.

COUNCIL PRESIDENT CLARKE: Thank you, Councilman.

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

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

COUNCIL PRESIDENT CLARKE: How many do you fund?

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

COUNCIL PRESIDENT CLARKE: So, we --

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

COUNCIL PRESIDENT CLARKE: We have like 267 schools?

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

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

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

COUNCIL PRESIDENT CLARKE: Okay.

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

COUNCIL PRESIDENT CLARKE: Okay.

DR. EVANS: Which is where we have services.

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

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

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

(Applause)

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

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

(Laughter)

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

Thank you.

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

Health Department is next.

- - -

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

- - -

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

Good afternoon. Please proceed.

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

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

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

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

Hospital Care Assessment Fund.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In addition, we've been in daily contact with travelers who are entering Philadelphia from the three effected countries in West Africa out to 21 days from their departure. On any given day, seven days a week this has involved calls between 30 and 50 people. And altogether, we have now worked with approximately 500 travelers of whom just a very few have required further medical evaluation. And none have had Ebola.

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

state and the national averages.

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

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

COUNCIL PRESIDENT CLARKE: Thank you.

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

DR. BUEHLER: We have eight.

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

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

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

COUNCIL PRESIDENT CLARKE: Okay.

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

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

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

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

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

COUNCIL PRESIDENT CLARKE: Do we pay for those?

DR. BUEHLER: No. They are independently operated.

COUNCIL PRESIDENT CLARKE: Okay.

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

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

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

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

Chair recognizes Councilman Greenlee.

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

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

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

by increase in use of electronic cigarettes by youth.

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

DR. BUEHLER: Yes.

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

(Applause)

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

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

And I think -- I think you were kind of

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

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

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

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

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

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

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

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

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

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

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

COUNCILMAN GREENLEE: Right.

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

We're also collaborating with a group at

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

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

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

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

Thank you, Mr. President.

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

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

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

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

DR. BUEHLER: I appreciate --

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

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

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

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

DR. BUEHLER: At Health Center 10 wait

time.

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

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

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

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

health services. We are stepping down that path.

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

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

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

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

DR. BUEHLER: Right.

COUNCILMAN NEILSON: After you provide

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

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

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

eligibility and get signed up.

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

No further questions, Mr. President.

COUNCIL PRESIDENT CLARKE: Thank you, Councilman.

Chair recognizes Councilman Jones.

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

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

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

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

it?

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

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

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

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

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

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

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

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

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

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

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

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

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

We worked with many other departments around the City to try to expand opportunities to be healthy to get exercise. We also worked with the food trucks to expand access to farmers markets. We worked with corner stores all around the City to help prove access to fresh fruits and vegetables there. We have a food bucks program that people can go to a farmers market and amplify the food stamp benefit that they get to buy fresh fruits and vegetables.

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

City.

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

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

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

hovered around ten deaths for every --

COUNCILMAN JONES: How does that compare to other cities?

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

COUNCILMAN JONES: Once again, the poverty issue.

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

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

help them get their kids get the healthiest possible start.

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

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

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

We've also, through social media,

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

COUNCILMAN JONES: Thank you, Mr. President.

COUNCIL PRESIDENT CLARKE: Thank you, Councilman.

Chair recognizes Councilwoman Reynolds Brown.

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

COUNCIL PRESIDENT CLARKE: Good morning.

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

DR. BUEHLER: Yes.

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

DR. BUEHLER: I'm sorry?

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

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

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

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

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

infrastructure in place.

Provide an update, please.

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

COUNCILWOMAN REYNOLDS BROWN: That's good.

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

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

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

COUNCILWOMAN REYNOLDS BROWN: Very good.

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

COUNCILWOMAN REYNOLDS BROWN: Okay. I

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

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

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

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

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

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

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

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

COUNCILWOMAN REYNOLDS BROWN: Is what?

DR. BUEHLER: Eleven for prenatal.

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

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

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

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

COUNCILWOMAN REYNOLDS BROWN: Okay.

DR. BUEHLER: We're not alone there.

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

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

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

DR. BUEHLER: Sure.

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

DR. BUEHLER: Yes.

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

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

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

COUNCILWOMAN REYNOLDS BROWN: Is that right?

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

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

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

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

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

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

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

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

Thank you, Mr. President.

COUNCIL PRESIDENT CLARKE: Thank you, Councilwoman.

Chair recognizes Councilwoman Tasco.

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

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

COUNCILMAN JONES: Real quick, Mr. President.

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

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

COUNCILMAN JONES: That means?

DR. BUEHLER: Oh. This is constantly an

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

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

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

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

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

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

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

DR. BUEHLER: Will do.

COUNCILMAN JONES: Thank you, Mr. Chairman.

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

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

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

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

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

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

COUNCILWOMAN REYNOLDS BROWN: Okay.

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

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

COUNCILWOMAN REYNOLDS BROWN: That's improvement.

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

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

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

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

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

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

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

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

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

Complete the sentence.

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

COUNCILWOMAN REYNOLDS BROWN: No two

health centers budgets are exactly the same?

DR. BUEHLER: I doubt it.

COUNCILWOMAN REYNOLDS BROWN: Okay. What is the nature of follow up after a patient leaves the health center?

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

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

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

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

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

COUNCILWOMAN REYNOLDS BROWN: All right.

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

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

DR. BUEHLER: Right.

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

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

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

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

DR. BUEHLER: Okay.

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

DR. BUEHLER: Yeah.

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

get? Where are the links?

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

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

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

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

DR. BUEHLER: Sure.

COUNCILWOMAN REYNOLDS BROWN: Okay.

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

DR. BUEHLER: Yes.

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

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

COUNCILWOMAN REYNOLDS BROWN: Okay.

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

COUNCILWOMAN REYNOLDS BROWN: Anything around children and youth?

DR. BUEHLER: I'd have to double check

on that.

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

DR. BUEHLER: Sure.

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

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

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

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

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

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

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

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

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

DR. BUEHLER: Thank you.

COUNCILWOMAN REYNOLDS BROWN: Thank you, Mr. President.

COUNCIL PRESIDENT CLARKE: Thank you Councilwoman.

Well, thank you very much for your testimony.

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

COUNCIL PRESIDENT CLARKE: Hold on one second, please.

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

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

COUNCILWOMAN REYNOLDS BROWN: Safe Routes Philly.

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

COUNCILWOMAN REYNOLDS BROWN: Give us an update.

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

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

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

COUNCIL PRESIDENT CLARKE: Thank you.

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

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

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

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

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

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

COUNCILWOMAN REYNOLDS BROWN: Okay.

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

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

Three, we try to coordinate our Safe

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

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

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

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

Thank you, Mr. President.

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

DR. BUEHLER: Thank you.

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

- - -

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

- - -

- - -

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

- - -

(Councilman Jones sits as Chair.)

COUNCILMAN JONES: Good afternoon, everyone.

("Good afternoon.")

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

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

(Witnesses approach witness table.)

COUNCILMAN JONES: Good afternoon, everyone.

COMMISSIONER HARLEY: Good afternoon.

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

COMMISSIONER HARLEY: Good afternoon. My name is Vanessa Garrett Harley, Commission for the Department of Human Services.

COUNCILMAN JONES: Good afternoon.

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

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

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

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

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

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

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

Philadelphia.

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

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

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

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

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

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

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

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

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

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

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

COMMISSIONER HARLEY: Absolutely.

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

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

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

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

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

COMMISSIONER HARLEY: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COUNCILMAN JONES: Excuse me a second. We have a slight change. I'll be over

there.

COMMISSIONER HARLEY: No problem.

COUNCILMAN JONES: Mr. President.

(Council President Clarke retakes Chair seat.)

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

Thank you.

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

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

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

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

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

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

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

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

COMMISSIONER HARLEY: Thank you.

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

Okay, Councilwoman Tasco.

COUNCILWOMAN TASCO: Thank you. Good afternoon.

COMMISSIONER HARLEY: Good afternoon.

COUNCILWOMAN TASCO: Have a couple of questions here.

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

COMMISSIONER HARLEY: So the -- your

question is how are the CUAs doing? And so, I would like to say the CUAs are evolving. I think that some progress is being made. We see some progress in several areas, in many area. Obviously, it's a new endeavor. We are in still what many would say are the preliminary or implementation phases. We are also still realizing some challenges, looking at the model, trying to determine where it may need to be tweaked. Ultimately, trying to ensure that the safety and well being of our children are met.

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

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

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

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

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

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

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

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

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

I do think that those CUAs who open

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

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

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

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

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

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

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

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

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

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

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

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

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

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

right now.

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

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

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

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

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

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

What kind of services do you provide to

the person left behind at the home?

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

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

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

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

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

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

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

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

And you answered a little bit.

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

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

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

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

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

COUNCIL PRESIDENT CLARKE: Thank you,

Councilwoman.

Chair recognizes Councilman Jones.

COUNCILMAN JONES: Thank you, Mr. President.

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

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

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

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

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

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

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

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

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

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

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

this question here.

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

COMMISSIONER HARLEY: I can get that for you.

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

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

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

COMMISSIONER HARLEY: Understood.

COUNCILMAN JONES: Fiscal Year 15 to Fiscal Year 14.

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

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

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

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

COUNCILMAN JONES: In total.

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

COUNCILMAN JONES: Okay.

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

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

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

COUNCILMAN JONES: So there were 50 deaths.

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

COUNCILMAN JONES: Okay.

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

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

COMMISSIONER HARLEY: I don't know, to be honest with you, I remember everything that was in that article.

COUNCILMAN JONES: Just OxyContin. And what was disturbing that there were five reports before that to that household that there was a problem there. And then, you know, we find him dead. So -- I don't know if that was a CUA or a direct supervision but --

COMMISSIONER HARLEY: So, that was not a community umbrella case. That was direct DHS involvement. Little bit difficult for me to talk about that case without having reviewed the case file or anything. But the CUA was not involved in that case. It had nothing to do with IOC. And so, some of it would be -- I would have to go back and look at what the reports were, what the nature of the reports were, what the investigation was at the time that those investigations took place and kind of what they found and what the disposition of them was.

I don't know, you know, off the top of my head whether or not they were founded, unfounded or what services we put in or did not put in as a result.

COUNCILMAN JONES: So based on the article, they were five calls. They were found unfounded. That's one. And then there's the Bridesburg case where there were a number of calls.

I think -- what was that fatality? He was -- that's the one where he was allegedly held hostage and then escaped and wind up killing his mother and father. I say that and what they have in common is that there were calls made before. That is the part where --

COMMISSIONER HARLEY: Understood.

COUNCILMAN JONES: -- if somebody cries out for help -- maybe we can't do them now, but we need to figure out what we can do better.

COMMISSIONER HARLEY: Absolutely.

COUNCILMAN JONES: To make sure that if there are five calls, you know, and they are found unfounded, we need to change the criteria.

COMMISSIONER HARLEY: I can tell you that some of the things we are looking at

sort of from a -- I understand what you're saying now in terms of a theme. It is important the prior history.

We certainly took some lessons learned from those particular cases as well as other cases. We have a robust Act 33 team, which is the legislation that requires every death to be looked at. And there's a multi-disciplinary team. Our is Chaired by the medical examiner. On that team is the First Deputy District Attorney Ed McCann as well as the Police Special Victims Unit, representatives from CHOP, St. Christopher's, Behavioral Health, the State.

All of the entities that would be -- need to be involve. And so, they do a very careful job of looking through the evidence and making recommendations. We track those recommendations over time to make sure they are not hollow and are actually implemented. We certainly talked about the very area you are talking about, the need to do additional stuff.

We are doing some additional stuff at DHS in terms of trying to -- it's a little difficult to try and quantify what is the right number, but trying to put some flags in place in terms of when you see X-number of reports come in on a family within X-amount of time, do you take a look at it differently. And that puts some red flags in the computer system, some other things. Certainly, though, the prior history is really important and trying to make sure that we get that across the staff, the importance of reviewing that prior history. It kind of might tell you a story in terms of what's going on. And so, some of it also depends on how long ago the reports were.

I do think we are doing a lot of things much better than many years ago when some of these reports were called in. And certainly, our investigation staff is pretty experienced and sophisticated and some of these we handle very difficultly.

For example, one of the changes we made in recent years were our fatalities and near

fatalities when they come in are investigated by, we call it MDT, our Multi-Disciplinary Team Unit. It tends to be your very experienced investigators who handle these cases in a different way. We didn't always do it that way. We always changed some other things that was in existence in our intake.

For example, used to be if a case came in and then within 60 days another report came in on the same family, it went back to the same worker to do the investigation. Well, I took that requirement away because sometimes a fresh set of eyes may get you a different, you know, set of circumstances. So, we are trying to look at all of those components that would help to make sure that we try and weed in that prior history piece.

COUNCILMAN JONES: So, I don't want you chasing frivolous cases because sometimes one motivation or another, a neighbor calls on somebody that they don't like; an ex calls on somebody that didn't get custody. I don't want you chasing, you know,

windmills and things like that. But when five calls come in, red light, yellow light, green light kind of system that says that maybe there is -- if there is smoke, there has to be fire. And we need to figure out what that is because, no, you're not going to play perfect percentages there. But we have to -- we have to up the percentages. And it needs to be a tipping point that, wow, after the third call, we need to send in that multi-disciplinary team to take a real forensic look.

I am going to hold the rest of my questions.

COUNCIL PRESIDENT CLARKE: You were the only round until just now.

Chair recognizes Councilwoman Quinones-Sanchez.

COUNCILWOMAN QUINONES-SANCHEZ: Thank you. Thank you, Commissioner.

Want to first say I know that transitioning in with all of these CUAs has been quite difficult and quite challenging. And I'm glad that as a result of the

hearings and other stuff, there's more increased communication. So, part of what the challenge was, was CUAs doing all the services, the prevention services.

If you had to articulate what your -- this budget calls for moving forward around prevention and groups like the stakeholders groups that you funded, how would you articulate what DHS' prevention strategy for the new year is going to be?

COMMISSIONER HARLEY: So, we have not moved. The bulk of the prevention stuff at DHS is still remaining with DHS. We have not moved it to the CUA. And I don't foresee we're going to move it within this fiscal year, FY16. I think the bulk of the prevention will probably stay at DHS. All the truancy contracts that still -- that comes under the prevention are maintained at DHS.

What we call the family empowerment service, which is another in-home service that is provided in those cases where there has not been an identified safety threat,

but family might be right on the cusp. You see that they need help. Those will remain at DHS. Our parenting programs for right now are still at DHS.

So the bulk of our prevention, if I was looking at the prevention landscape, will remain at DHS and remain with the other providers who have been providing those services.

COUNCILWOMAN QUINONES-SANCHEZ: And what is going to be the decision moving forward around the stakeholders groups?

COMMISSIONER HARLEY: I'm not sure I understand your question about the stakeholders.

COUNCILWOMAN QUINONES-SANCHEZ: The community stakeholders groups that we have. I have Kensington stakeholders, Hunting Park stakeholder groups that are funded through DHS. What is the thinking moving forward? Because at one point it was a discussion that the CUAs were going to manage it and then they weren't going to manage it. So, where are we with that?

COMMISSIONER HARLEY: I'm hoping I understand your question right, Councilwoman. If we are talking about, for example, the SCOP. We do a number of -- we call them SCOP, which are basically contracts with smaller providers in the communities that tend to be community groups. Those are staying with DHS. I'm not sure if you're talking about EPIC Stakeholder groups, which were community based.

COUNCILWOMAN QUINONES-SANCHEZ: EPIC Stakeholders.

COMMISSIONER HARLEY: Those will most likely be phased out if they have not already been phased out eventually. We have been -- those are going to be taken over by the community umbrella agencies. Some of which have already taken place. Some of the community umbrella agencies have worked very well with the group.

And then the EPIC groups in their CUA catchment area, some better than others. Some have hired some of the EPIC staff to be

part of their community engagement staff. But the CUAs are required to do community engagement. And they are all required to have a community advisory board and to have a member of that community advisory board that serves on the board of the community umbrella agency.

COUNCILWOMAN QUINONES-SANCHEZ: So, it's going to be up to the CUA to determine whether they want to continue to contract with the agency that's providing the services or they want to bring it in house? Again, I am just doing the issue of folks wanting to bring everything in house.

COMMISSIONER HARLEY: It is not up to the CUA. Pretty much the decision was made at DHS that the EPIC groups will be phased out over time because it is part of what the CUA is required to do and part of the IOC plan or the CUA model, if you will, that they do community engagements. It would have been a duplicity of services to continue to have the EPIC group in some fashion do that under a paid contract.

But we have been trying to make sure that we try and work together because you don't want to lose the traction that those groups were able to develop in the communities. And so for some of the CUAs that have been working closely with those groups. It has been transitioning pretty well. We are trying to the extent we can help facilitate those transitions, as well.

COUNCILWOMAN QUINONES-SANCHEZ: Okay. So three months, six months from now, if the same type of community outreach is not happening, who is going to be monitoring that?

COMMISSIONER HARLEY: So, we monitor community engagement. There is a community engagement group. We have a IOC Steering Committee that is sort of the stakeholders from around the City and various areas that are part of that. One of the subgroups under the IOC Steering Committee is community engagement. They would definitely be looking at it and trying to develop where it's working, where it's not, what's better

plans, how do we do it.

But in addition, it is something that we are very cognizant of on a -- at DHS. And certainly, we will also be monitoring where it's taking place and not taking place.

COUNCILWOMAN QUINONES-SANCHEZ: In some communities, you know, I will take for instance my Frankford community, it's very diverse. It's really been hard to build up the level of confidence to bring certain people around the table. I want to make sure we don't lose that kind of in this transition because there are a lot of partners, a lot of grass roots partners at the table. And we want to make sure that they stay engaged at that level.

I want to be able to come back here in three months and say what's the plan. So, I should be able to go to my CUA folks and say what's your community outreach engagement plan.

COMMISSIONER HARLEY: Yes. And one of the things I'm also doing, my communications director is working with the sort of

community engagement people. And we are actually working on developing or revising. There were plans already, but also revising and maybe developing some new community engagement plans and structures.

I have to take a little bit more robust look at it myself to be honest with you. Sort of was focusing on some other things as I came in. But I will be beginning to go to some of the community advisory board meetings so that I can meet the board, so that I can see them and see what's going on.

And we're also -- Kim is my implementation officer who takes a real interest in that kind of stuff. She also does and attends as well as my deputies and some others, some community meetings and some other stuff so we can try and help bridge that gap and to try and make sure that it's actually taking place.

COUNCILWOMAN QUINONES-SANCHEZ: Okay. There's a group -- and I had asked about the group before, but we are getting ready to do a major renovation. And it will impact.

You have Little Red Boxing Gym at $50,000 at Rivera Recreation Center. They are never there. I don't know what their schedule is. I don't know who they report to. I don't know who participates. We are going to do a major renovation at that facility, so I would like to see whatever they are supposed to do for that $50,000 and who they are supposed to serve.

COMMISSIONER HARLEY: Absolutely.

COUNCILWOMAN QUINONES-SANCHEZ: Because we may need to move them around as we renovate that facility. They are never there, so I don't --

COMMISSIONER HARLEY: And I will take a look at that, too. I need to take a look at the prevention contract myself to see exactly what the contract entails. And we will definitely get back to you. All I know is that it is a boxing --

COUNCILWOMAN QUINONES-SANCHEZ: It's a boxing gym. We have been going there a lot because we are getting ready to gut the place out.

COMMISSIONER HARLEY: Understood.

COUNCILWOMAN QUINONES-SANCHEZ: They are never there, so I want to make sure. So, one of the things that Council President's been talking about is this kind of co-locating similar to what we did with the SUV unit. How are we doing around trying to get local placements for, you know, programs like the Bridge?

How are we doing in terms of planning so that we are not sending kids when we have to place them so far away from their homes?

COMMISSIONER HARLEY: So, we are definitely continuing to plan in that area. And that's one of the outcomes that we are measuring for improving outcomes to make sure that -- we try to keep kids as close to home as possible. We know that that's the best for them as well as their families. It helps with reunification in terms of proximity from visits and other things. We continue to monitor that.

We do regularly monitor how many kids are place out of their homes and how far

from their homes in terms of how many miles is a kid placed from their home. And I believe for those kids who are not in a kin placement, meaning with family, about 52 percent of them are placed within five miles of the home that they originally came from. So, we are beginning to monitor that. That is one of the progresses of IOC that we have seen that we allow kin homes to -- we wave that requirement because we know that it's more important to put a kid with a family member than in the proximity of the community. Even if family member lives further, we will still let them reside with the family.

COUNCILWOMAN QUINONES-SANCHEZ: Have we talked to any of our partners? I have two or three close school facilities in the district. Have we begun to talk to some providers to see if we can build some more slots within the City grounds?

COMMISSIONER HARLEY: Well, we're always having conversations with providers. I think some of it is about what is the

service needs that we need and what is the continuum of services. So, really try to look at the array of services that we have in terms of where the need is.

Truthfully, our service need for some of those kinds of slots that you were referring to would be considered more group home or institution. We are actually shrinking the system in that way because we are trying to get more kids in family-like settings. So, we are trying to have more kids in foster care or in kinship care if they cannot remain in the home because we believe that they do better and certainly better for them overall to be with a family.

I don't know that we've actually started full fledge negotiations with some. I have talked to some and there are some facilities who are close by who have expanded a little bit that are either within the City arena or whatever. We are really trying to shrink.

COUNCILWOMAN QUINONES-SANCHEZ: Yeah. There is a group. I was dealing with a young woman who, unfortunately, had been

raped at home. She was fostered out. So, she was 19 years old. You know, Covenant House does such a great work, job on Kensington Avenue in terms of providing kind of studio, very affordable housing.

Are we looking to do any more of that? I just find that there's a group of kids who are like not home and are -- they are technically homeless because they end up living with different people. I'm just wondering if there is a model as we talk about housing moving forward, if there's a model. As much as I hate these 450-foot square apartments, I just feel like that's a request we get all the time that we are unable to meet.

COMMISSIONER HARLEY: We are very conscious of the need for housing. It's a huge need for our families in terms of parents often. But in particular, that population of kids that you're talking about, I would say that 18 to 21 year olds for us that definitely need housing.

We do have a number of housing programs

that we are working on and trying to enhance. We actually started, which was a model one. I don't believe there are any others in the country. I program with PHA where they gave us, we call them quads, where there are, like, four apartments in one building they gave us. Three of our kids reside in all of them. Then the fourth quad, they put a disabled person and kind of pay or develop a job that our kid helps to do some things in the common areas or for that person.

That model has worked well. We actually have some meetings coming up to talk about expansion of that model with PHA. We are also looking at some other things with PHA around some scattered sites. It goes to that particular population that you are referring to, that 18 to 21 year old. Yes, we are trying to expand.

COUNCILWOMAN QUINONES-SANCHEZ: It would be important, and I will mention this to you. I have about 200 folks who are over-house or what PHA consider over-housed.

They are in big homes that, you know, at one point, you know, there were more people living in the house. And PHA has to over the next couple of years transition those folks out.

For me, the thought of having someone who has lived in a house for 47 years and remove that senior from that house, that model that you talked about might be one where we can keep some of those seniors particularly scattered sites. In my case, I have a lot of Latinos who are in scattered sites -- well, not a lot because PHA's numbers is, like, 2 percent. In those situations, I like to entertain that kind of kinmanship relationship where maybe that's a place where we can put some of these fostered-out overaged kids with a senior in a home but keep that senior in their home.

COMMISSIONER HARLEY: Right.

COUNCILWOMAN QUINONES-SANCHEZ: Just to introduce that to you. That is something I am very concerned about. Because neighborhoods where I live in Norris Square

where I live, I have 40, 50 people that are going to be impacted in this, what they are calling, over-housed situation.

COMMISSIONER HARLEY: Yes. Understood.

COUNCILWOMAN QUINONES-SANCHEZ: Okay. Thank you.

COUNCIL PRESIDENT CLARKE: Thank you, Councilwoman.

Chair recognizes Councilman Jones.

COUNCILMAN JONES: He said Jones? I thought he said Johnson. All right. Thank you, sir.

Couple of quick questions.

Number one, on special ed programs in the school that you're administering and you're trying to come up with a truancy plan, are you taking into account school refusal versus school truancy? Because that is a subtle difference by way of some young people who feel bullied or intimidated because of their special needs just aren't going to school. That kind of counts against their attendance record.

Are you making a delineation between

those two different things?

COMMISSIONER HARLEY: I don't know about delineation in terms of the numbers, but very cognizant of the issues that -- my rate of issues, why kids are saying that they're not going to school. Often safety and bullying is one of them. That's why we were trying to work and redesign the model so that we work so closely with the School District so that they're staff is at the table. The climate in the school would be something that they control as opposed to us. Our truancy providers are very aware of that and will try to assist the family in working through those issues and try to determine how we can find out what's best for that particular child.

And then our education support center is there at the table to help make sure we have the child in the best school. Or if for some reason it needs to be navigated that the child is moved or something, that they help navigate through the School District sort of red tape, so to speak, to make sure

we get them where the are. They are working on those kind of what are the underlying issues contributing to the truancy.

COUNCILMAN JONES: In a case where a kid, a child or a parent, identifies the fact that their child doesn't feel comfortable and they feel intimidated and/or bullied, do you make an adjustment -- work with the School District to move them?

COMMISSIONER HARLEY: Well, we would work with the School District to see what goes on. In terms of whether or not it's truancy, if the child is not going to school, they are still counted as not going to school. If their unexcused absences, it might still be counted that way. But we would be willing, yes, to work with the family and assist them in working with the School District to try and come up with a resolution to that problem.

COUNCILMAN JONES: That was brought to my attention by a parent, so I just wanted to put that in your hands.

Last year -- we have asked this question

before and it's an uncomfortable question for me, but I'm going to ask it anyway.

How many children have registered abuse cases while in custody of foster parents last year?

COMMISSIONER HARLEY: I will try to find that answer for you.

COUNCILMAN JONES: And has it gone down from fol -- from previous years?

COMMISSIONER HARLEY: In Fiscal Year 14, 13 children were abused while in DHS care. That's approximately about 3.6 percent of all of the reports that we get of kids in care. And it actually has gone down. Because in FY13, 14 kids was abused. That was 4.5 percent of all reports. The reason the percentage is lower is we have more kids in care. Even though we have more kids in care, it went down a little bit in terms of the number of kids who were abused while in care.

COUNCILMAN JONES: So in those cases, what have -- are the -- what has been the disposition of those cases? Meaning, was it

founded? Unfounded? Prosecuted? Not prosecuted?

What was the disposition?

COMMISSIONER HARLEY: So the 13 I'm giving your were all cases either founded or indicated. Because what happens is if an allegation is made that a kid is being injured while they're in care, then the State does the investigation. And then the State makes a determination as to whether they are going to found or indicate. So, those 13 kids were indicated or found. I cannot tell you whether or not the perpetrators were -- law enforcement proceeded against the perpetrators. That, I don't have with me.

COUNCILMAN JONES: So in a case where there's an allegation, is the foster provider, foster care provider immediately taken out of the system so that, you know, no other child will wind up in that similar circumstance?

COMMISSIONER HARLEY: So what happens is the State is actually the one, Pennsylvania

Department of Human Services, who licenses foster homes and facilities. We don't do the licensing.

However, if I find out that there's an allegation against a foster parent, we do obviously and immediately remove all children who are in their care that aer foster children for us. I don't have the ability to shut a home down, meaning they can never get kids. But I do have the ability to control which Philadelphia kids go. And what we do is we flag it in our system so that we don't send any other Philadelphia kids once we get the notice from the State.

COUNCILMAN JONES: Share that information with other providers?

COMMISSIONER HARLEY: Once we flag it in our system, there's something like a provider code. So, the home can't get a code. It can't operate if it does not have a code in it.

COUNCILMAN JONES: What I'm -- maybe I didn't say it right. I understand you cease

and desist placing kids there. Do you share that with other agencies that may have different sources of young people?

COMMISSIONER HARLEY: I'm not -- we don't go to other counties, for example, and share it. But certainly, if we don't place -- one of our providers can't place a kid there if we already closed the home to that.

COUNCILMAN JONES: There is no reciprocity.

So for example, suppose somebody outside of your system uses the same foster care people and they have a allegation. Do they let you know that there might be an open investigation in that facility or site?

COMMISSIONER HARLEY: There is registry, a foster parent registry that they would go on that is maintained by the State that they would put on. And all of us in whatever county across the state would have access to it, would be able to look at it. There is a registry that is maintained.

COUNCILMAN JONES: Okay. And in cases

of alleged abuse, are -- I think there was an article that talked about allowing them to use pseudo names because they didn't -- a lot of kids feel the stigma, oh, I was abused, I was attacked or I was bothered. Are they given anonymity so they don't wind up ostracized or picked on or any of those things?

COMMISSIONER HARLEY: I don't know anything about allowing kids to use pseudo names. However, certainly whenever a investigation is conducted, the child is talked to privately as part of the investigation. And when we remove a child, we would remove a child. Often where they are moved to, depending upon what's going on, may not have any information as to what happened before.

I don't know of too many instance where a child has been abused that it follows them or it becomes, you know, another problem or pattern for them. Because everything is done confidentially surrounding the investigation into the initial home.

COUNCILMAN JONES: Finally, by way of selection of foster care parents' homes, I know it's difficult to recruit good foster care parents. How are we doing in that particular area by way of service providing for children?

COMMISSIONER HARLEY: So, it is very difficult to recruit good foster care homes. We call them resource homes sometimes. We are trying very hard to recruit more resource homes. We are beginning to do some work and trying to do some work within, say, the faith-based community hoping that maybe we can recruit some homes because other jurisdiction have had success recruiting out of that, out of the faith-based community or congregations of various type.

It is difficult. It is also difficult to make sure that you have the children in the right home when you put them in the home. And so, we are doing okay. But we have a lot more work to do in terms of needing to develop foster care and resources.

COUNCILMAN JONES: I don't know what we can do as a legislative body budget appropriating body. But whatever we can do to help you up the level of recruitment and then quality, please let us know. Because the outcomes are real clear that when you get it right, you can save a life. When you get it wrong, you set them on a track of problems throughout their life. We are watching -- which leads me to my final, final point.

How are we doing with those that age out of the system? And are we improving on those outcomes as opposed to the past?

COMMISSIONER HARLEY: So, kids who age out of the system continue to be a challenge in making sure that when they age out, they get the services that they need. It happens to be an area that I'm very interested in. And we are trying to do better in a number of ways. I think in some ways we are doing better and some ways we still have a long way to go, quite honestly.

We are trying to improve our IL

services, which are independent living services, to try and make them be able to be self sufficient when they leave. We have made a lot of progress with our Achieving Independence Center. Now we are housed at Broad and Master in the Old Leon Sullivan building. It's sort of the one-stop shop for independent living services for our kids. It's kind of a model.

And they have everything there from assisting them with tutoring or issues that they may be having academically or school, to helping them to fill out college applications, financial aid applications, employment applications. They do employment readiness with them. They do mock interviews. We have a little boutique where they can go and get clothes so they have appropriate clothing for job interviews, things of that nature.

But they also teach them basic, what some people would consider, basic skills. What might not be as basically taught for our kids, things such as budgeting and

planning and how to balance a checkbook and banking and, you know, just other skill-building type of things. We are trying to work on that. Very difficult.

Philadelphia, of many of the counties across the state, we actually have a large number of kids who are age 18 to 21 because we believe in trying to help our kids as long as we can help them and help them to transition out. We have been doing that for a long time. We actually try to put as many services in place as we can for our kids that are 18 to 21.

I talked a little bit earlier in response to Councilwoman Sanchez' question in terms of us having a concern about that population and the housing need also. Within that population are kids who age out. Sort of creative model programs we are trying to work out with PHA and others to try and assist them with housing needs and other needs that they have.

We also do, in response to law, Act 91 came out which is a reentry program. What

we find is sometimes you have a young person, they turn 18 and they say, I want out of the system. Because legally they are an adult, although I might not think they are ready to go out there on our own like most of our kids who are not ready at 18 to go out into the world on their own. Sometimes they want to and they do, and then they realize they made a mistake. And so, years ago it was nothing I could do. If you left at 18, we cannot use our money or anything else to bring you back.

But recent law changes allow us now. They can apply for reentry into the system. We can bring them back in up until age 21 to help them get whatever the services are that they need. It allows us to be able to help them connect with everything from, you know, they need housing or their behavioral health services or whatever else that they need.

Also under the Obama legislation, we've been trying to help them connect and know that they can still get medical benefits up until age 26. And so, just getting that

word out there and trying to help them navigate the services that are available to them.

COUNCILMAN JONES: I see you have Former Mayor Wilson Goode with you. And, you know, you brought your big gun today. And I understand he deals with issues related to families that are incarcerated and provided. Could you talk about that for a moment. And I'm really, really proud that he's still giving of himself to public service in that regard.

COMMISSIONER HARLEY: So, Mayor Goode's Program, obviously, he would be able to talk about it much better than this. I do know that it is a program that provides mentoring. It's a model mentoring program for incarcerated people. Mentoring is something that we are trying to work on and develop more. We need it for our older youth and we are in need of mentors.

If you know of anybody who is willing, have them contact us. We are definitely in need of mentors for our teenage kids in

particular. They are developing mentoring programs at our Achieving Independence Center. We are now embarking on what's called sort of natural mentoring. Which means we have our kids sometimes identify who they might want to mentor them.

Sometimes they now found a teacher or coach or somebody else who wants to mentor them. One of the things we have done, though, in recent years is try and increase our outreach to incarcerated parents. Because while they are incarcerated, they still have a right to see their children, still have a right to participate in the planning for their children in DHS care.

And so, we now started doing some video conferencing with them. We now have, you know, some equipment at the department in the room where they can be involved sometimes in the team meeting that might be taking place through conferencing. We've some visitation through that. Also, we tried to emphasize more and have done much better with our workers in terms of working

around taking kids to visit their parents and trying to -- we've done, I call it commercial. I think they called it infomercial -- that runs at the prisons at the City of Philadelphia prisons, which tells incarcerated people what their rights are kind of but also what their obligations are. Because the clock doesn't stop ticking on you because you're incarcerated because of what you are supposed to do on behalf of your child. We have that running in English and Spanish, which runs throughout on the -- in the common areas of the prison and on the TVs there that gives them other information.

And we've also in recent years sort of expanded working with prison social workers around trying to make sure that certain programs are offered or that the parents who are incarcerated have access to those programs, as well.

COUNCILMAN JONES: Mr. President, I just -- it's incredible to me that sometimes we have generational attendance in some of our prison facilities where father and a son

and a grandfather all in the same institution. So, this is God's work working to prevent some of those negative outcomes and provide those services. Because it is a victim, but there are other victims by the actual perpetrators. Because if he has children, that's a household that doesn't have a father, a mother and another parent to be a helping hand to help with homework and stuff like that. So, there are number of victims once something happens like that.

Thank you for what you're doing.

COMMISSIONER HARLEY: You're welcome.

COUNCIL PRESIDENT CLARKE: Thank you, Councilman.

Chair recognizes Councilwoman Quinones-Sanchez.

COUNCILWOMAN QUINONES-SANCHEZ: I have just one last question.

We -- one of the things I had asked Dr. Evans that I'm going to ask for your department is if you can map out by district what are your service providers both on the prevention and then the CUA. One of the

things we have to get a hold of, and I wasn't here for the Health Department, is for people in the community, service is service. I think it's important for us to get a good visual of what kind of services we have in every single neighborhood. And now that you have the CUAs that have given you a foothold in the community, I would like to see what all of those things like look.

I notice you have a robust list of prevention services and other things, I think that would be beneficial. If you can forward that with like phone numbers and contacts, sometimes we get tons of calls from some of these agencies. I just want to be clear, like, what is your role. It's easy for you to give us constituent services. Sort of like where are you located in all of this and how we can be more proactively helpful, so that would be helpful if you can forward that.

And I have a question. You know, we are starting this police oversight. We see

what's going on in Baltimore, clearly the scenes are graphic. The mother hitting her son.

If we were to be in a similar situation, what would be DHS protocols in helping us? I would hate to see -- I know you have some really good model programs about first offenders. What could we be doing or what could DHS be doing to help us? You know, you see these scenes, kids beating up kids underneath SEPTA.

How many of those kids are in your system, and what else could we be doing?

COMMISSIONER HARLEY: I don't know exactly how many of the kids you are referring to are in our system. I do have my deputy sitting out here for Timene Farlow for Juvenile Justice who probably can answer some of these questions a little bit better than I could and is very committed to trying to come up with diversionary programs and programs that will decrease recidivism for those kids who do come into our system, so that hopefully we help them successfully

reintegrate back into their communities and we no longer need to come back in.

I think we do have the school diversion program that we sort of support with the Police Department, which is I think the program that you might have been referring to. Where at this point over 400 kids have been diverted that are first-time offenders. We are excited about that program because that's 400 kids that would have been incarcerated somewhere or in our detention center. Many of them were DHS children on the dependent side. Okay. So, it gave them the opportunity to have another children for sometimes what is seemingly a small infraction and then you put a kid on that trajectory and that's the road that they sort of go on.

Definitely looking at that. We have a delinquency leadership meeting coming up, which are the stakeholders in the delinquency around the City. The DAs, the Police, ourselves and Family Court, being housed at Family Court soon so we can talk

about kind of where we are. Actually, our numbers are going down in terms of number of arrests our City for youth have gone down some to the extent that some of our facilities are experiencing shrinking in terms of placing there.

There are a number of -- we have evening reporting centers. There are number of other centers that we are trying to use. And that has been going so well. That is sort of pre-adjudication that we are now trying to --

COUNCILWOMAN QUINONES-SANCHEZ: I saw the reporting centers. Again, where are they located? Kind of how do they work?

COMMISSIONER HARLEY: I'm going to ask Timene if she can come up. She probably can provide these answers a little bit better than I can.

COUNCILWOMAN QUINONES-SANCHEZ: I don't know if that was kind of taking place for our truancy centers that we had, our evening centers.

DEPUTY COMMISSIONER FARLOW: Good

afternoon.

COUNCILWOMAN QUINONES-SANCHEZ: It's evolution of our centers.

DEPUTY COMMISSIONER FARLOW: Good afternoon. I'm Timene Farlow. I'm Deputy Commissioner for Juvenile Justice Services. There are two evening reporting centers. One of which is run by Northeast Treatment Centers located at about 2nd and Berks. And the other is Philadelphia Youth Advocacy Programs. That is --

COUNCILWOMAN QUINONES-SANCHEZ: That's a perfect example. I live around the corner. I talked to -- I didn't know that was considered one of the drop off centers. That is right around the corner from my house.

DEPUTY COMMISSIONER FARLOW: Okay.

COUNCILWOMAN QUINONES-SANCHEZ: I didn't know that.

DEPUTY COMMISSIONER FARLOW: Well, the evening reporting centers are actually alternatives to secure confinement. They are not for your run-of-the-mill young

person. It is really a diversion, an opportunity for a young person to experience being at home with his own -- his or her own family instead of being locked in a secure facility. Both of those programs are --

COUNCILWOMAN QUINONES-SANCHEZ: Who takes the kid there? An incident happens --

DEPUTY COMMISSIONER FARLOW: So, it's at judicial discretion. The judges make the decisions as to which young people will get that as an opportunity and which won't. So, judges make those decisions based on a number of risk factors. They are using now the Detective Risk Assessment Instrument. And provided a young person scores within a range that suggests that he or she can be safely managed in the community without creating new victims, then the child is referred.

COUNCILWOMAN QUINONES-SANCHEZ: Okay. Thank you. And one last thing.

One of the things that came out at the last hearing was the issue of when CUA members and folks have to go to court. And

we heard some complaints for more advocates in the court system. Has that process gotten better in terms of training staff to be able to go in front of the Court and be prepared?

In our hearings last time, that was one of the items that came up. Have we improved that?

COMMISSIONER HARLEY: I'm sorry, Councilwoman. I think I missed the beginning. You're asking me about CUA performance in court?

COUNCILWOMAN QUINONES-SANCHEZ: Yeah. She mentioned the court in terms of court ordered stuff. One of the complaints or the criticism we got was that some staff is unprepared to go into court with some of the children. And so, she's saying about a referral.

Have we strengthened that? What have we done since the last hearing around the communication?

COMMISSIONER HARLEY: So, what we have done since the last hearing around that is a

number of things to try and help to improve the quality of preparation and the quality of performance before the courts with the community umbrella agency staff.

One of the things that we have done since the last hearing is we have developed a Department of Technical Assistance, which comes under my DHS university which is typically our training arm that provides coaching and other things for the CUA and CUA staff. They have started doing what we call DRO, which means Disposition or Review Order. In other words, court-ordered clinics.

Which means that CUA staff can come, bring a court order that they have. They can help explain that court order, help them understand if there's some language on there or other things that they don't know how to navigate or what the judge wants, what the time requirements are. So, we put that in place. There has been some work done with our law department has been going out to different CUAs, talking to them, trying to

develop some things in terms of training and other things.

So, we are also developing some booster trainings, if you will, around how to prepare for court. I have personally, along with Kimberly Ali, been going out and meeting with the line level staff in each of the CUAs. I've been to eight so far. I think I have two more coming up.

One of the things that I found as I'm talking to staff and trying to see, is we do ask the staff to do a lot. Sometimes it's about how do you prioritize. I talk to them a little bit about the prioritization of what it is we ask them to do. Also, I talk to them about court preparation and having, you know, practice in family court. You know, kind of what it is the judges are looking for. How you, you know, address that.

I do think that court performance is getting better. I have regular meetings with Family Court Administration. And we do talk about some of these things. We are

also beginning to track different things. In terms of, I have a DHS court representative, we call them, in each courtroom. They are also there in trying to assist and help bring some closure. We have some of those DHS representatives sit in our law department and sort of facilitate getting information between the City solicitors and the dependents.

And then I've also done some going to some staff meetings and talking to our lawyers around, you know, how they can be useful in prepping and helping particularly staff who may not be as useful in going to court as much.

MS. ALI: In addition to the stuff that the department has done to help the CUAs enhance their preparation, presentation at court, we also talk to CUA leadership and their administrators. Their case management directors on up will actually go to court every other month so they can observe the presentation of their staff so that they can also provide constructive feedback to the

staff to help enhance their preparation and their presentation at court.

So, we look at a two-prong process. Both the department helping to enhance as well as CUA leadership helping to enhance the practice at court, as well.

COUNCILWOMAN QUINONES-SANCHEZ: That's so important. Because that interaction with the courts and whether this child ends up in a situation that, you know, potentially could be permanently damaging to their record versus diverting them because we know the problems.

I had an opportunity to visit a couple of centers. And I will tell the story because it's really, really telling. At one of the centers, you know, you have a child who gets in trouble in school. If people don't ask the right questions, this child ends up in the situation within our judicial system when they could have had a death or you know, the trauma situation that we have seen.

So, that is important about what

happened in what context, what was going on in the child's life to make sure that whatever the decisions happen in the court are in the best interest of the child not only short term but long term.

Thank you. Thank you very much, Mr. Chair.

COMMISSIONER HARLEY: Thank you.

COUNCIL PRESIDENT CLARKE: Thank you, Councilwoman.

Chair recognizes Councilwoman Blackwell.

COUNCILWOMAN BLACKWELL: Thank you, Mr. President. Thank you, Commissioner. I want to thank your deputy with whom I met at Youth Study Center. And it's such a special place. And they really, really care about the kids there. So, I hope she will maybe privately we can talk about a young lady who is there that we were so worried about.

It's so sad that these children when they're ready to finish school get transferred since they don't stay there. It's a big issue. In fact, I talked to Kevin Dougherty on one of the campaign stops

about that issue of us losing kids who are doing so well in the environment when people care about them. And then about 19 days later, they are sent to the suburbs someplace and they fall down and don't finish school because it's not local. We really have to do something about allowing our children to stay here.

But thank you for your efforts. And really would like to explore that any way you can.

COMMISSIONER HARLEY: So, thank you for recognizing those efforts. We are blessed that we have a very good education program at the Philadelphia Juvenile Justice Services Center, our new name for Youth Study Center. And it is actually a School District principal who is very dedicated and committed to these young people. The educational opportunities there are really, really good.

I do definitely understand what you're saying in terms of some of the kids do well there. I am sure that I or Timene would be

happy to talk to you about this young lady. Timene certainly knows them all much better than I do because she is very into the trajectory for all of these kids. But thank you for recognizing the center and Timene.

COUNCILWOMAN BLACKWELL: Thank you. Thank you, Mr. President.

COUNCIL PRESIDENT CLARKE: Thank you, Councilwoman. Commissioner, thank you so much for your very thoughtful and in-depth testimony and you responses. Most definitely going to have a follow up with you.

I'm not sure have you gotten -- have you had a chance to look at this family-based services?

COMMISSIONER HARLEY: I don't think I have. I think I might be familiar with parts of it. I haven't seen the document.

COUNCIL PRESIDENT CLARKE: I would like to give you a copy of it and ask for you to just kind of look through it and just give us some suggestions. You know, the theme as we go through some of the department's

testimony today, it's clear that there are a number of certain levels of resources that address these concerns and a significant number of cases you all are already doing this, the approach to some degree kind of consolidating some of those services in a particular location.

COMMISSIONER HARLEY: Yes.

COUNCIL PRESIDENT CLARKE: I think we all understand the proximity of services makes a whole lot of sense. And we've been working with a number of stakeholders that had a really great presentation. All the presenters were from outside the City. It gave us a different perspective.

Baltimore, we talked about the Cincinnati model. We really would like to be in a position to follow up with you so you can give us some recommendations and suggestions. The universities are involved. They are excited about possibilities in some of the hospitals. So we really would look for your very, very critical --

COMMISSIONER HARLEY: Absolutely.

COUNCIL PRESIDENT CLARKE: -- solutions to some of these activity that we'd like to embark on. Thank you so much for your testimony.

COMMISSIONER HARLEY: Thank you.

COUNCIL PRESIDENT CLARKE: We will follow up.

COMMISSIONER HARLEY: Thank you all.

COUNCIL PRESIDENT CLARKE: Thank you.

Next up we will have Office of Supportive Housing.

(Witnesses approach witness table.)

- - -

(Councilman Greenlee sitting as Chair.)

COUNCILMAN GREENLEE: Good afternoon, everyone. We have your -- obviously, we have your -- what you sent us already, written testimony. If you could briefly state your position and then we can have some questions.

MS. NAHIKIAN: Good afternoon, Members of the City Council.

COUNCILMAN GREENLEE: Pull the microphone just a little closer. Yeah.

There you go. Thank you.

MS. NAHIKIAN: I am Marie Nahikian. I'm the Director of the Office of Supportive Housing.

How might Philadelphia end homelessness? We know how. On April 10 the Office of Supportive Housing joined in announcing that Philadelphia will end homelessness for our Veterans by November 11, 2015. When that happens, Philadelphia will be the largest city in our nation to accomplish this.

How did it happen? And it's a critical lesson for how we might look at homelessness in the City today. Three critical factors:

Leadership. The efforts for Vets began in 2013 with a commitment from top leaders from our City, from the Federal Government and the local community that provides services.

Collaboration and partnership. There is an unprecedented system designed by multiple parters with one point of entry for persons who are Vets and who are homeless.

And finally, resources. The Federal

Government has provided sufficient types of resources that with effective local stewardship ensures that a Veteran no longer has to be homeless. The mission of the Office of Supportive Housing is to help individuals and families do the same thing, moving toward independent living and self sufficiency and stable housing.

OSH fulfills this mission by incorporating leadership, working closely with national and regional leaders and the many public and private partnerships that support our system. We balance diverse needs capturing as many resources as possible through multiple sub-populations.

For example, we have the federally funded homeless continuum of care where OSH plans the development of new initiatives and is provided over 5,500 units of permanent supportive housing since the beginning of the continuum. The continuum includes over 50 local nonprofit organizations. OSH manages the Riverview Home, where up to a hundred low income persons in needs of

personal care now can reside.

In 2014, OSH provided food for 1.6 million meals served in Philadelphia's soup kitchens and 4.2 million onsite meals and emergency shelter. We provide support to many City agencies including L&I where our trained emergency assistant staff carry out cease and desist orders. OSH provides emergency housing to individuals and families. And since the beginning of FY2014 -- 2015, excuse me, OSH has placed 632 persons in permanent housing and 408 persons in transitional housing. These resources largely coming from the Philadelphia Housing Authority.

The Homeless Prevention Program has assisted over 600 persons in FY2015 preventing evictions, mortgage foreclosures and providing relocation security deposit assistance. I'm pleased to tell you something about the OSH budget request for Fiscal Year 2016.

The proposed FY16 budget is $91 million. It includes an allocation of $45.2 million

in general funds representing 49 percent, and 46.5 percent in grant funds, about 51 percent. The general fund proposed allocations is a bit higher than FY15 currently because of employee salary increases as a result of union contracts. The title FY16 proposed operating budget to OSH is, however, on par with our FY current projections for FY15.

FY16 challenges include a growing demand for emergency housing. Although Philadelphia's nationally recognized for our homeless programs and our homeless prevention programs, the need for affordable housing, the high levels of poverty and unemployment continue to increase the number of the persons at OSH front door. A growing number of low income and poor citizens, many with full-time jobs, 30 percent of our single men are in shelter have jobs.

They turn to the homeless system for affordable housing. On any given day, OSH is operating at full capacity. On average, about 30 families come daily to our

Appletree Family Intake Center. The OSH front door is a safety net for these families. Our No Vacancy signs leaves family with the reality of not being assisted and the painful job for OSH staff who must say no. OSH continues to assist with prevention strategy and seeking resources from family, friends or other relatives whenever it's possible and safe to do so when we have to say no.

In FY16, OSH will join the federal goals of ending chronic homelessness in 2016, family homelessness in 2017. And with any good luck, youth homelessness in 2020.

Since August 2013 through March 2015, the City and partners including the Vets Administration, Public Housing Authority, HUD and nonprofits have ended homelessness for 905 Veterans. OSH wishes -- is planning to extend the Philly Vets team home goal for Vets to all Philadelphia residents so that future homelessness will be rare, brief and non-reoccurring.

We're happy to answer questions. With

me is Rodney Cherry, our fiscal officer; Joy Presson, our -- my Chief of Staff as well our deputies in the various program areas.

COUNCILMAN GREENLEE: Okay. Thank you very much. Thank you for all the work you do. I have just a couple questions regarding the work you do with domestic violence -- domestic violence issue.

First, I know there has been money consistently in the budget last couple years for the second domestic violence shelter. And I wasn't real clear because I know money in the budget is kind of in a lump sum. I believe there should be $2.7 million directed towards women against abuse for that second shelter. Is that part --

MS. NAHIKIAN: 2.5 million. And then they got an additional transfer ordinance for another 200,000.

COUNCILMAN GREENLEE: Okay.

MS. NAHIKIAN: It's a total of 2.7.

COUNCILMAN GREENLEE: It's a total of 2.7. Good. Good. And then you talk about in the written testimony about the issue of

the Citywide coordinated response to domestic violence. Could you just go in a little bit on what exactly OSH does in that effort.

MS. NAHIKIAN: We are participant as are many organizations. I think that are staff participating on a regular basis has provided leadership. And we will continue to participate.

COUNCILMAN GREENLEE: And I think you -- who else is involved in that; do you know?

MS. NAHIKIAN: You mean in terms of OSH or in terms of the City?

COUNCILMAN GREENLEE: Well, both in this case? How about with the City?

MS. NAHIKIAN: Department of Behavioral Health. I know the Deputy Mayor for Health and Opportunity has been involved. I'm trying to think what other. I know DHS has been involved.

COUNCILMAN GREENLEE: Okay.

MS. NAHIKIAN: It's been a pretty broad group from the City.

COUNCILMAN GREENLEE: Okay. All right.

Appreciate that. Thank you.

MS. NAHIKIAN: You know, the largest number of women in our system has been domestically abused. And we keep a full-time person in our intake center that can screen for domestic abuse. We're getting ready to do special training with all of our workers in shelters and our housing facilities to help them more readily spot issues of domestic abuse which are -- sometimes people can't talk about it.

COUNCILMAN GREENLEE: Yeah. They won't talk about it. I know that often. I remember years ago there was a concern with a bill we did to give people some -- victims time off to deal with the issues around domestic violence. And some concern was raised that people would lie about that they were victims of domestic violence. I said, that's not the problem that they lie about that. The problem is they don't tell you when they really are victims.

But again, I appreciate all you do in that effort, too.

Councilman Jones.

COUNCILMAN JONES: I just want to thank you, Mr. Chairman, for all your work in lobbying you and Kenyatta and Councilwoman Blackwell do to deal with domestic violence and also homelessness in general. Thank you guys for what you do. Seven years I've been here, I been able -- my first constituent service case after all of the confetti had fallen to the ground and sworn me in, the people were sitting at the little party we had outside my office. Little family. First case I got was a homeless case. They told me, yeah, party was nice, but we don't have anywhere to go.

I'll never forget that. And I thank you for being responsive. They sent over a team and we got them -- it was almost like a salesman at a store. I wanted to solve my first case. And thanks to you guys, I've been able to do that. So, thank you for what you do.

Let me ask a few questions. How many homeless people are there in the City of

Philadelphia?

MS. NAHIKIAN: There a couple of ways to answer the question. But if you count everybody that is in shelter and everybody that is privately placed in shelter or supportive housing, about 15,000.

COUNCILMAN JONES: 15,000. Of that 15,000, how many then wind up recurring recipients of shelter service, or how many matriculate out into some form of permanent housing?

MS. NAHIKIAN: The majority once they're in the system do move out. The repeats, I don't really have -- I'll have to get back to you on that.

COUNCILMAN JONES: It's an interesting statistic. We are successfully transitioning them into permanent housing, that's one thing. If they are coming back because of circumstances, we need to address it differently.

MS. NAHIKIAN: And we know that happens.

COUNCILMAN JONES: Okay. What I'm intrigued about is some of the foresight

that you had on preventing homelessness. I understand there's a program. And we've used it actually where if you find out someone's in imminent circumstances where they are going to be evicted or things like that, you step up to try to prevent that because it's cheaper to keep them in place then to actually shelter them through the system. Is that close to correct?

MS. NAHIKIAN: That's absolutely --

COUNCILMAN JONES: Can you describe that program, please?

MS. NAHIKIAN: That's absolutely correct. Our Housing Prevention Program can step in when a family is facing eviction. For the most part, it's very low income families. In fact, it's always very low income families.

And the events that trigger eviction are interestingly enough reduction of hours of work. Someone who suddenly gets reduced to 20 hours a week from 40, a family event like needing to provide money for a burial or a catastrophic event. And sometimes we just

have families who spend badly, and they may have not budgeted correctly.

We do step in to prevent them from being evicted with funds generally not more than a thousand dollars per family. And the families generally have to pay down some of their arrears to match that.

In FY15, we have assisted I think 400 -- a total of 689 families to date with either security deposits because they're moving into a new unit, rent to forestall evictions or funds to assist with mortgage to stop a mortgage foreclosure.

COUNCILMAN JONES: Generally, how much money out of your budget goes towards those efforts?

MS. NAHIKIAN: I'm not sure about the exact percentage, but I think the funding -- what's about 3 million percentage of 90 something. It's a small percentage of the budget. And we know -- we know that it's effective.

COUNCILMAN JONES: My point in asking the question is that find out that

percentage and provide it to the Chair. I'm of the opinion that if you do the cost analysis, it's cheaper to keep them. And if we can be penny wise and pound foolish, I think we should appropriate more money towards that end as opposed to catching them on the back end and taking them through the entire system, which is more financially burdensome to the taxpayer. I mean, even my most conservative colleagues would argue and be able to agree, actually, that if we can do a thousand dollars here versus five thousand, ten thousand dollars on the other end makes sense.

And I realize this because at the middle of the year, it's probably a lot of demand for that. And it's gone by the middle of the year. We are winding up spending even more at the tail end.

If you can justify that in a quantitative manner, there might be some support for that. That guy right up there is a soft touch for helping people. Maybe we can convince him and eight others.

MS. NAHIKIAN: We will be glad to provide that information.

COUNCILMAN JONES: Thank you, Mr. Chair.

COUNCILMAN GREENLEE: Thank you, Councilman.

Councilwoman Blackwell.

COUNCILWOMAN BLACKWELL: Thank you. Let me say thank you and thank the whole team whom I have known forever for the great job you are doing. Let me ask you again. Can you repeat those numbers.

We know we're saying we're going to get rid of homeless Vets. When?

MS. NAHIKIAN: November 11, 2015. There about 1,538 identified homeless Vets. We have housed a few over 900. We know where about 400 of the 600 left are because they are in shelter and ready to move into permanent supportive housing. So, we have a little over 200 that we are looking for.

COUNCILWOMAN BLACKWELL: That's great. Give me the other statistics you mentioned for me. 16? 17?

MS. NAHIKIAN: Oh, ending family

homelessness in 20 -- wait a minute. Let me make sure.

COUNCILWOMAN BLACKWELL: I didn't know if I live long enough for this day. I'm writing these statistics down.

MS. NAHIKIAN: The federal goals are to end chronic homelessness in 2017, family homelessness, excuse me, in 2016 -- family homelessness in 2017 and youth homelessness in 2020. I'll be glad to forward some information about those goals.

COUNCILWOMAN BLACKWELL: Thank you. I would appreciate that.

Again, thank you. And thanks to the whole team. All the folks who you worked with over the years. Thank you.

MS. NAHIKIAN: Thank you, Councilwoman.

COUNCILWOMAN BLACKWELL: Thanks.

COUNCILMAN GREENLEE: Thank you, Councilwoman.

Again, thank you for all the work you do. It's obviously very important part of the City.

No further questions, that concludes our

hearing for today. Again, thank you all very much. This Committee will be continued until next Tuesday, May 5, 2015 at 10:00 a.m.

Correction everybody. This Committee will stand in recess until five o'clock today, at which time we will have Public Testimony here in Room 400, City Hall. Thank you.

(Committee of the Whole recessed at 4:00 p.m.)

- - -

(Public Testimony commences at 5:00 p.m.)

COUNCILWOMAN BLACKWELL: Good evening. We thank all of you for coming and we are very, very happy to have you here tonight to testify. This is a continuation of the Public Hearing of the Committee of the Whole.

Public testimony ground rules. We are here this evening to hear from you about the Proposed 2016 Operating and Capital Budgets and where you believe the City should focus it's spending priorities. To ensure that there's an opportunity for all here this

evening to be heard, certain ground rules have been established as follows.

Number one, your testimony should be about the budget and proposed spending priorities. Copies are available on the table where you signed in.

Two, all speakers must sign up in order to testify. If you have not already signed up, please do so now by signing your name on the list at the same table to my left. Your name will be called in the order in which you signed up. You will have up to three minutes to speak. In order to be fair and give the public an opportunity to speak, we intend to hold to the three-minute limit.

Finally, we have a timer that will be set to three minutes. When the timer buzzes, please complete your sentence and allow the next speaker to approach the microphone.

Ms. Lewis, please read the name of our first speaker.

MS. LEWIS: I will call them in groups of three.

COUNCILWOMAN BLACKWELL: Thank you.

MS. LEWIS: Bob Previdi; Waffiyyah Murray and Sarah Stuart.

MR. PREVIDI: Can we have Cindy go in the place of Sarah Stuart?

COUNCILWOMAN BLACKWELL: We can't hear you, Bob.

MR. PREVIDI: Can we have somebody else go in the place of Sarah?

Hi. It's Bob Previdi from the Bicycle Coalition. Sarah Stuart is not able to attend. We'd like to have Principal Cindy join us.

COUNCILWOMAN BLACKWELL: Yes. Just identify yourself for the record before you speak. Thank you.

MR. PREVIDI: Why don't you go ahead.

MS. FARLINO: Good afternoon and thank you for the opportunity to speak. I'm here today to really urge you -- louder?

Oh, my name is Cindy Farlino. I'm the principal of --

COUNCILWOMAN BLACKWELL: Say that again.

MS. FARLINO: Cindy Farlino, Farlino. I

am the principal of Meredith Elementary School in Queen Village. I'm here today to urge you to consider restoring the funding to the Safe Routes Philly. We have been working with Safe Routes Philly since 2012 as a school. We are one of six schools that received a grant to support a biking program. And I just want to tell you from our point of view, it has changed our school in immeasurable ways as I know it has the other five schools.

We have bike to school days once a week. Well over 100 people take place, kindergarten through eighth graders. We are able to do an entire science curriculum that has to do with environmental impact, that has to do with science fair project, energy conservation. And all of that happened because of the grant we got from Safe Philly -- from Safe Routes Philly.

I also want to say that I think because it's really important that our City, and I'm looking at the signs behind you, have a clear sustainability both policy and

problematic approach, that this is very much in keeping with who are the future citizens. Do they decide to ride a bike instead of getting in the car? Do they decide to walk instead of using transportation that would use up energy?

For us and Meredith Elementary School this has been an inspirational journey. The money was incredible. We were able to outfit kids who could not afford a helmets, safety vests, bells on their bikes, all kinds of things that make this an amazing and engaging youth program that I think has changed our schools and the other schools that are involved.

So, I urge you again to restore the cuts in this program. Thank you.

COUNCILWOMAN BLACKWELL: Thank you.

MS. MURRAY: Hello. My name is Waffiyyah Murray, and I coordinate the Safe Routes Philly Program for the Bicycle Coalition for Greater Philadelphia. If you're not familiar, Safe Routes Philly is a program. And we promote walking and biking

as a fun and healthy form of transportation from Philadelphia Elementary Schools. We really promote safety, making sure that students are safe when they're going to and from school.

We are here today because last month we learned that the Health Department zeroed out it's $50,000 contribution to our Safe Routes Philly Program. And that cut would take place in their 2016 budget, which goes into effect July 1. With the elimination of that $50,000, that's half of our Safe Routes Philly budget, which is $100,000. And without that money from the Health Department, we would be unable to continue funding our Safe Routes Philly program. It would have to be eliminated completely.

Just to give you a few things about Safe Routes Philly. Since 2010, we have worked with over 75,000 students in 133 schools. And we have trained over 150 PE teachers on our Safe Routes Philly bike and pedestrian safety curriculum. We worked with schools to provide one-on-one training with teachers

and school officials on our curriculum and other programs.

We have assisted 22 schools with walkability audits. That's where we work with the City and the school to check, identify physical changes that can increase safety for students going to and from schools. We work with schools to create safe routes map so that students know the safest routes to take when going to and from school. We work with schools to implement walking clubs and biking clubs.

We promote district-wide Walk and Bike To School Day. This year we have 15 schools sign up for Walk To School Day in October. And we had nine schools register for Walk to School Day next month. And that's the most that Philadelphia has ever had, so we are really excited about that. And we just work with schools to encourage anything around walking and biking and physical activity.

As we all know, it's important to promote that among students with the rates of obesity and childhood diabetes. It's

important that they get around and are physically active. And it's important that they are being safe when going to and from school and just in their community. So, Safe Routes Philly is a very important program. So, I hope that you guys would consider putting that money back into the budget.

Thank you.

COUNCILWOMAN BLACKWELL: Thank you. Bob.

MR. PREVIDI: Hi. I'm Bob Previdi from the Bicycle Coalition. I'm not going to reiterate the things that were said here, but I just want to focus on a couple of key points.

One is that the program is relatively cheap given the outcomes, impacting 75,000 kids and 133 schools, public schools, throughout the City I think is outstanding. And when you think about that horrible case where the four-year-old in Southwest was run over because she happened to be running between two cars, it's important that we

teach our young people how to walk and bike to school safely.

There was actually a story in -- on the NPR Philly and in New York last year where in just one year, 1,800 students were hit by cars at dropoff and pickup time going to school. We all -- many of us know the chaos that goes on around our public schools. I think it's a good idea that we train the students to be aware about what they need to be doing because clearly some of -- they're not learning it from anywhere.

And this is one of those programs we all know the problems that the School District is under right now. This is one of those programs that if we can pull the money out of transportation budget to help our schools, we can. So, we are looking for you to put the $50,000 back into the Health Department's budget so we can take advantage of the other 50,000 that's provided by NITSA, which is National Safety Program coming out of the Federal Government.

We hope you'll reconsider and get that

money back in. Thank you very much.

COUNCILWOMAN BLACKWELL: Thank you very much. Any questions?

(No questions.)

Thank you. Thank you very much.

MS. LEWIS: The next three speakers: Hans Kersten, Judith Robinson and Jeannine Lisitski. Hans Kersten, Judith Robinson and Jeannine Lisitski.

How about Beth McConnell and Margaret Lukoski?

(Witnesses approach witness table.)

COUNCILWOMAN BLACKWELL: Good evening. Please give us your name for the record and begin your testimony.

MS. LISITSKI: Jeannine Lisitski, Executive Director, Women Against Abuse.

COUNCILWOMAN BLACKWELL: Go ahead.

MS. LISITSKI: Good evening. We appreciate the ongoing support of City Council in addressing issues concerning family violence. As many of you are aware, Women Against Abuse is the largest domestic violence service provider and advocate in

Pennsylvania serving approximately 15,000 individuals each year. And in addition to those we're able to serve, last year we had to turn away 12,000 who were in need of safe shelter due to our 100-bed safe haven operating consistently at full capacity.

Thanks to you, we did open our second safe haven this fiscal year. But given that we will still not be able to serve all the victims of domestic violence that come forward in need of a myriad of services, we are constantly working to intervene earlier in the cycle of violence. Understanding that there is up to a 75 percent overlap between domestic violence and child maltreatment, creating safe family, safe children and safe communities will require us to work collaboratively to address the ways in which domestic violence interacts with all systems.

For over a year, we have been working attentively with the Department of Human Services to infuse domestic violence inform care into their practice in a way that would

be sustainable. DHS has been a supportive and open partner. To that end, we want to emphasize four interventions that we've created in collaboration with DHS that we hope to be able to identify funding for in Fiscal Year 16.

One is continued funding for the Safe Families Legal Project. This provides legal expertise to support DHS through direct intervention with families in their care and consultation for DHS staff.

Second, implementing a comprehensive domestic violence training and evaluation plan for child welfare workers that includes all CUA staff.

Third, preventing teen dating violence among the highest risk population through an expansion of our school-based healthy relationships curriculum to the highest risk children.

And lastly, the largest of these initiatives, implementing our Safe Families Equals Safe Children Project that would expand the capacity of both DHS and the CUAs

to protect children by embedding a part-time domestic violence specialist into each CUA to serve as a resident expert on the intersection between domestic violence and child welfare.

I just want to thank you again for all of your support.

COUNCILWOMAN BLACKWELL: Thank you. We thank you for all the work that you do. Thank you.

MS. ZUKOSKI: Good evening, Members of City Council. My name is Margaret Zukoksi. And I'm the Associate Director of the Pennsylvania Council of Children Youth and Family Services, a statewide provider association that represents private agencies that deliver a vast array of services to Philadelphia's children and youth including prevention services such as out of school time, family intervention services, in-home services to families and an array of foster care services.

Today you heard from Commissioner -- DHS Commissioner Vanessa Garrett Harley much

about Improving Outcomes of Children initiative. I want to follow up on the Commissioner's testimony and talk to you about the providers perspective about the IOC initiative in Philadelphia. I'd also like to take this opportunity to remind everyone that private providers in Philadelphia have been delivering services through DHS contracts for many decades to citizens of Philadelphia.

At this moment, DHS private providers and those we serve are experiencing some very serious challenges. And you heard earlier today from our commissioner that the number of active cases in DHS has exploded over the past two years. Currently, over two years the number of cases -- active cases has risen 46 percent. Two years ago there were approximately 4,000 children in placement. And currently, there are 5,400 children in the foster care system. Simultaneously, the number of children receiving in-home services has grown almost 50 percent.

Why are we seeing these increase in numbers? Well, there are a number of reasons that we can look at right now to see why our numbers going up so dramatically. First of all, as Commissioner Garrett Harley addressed, there were significant changes in Pennsylvania Child Protective Service Law this year. In fact, 27 separate pieces of legislation were interacted. What this did is it changed and expanded the definition of child abuse, the definition of perpetrator and who is required to be a mandated reporter. As a result of these changes, we have seen and I -- Commissioner again spoke to this -- a dramatic increase in the number of reports coming into the DHS hotline.

Additionally, along with the number of reports, when we compare the first two quarters of last fiscal year to this fiscal year, we have seen a 13 percent increase in the spike of cases. That's not the only reason that we are seeing an increase in the number of kids/children in placement. Along with the increase in numbers coming in,

there has been a decrease in the number of children exiting the system.

This is not a new phenomena. Several years now providers, DHS, advocates and the court have been addressing issues of delays in court hearing. This is a result in several years ago there was a effort to increase the number of hearings that each child and family would have in a year. We went from six-month hearings to 90-day hearings. The 90-day hearing along with the increase and the numbers of care have backed up our court system.

I also want to reference that other systems, other jurisdictions around the country have implemented lead case management models like Philadelphia's IOC model. When these are implemented, it's very natural and expected that systems will go through an adjustment period. And we have gone through an adjustment period and we're still going through that adjustment period as the last five CUAs under IOC have been on board for less than a year.

As the number of kids in the system has increased, we know DHS is faced with some very hard choices. How do they meet the needs of all the children in the system? How do they provide mandated services like foster care and non-mandated prevention services? We feel very strongly that we need to keep both levels of service, mandated and non-mandated services, as we move through with this system transformation.

Already we have heard that DHS might be contemplating cutting prevention services this upcoming fiscal year. We saw some out of school time slots cut already. This is a very shortsighted view and we would really strongly advocate against any system changes. And I'm going to finish up.

We have some suggestions from the provider community. We must bring all stakeholders together to address this increase of children in the system. Providers who are delivering services under the IOC system have several recommendations.

First of all, again, do not cut prevention services. They will be the first line of keeping children out of the system.

Secondly, we must reduce IOC CUA case manager case loads. Recently, DHS raised the case loads for the case managers from 10 to 13 families. That's about 30 children now in each case manager's case load. That's double what national recommendations suggest. Fifteen children is recommended by the Child Welfare League of America Council on Accreditation. We also believe that CUAs need to have the opportunity and flexibility to implement some innovative programming such as supporting foster care parents and foster children in the home.

These are not budget neutral recommendations. And at this point in the state funding cycle, we know that the state has already allocated dollars from DHS. It's a complicated funding stream. They're federal dollars, state dollars and you're providing $102 of local match. We are here today to say we hope that the City considers

contributing more dollars to support the IOC and CUA agencies as we go through this period of growth in Philadelphia. This is -- your budget reflects your values. And what is more valuable than the children in our City.

This is a critical juncture. And again, we recommend that we look at how we are allocating dollars in DHS so that more can reach the folks that need the services and that, again, we might have to consider raising the City's share to meet the need.

Thank you very much.

COUNCILWOMAN BLACKWELL: You're welcome.

MS. McCONNELL: Good evening. My name is Beth McConnell, Policy Director at the Philadelphia Association Community Development Corporations, PACDC. Thank you for the opportunity to testify, Councilwoman Blackwell, Councilman Goode, Councilman Neilson.

I am going to submit some longer written testimony, so I will abbreviate. I just want to note some of the materials that I'm

handing out focus on our neighborhood commercial corridor programs, a map of our corridor programs, a map of our neighborhood advisory committee. I'm going to talk about, as well.

In general, PACDC is urging that the City provide a million dollars in new general fund revenue for our commercial corridor programs, but I am going to focus my three minutes on the Store Front Improvement Program tonight as well as the Neighborhood Advisory Committee Program.

SIP, store front improvement program, has been a dramatically powerful tool to transform our neighborhood commercial corridors, but the program is at risk right now. SIP provides grants to small neighborhood-based businesses to fix up their facades. It is leading to an increase in sales revenue that the businesses are seeing as well as leveraging other private investment on our corridors. But the program is in danger.

The Commerce Department was forced to

revise the guidelines in December in order to comply with federal rules that require paying contractors prevailing wage if more than $2,000 in federal funds are involved. And then also submit very complex and time consuming paperwork to provide approved compliance. And since these new guidelines were put in place, applications to SIP have dropped by more than half. In fact, just last -- just two weeks ago, the Tacony CDC had to cancel plans to do 11 store fronts on Torresdale Avenue because the prevailing wage bids were just too high for the businesses to comply with.

Some neighborhood-based contractors are simply declining to even bid on the projects because of the complex paperwork for just a few thousand dollars worth of work. We do believe that contractors should be paid a fair wage for their work. But the federal rules are leading to fewer jobs and are overly burdensome for small projects that are valued at just a few thousand dollars.

The only way to avoid the federal rules

and design a storefront improvement program that works for Philadelphia small businesses is to use a different source of funding. So, we're calling on the Council and Mayor Nutter to put 531,000 in general funds to the SIP program. That would free up federal funds for the Neighborhood Advisory Committee program. So, we're urging that the freed up federal funds go to help strengthen and expand the NAC program that has suffered more than $700,000 in federal cuts just over the last few years.

And in closing, this is a program that is literally helping people save their homes from foreclosures, distributing turkeys on Thanksgiving, helping people find jobs and affordable homes. We really need to bolster that program or restore some of the cuts that have decimated it.

Thank you for the opportunity to testify.

COUNCILWOMAN BLACKWELL: Do we have any questions?

Councilman Goode. I'm sorry, Councilman

Goode.

COUNCILMAN GOODE: Thank you, Madam Chair. Just one question for Ms. McConnell just for clarity of the record. I'm supportive of the request. I just wanted to say for the record that I think the request assumes that we are and will be at least half a million dollars above the mandate that 5 percent of CDBG money go toward CDC development. I don't want to see us fall below that. We are above that, have been above that, I mean, at 5 percent threshold. But I don't want us to get into a pull where on an annual basis where are pulling between economic development needs and housing needs where we set aside at least 5 percent of that money for CDC economic development.

If this assumes that we are at least a half a million dollars above, I'm definitely supportive of the proposal.

MS. McCONNELL: Thank you, Councilman.

COUNCILMAN GOODE: Thank you, Madam Chair.

COUNCILWOMAN BLACKWELL: Thank you very

much. Any other questions?

(No further questions.)

Thank you very much.

MS. LEWIS: The next presenter is Charles Younger, David Fare and Angel Rodriguez. Charles Younger, David Fair and Angel Rodriguez.

Is Kelly Davis here?

MS. DAVIS: Yes.

(Witnesses approach witness table.)

COUNCILWOMAN BLACKWELL: Good evening. Thank you very much. Identify yourself for the record and begin your testimony. It's nice to see you.

MS. DAVIS: Kelly Davis, Executive Director of Lutheran Settlement House.

Hi, Councilmembers. Thank you so much for having me. This is actually my first time testifying in front of the City Council, so I'm excited to be here. I'm the Executive Director of Lutheran Settlement House. We are a multi-services citywide agency.

In Fishtown we run domestic violence

program, which includes medical advocacy in the main hospitals in Philadelphia. And a STAR Program and afterschool program and summer Work Ready Program. We also have an adult literacy program, an urban farm that links our teens with our senior center. And what I'm here to talk about, though, today is our family shelter in West Philadelphia that Councilwoman Blackwell is very familiar with, Jane Adams place.

We need more money. We have not had any increase in our budget since we've opened. That's a little bit of an exaggeration. A few years ago, we had $9,000 more to run our family shelter. What that has meant is that we have had to cut positions. We no longer have a maintenance -- full-time maintenance person. We no longer have an assistant director. We have not really given raises. But any raises that we have had to do, has meant collapsing positions.

We run a shelter for 100 people for 365 days a year on less than $1.1 million, so that's $1.09 million for 25 staff, all of

the food, all of the maintenance, everything. So, it's really not enough. We need some money to meet the $12 an hour. We need about $24,000. We went a couple years ago to 10.88. Please help us.

Our courtyard is closed because of leaks. We're begging for any small amount of money.

Thank you very much.

COUNCILWOMAN BLACKWELL: Thank you. Mr. Fair, good to see you.

MR. FAIR: Good afternoon. My name is David Fair, F-a-i-r. I'm Deputy Chief Executive Officer for Turning Points for Children. I'm delivering this testimony this afternoon on behalf of the seven agencies contracted with the Department of Human Services to provide community umbrella agencies family services as part of the Improving Outcomes for Children initiative.

We testify today in full support of DHS and the IOC initiative and with the request that this Council invest additional City general funds to ensure its success.

This historic advance in the delivery of child welfare services, which is still in its infancy is being watched across the nation. As child welfare across the country seeks to redesign itself to support 21st century families with 21st century solutions. DHS and its leaders are to be commended for its courage in recognizing the limitations of past approaches to protecting an advancing the safety and well being of our most vulnerable children. But DHS has been hampered in maximizing the full potential of the IOC project by a number of factors far beyond its own control.

The Commissioner and the Pennsylvania Council have already shared with you the data on the explosion in new demand for child welfare services. Add to these children the number of children requiring foster care services has jumped at and the number of foster families available to them has stayed relatively constant. Meaning, that we are running out of foster homes in which to place these children.

All of this is happening in a system that receives significantly less funding today than it did ten years ago. DHS is doing the best it can within limited resources. But as a result of this lack of resources, case loads continue to increase endanger the very children we are charged to protect. This lack of resources for child welfare services is a tragedy waiting to happen.

The failure to adequately fund child welfare services has created a crisis similar to that affecting our public education system. But unlike the public schools, the fate of the almost 11,000 children in the child welfare system is not the stuff of front page headlines or mayoral debates.

This is an emergency, one that worsens Philadelphia's ability to protect the thousands of vulnerable children charged to its care. With federal and state agencies failing to do their part, it falls on the City with its own funds to fill the gap. We

strongly encourage you to increase the City's portion of the DHS budget to ensure that these children are safe and their well being is ensured.

Thank you for allowing me to testify.

COUNCILWOMAN BLACKWELL: Thank you.

Mr. Rodriguez.

MR. RODRIGUEZ: Good evening, esteemed Councilmembers. Thank you for having me. My name is Angel Rodriguez, Vice President of Asociacion of Puertorriquenos En Marcha, APM for short. I'm here before you today in support of an allocation of additional $1 million in general funds to support our neighborhood small businesses and commercial corridors and the NAC Program, Neighborhood Assistance Committees. I have submitted written testimony so I will be brief and hit just the high points.

The NAC program is a critical program in terms of redevelopment in our neighborhoods throughout Philadelphia. As many of you may know, the NAC program connects residents to services that will help them stop

foreclosures on their homes, find them -- help them find affordable homes, help them with their heat, address food and security which is a growing concern in Philadelphia and find employment.

It's also an area where Philadelphians are able to understand and involve themselves with what's happening in Philadelphia as it goes with physical development. It's very important as we become a world class city and we have transformative neighborhoods, that we are actually bringing our current residents into that new city and understand what the impact of new development in the City is. That happens throughout the -- with the NAC Program.

Done well, a NAC program is also an opportunity to leverage other resources and funds. Typically, you will see a NAC program funded at about $75,000. In our situation at APM, we've been able to leverage that 75,000 to bring in an additional half million dollars which has

allowed us to do crime prevention programs, lead and healthy home services, energy savings initiative and basic systems repairs and numerous health initiatives.

We ask you today, myself and my colleague Beth McConnell, to actually reallocate an additional million dollars.

Thank you.

COUNCILWOMAN BLACKWELL: Thank you very much. Are there any questions?

Councilman Neilson?

COUNCILMAN NEILSON: Thank you, Madam Chair.

COUNCILWOMAN BLACKWELL: Mr. Rodriguez, thank you for your work with -- in housing and rebuilding. Thank you.

COUNCILMAN NEILSON: The NAC program, can you tell us how many people are on the waiting list right now to get help and assistance in some of the maintenance problems with their homes?

MR. RODRIGUEZ: You mean in terms of basic systems repair?

COUNCILMAN NEILSON: Basic systems

repair.

MR. RODRIGUEZ: Well, I would say that in this past year in conjunction with our NAC coordinator, we've been able to provide 20 houses this year. In terms of basic systems repair, I can tell you that in eastern North Philadelphia, we have about twelve blocks that need more. So, you figure about 16 -- on one side of a block about 16 units.

COUNCILMAN NEILSON: Out on the trail someone told me that what you have projected on your list to do currently, that would take you two and a half years with current funding levels that you have just to try and --

MR. RODRIGUEZ: Just to have an impact, yes, correct.

COUNCILMAN NEILSON: I just wanted to put that on the record because we're not funding enough to stretch that out.

MR. RODRIGUEZ: Clearly not enough. Especially when you look at the impact of what immediate equity means to homeowners

and senior homeowners in Philadelphia where you have basic systems repairs. And immediately, they can weather the storm where taxes go up and you have new development in certain neighborhoods. It actually helps knit the community together and allow us to have mixed-income communities in Philly.

COUNCILMAN NEILSON: Thank you, Madam Chair. I have no further questions. Thank you for your testimony today.

COUNCILWOMAN BLACKWELL: Thank you very much. Any other questions?

(No further questions.)

Thank you very much.

MS. LEWIS: Maurice D. Jenes --

COUNCILWOMAN BLACKWELL: Jones.

MS. LEWIS: Maurice Jones. I'm going to read the names of folks who have signed up that didn't come to the table. Sarah Stuart, Sarah Stuart? Hans Kersten, Hans Kersten? Judith Robinson, Judith Robinson? Charles Younger, Charles Younger?

(Witness approaches witness table.)

COUNCILWOMAN BLACKWELL: Good afternoon, Mr. Jones. Always a pleasure, sir.

MR. JONES: Always a pleasure to see you, Councilwoman.

COUNCILWOMAN BLACKWELL: Thank you.

MR. JONES: I have prepared testimony and materials for Sergeant of the Arms.

COUNCILWOMAN BLACKWELL: Thank you.

MR. JONES: There's one for each Councilmember present.

COUNCILWOMAN BLACKWELL: Thank you.

MR. JONES: I will start off. My name is Maurice Jones. I'm coming from the Henry C. Lea School in West Philadelphia. My testimony is concerning the Safe Routes program.

Starting off, this is a decision that I regret the most of my mayoral service. That was something said by Mayor Nutter. These words were spoken by Mayor Nutter in the beginning of March in his last budget address. He was referring to libraries. In an attempt to reduce spending across the government, he attempted to close 11

libraries based on incomplete information by well meaning members of his administration.

As we come into 2016 with the expectation of internal budget cuts at the Philadelphia Department of Public Health, which will effect safe routes, the words rang true for this program, as well. The fact that $50,000 in cuts will be devastating to programming which will create hardship for those who can least afford it. As we found with the decision to close libraries, there are nuances which are not being looked at in this decision.

This cut in Safe Routes will also cause the loss of matching NHTSA funding. The communities that most need those services have no recourse to replace them. So if you look, there is an attachment on there of the community health improvement plan for 2014 to 2018. And one of the key priorities is increasing physical activity among children and adults.

So although violent crime in the City has gone down over the years, there are

still dangerous and concerns with children traveling to school. In the last few years, 24 schools were closed which created additional travel in some of the communities. Safe Routes was a resource which was geared on making that travel safer. Lea was one of the schools affected by these closings by having the Wilson school merge with it. Children have to travel past extremely busy streets and cross some of the top ten most traveled SEPTA routes. This created a danger for students and increased stress for parents.

Safe Routes is a program whose mission is to lessen the safety issues with children traveling to school. It is also geared towards helping to train them in best practices of walking and riding which in turn directly affects their physical being. And there is a safety report concerning the merger of the two schools that will highlight that.

Considering the fact that 54 percent of children, Philadelphia children, age 6 to 11

are overweight or obese with an outstanding 70 percent in North Philadelphia, this is more than just an issue; but, in fact, a crisis. To take away a program which could directly affect change in those numbers is ill conceived especially considering the nominal costs of this program. As we look at budgets and what is important or not important, we must set priorities.

With the Philadelphia Department of Public Health making children's physical activity one of its priority for the 2014/2018 that is a great start. To cut a program from the budget which could economically facilitate this could be a decision which would be in the future called "the decision I regret the most."

So, I thank you -- I ask for the health and safety of the children of Philadelphia that this funding be restored. And I thank you for allowing me to testify.

COUNCILWOMAN BLACKWELL: Thank you, Mr. Jones. And I thank you for fighting for this since they closed Wilson school. And

any of you who know the area realized that 46 and Woodland where you have to cross Woodland and Chester/Springfield get over to Baltimore. Then after you even get to Baltimore as large as that intersection is, you still got to find your way to Spruce Street. It's absolutely unbelievable.

We thank you for sticking with this. And I don't know how we -- frankly, I don't know how we survived this long because it's just unconscionable that these little children have to go that far.

Thank you. Any questions for Mr. Jones? I will be in touch with you on this again. Thank you, sir.

MS. LEWIS: Pastor Rob Harrison, Stenton -- oh, Pastor Rob Harrison of Stenton and Family Manor.

PASTOR HARRISON: Good evening.

COUNCILWOMAN BLACKWELL: Good evening.

PASTOR HARRISON: I come this afternoon on behalf of the homeless initiative and the homeless family shelters. I also come on behalf of Bishop Ernest Carl Morris who is

CEO of Stenton Family Manor.

Since 1991, Stenton Family Manor has been a part of the homelessness in providing homeless shelter for families within the City of Philadelphia. That has been since 1991. Since that, we have been providing not just for shelters but we have been one of the only homeless family shelters that have been providing shelter for teenagers living with their parents. We also have been providing for homeless fathers who wanted to be a part of their children's family.

So, we have done pretty unique things. The City of Philadelphia has been a great asset to that. However, since 2005, we have been told under the budget that we are to be able to survive with what is called equal funding. No addition. Since that time, we have been able -- we have had and been forced to cut back on our providing shelter, food, transportation for these homeless individuals over 75 families, 250 people, 175 on the average individual children

within the City of Philadelphia.

We have been told that we have to receive cutbacks because of this. I am coming on behalf of Stenton Family Manor and all of the other shelters that you may have heard from today to ask that there be some prohibition that would be allotted for some type of increase for us.

Since 2004, we have had equal funding, level funding and not one dime more. Cost of living has gone up, gas has gone up astronomically but jobs have been decreasing within us. We are basically working on a skeleton, and I mean skeleton, crew. I have a staff of individuals. 50 percent of my staff which are approximately 52 people. Approximately, 42 of them are ex or prior homeless individuals who we have employed to working with us. However, with the way the cost of living and the funding is going, we may be forced to cut those people back that they may be put back in the same recidivism of being homeless again.

What I'm coming forth on behalf of

Stenton Family Manor and the Office of Supportive Housing is that you look at OSH and some type of funding that we may be able to be adequate in our level funding. We have received orders from the Mayor that we are to raise our funding to become where we first started back in 2004. The average person was being paid $8.25 an hour. That same individual is required to pay $12 an hour now and potentially $12.30 come January 2016. That with the same coordinates -- the same ordinance of us having to work with the same equal level funding that we have since 2004.

This is a very hard labor that has been put on the shelters, Stenton Family Manor as well. We ask that you take into consideration on this budget of some of the acknowledgements that is needed to support those who are homeless that we may be able to have some type of increase knowing what it is. But I can't see us telling homeless people or telling homeless families we can't provide you with housing, jobs, funding or

anything because we don't have enough.

I thank you for your time.

COUNCILWOMAN BLACKWELL: Thank you, Pastor Harrison. You have met with OSH?

PASTOR HARRISON: Yes, ma'am.

COUNCILWOMAN BLACKWELL: All right. Well, I will work on this with you and we will see what we can do always.

PASTOR HARRISON: Thank you, Councilwoman.

COUNCILWOMAN BLACKWELL: Thank you. How is your family?

PASTOR HARRISON: Everybody is fine. Mom is 90.

COUNCILWOMAN BLACKWELL: My goodness. Thank you. This is a gentleman I've known all his life. Yes. Thank God you still have her.

PASTOR HARRISON: Yes, ma'am.

MS. LEWIS: Councilwoman, there are no more speakers on the list.

COUNCILWOMAN BLACKWELL: All right. Is there anyone else who would like to make a statement or speak? My colleagues okay?

All right, having seen none, then this Committee will stand in recess until Tuesday, May 5, 2015 at ten o'clock a.m. At which time, we will reconvene here in Room 400, City Hall.

Thank you all.

(Committee of the Whole adjourned at 5:50 p.m.)

C E R T I F I C A T I O N

I, hereby certify that the proceedings and evidence noted are contained fully and accurately in the stenographic notes taken by me in the foregoing matter, and that this is a correct transcript of the same.

ANGELA M. KING, RPR
Court Reporter - Notary Public

(The foregoing certification of this transcript does not apply to any reproduction of the same by any means, unless under the direct control and/or supervision of the certifying reporter.)

City of Philadelphia

Recessed Hearing Notice

April 28, 2015

The **Committee of the Whole** of the Council of the City of Philadelphia held a Public Hearing on **Tuesday, April 28, 2015,** and recessed the public hearing until **Wednesday, April 29, 2015** at **10:00 AM**, in **Room 400, City Hall,** to hear further testimony on the following:

150162	An Ordinance to adopt a Capital Program for the six Fiscal Years 2016-2021 inclusive.
150163	An Ordinance to adopt a Fiscal 2016 Capital Budget.
150164	An Ordinance adopting the Operating Budget for Fiscal Year 2016.
150179	Resolution providing for the approval by the Council of the City of Philadelphia of a Revised Five Year Financial Plan for the City of Philadelphia covering Fiscal Years 2016 through 2020, and incorporating proposed changes with respect to Fiscal Year 2015, which is to be submitted by the Mayor to the Pennsylvania Intergovernmental Cooperation Authority (the "Authority") pursuant to the Intergovernmental Cooperation Agreement, authorized by an ordinance of this Council approved by the Mayor on January 3, 1992 (Bill No. 1563-A), by and between the City and the Authority.

Immediately following the public hearing, a meeting of the Committee of the Whole, open to the public, will be held to consider the action to be taken on the above listed items.

Copies of the foregoing items are available in the Office of the Chief Clerk of the Council, Room 402, City Hall.

Michael Decker
Chief Clerk

City of Philadelphia

City Council
Chief Clerk's Office
402 City Hall
Philadelphia, PA 19107

BILL NO. 150164

Introduced March 5, 2015

**Councilmember Jones
for
Council President Clarke**

**Referred to the
Committee of the Whole**

AN ORDINANCE

Adopting the Operating Budget for Fiscal Year 2016.

WHEREAS, The Mayor on March 5, 2015 submitted to Council his operating budget message and his estimate of revenues available for appropriations for Fiscal Year 2016 pursuant to Section 4-101 of The Philadelphia Home Rule Charter; therefore

THE COUNCIL OF THE CITY OF PHILADELPHIA HEREBY ORDAINS:

SECTION 1. The following financial program is hereby adopted for the Fiscal Year 2016 and appropriations are hereby made from the various operating funds to the various offices, departments, boards and commissions as indicated in the following sections:

SECTION 2. Appropriations in the sum of three billion, nine hundred fifty-four million, nine hundred sixty-one thousand (3,954,961,000) dollars are hereby made from the GENERAL FUND, as follows:

2.1 TO THE COUNCIL

Personal Services	$ 14,309,858
Purchase of Services	1,804,485
Materials, Supplies and Equipment	410,650
Contributions, Indemnities and Taxes	100
Payments to Other Funds	100
Advances and Other Miscellaneous Payments	100

Total	$ 16,525,293

2.2 TO THE MAYOR - OFFICE OF THE INSPECTOR GENERAL

Personal Services	$ 1,470,611
Purchase of Services	192,975
Materials, Supplies and Equipment	5,225
Total	$ 1,668,811

2.3 TO THE MAYOR

Personal Services	$ 4,166,124
Purchase of Services	990,336
Materials, Supplies and Equipment	50,165
Total	$ 5,206,625

2.4 TO THE MAYOR - SCHOLARSHIPS

Contributions, Indemnities and Taxes	$ 200,000
Total	$ 200,000

2.5 TO THE MAYOR - OFFICE OF LABOR RELATIONS

Personal Services	$ 559,029
Purchase of Services	5,277
Materials, Supplies and Equipment	8,160
Total	$ 572,466

2.6 TO THE MAYOR - OFFICE OF INNOVATION AND TECHNOLOGY

Personal Services	$ 19,900,681
Purchase of Services	54,383,430
Materials, Supplies and Equipment	9,598,351
Total	$ 83,882,462

2.7 TO THE MAYOR - OFFICE OF HOUSING AND COMMUNITY DEVELOPMENT

Purchase of Services	$ 2,520,000
Total	$ 2,520,000

2.8 TO THE MAYOR - OFFICE OF ARTS AND CULTURE AND THE CREATIVE ECONOMY - MURAL ARTS PROGRAM

Personal Services	$ 464,216
Purchase of Services	1,181,800
Total	$ 1,646,016

2.9 TO THE MAYOR - OFFICE OF TRANSPORTATION AND UTILITIES

Personal Services	$ 474,340
Purchase of Services	259,930
Total	$ 734,270

2.10 TO THE MAYOR - OFFICE OF COMMUNITY EMPOWERMENT AND OPPORTUNITY

Personal Services	$ 605,000
Total	$ 605,000

2.11 TO THE OFFICE OF SUSTAINABILITY

Personal Services	$ 537,979
Purchase of Services	279,508
Materials, Supplies and Equipment	17,840
Total	$ 835,327

2.12 TO THE MANAGING DIRECTOR

Personal Services	$ 16,316,293
Purchase of Services	17,589,271

Materials, Supplies and Equipment 538,979

Total ..... $ 34,444,543

2.13 TO THE MANAGING DIRECTOR – LEGAL SERVICES

Purchase of Services ..... $ 43,159,131

Total ..... $ 43,159,131

2.14 TO THE MANAGING DIRECTOR - OFFICE OF FLEET MANAGEMENT

Personal Services ..... $ 16,544,893
Purchase of Services 5,104,396
Materials, Supplies and Equipment 24,963,211

Total ..... $ 46,612,500

2.15 TO THE MANAGING DIRECTOR - OFFICE OF FLEET MANAGEMENT - VEHICLE PURCHASE

Purchase of Services ..... $ 4,500,000
Materials, Supplies and Equipment 10,465,000

Total ..... $ 14,965,000

2.16 TO THE POLICE DEPARTMENT

Personal Services ..... $ 622,058,347
Purchase of Services 7,262,807
Materials, Supplies and Equipment 13,417,702

Total ..... $ 642,738,856

2.17 TO THE DEPARTMENT OF STREETS

Personal Services ..... $ 22,485,373
Purchase of Services 8,426,338
Materials, Supplies and Equipment 2,201,750
Contributions, Indemnities and Taxes 5,000

Total	$ 33,118,461

2.18 TO THE DEPARTMENT OF STREETS - SANITATION DIVISION

Personal Services	$ 50,238,759
Purchase of Services	40,393,117
Materials, Supplies and Equipment	1,608,212
Contributions, Indemnities and Taxes	48,171
Total	$ 92,288,259

2.19 TO THE FIRE DEPARTMENT

Personal Services	$ 196,783,581
Purchase of Services	5,895,975
Materials, Supplies and Equipment	7,556,014
Payments to Other Funds	8,847,226
Total	$ 219,082,796

2.20 TO THE DEPARTMENT OF PUBLIC HEALTH

Personal Services	$ 50,298,254
Purchase of Services	59,953,424
Materials, Supplies and Equipment	5,490,768
Payments to Other Funds	500,000
Total	$ 116,242,446

2.21 TO THE DEPARTMENT OF PUBLIC HEALTH - OFFICE OF BEHAVIORAL HEALTH AND INTELLECTUAL DISABILITY

Personal Services	$ 1,000,066
Purchase of Services	12,875,510
Total	$ 13,875,576

2.22 TO THE DEPARTMENT OF PARKS AND RECREATION

Personal Services	$ 43,429,053
Purchase of Services	9,319,525
Materials, Supplies and Equipment	2,673,805

Contributions, Indemnities and Taxes	2,289,500
Total	$ 57,711,883

2.23 TO THE MAYOR - OFFICE OF ARTS AND CULTURE AND THE CREATIVE ECONOMY- ART MUSEUM SUBSIDY

Contributions, Indemnities and Taxes	$ 2,550,000
Total	$ 2,550,000

2.24 TO THE MAYOR - OFFICE OF ARTS AND CULTURE AND THE CREATIVE ECONOMY - BOARD OF TRUSTEES OF ATWATER KENT MUSEUM

Personal Services	$ 243,498
Contributions, Indemnities and Taxes	50,000
Total	$ 293,498

2.25 TO THE DEPARTMENT OF PUBLIC PROPERTY

Personal Services	$ 8,400,083
Purchase of Services	26,787,008
Materials, Supplies and Equipment	1,338,535
Payments to Other Funds	23,367,706
Total	$ 59,893,332

2.26 TO THE DEPARTMENT OF PUBLIC PROPERTY-CITY SUBSIDY FOR SEPTA

Purchase of Services	$ 74,215,000
Total	$ 74,215,000

2.27 TO THE DEPARTMENT OF PUBLIC PROPERTY - UTILITIES

Purchase of Services	$ 33,092,334
Total	$ 33,092,334

2.28 TO THE DEPARTMENT OF PUBLIC PROPERTY - SPACE RENTALS

Purchase of Services	$ 20,624,429
Total	$ 20,624,429

2.29 TO THE DEPARTMENT OF HUMAN SERVICES

Personal Services	$ 24,637,310
Purchase of Services	76,779,935
Materials, Supplies and Equipment	1,312,076
Total	$ 102,729,321

2.30 TO THE DEPARTMENT OF PRISONS

Personal Services	$ 133,469,579
Purchase of Services	105,351,301
Materials, Supplies and Equipment	4,768,744
Contributions, Indemnities and Taxes	1,306,757
Total	$ 244,896,381

2.31 TO THE DEPARTMENT OF HUMAN SERVICES - OFFICE OF SUPPORTIVE HOUSING

Personal Services	$ 8,281,213
Purchase of Services	36,586,621
Materials, Supplies and Equipment	344,127
Contributions, Indemnities and Taxes	32,421
Total	$ 45,244,382

2.32 TO THE DEPARTMENT OF LICENSES AND INSPECTIONS

Personal Services	$ 19,770,711
Purchase of Services	10,261,906
Materials, Supplies and Equipment	1,443,941
Total	$ 31,476,558

2.33 TO THE DEPARTMENT OF LICENSES AND INSPECTIONS - BOARD OF LICENSE AND INSPECTION REVIEW

Personal Services	$ 157,354
Purchase of Services	10,436
Total	$ 167,790

2.34 TO THE DEPARTMENT OF LICENSES AND INSPECTIONS - BOARD OF BUILDING STANDARDS

Personal Services	$ 73,970
Total	$ 73,970

2.35 TO THE DEPARTMENT OF LICENSES AND INSPECTIONS - ZONING BOARD OF ADJUSTMENT

Personal Services	$ 337,749
Purchase of Services	34,541
Total	$ 372,290

2.36 TO THE DEPARTMENT OF RECORDS

Personal Services	$ 3,058,832
Purchase of Services	1,618,779
Materials, Supplies and Equipment	143,758
Contributions, Indemnities and Taxes	1,456
Total	$ 4,822,825

2.37 TO THE DEPARTMENT OF PUBLIC PROPERTY - PHILADELPHIA HISTORICAL COMMISSION

Personal Services	$ 422,771
Purchase of Services	980
Materials, Supplies and Equipment	809
Total	$ 424,560

2.38 TO THE DIRECTOR OF FINANCE

Personal Services	$ 8,801,920
Purchase of Services	4,370,961
Materials, Supplies and Equipment	110,774
Contributions, Indemnities and Taxes	3,950,000
Total	$ 17,233,655

2.39 TO THE DIRECTOR OF FINANCE - FRINGE BENEFITS

Personal Services-Employee Benefits	$ 1,172,182,395
Total	$ 1,172,182,395

2.40 TO THE DIRECTOR OF FINANCE - COMMUNITY COLLEGE OF PHILADELPHIA

Contributions, Indemnities and Taxes	$ 30,309,207
Total	$ 30,309,207

2.41 TO THE DIRECTOR OF FINANCE - HERO AWARD

Contributions, Indemnities and Taxes	$ 25,000
Total	$ 25,000

2.42 TO THE DIRECTOR OF FINANCE - REFUNDS

Contributions, Indemnities and Taxes	$ 250,000
Total	$ 250,000

2.43 TO THE DIRECTOR OF FINANCE - INDEMNITIES

Contributions, Indemnities and Taxes	$ 38,000,000
Total	$ 38,000,000

2.44 TO THE DIRECTOR OF FINANCE - WITNESS FEES

Purchase of Services	$ 171,518

Total	$ 171,518

2.45 TO THE DIRECTOR OF FINANCE - CONTRIBUTION TO SCHOOL DISTRICT

Contributions, Indemnities and Taxes	$ 69,184,673
Total	$ 69,184,673

2.46 TO THE DEPARTMENT OF REVENUE

Personal Services	$ 19,617,564
Purchase of Services	5,352,949
Materials, Supplies and Equipment	800,976
Total	$ 25,771,489

2.47 TO THE DEPARTMENT OF REVENUE - SINKING FUND COMMISSION

Purchase of Services	$ 104,546,913
Debt Service	141,398,213
Total	$ 245,945,126

2.48 TO THE PROCUREMENT DEPARTMENT

Personal Services	$ 2,472,351
Purchase of Services	2,316,267
Materials, Supplies and Equipment	49,054
Total	$ 4,837,672

2.49 TO THE CITY TREASURER

Personal Services	$ 985,689
Purchase of Services	118,444
Materials, Supplies and Equipment	22,224
Total	$ 1,126,357

BILL NO. 150164 continued

2.50 TO THE CITY REPRESENTATIVE

Personal Services	$ 418,201
Purchase of Services	561,730
Materials, Supplies and Equipment	54,000
Total	$ 1,033,931

2.51 TO THE DIRECTOR OF COMMERCE

Personal Services	$ 1,943,211
Purchase of Services	1,433,481
Materials, Supplies and Equipment	26,654
Contributions, Indemnities and Taxes	500,000
Total	$ 3,903,346

2.52 TO THE DIRECTOR OF COMMERCE - ECONOMIC STIMULUS

Purchase of Services	$ 3,294,448
Total	$ 3,294,448

2.53 TO THE DIRECTOR OF COMMERCE - CONVENTION CENTER SUBSIDY

Purchase of Services	$ 15,000,000
Total	$ 15,000,000

2.54 TO THE MAYOR - OFFICE OF ARTS AND CULTURE AND THE CREATIVE ECONOMY

Personal Services	$ 201,367
Purchase of Services	593,800
Materials, Supplies and Equipment	7,000
Contributions, Indemnities and Taxes	2,070,688
Total	$ 2,872,855

2.55 TO THE LAW DEPARTMENT

Personal Services	$ 7,383,566
Purchase of Services	7,010,034
Materials, Supplies and Equipment	248,676
Total	$ 14,642,276

2.56 TO THE BOARD OF ETHICS

Personal Services	$ 924,511
Purchase of Services	96,000
Materials, Supplies and Equipment	14,000
Total	$ 1,034,511

2.57 TO THE YOUTH COMMISSION

Personal Services	$ 92,660
Purchase of Services	46,000
Materials, Supplies and Equipment	4,080
Total	$ 142,740

2.58 TO THE CITY PLANNING COMMISSION

Personal Services	$ 2,309,534
Purchase of Services	79,592
Materials, Supplies and Equipment	40,652
Total	$ 2,429,778

2.59 TO THE BOARD OF TRUSTEES OF THE FREE LIBRARY OF PHILADELPHIA

Personal Services	$ 35,777,252
Purchase of Services	2,922,077
Materials, Supplies and Equipment	2,302,659
Total	$ 41,001,988

2.60 TO THE COMMISSION ON HUMAN RELATIONS

Personal Services	$ 2,099,408

Purchase of Services	34,657
Materials, Supplies and Equipment	13,031
Total	$ 2,147,096

2.61 TO THE CIVIL SERVICE COMMISSION

Personal Services	$ 147,343
Purchase of Services	29,500
Materials, Supplies and Equipment	1,094
Advances and Other Miscellaneous Payments	6,906,535
Total	$ 7,084,472

2.62 TO THE OFFICE OF HUMAN RESOURCES

Personal Services	$ 5,399,621
Purchase of Services	964,070
Materials, Supplies and Equipment	69,932
Total	$ 6,433,623

2.63 TO THE OFFICE OF PROPERTY ASSESSMENT

Personal Services	$ 10,424,420
Purchase of Services	2,078,126
Materials, Supplies and Equipment	782,600
Total	$ 13,285,146

2.64 TO THE AUDITING DEPARTMENT

Personal Services	$ 7,772,885
Purchase of Services	497,450
Materials, Supplies and Equipment	25,000
Total	$ 8,295,335

2.65 TO THE BOARD OF REVISION OF TAXES

Personal Services	$ 819,627
Purchase of Services	20,200

BILL NO. 150164 continued

Materials, Supplies and Equipment	15,727
Total	$ 855,554

2.66 TO THE REGISTER OF WILLS

Personal Services	$ 3,232,166
Purchase of Services	75,486
Materials, Supplies and Equipment	33,210
Total	$ 3,340,862

2.67 TO THE DISTRICT ATTORNEY

Personal Services	$ 32,490,021
Purchase of Services	2,467,172
Materials, Supplies and Equipment	525,021
Total	$ 35,482,214

2.68 TO THE SHERIFF

Personal Services	$ 17,104,325
Purchase of Services	715,267
Materials, Supplies and Equipment	393,207
Total	$ 18,212,799

2.69 TO THE CITY COMMISSIONERS

Personal Services	$ 5,624,276
Purchase of Services	3,497,350
Materials, Supplies and Equipment	541,617
Total	$ 9,663,243

2.70 TO THE FIRST JUDICIAL DISTRICT OF PENNSYLVANIA

Personal Services	$ 97,206,858
Purchase of Services	10,656,574
Materials, Supplies and Equipment	2,391,868

Total ..... $ 110,255,300

SECTION 3. Appropriations in the sum of seven hundred sixty-seven million, three hundred fourteen thousand (767,314,000) dollars are hereby made from the WATER FUND, as follows:

3.1 TO THE MAYOR - OFFICE OF INNOVATION AND TECHNOLOGY

Personal Services ..... $ 6,265,289
Purchase of Services 14,706,497
Materials, Supplies and Equipment 2,025,150

Total ..... $ 22,996,936

3.2 TO THE MAYOR - OFFICE OF TRANSPORTATION AND UTILITIES

Personal Services ..... $ 138,550

Total ..... $ 138,550

3.3 TO THE MANAGING DIRECTOR - OFFICE OF FLEET MANAGEMENT

Personal Services ..... $ 2,969,317
Purchase of Services 1,489,000
Materials, Supplies and Equipment 4,274,640

Total ..... $ 8,732,957

3.4 TO THE DEPARTMENT OF PUBLIC PROPERTY

Purchase of Services ..... $ 4,042,633

Total ..... $ 4,042,633

3.5 TO THE WATER DEPARTMENT

Personal Services ..... $ 102,961,600
Purchase of Services 151,645,200

BILL NO. 150164 continued

Materials, Supplies and Equipment	47,460,200
Contributions, Indemnities and Taxes	100,000
Payments to Other Funds	65,000,000
Total	$ 367,167,000

3.6 TO THE DIRECTOR OF FINANCE - FRINGE BENEFITS

Personal Services-Employee Benefits	$ 110,915,262
Total	$ 110,915,262

3.7 TO THE DIRECTOR OF FINANCE - INDEMNITIES

Contributions, Indemnities and Taxes	$ 6,500,000
Total	$ 6,500,000

3.8 TO THE DEPARTMENT OF REVENUE

Personal Services	$ 11,138,839
Purchase of Services	4,484,480
Materials, Supplies and Equipment	640,920
Contributions, Indemnities and Taxes	5,000
Total	$ 16,269,239

3.9 TO THE DEPARTMENT OF REVENUE - SINKING FUND COMMISSION

Debt Service	$ 227,139,336
Total	$ 227,139,336

3.10 TO THE PROCUREMENT DEPARTMENT

Personal Services	$ 77,383
Total	$ 77,383

3.11 TO THE LAW DEPARTMENT

Personal Services	$ 2,506,206
Purchase of Services	691,614
Materials, Supplies and Equipment	43,010
Total	$ 3,240,830

3.12 TO THE OFFICE OF SUSTAINABILITY

Personal Services	$ 63,874
Purchase of Services	30,000
Total	$ 93,874

SECTION 4. Appropriations in the sum of thirty-four million, seven hundred twenty-four thousand (34,724,000) dollars are hereby made from the WATER RESIDUAL FUND, as follows:

4.1 TO THE WATER DEPARTMENT

Payments to Other Funds	$ 34,724,000
Total	$ 34,724,000

SECTION 5. Appropriations in the sum of four million, nine hundred fifty thousand (4,950,000) dollars are hereby made from the COUNTY LIQUID FUELS TAX FUND, as follows:

5.1 TO THE DEPARTMENT OF STREETS

Personal Services	$ 3,734,000
Purchase of Services	861,000
Materials, Supplies and Equipment	336,330
Payments to Other Funds	18,670
Total	$ 4,950,000

SECTION 6. Appropriations in the sum of twenty-nine million, five hundred thousand (29,500,000) dollars are hereby made from the SPECIAL GASOLINE TAX FUND, as follows:

6.1 TO THE DEPARTMENT OF STREETS

Personal Services	$ 3,000,000
Purchase of Services	15,558,550
Materials, Supplies and Equipment	9,926,450
Payments to Other Funds	15,000
Total	$ 28,500,000

6.2 TO THE DIRECTOR OF FINANCE-FRINGE BENEFITS

Personal Services-Employee Benefits	$ 1,000,000
Total	$ 1,000,000

SECTION 7. Appropriations in the sum of nine hundred sixty-one million, five hundred fifty-two thousand (961,552,000) dollars are hereby made from the HEALTHCHOICES BEHAVIORAL HEALTH REVENUE FUND, as follows:

7.1 TO THE DEPARTMENT OF PUBLIC HEALTH - OFFICE OF BEHAVIORAL HEALTH AND INTELLECTUAL DISABILITY

Purchase of Services	$ 960,002,000
Materials, Supplies and Equipment	50,000
Payments to Other Funds	1,500,000
Total	$ 961,552,000

SECTION 8. Appropriations in the sum of sixty-two million, seven hundred thousand (62,700,000) dollars are hereby made from the HOTEL ROOM RENTAL TAX FUND, as follows:

8.1 TO THE DIRECTOR OF COMMERCE

Contributions, Indemnities and Taxes	$ 62,700,000
Total	$ 62,700,000

SECTION 9. Appropriations in the sum of one billion, five hundred fifty-eight million, six hundred thirty-four thousand (1,558,634,000) dollars are hereby made from the GRANTS REVENUE FUND, as follows:

9.1 TO THE MAYOR

Personal Services	$ 1,043,688
Personal Services-Employee Benefits	72,576
Purchase of Services	658,412
Materials, Supplies and Equipment	9,336
Total	$ 1,784,012

9.2 TO THE MAYOR - OFFICE OF INNOVATION AND TECHNOLOGY

Purchase of Services	$ 967,655
Payments to Other Funds	44,702,879
Total	$ 45,670,534

9.3 TO THE MAYOR - OFFICE OF HOUSING AND COMMUNITY DEVELOPMENT

Purchase of Services	$ 128,117,000
Total	$ 128,117,000

9.4 TO THE MAYOR - OFFICE OF COMMUNITY EMPOWERMENT AND OPPORTUNITY

Personal Services	$ 2,349,085
Personal Services-Employee Benefits	451,559
Purchase of Services	13,075,621
Materials, Supplies and Equipment	48,125
Total	$ 15,924,390

9.5 TO THE OFFICE OF SUSTAINABILITY

Personal Services	40,000
Total	$ 40,000

9.6 TO THE MANAGING DIRECTOR

Personal Services	$ 1,864,474
Purchase of Services	4,021,103
Materials, Supplies and Equipment	383,008
Total	$ 6,268,585

9.7 TO THE POLICE DEPARTMENT

Personal Services	$ 5,900,458
Personal Services-Employee Benefits	349,468
Purchase of Services	6,276,769
Materials, Supplies and Equipment	14,402,546
Total	$ 26,929,241

9.8 TO THE DEPARTMENT OF STREETS

Personal Services	$ 720,000
Purchase of Services	31,905,144
Materials, Supplies and Equipment	3,604,856
Total	$ 36,230,000

9.9 TO THE FIRE DEPARTMENT

Personal Services	$ 5,434,360
Personal Services-Employee Benefits	4,057,636
Purchase of Services	1,388,014
Materials, Supplies and Equipment	368,681
Total	$ 11,248,691

9.10 TO THE DEPARTMENT OF PUBLIC HEALTH

Personal Services	$ 11,141,642
Personal Services-Employee Benefits	4,217,090
Purchase of Services	56,755,608
Materials, Supplies and Equipment	1,701,279
Payments to Other Funds	865,555
Total	$ 74,681,174

9.11 TO THE DEPARTMENT OF PUBLIC HEALTH - OFFICE OF BEHAVIORAL HEALTH AND INTELLECTUAL DISABILITY

Personal Services	$ 15,278,526
Personal Services-Employee Benefits	7,864,363
Purchase of Services	231,221,587
Materials, Supplies and Equipment	357,190
Payments to Other Funds	76,248
Total	$ 254,797,914

9.12 TO THE DEPARTMENT OF PARKS AND RECREATION

Personal Services	$ 3,352,225
Personal Services-Employee Benefits	484,127
Purchase of Services	922,703
Materials, Supplies and Equipment	6,405,874
Contributions, Indemnities and Taxes	110,000
Total	$ 11,274,929

9.13 TO THE DEPARTMENT OF HUMAN SERVICES

Personal Services	$ 79,773,120
Personal Services-Employee Benefits	37,175,926
Purchase of Services	451,172,464
Materials, Supplies and Equipment	2,707,544
Total	$ 570,829,054

9.14 TO THE DEPARTMENT OF PRISONS

Purchase of Services	$ 30,000

Total ..... $ 30,000

9.15 TO THE DEPARTMENT OF HUMAN SERVICES - OFFICE OF SUPPORTIVE HOUSING

Personal Services ..... $ 710,423
Purchase of Services 44,956,142
Materials, Supplies and Equipment 887,489

Total ..... $ 46,554,054

9.16 TO THE DEPARTMENT OF LICENSES AND INSPECTIONS

Purchase of Services ..... $ 4,500,000

Total ..... $ 4,500,000

9.17 TO THE DIRECTOR OF FINANCE - PROVISION FOR OTHER GRANTS

Advances and Other Miscellaneous Payment ..... $ 203,800,721

Total ..... $ 203,800,721

9.18 TO THE DEPARTMENT OF REVENUE

Purchase of Services ..... $ 21,150,000

Total ..... $ 21,150,000

9.19 TO THE DIRECTOR OF COMMERCE

Personal Services ..... $ 49,814
Purchase of Services 10,811,988

Total ..... $ 10,861,802

9.20 TO THE MAYOR - OFFICE OF TRANSPORTATION AND UTILITIES

Personal Services ..... $ 127,583
Purchase of Services 1,698,435

BILL NO. 150164 continued

Materials, Supplies and Equipment	2,500
Total	$ 1,828,518

9.21 TO THE CITY PLANNING COMMISSION

Personal Services	$ 333,614
Personal Services-Employee Benefits	141,647
Purchase of Services	955,206
Payments to Other Funds	1,600
Total	$ 1,432,067

9.22 TO THE BOARD OF TRUSTEES OF THE FREE LIBRARY OF PHILADELPHIA

Personal Services	$ 1,093,985
Personal Services-Employee Benefits	132,099
Purchase of Services	3,921,223
Materials, Supplies and Equipment	3,366,737
Total	$ 8,514,044

9.23 TO THE AUDITING DEPARTMENT

Materials, Supplies and Equipment	$ 249,999
Total	$ 249,999

9.24 TO THE DISTRICT ATTORNEY

Personal Services	$ 14,930,000
Personal Services-Employee Benefits	545,000
Purchase of Services	1,124,880
Materials, Supplies and Equipment	110,462
Total	$ 16,710,342

9.25 TO THE CITY COMMISSIONERS

Personal Services	$ 100,000
Purchase of Services	600,000

Materials, Supplies and Equipment	200,000
Total	$ 900,000

9.26 TO THE FIRST JUDICIAL DISTRICT OF PENNSYLVANIA

Personal Services	$ 34,698,587
Personal Services-Employee Benefits	16,017,324
Purchase of Services	6,775,539
Materials, Supplies and Equipment	815,479
Total	$ 58,306,929

SECTION 10. Appropriations in the sum of four hundred forty million, three hundred eighty-three thousand (440,383,000) dollars are hereby made from the AVIATION FUND, as follows:

10.1 TO THE MAYOR - OFFICE OF INNOVATION AND TECHNOLOGY

Personal Services	$ 297,690
Purchase of Services	8,607,358
Materials, Supplies and Equipment	715,000
Total	$ 9,620,048

10.2 TO THE MAYOR - OFFICE OF TRANSPORTATION AND UTILITIES

Personal Services	$ 191,299
Total	$ 191,299

10.3 TO THE OFFICE SUSTAINABILITY

Personal Services	$ 63,873
Purchase of Services	30,000
Total	$ 93,873

BILL NO. 150164 continued

10.4 TO THE MANAGING DIRECTOR - OFFICE OF FLEET MANAGEMENT

Personal Services	$ 1,364,188
Purchase of Services	588,000
Materials, Supplies and Equipment	1,493,000
Total	$ 3,445,188

10.5 TO THE MANAGING DIRECTOR - OFFICE OF FLEET MANAGEMENT-VEHICLE PURCHASE

Materials, Supplies and Equipment	$ 4,800,000
Total	$ 4,800,000

10.6 TO THE POLICE DEPARTMENT

Personal Services	$ 15,611,887
Purchase of Services	77,500
Materials, Supplies and Equipment	93,000
Total	$ 15,782,387

10.7 TO THE FIRE DEPARTMENT

Personal Services	$ 6,563,366
Purchase of Services	15,000
Materials, Supplies and Equipment	125,000
Payments to Other Funds	23,000
Total	$ 6,726,366

10.8 TO THE DEPARTMENT OF PUBLIC PROPERTY - UTILITIES

Purchase of Services	$ 26,900,000
Total	$ 26,900,000

10.9 TO THE DIRECTOR OF FINANCE

Purchase of Services	$ 4,146,000

Total ..... $ 4,146,000

10.10 TO THE DIRECTOR OF FINANCE - FRINGE BENEFITS

Personal Services-Employee Benefits ..... $ 57,194,271

Total ..... $ 57,194,271

10.11 TO THE DIRECTOR OF FINANCE - INDEMNITIES

Contributions, Indemnities and Taxes ..... $ 2,512,000

Total ..... $ 2,512,000

10.12 TO THE DEPARTMENT OF REVENUE - SINKING FUND COMMISSION

Debt Service ..... $ 123,505,128

Total ..... $ 123,505,128

10.13 TO THE DIRECTOR OF COMMERCE

Personal Services ..... $ 46,218,000
Purchase of Services 96,372,841
Materials, Supplies and Equipment 12,050,000
Contributions, Indemnities and Taxes 4,205,000
Payments to Other Funds 24,600,000

Total ..... $ 183,445,841

10.14 TO THE LAW DEPARTMENT

Personal Services ..... $ 1,563,803
Purchase of Services 432,439
Materials, Supplies and Equipment 24,357

Total ..... $ 2,020,599

SECTION 11. Appropriations in the sum of ninety-four million, one hundred sixty-one thousand (94,161,000) dollars are hereby made from the COMMUNITY DEVELOPMENT FUND, as follows:

11.1 TO THE MAYOR - OFFICE OF HOUSING AND COMMUNITY DEVELOPMENT

Personal Services	$ 4,632,873
Purchase of Services	54,626,411
Materials, Supplies and Equipment	281,000
Payments to Other Funds	30,000
Total	$ 59,570,284

11.2 TO THE DEPARTMENT OF LICENSES AND INSPECTIONS

Personal Services	$ 514,818
Total	$ 514,818

11.3 TO THE DIRECTOR OF FINANCE-FRINGE BENEFITS

Personal Services-Employee Benefits	$ 4,236,559
Total	$ 4,236,559

11.4 TO THE DIRECTOR OF FINANCE - COMMUNITY DEVELOPMENT BLOCK GRANT - TO BE ALLOCATED

Advances and Other Miscellaneous Payment	$ 20,000,000
Total	$ 20,000,000

11.5 TO THE DIRECTOR OF COMMERCE

Personal Services	$ 935,454
Purchase of Services	8,461,248
Materials, Supplies and Equipment	8,000
Total	$ 9,404,702

11.6 TO THE LAW DEPARTMENT

Personal Services ..... $ 154,637

Total ..... $ 154,637

11.7 TO THE CITY PLANNING COMMISSION

Personal Services ..... $ 280,000

Total ..... $ 280,000

SECTION 12. Appropriations in the sum of six million (6,000,000) dollars are hereby made from the CAR RENTAL TAX FUND, as follows:

12.1 TO THE DEPARTMENT OF REVENUE-SINKING FUND COMMISSION

Purchase of Services ..... $ 6,000,000

Total ..... $ 6,000,000

SECTION 13. There is hereby authorized nine million nine hundred seventy-one thousand (9,971,000) dollars to be paid from the MUNICIPAL PENSION FUND, the recurring costs of administering the functional activities of the Board of Pensions and Retirement. The Director of Finance is authorized to transfer these costs to the appropriate funds based on the appropriate allocation plan, as he/she shall determine:

13.1 TO THE BOARD OF PENSIONS AND RETIREMENT

Personal Services ..... $ 3,750,000
Personal Services-Employee Benefits 3,420,000
Purchase of Services 2,538,000
Materials, Supplies and Equipment 138,000
Payments to Other Funds 125,000

Total ..... $ 9,971,000

SECTION 14. Appropriations in the sum of twenty-four million, five hundred thousand (24,500,000) dollars are hereby made from the HOUSING TRUST FUND, as follows:

14.1 TO THE MAYOR - OFFICE OF HOUSING AND COMMUNITY DEVELOPMENT

Personal Services	$ 1,250,000
Purchase of Services	23,250,000
Total	$ 24,500,000

SECTION 15. Appropriations in the sum of one hundred sixty-three million, one hundred sixty-six thousand (163,166,000) dollars are hereby made from the ACUTE CARE HOSPITAL FUND, as follows:

15.1 TO THE DEPARTMENT OF PUBLIC HEALTH

Personal Services	$ 5,058,008
Purchase of Services	6,638,915
Materials, Supplies and Equipment	81,000
Payments to Other Funds	2,000,000
Total	$ 13,777,923

15.2 TO THE DEPARTMENT OF PUBLIC HEALTH – STATE PAYMENT

Purchase of Services	$ 149,000,000
Total	$ 149,000,000

15.3 TO THE DIRECTOR OF FINANCE

Personal Services	$ 75,000
Total	$ 75,000

15.4 TO THE DIRECTOR OF FINANCE-FRINGE BENEFITS

Personal Services-Employee Benefits	$ 268,077

Total	$ 268,077

15.5 TO THE DEPARTMENT OF REVENUE

Personal Services	$ 30,000
Materials, Supplies and Equipment	15,000
Total	$ 45,000

SECTION 16. General Provisions.

(1) The sums herein appropriated under Items 2.41, 3.7, and 10.10 "To the Director of Finance-Indemnities" shall be used for the purpose of settling claims against the City. Payments therefore shall be made by the Director of Finance only upon the authorization of the City Solicitor or his/her designated representative for this purpose.

(2) If any function is transferred from one office, department, board or commission to another office, department, board or commission, the Director of Finance may not, without Council approval by ordinance, transfer to the successor office, department, board or commission those portions of the appropriations which appertain to the function transferred.

(3) Whenever, pursuant to the provisions of Section 8-401 of The Philadelphia Home Rule Charter, employees of any office, department, board or commission are used by another office, department, board or commission, the compensation of such employees for the period of such use may, at the discretion of the Director of Finance, be charged against the applicable appropriations to the using office, department, board or commission. The Director of Finance shall notify the President of Council, the Chief Clerk of Council and the Chair of the Appropriations Committee at least two (2) days prior to making any such charge against appropriations.

(4) In respect to any grant received by the City under Sections 5, 6, 7 or 9 of this Ordinance, the Director of Finance may, upon written authorization by the grantor transfer non-City funds between and among classes. The authorizations for such transfers shall be transmitted by the Director of Finance to the Clerk of Council within two (2) working days of any such transfer, along with a statement explaining the reason for such transfer. Transfers between and among departments respecting grants of two hundred fifty thousand (250,000) dollars or greater shall not be made except with the prior approval of the Council by resolution or ordinance. Approval shall not be granted

to any such transfer request submitted to Council unless it is accompanied by a copy of the grant proposal (and, if received, the grant award) which has caused the transfer request to be made. Transfers between and among departments respecting grants of less than two hundred fifty thousand (250,000) dollars shall be made upon written authorization of the Director of Finance; provided however, that such authorization, along with a full description of the grant affected is transmitted to the President of Council at least two (2) days before the effective date of such authorization.

In respect to funds from the Department of Housing and Urban Development's Community Development Block Grant (CDBG) appropriated under Section 11 of this Ordinance, the limitations set forth in the provisions of Chapter 21-1100 of The Philadelphia Code shall govern any transfer of CDBG funds between and among classes, departments and elements (grants).

(5) In respect to the appropriation made in Item 11.4 of this Ordinance "To the Director of Finance-Community Development Block Grant-To be Allocated", the sums shall not be construed as being available for commitment prior to the adoption of any ordinance appropriating moneys to be made available by the Department of Housing and Urban Development for the Fiscal Year 2016.

(6) The Director of Finance may make adjustments for obligations incurred in Fiscal Year 2015 and prior years. These may be made out of the appropriations therefore to the respective offices, departments, boards, commissions and agencies for Fiscal Year 2016. Within one week of taking any action authorized by this subsection (6), the Director of Finance shall provide written notice to the President and all members of the Council, with a copy to the Chief Clerk of Council, detailing such action.

(7) Except as otherwise provided by this Ordinance, special funds heretofore established pursuant to ordinance or statute, shall continue to be utilized in Fiscal Year 2016 for the purposes and in the manner prescribed by such ordinance or statutes to the extent that they are consistent with the provisions of The Philadelphia Home Rule Charter.

When under The Philadelphia Home Rule Charter an appropriation is a prerequisite to payments of money from such special funds, this paragraph should be construed as an appropriation of the full receipts of such funds for the purpose heretofore authorized by such ordinance or statutes, except that this paragraph shall not be construed as an appropriation of any funds contained in the Housing Trust Fund created under Chapter 21-1600 of The Philadelphia Code, and expenditures from the Housing Trust Fund shall be made only pursuant to appropriations made in Section 14 of this Ordinance. The provisions in the prior sentence relating to the Housing Trust Fund are not severable from the remainder of that sentence or from any of the other provisions of this subsection

(7), but are essentially and inseparably connected with those provisions, it being Council's intent that no portion of this subsection (7) would have been enacted if it did not also contain the provisions relating to the Housing Trust Fund.

The Director of Finance is authorized and directed to impound the balance of any special fund with respect to which he/she finds that the purposes for which the fund is being expended were intended by ordinance or law to be funded by an appropriation made in other Sections of this Ordinance.

(8) The City Treasurer is authorized and directed to make temporary advances in such amounts as the Director of Finance shall specify between any of the operating funds receiving appropriations in this Ordinance or between any operating fund and the Capital Projects Fund, and the Industrial and Commercial Development Fund, in anticipation of the collection of revenues or other receipts which are estimated to be receivable during the Fiscal Year 2016. Such advances shall bear interest at such rates as the City Treasurer, upon approval of the Director of Finance, shall determine.

(9) The amounts herein appropriated for Purchase of Services; Materials, Supplies and Equipment; Contributions, Indemnities and Taxes; and Debt Service shall be deemed to be available for encumbrance upon the effective date of this Ordinance, to the extent necessary to facilitate the operations of the various offices, departments, boards and commissions for Fiscal Year 2016; provided, that no service shall be rendered prior to July 1, 2015 and no materials, supplies or equipment acquired shall be used in Fiscal Year 2015 except to the extent required to prepare for Fiscal Year 2016.

Such portions of the appropriations herein made for debt service to the Sinking Fund Commission may be paid over to the City's fiscal agent prior to July 1, 2015 as in the judgment of the Director of Finance is necessary to meet interest and principal on the debt of the City due on July 1, 2015.

(10) The Director of Finance is authorized to charge or credit fund balances available for appropriations as of June 30, 2015 to record properly actual charges for Interfund Services for the Fiscal Year 2015.

(11) The Director of Finance is authorized to charge to fund balance payment of any obligation properly incurred in Fiscal Year 2015 or in any prior year, provided that at the time such obligation was incurred an appropriation was available against which it could have been charged, but that such appropriation shall have ceased to exist due to merger into surplus. It is further provided that the payment of any such obligation be in the same manner and subject to the same controls as would have been followed had the obligation been paid in a timely manner. Within one week of taking any action authorized by this subsection (11), the Director of Finance shall provide written notice to

the President and all members of Council, with a copy to the Chief Clerk of Council, detailing such action.

(12) Provided that the appropriation contained in Sections 7, 9 and 11 of this Ordinance shall be made available for encumbrances and/or expenditure only when the Director of Finance has certified that he/she has been responsibly advised that funds necessary to finance such appropriation or portion thereof have been received or are to be forthcoming from another government or from a nongovernmental source.

In such event the Director of Finance is authorized to accept the award for the City and to provide for the appropriation as may be required to execute the program covered by the award.

(13) The Director of Finance is authorized and directed to restore any deficiency in any Sinking Fund Reserve established pursuant to a revenue bond general ordinance, when such deficiency results from a decline in the market value of its investments, by charging the amount of the deficiency against available loan balances, or in the absence of available loan balances, against the appropriate operating fund balance. Within one week of taking any action authorized by this subsection (13), the Director of Finance shall provide written notice to the President and all members of Council, with a copy to the Chief Clerk of Council, detailing such action.

(14) None of the appropriations herein provided in Section 11 shall be encumbered against or expended out of the thirty eighth entitlement grant prior to the formal award thereof: Provided, that pending the receipt of all or a portion of the aforesaid grant award the Director of Finance is authorized to finance the appropriations herein provided from balances of prior entitlement grants awards. The authorization for such financing shall be transmitted by the Director of Finance to the Clerk of Council within two (2) working days of any such authorizations.

(15) In respect to the authorization amounts as set forth in Section 13 for purposes of operating the Board of Pensions and Retirement, the Director of Finance may increase each class amount by an amount not to exceed fifteen percent (15%) of the total budget for the fund for Fiscal Year 2016. The authorization for such increases shall be transmitted by the Director of Finance to the Clerk of Council within two (2) working days of any such increases.

(16) The appropriation contained in Section 9.3 of this Ordinance shall only be made available for obligation upon certification by the Director of Finance that Community Development Block Grant unexpended funds are available for Interim and Construction Assistance and that the amounts to be made available are guaranteed by an irrevocable Letter of Credit or similar security. At such time the Director of Finance may

authorize amounts to be provided from his/her appropriation, which amounts shall be financed by Community Development Block Grant revenues. Amounts which are repaid shall be credited as program income to finance Community Development Fund activities.

The Director of Finance and the Director of Housing, in accordance with the regulations of the Department of Housing and Urban Development (HUD), are authorized and directed to draw funds in a single lump sum from HUD's Community Development Block Grant (CDBG) to the City of Philadelphia for the appropriation contained in Section 11.1 of this Ordinance to establish a rehabilitation fund in one or more private institutions for the purpose of financing the rehabilitation of privately owned properties as part of the City's CDBG program. Funds drawn down from HUD, pursuant to this authorization, may be deposited in any private financial institution as defined by the applicable HUD regulations notwithstanding the limitations on the placement of City deposits set forth in Chapter 19-200 of The Philadelphia Code.

(17) The Director of Finance, with the concurrence of the U. S. Department of Housing and Urban Development (HUD), shall as of June 30 of the fiscal period preceding the start of this Operating Budget Ordinance, transfer all unobligated encumbrances and other available balances from the oldest Community Development Program Year not previously closed out to the next oldest Program Year as of July 1. Further, any questioned cost items from the closed out Program Year which are determined by HUD to be ineligible costs shall be transferred to the oldest open Program Year after such costs are removed. Program regulations governing such transferred funds shall be determined by HUD. The Director of Finance shall notify the Clerk of Council periodically concerning Program Year close outs and transfers.

(18) The Director of Finance is hereby authorized, at his/her discretion, to transfer the amount of the authorization and/or the obligations in respect to indemnities, advertising, insurance, telephone, postage, rental, leases, vehicle purchases, utilities, employer's share of fringe benefits and data processing services from the appropriations herein made to the appropriate offices, departments, boards, commissions or other agencies of the City.

DEPARTMENT OF BEHAVIORAL HEALTH AND INTELLECTUAL DISABILITY SERVICES
FISCAL YEAR 2016 BUDGET TESTIMONY
APRIL 29, 2015

EXECUTIVE SUMMARY

DEPARTMENT MISSION AND FUNCTION

Mission: The Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) supports a vision of recovery, resilience, and self-determination. DBHIDS continues to transition to a model of care directed by the person in recovery. Professional treatment is one component, among many, that supports people in managing their own challenges while building their own recovery resources. The recovery process is viewed as a lifetime journey.

Description of Major Services: DBHIDS provides comprehensive behavioral health and intellectual disability services through a network of provider agencies. DBHIDS is comprised of four components: the Office of Addiction Services (OAS), the Office of Mental Health (OMH), Community Behavioral Health (CBH - Philadelphia's Medicaid managed care behavioral health program), and Intellectual disAbility Services (IDS). Prior to 2003, three of the four components, OMH, OAS, and IDS, were units within the Philadelphia Department of Public Health. The fourth component, CBH, is Philadelphia's not-for-profit managed care entity. The City established CBH in 1997 to manage behavioral health care services for Philadelphia's 475,000 Medicaid recipients. The creation of CBH served as the catalyst for the development of Philadelphia's current behavioral health system. DBHIDS also partners with multiple other systems including child welfare, homeless services, criminal justice and the School District of Philadelphia to promote recovery, resilience & self-determination.

PROPOSED BUDGET HIGHLIGHTS/FUNDING REQUEST

Budget Highlights: Ninety-nine percent (99%) of DBHIDS of Behavioral Health and Intellectual disAbility Services (DBHIDS) funding comes from the State and Federal governments, including over $960 million from the State to provide managed behavioral health care for 120,000 city residents receiving medical assistance benefits annually. The greatest challenges facing DBHIDS involve unknowns concerning State and Federal budgets. General fund support for DBHIDS is used as a match to receive nine times the investment in State and Federal funds and will remain roughly on par in FY16 with the FY15 Current Projection. The FY16 budget appropriates an additional $112 million to DBHIDS, primarily through the HealthChoices Behavioral Health Revenue Fund, to plan for potential changes in per person allocations received. The overall FY16 Proposed Operating budget for DBHIDS is 10% higher than the FY15 Current Projection.

The FY16 DBHIDS Operating Budget request totals $1,230,225,490: $13,875,576 in the General Fund, $254,797,914 in the Grants Revenue Fund, and $961,552,000 in the HealthChoices Behavioral Health Revenue Fund. The DBHIDS FY16 Budget will support 259 positions, 16 in the General Fund and 243 in the Grants Revenue Fund. Of the $1,230,225,490, $61,048,663, or 5%, is for intellectual disability and early intervention services, and $1,169,176,827, or 95%, is for behavioral health services.

Fund	Class	FY14 Actual	FY15 Current Projection	FY16 Proposed Budget	FY16-FY15 Change	FY16-FY15 Percent Change
General	100	974,425	991,846	1,000,066	8,220	0.8%
	200	12,693,482	12,975,510	12,875,510	-100,000	-0.8%
	Total	13,667,907	13,967,356	13,875,576	-91,780	-0.7%
	Positions	15	16	16	0	0.0%
Other*	100	22,396,786	22,243,030	23,142,889	899,859	4.0%
	200	1,102,835,254	1,080,027,573	1,191,223,587	111,196,014	10.3%
	300/400	277,722	457,190	407,190	-50,000	-10.9%
	800	1,760,706	1,571,553	1,576,248	4,695	0.3%
	Total	1,127,270,468	1,104,299,346	1,216,349,914	112,050,568	10.1%
	Positions	225	249	243	0	-2.5%
All	**100**	**23,371,211**	**23,234,876**	**24,142,955**	**908,079**	**3.9%**
	200	**1,115,528,736**	**1,093,003,083**	**1,204,099,097**	**111,096,014**	**10.2%**
	300/400	**277,722**	**457,190**	**407,190**	**-50,000**	**-10.9%**
	800	**1,760,706**	**1,571,553**	**1,576,248**	**4,695**	**0.3%**
	Total	**1,140,938,375**	**1,118,266,702**	**1,230,225,490**	**111,958,788**	**10.0%**
	Positions	**240**	**265**	**259**	**-6**	**-2.3%**

* Other Funds includes: County Liquid Fuels Tax Fund, Special Gasoline Tax Fund, HealthChoices Behavioral Health Fund, Hotel Room Rental Tax Fund, Grants Revenue Fund, Community Development Fund, Car Rental Tax Fund, Housing Trust Fund, Water Fund, Water Residual Fund, Aviation Fund, and Acute Care Hospital Assessment Fund.

Staff Demographics Summary (as of January 23, 2015)

	Total	Minority	White	Female
Full-Time Staff	243	186	57	178
Executive Staff	8	5	3	3
Average Salary - Executive Staff	$121,605	$135,067	$104,490	$119,552
Median Salary - Executive Staff	$122,422	$129,375	$104,490	$120,643

Employment Levels (as of January 23, 2015)

	Budgeted	Filled
Full-Time Positions	259	243
Part-Time Positions	2	2
Executive Positions	8	8

Contracts Summary (*as of December 2014)

	FY10	FY11	FY12	FY13	FY14	FY15*
Total amount of contracts	$7,047,196	$6,683,218	$8,935,044	$11,247,368	$11,667,684	$13,317,812
Total amount to M/W/DBE	$124,000	$398,933	$1,521,673	$1,609,768	$1,587,173	$1,395,545
Participation Rate	2%	6%	17%	14%	14%	10%

PERFORMANCE, CHALLENGES AND INITIATIVES

DEPARTMENT PERFORMANCE (OPERATIONS)

The number of unique clients served in out-patient treatment facilities decreased by 3.4% from FY13 to FY14. As of the first half of FY15, 56,174 clients have been served, a decrease of 5.99% from the same period in FY14. These recent reductions in outpatient utilization result from the expansion of other levels of care including three recently established partial hospital treatment programs. Use of out-of-state Residential Treatment Facilities (RTFs) has dropped significantly over time, from 303 individuals in FY08 to 23 individuals in FY13 and FY14. However, there are a relatively small number of people who require highly specialized services that are not available in-state and would be cost prohibitive to establish locally. Further decreases in out-of-state RTF placements are unlikely as a result. The number of new RTF admissions was introduced as a performance metric in FY14. The number of new admissions has dropped significantly since FY08 from 1,689 to 665 in FY14. Performance for this measure showed little variance from FY13 to FY14 (3.3% drop) and is on pace to meet the target of 680 new admissions in FY15. Measures for inpatient psychiatric facility discharge and readmission have a reporting window of 120 days. As a result, data is not yet available for FY15. From FY13 to FY14, the percent of follow-up within 30 days of discharge from an inpatient psychiatric facility (to help connect individuals to outpatient services and reduce recidivism) decreased by 11%, and the percentage remains below the initial FY08 benchmark. DBHIDS still expects to meet its FY15 goal of 63%. The percent of readmissions within 30 days to an inpatient facility declined from 21.4% in FY08 to 17.2% in FY14, and DBHIDS is working toward the goal of decreasing this percentage to 12% for FY15 and FY16.

Performance Measure	FY08	FY13	FY14	FY14-FY13 Change	FY14 Q1-Q2	FY15 Q1-Q2	FY15-FY14 Q1-Q2 Change	FY15 Goal	FY16 Goal
Number of unique clients served in out-patient treatment facilities	46,189	77,760	75,142	-3.4%	59,751	56,174	-5.99%	70,500	70,500
Number of unique clients served in out-of-state Residential Treatment Facilities	303	23	23	0.0%	19	25	28.9%	28	28
Number of new admissions to Residential Treatment Facilities	1,689	688	665	-3.3%	352	279	-20.7%	680	680
Percent of follow-up within 30 days of discharge from an inpatient psychiatric facility	62.4%	67.2%	59.8%	-11.0%	59.1%	N/A	N/A	63.0%	63.0%
Percent of readmission within 30 days to inpatient psychiatric facility (Substance Abuse & non-Substance Abuse)	21.4%	16.2%	17.2%	6.2%	16.7%	N/A	N/A	12.0%	12.0%

Performance Incentives: 2014 marked the fifth year that DBHIDS awarded payment bonuses to service providers based on their performance corresponding to a range of established measures. Performance incentives were available to providers across 15 levels of care. Standards required to earn Pay-for-Performance (PFP) awards were raised this year, resulting in 17% of agencies, or 73 providers, qualifying for incentives in 2014. The prior year, 45% of providers received performance awards. Continued performance improvement was observed for multiple measures including the following: 30-Day follow-up of persons discharged from Adult Inpatient Psychiatric treatment (from 71% in CY12 to 73% in CY13); the percent of appointments occurring within seven days of referral for adult mental health outpatient treatment (from 47% in CY12 to 51% in CY13); and the percentage of individuals having case management contact within two days of inpatient treatment admissions (from 87.9% in FY13 to 89.3% in FY14). A new measure is being piloted in 2015 to assess the participation of outpatient providers in public behavioral health screening events. Another new 2015 pilot measure involves gathering outcome data directly from service recipients and families via surveys. Both of these new measures will enhance efforts to comprehensively assess and improve service quality.

Performance Improvement and Accountability: In 2011, DBHIDS instituted the Network Improvement and Accountability Collaborative (NIAC) to streamline the measurement and analysis of behavioral health contract agency performance. This comprehensive approach is being progressively refined and used to promote efficiency, service quality, accessibility, as well as individualized and holistic care. Emphasis is placed on building program strengths while promoting community support and mobilization. In 2014, the monitoring team visited 66 service sites and evaluated 299 behavioral health programs.

DEPARTMENT CHALLENGES

- Continued Impact of State Cuts: Efforts continue to manage the fallout from the 10% behavioral health funding reduction enacted by the State FY13 combined with the elimination of General Assistance payments. The void left by the loss of these funds and entitlements continues to diminish the quality of life for thousands of local residents. The proposed FY16 state budget includes a provision for the restoration of the prior ten percent (10%) funding cut. This recommendation is encouraging; however, it is unclear if the final version of the commonwealth's budget will restore these funds.
- School District of Philadelphia: DBHIDS has a long history of collaboration with the School District of Philadelphia to provide medically necessary behavioral health treatment to children and families. School-based care includes behavioral health prevention, early intervention, assessment, and clinical treatment. Plans to optimize the deployment of school-based interventions will be assessed and adjusted on an on-going basis until the School District of Philadelphia's budget has been finalized.
- Healthy PA: Ensuring that individuals have access to behavioral health services in the wake of health reform constitutes a foremost DBHIDS priority. Under the prior State Administration, Pennsylvania opted for an alternative Medicaid reform plan, reforming the State's prior Medicaid program. "Healthy PA" significantly altered the Medicaid plan, eliminating most of the current Medical Assistance (MA) categories and creating two new benefit categories (low and high risk) as well as a private coverage option. These changes placed many people into plans that were no longer comprehensive enough to meet their health needs. In February 2015, newly elected Governor Wolf announced the intent to eliminate the Healthy PA plan and create one adult Medicaid expansion benefit package. The new State plan addresses many of the challenges posed by Healthy PA; however, it will take until the fall for all individuals to be transitioned from the Healthy PA program.

ACCOMPLISHMENTS & INITIATIVES

Transformation Decade: Over the past 10 years, DBHIDS has partnered with Mayor Michael Nutter, City Council, service recipients, family members, providers, other City Departments, and additional stakeholders to fundamentally transform the local network of care. Behavioral health and intellectual disability services have traditionally focused on symptom stability and crisis response. Over the past decade, DBHIDS has replaced these priorities with services and expectations promoting genuine recovery from behavioral health and addiction challenges, strengthening the resiliency of children, and offering individuals with intellectual disabilities opportunities to exercise choice and self-determination. Accomplishments achieved during this "Transformation Decade" have garnered local, national and international attention due the incontrovertible fact that Philadelphia's approach is working.

A major component of this transformation has involved strategic and sustained investments to foster the broad adoption of state-of-the-art approaches to treatment. The pervasive use of evidence-based treatment models has resulted in decreased use of crisis services, diminished in-patient recidivism, increased clinical stability, and enhanced cost efficiency. Simultaneously, DBHIDS has progressively increased the number of people being served and improved outcome performance across many levels of care.

Local innovations have attracted visitors from across the United States and around the world who seek to replicate Philadelphia's success. DBHIDS' achievements have been recognized by major news outlets including the New York Times, National Public Radio, and most recently the Wall Street Journal. Numerous behavioral health journals and professional organizations have cited DBHIDS' progressive, forward thinking approaches, frequently referenced as the "Philadelphia Model." Additional acknowledgments are anticipated this year as DBHIDS sponsors a series of events celebrating accomplishments achieved over the last decade that have immeasurably improved the quality of life for thousands of Philadelphians.

Public Health Approach: DBHIDS' emphasis on advancing a Public Health approach to service delivery has been a cornerstone of the aforementioned transformation. This expanded orientation transcends behavioral health and intellectual disability services to include population health promotion, community wellness, and a focus on social determinants of health. DBHIDS has instituted a number of initiatives consistent with Public Health promotion that are detailed later in this testimony. Several Public Health events and accomplishments of particular note include the following:

- The first annual "I Will Listen Day" was hosted by Philadelphia on June 3rd when hundreds of people, including the Mayor and members of City Council, recorded personal video messages vowing to listen to others without passing judgment. Thousands of additional local citizens signed pledges indicating their commitment to the "I Will Listen" campaign.
- National Depression Screening Day, October 9, 2014, involved over a dozen events across the City including college campuses, the Free Library and City Hall. This event contributed significantly to a 434% increase in the total number of online screenings last year via the DBHIDS' public health portal, HealthyMindsPhilly.org.
- Philadelphia pioneered the widespread application of Mental Health First Aid. This innovative early intervention and public education program teaches community members how to assist individuals experiencing behavioral health challenges. Per the Thomas Scattergood Foundation, "Philadelphia is using a public health approach to organize and implement Mental Health First Aid (MHFA) in a manner that will create change and impact all levels of society."
- The 2014 Recovery Walks event in Philadelphia attracted 23,000 participants for this annual procession through historic Old City. To date, this is believed to be the single largest recovery event worldwide.

Recovery Transformation: While behavioral health systems across the nation are now engaging in recovery-oriented care, DBHIDS was the trailblazer in transitioning away from a system primarily focused on mitigating symptoms and responding to acute distress. The "Philadelphia Model" is designed to enable individuals to recover from mental illness or addictions via enhanced access to individualized care, including an emphasis on prevention, early intervention, recovery and treatment. This work was made possible through unprecedented collaboration between City Departments, DBHIDS' network of service providers, service recipients, and family members, as well as top innovators and thinkers in the field of behavioral health.

Public Health Strategies to Address Behavioral Health Issues: A number of DBHIDS initiatives are consistent with an emphasis on a Public Health approach to service delivery, including the following:

- Community Wellness Coalitions: In 2014, DBHIDS established additional Community Wellness Coalitions (CWC). At a minimum, each Coalition consists of a community-based organization, a faith-based organization, a primary health care organization, and a licensed outpatient behavioral healthcare provider. These partners work together to share their resources, relationships and expertise to meet unaddressed behavioral health care needs presented by individuals in their shared communities. DBHIDS recently expanded this project to engage several populations facing unique challenges including Males of Color, refugees/immigrants, and Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual or Ally (LGBTQIA) communities. The Philadelphia Refugee Mental Health Coalition connects immigrant and refugee children to culturally appropriate mental health care where approximately 30-50 individuals receive service per day.
- Behavioral Health Screenings: Free behavioral health screenings are a component of Healthy Minds Philly, a DBHIDS public health strategy to extend non-treatment services to Philadelphians while offering treatment linkages as needed. DBHIDS, in partnership with the Scattergood Foundation and Screening for Mental Health, Inc., has created the nation's first behavioral health screening kiosk located in a retail clinic setting, called QCare, at a ShopRite in North Philadelphia. Behavioral health screenings are quick, free and anonymous; they are not diagnostic; they are available in English and in Spanish both online and via paper forms. To date, 3,630 online behavioral health screenings have taken place; 1,835 have occurred since May 2014. Screenings are available any time online at www.healthymindsphilly.org/screenings.
- Promoting Recovery through Art (The Porch Light Program): DBHIDS is collaborating with the City of Philadelphia's Mural Arts Program (MAP) to create a series of themed mural projects designed to promote community wellness, de-stigmatize mental health and addiction challenges, and create supportive, recovery-focused communities. To date, 27 projects have been completed. In 2014, one large scale mural was completed that conveyed universal themes of resilience, recovery, healing, as well as collective and individual strength. Murals currently in progress include "Community Wellness, "Southeast by Southeast,", "Finding Home", and "My Brother's Keeper."
- Cross Systems Contributions Over the course of the past year, DBHIDS contributed funding to support other City Departments engaged in collaborative efforts to address the holistic needs of vulnerable populations. These contributions totaled over $1 million and included the allocation of funds for services rendered to homeless persons involved with the Office of Supportive Housing (OSH).

Community Engagement Initiatives: The following initiatives are among those designed to involve and engage traditionally underserved populations:

- Faith-based initiatives: =The DBHIDS Faith and Spiritual Affairs (FSA) Unit is dedicated to informing faith and spiritual communities regarding behavioral health care while reducing associated stigma. Recent accomplishments include multiple workshops, presentations, articles, as well as radio and television interviews promoting faith-based unity, collaboration and proactive behavioral health care. Attendance at the annual Philadelphia FSA Conference grew from 280 attendees in 2013 to 500 in 2014. Local faith-based efforts also attracted national attention resulting in an invitation for the DBHIDS FSA Director to attend a White House event acknowledging the role of this local initiative in promoting enrollment in the Affordable Care Act.
- Mini grants: DBHIDS issued 10 mini grants of $5,000 each to address the issue of problem gambling. These two year grants, concluding in FY15, focus on gambling prevention, treatment, and education. Efforts were made to ensure that these resources benefitted a wide range of populations including African immigrants, Asian Americans, Vietnamese and Cambodian seniors, high school students, clergy, parents and children victimized by violence, mental health professionals, and homeless persons. To date, 6,492 individuals have participated in problem gambling prevention and education events provided by grant recipients.
- Re:Mind: Via this initiative, text messages are being employed to improve continuity of behavioral health care by supporting transitions to outpatient treatment following hospital stays. Specifically, this low cost mechanism issues outpatient appointment reminders via text messages to individuals who may be at risk of inpatient recidivism. 261 individuals, including adults and adolescents, have enrolled since this initiative was introduced in October 2014. Fifteen inpatient treatment providers from across the City are participating.

Creating a Stellar System – Expanding Evidence Based Practices: DBHIDS remains committed to the concept that Philadelphia residents who depend upon DBHIDS services should be afforded ample access to state of the art behavioral health interventions. Based on this commitment, DBHIDS continues to expand the availability of evidence-based treatment and technologies and is incorporating evidence-based expectations into our procurement and contracting processes. To enhance the impact of these approaches, DBHIDS has partnered with multiple internationally acclaimed originators of Evidence Based Practices (EBPs). To date, over 500 therapists from 60 programs have received EBP training. The following EBPs, promoting positive health outcomes, are supported by DBHIDS: Parent-Child Interaction Therapy, Child Parent Psychotherapy, Child Family Traumatic Stress Intervention, Trauma Focused Cognitive Behavior Therapy, Cognitive Behavior Therapy, Ecosystemic Structural Family Therapy, Functional Family Therapy, Multisystemic Therapy for Problem Sexual Behavior, Cognitive Behavior Therapy, Prolonged Exposure, Dialectical Behavior Therapy, Partners in Change Outcomes Management System, Assertive Community Treatment, and Beating the Blues Computer-based Cognitive Behavior Therapy. Detail regarding several EBPs is provided below:

- Ecosystemic Structural Family Therapy (ESFT): In partnership with Dr. Marion Linblad-Goldberg and the Philadelphia Child and Family Therapy Training Center, DBHIDS is currently training 24 therapists at 4 agencies to provide ESFT. Intensive training takes place twice each month over a 3 year period from January 2014-December 2016. This treatment approach is designed to assist families with children who are experiencing behavioral health problems and are at risk of out-of-home placement. Via ESFT, families learn skills needed to support their children at home and in community settings, alleviating the need for more intensive services.
- Improving Service Outcomes (Partners in Change Outcomes Management System - PCOMS): The Partners for Change Outcome Management System (PCOMS) is a federally recognized evidence-based, feedback-informed tool designed to improve service outcomes. This technology enhances outcomes for persons with challenging behavioral health needs through continual monitoring of achievements related to individualized recovery goals. PCOMS complements treatment by incorporating robust predictors of therapeutic success into an outcome management system that includes routine input from service recipients. To date, 21 programs across 13 local agencies have implemented this state-of-the art management system.
- Beating the Blues (BtB): Beating the Blues is a web-based, evidence-based, Cognitive Behavioral Therapy (CBT) program for the treatment of mild to moderate depression and anxiety. This resource is designed to benefit people who are awaiting therapy appointments and to foster increased communication and collaboration between clients and clinicians. The effectiveness of this user friendly, treatment modality has

been repeatedly confirmed via worldwide independent research studies. BtB was recently paired with peer support staff and piloted with 150 individuals who are unlikely to participate in traditional treatment options.

Addressing Community Trauma: DBHIDS is engaged in a multiyear, multifaceted, trauma transformation effort. Beginning with behavioral health practitioners and reaching out to partners across the City, DBHIDS is combining evidence-based practices and other innovative approaches to raise levels of resilience and heal the effects of trauma. The comingled impacts of trauma induced stress are often associated with chronic illness, mental health challenges, addiction, patterns of victimization, destructive relationships, as well as problems at home, work and school. DBHIDS has introduced a growing number of initiatives intended to counteract the effects of trauma and prevent repeated traumatization. The following resources are among those designed to address trauma-related symptoms and suppress trauma recurrence.

- Early Trauma Intervention (Healing Hurt People - HHP): Healing Hurt People is a trauma intervention program based in medical emergency departments that provides assistance to individuals and families victimized by physical violence. Youth and young adults who present in Emergency Rooms with violence precipitated injuries are screened to assess levels of need for behavioral health and social services. Licensed social workers assist young victims of intentional injury to access services intended to moderate the impact of trauma and encourage rapid recovery. Follow-up supports are provided in hospital settings and in family homes to decrease repeat victimization, prevent retaliation by victims or their families, and facilitate behavioral health service linkages. Currently these services are provided on-site at Hahnemann Hospital and St. Christopher's Hospital for Children. In 2015, HHP will expand to include Temple University Hospital. Further expansion is projected in FY16.
- Mental Health First Aid: Philadelphia has emerged as a national leader in the public promotion of behavioral health via the Mental Health First Aid (MHFA) initiative. MHFA is a groundbreaking early intervention, public education program that teaches community members how to identify, understand, and respond to individuals experiencing behavioral health challenges. MHFA training dispels stigma and misinformation about behavioral health challenges that impedes efforts to connect individuals with appropriate care. This training has been made available to the public, faith communities, the Police and Fire Departments, the School District, and many other organizations. This project is on track to have trained 10,000 individuals by the end of 2015.
- Treating Post Traumatic Stress: Prolonged Exposure Trauma Training, designed to treat Post Traumatic Stress Disorder (PTSD), has been provided for 33 therapists across 10 addiction treatment agencies that serve parenting and non-parenting women. Anticipated outcomes include increased understanding of trauma impacts and expanded public awareness of symptoms and resources. Further trainings are being targeted to key populations including faith-based organizations, LGBTQIA groups, and a range of other community stakeholders.
- Preventing Suicide and Self-Harm (Dialectical Behavior Therapy): This highly specialized treatment approach was conceived to help adults and adolescents who engage in very high risk behaviors including repeated attempts to harm themselves or commit suicide. Dialectical Behavior Therapy (DBT) focuses on improving emotion self-regulation skills that allow individuals to remain safe, avoid crisis events and hospitalizations, utilize less restrictive levels of care, and increase their quality of life. To date, 40 clinicians from six agencies have received intensive DBT training. DBHIDS has partnered with the Treatment Implementation Collaborative (TIC) to ensure that the delivery of DBT treatment is supported and retained in the local system of care. In 2015, TIC will tailor trainings to address areas of need identified by providers, including advanced behavioral assessments and trauma treatment. This initiative has been expanded to include the provision of this state-of-the-art treatment to high need adolescents.
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT): TF-CBT is a psychotherapy model with exceptionally strong research evidence confirming its effectiveness as a treatment for children and youth who have experienced trauma. Via TF-CBT, children and families are equipped with the skills needed to manage intrusive and upsetting trauma memories; reduce or eliminate avoidance of trauma triggers, and address depression, anxiety, sexualized behaviors and dysfunctional behaviors. To date, 151 Therapists and Supervisors from 15 Behavioral Health Agencies have received TF-CBT training.
- Child and Family Traumatic Stress Intervention (CF-TSI): CF-TSI is a brief, intensive intervention designed to decrease the negative impact of exposure to potentially traumatic events including sexual and physical abuse, domestic violence, and motor vehicle accidents, for children ages 7 to 18. Treatment is designed to be

delivered within the first 45 days of exposure to a potentially traumatic event to prevent onset of Post-Traumatic Stress Disorder (PTSD). Treatment goals include improved screening and identification of children impacted by traumatic stress, reduced traumatic stress symptoms, improved communication between caregiver and child, enhanced skills to master trauma reactions, and assessments of need for longer-term treatment. To date, CF-TSI training has been provided to 18 clinicians from three behavioral health and two hospital-based violence intervention programs (Children Hospital Of Philadelphia's Violence Intervention Program (VIP) and St. Christopher's Hospital).

- Promoting Safety (The Sanctuary Model): The Sanctuary Model is a trauma-informed approach, designed to create organizational change. This model promotes creation of safe therapeutic communities for staff and service recipients. Emphasis is placed on tailoring services to respond to the varied impacts of trauma and establish organizational cultures where individuals and families are able to recover in safe therapeutic environments. To date, personnel from thirty-three agencies have received trauma-focused, evidence-based training.
- Responding to Emergencies (Community Response Teams - CRT): Community Response Teams provide emotional support to communities affected by disasters, emergencies, or other large scale events, including community violence, that require community support and intervention. Teams focus on reducing stress, supporting individuals and impacted communities, providing as needed service referral assistance, and following-up with individuals to track progress. All team members are trained in Psychological First Aid. Over the course of last year, teams responded to incidents of community violence involving shootings, fatal auto accidents; and fire fatalities including the active duty death of Firefighter Craig Lewis. Response Teams have also collaborated in city-wide, cross-systems planning and response efforts to insure that coordinated emergency supports and services are provided as needed.

Addressing Behavioral Health Disparities: DBHIDS seeks to encourage promising efforts designed to eliminate racial and ethnic health disparities and promote health equity and wellness for all people. The Office of the Surgeon General has documented nationwide disparities impacting minority groups including factors such as service access, availability, quality, and outcomes. To address these disparities, DBHIDS has implemented initiatives to enhance service access, engagement, and treatment retention. Recent efforts to reduce health disparities include the following:

- Engaging Men of Color (EMOC): Engaging Males Of Color (EMOC) is a project that seeks to promote an enhanced awareness of the behavioral health challenges experienced by males of color across the Philadelphia region. EMOC is focused on cultivating equity by addressing the impact of health, economic and educational disparities. The goal is to improve overall quality of life for this marginalized population. These efforts incorporate transformative approaches that emphasize recovery, resilience and self- determination. These measures are intended to result in the development of a continuum of engagement approaches. Target populations include African-American, African, Asian, and Latino men and boys who live in Philadelphia. To date, EMOC has served over 100 men and boys. In partnership with the Mural Arts program, EMOC is creating the first mural in the country dedicated to the lived experience of men and boys of color. In January of 2015, EMOC held its first Martin Luther King Day of Service project at the Juvenile Justice Services Center (JJSC), benefitting 30 youth and young men housed in that facility. Monthly workshops will be conducted at JJSC on a range of relevant topics including resilience, overcoming challenges, and making positive decisions.
- Improving Access to Behavioral Health Outpatient Treatment: In January 2014, two new outpatient programs were established in Southwest Philadelphia to expand behavioral health treatment access for adults and children living in historically underserved communities. A third outpatient facility opened in mid 2014 and a fourth program is projected to become operational in 2015. The fourth and final outpatient site is being developed in partnership with West African community stakeholders. These new resources were created to address long standing service access disparities in targeted areas of Southwest Philadelphia. These new, high quality treatment programs have a combined capacity to serve 400 individuals at a total annual cost of approximately $400,000, reimbursed via Medical Assistance billing. Cost offsets are anticipated resulting from participants' decreased utilization of acute inpatient treatment and crisis services.

Embracing Health Care Reform: DBHIDS continues to partner with local, state and federal organizations to acquire, apply and disseminate Healthcare Reform information relevant to the local behavioral health system. These efforts

include monthly newsletters, bimonthly policy updates, the use of social media, and a regularly updated website. Technical support is being extended to internal staff and external partners regarding varied provisions of the Affordable Care Act. DBHIDS also tracks state Medicaid laws and their impact on behavioral health services. Monthly Lunch & Learn educational sessions will continue and an evaluation of these efforts will be conducted to ensure that stakeholder' needs are being addressed.

Intellectual disAbilities Services: DBHIDS serves approximately 7,700 children and adults with intellectual disabilities annually. An additional 6,100 infants and toddlers receive Early Intervention Services each year. The Infant Toddler/Early Intervention program has a significant impact on the developmental trajectory of children from birth to age three. As a result, many of these children enter elementary school without the need for additional supports. Specific accomplishments include the following:

- Philadelphia Infant Toddler Early Intervention: This initiative served over 6,300 infants and toddlers in FY14; 200 more children than were served the prior year.
- Employment: In FY14, 500 individuals with intellectual disabilities were employed which marks a 3% increase in comparison to FY13.
- Implementing Behavioral Health/Intellectual Disability Community Treatment: A mobile service was established to provide intensive supports, including case management and psychotherapy, to people with co-occurring mental illness and intellectual disabilities. Special emphasis is placed upon decreasing hospitalizations and crisis visits, promoting recovery outcomes, and allowing individuals to remain in their homes and communities. The team accepted their first referral in 2014 and finished that year with 18 enrolled participants. It is anticipated that by the conclusion of FY15, the caseload will grow to 90 service recipients.

Intellectual disAbility Employment: In FY16, efforts to increase employment for individuals with intellectual disabilities will include the following:

- Working with schools to support transition planning that includes connections to employment and plans to facilitate transitions at earlier ages.
- Use of a peer support model to encourage families to pursue employment and employment supports.
- Collaboration with parents to help identify employment resources in their communities that may benefit their family members.
- Continued involvement in the Commonwealth's 'Futures Planning,' to promote county-based, employment strategies.

Improving Autism Services: DBHIDS continues to explore and provide person and family directed approaches for those impacted by Autism Spectrum Disorders (ASD). Interventions for this condition continue to evolve and emerge. Recent efforts by DBHIDS to provide additional ASD supports include the following:

- Specialized ASD Services: DBHIDS continues to expand the number of specialized autism treatment services provided to youth and families. In FY14, 4,952 unique youth accessed ASD services; this constitutes a 5.56% increase in comparison to FY13. Community-based treatment supports have increased and hospitalizations have decreased. The continuum of specialized ASD resources now includes Extended Assessment Services (EAS), Outpatient Therapy, Medication Management, Behavioral Health Rehabilitation Services, Blended Case Management, Summer Programs, After-School Programs, and Family Based Services. Provider agencies are also developing a range of educational and support groups.
- Establishment of Autism Centers of Excellence (COEs): Autism Centers of Excellence enhanced their treatment service continuum by implementing after school programming in 2014. They also provided opportunities for family training and support, including the establishment of a Parent Advisory Board. Furthermore, COEs have developed relationships with community stakeholders including academic centers, the School District of Philadelphia, parent and advocacy groups, and the Eastern Region Autism Services, Education, Resources and Training (ASERT) Collaborative (a statewide initiative funded by the Bureau of Autism Services, PA Department of Human Services). The provision of advocacy and psychoeducation trainings for families and community stakeholders is ongoing.

Leadership Development: DBHIDS remains committed to encouraging and equipping department personnel to acquire the skills and abilities needed to optimize productivity and advance careers. The Leadership Development

Program serves as a cornerstone of these efforts. This initiative prepares leaders and those aspiring to positions of leadership to grasp organizational challenges, embrace professional development opportunities, and implement DBHIDS' transformational vision. The Leadership Development Program is based on evidence-based research that employs comprehensive instruction, personality assessments (Myers Briggs), shadowing of senior staff and action learning projects that encourage innovation, teambuilding, and skill application. As of June 2015, 449 DBHIDS employees will have graduated from this training, including 214 supervisors/managers and 235 front line staff.

Peer Specialists: The infusion of Peer Specialists into multiple levels of care across the local, behavioral health network has served as a cornerstone for system transformation. Since the inception of the Certified Peer Specialist (CPS) program in 2006, over 700 Peer Specialists have been trained and certified in Philadelphia. In FY16, DBHIDS will continue to increase peer staff opportunities across the provider network with an emphasis upon impacting specialized populations (forensic, youth, veterans, LGBTQIA communities, etc.). Consistent with these efforts, DBHIDS is restructuring the Certified Peer Specialist training to promote better employment outcomes for these individuals and provide enhanced, ongoing support of peer staff. In FY12, DBHIDS introduced the Philadelphia Warmline, staffed by Peer Specialists, as a resource for citizens who are experiencing anxiety, depression, loss, relationship difficulties, or other life challenges. From November 1, 2013 through November 30, 2014, Peer Specialists staffing the Warmline received 812 calls.

Homelessness: DBHIDS has introduced best practices and evidence-based, data-driven strategies to better serve people confronted with behavioral health challenges who are experiencing homelessness. Partnerships with the Office of Supportive Housing, the Philadelphia Housing Authority, and other organizations have greatly expanded housing and supports, including Medical Assistance funded services, for this highly vulnerable population. More than 2,000 homeless individuals and 1,200 homeless families have benefited to date. This work has garnered praise as a national model and prompted visits from across the country.

Permanent Supported Housing (PSH): Permanent Supported Housing combines DBHIDS behavioral health services, including case management, with approximately 700 rental subsidies provided by affordable housing funding sources including the Philadelphia Housing Authority. This project is intended to promote recovery and independence via a blend of flexible supports provided to people with significant behavioral health needs who are living in stable, subsidized housing arrangements. It has been determined that participants used far less inpatient and other acute care services one year post PSH placement, in comparison to one year before entering this program. Acute care savings were estimated to total $6.6 million across the entire population of PSH residents over a three year period.

Partnership with the School District of Philadelphia: DBHIDS continues its longstanding, strong partnership with the School District of Philadelphia to make schools safer and healthier learning environments. The investment in school-based, behavioral health services is unparalleled across the nation and specifically designed to support at-risk students before they need help. These efforts include School Therapeutic Services where clinicians are deployed to provide mental health supports for students, guided by treatment plans developed in collaboration with teachers, students, parents, and other care givers. In the FY14 academic school year, more than 37,000 students received drug and alcohol prevention services. Addiction prevention services are expected to reach 38,000 students in FY15 and 39,000 students in FY16. The goal for other school-based, behavioral health services is to maintain existing levels of support and endeavor to address emerging needs as they become evident. Efforts are currently underway to apply for a Federal System of Care cooperative agreement to expand the provision of behavioral health services to children, youth and families.

Acquisition and Application of External Resources: DBHIDS continues to explore opportunities to pursue additional funding and resources including government and foundation grants. Recent successes include the following grant awards:

- Comprehensive Assessment for Placement and Services for the First Judicial District Mental Health Court (FJDMHC): This federal grant funded project began in October 2014 and is scheduled to conclude in September 2016. The project seeks to improve the FJDMHC's response to justice-involved persons with severe mental illnesses in order to decrease criminal recidivism and improve behavioral-health functioning and recovery among court participants. DBHIDS plans to evaluate current FJDMHC practices and facilitate the

implementation of a more evidenced-based protocol that includes: (1) screening/assessment of both criminogenic and behavioral health risk/needs; (2) enhanced interventions that target criminogenic risk/needs and behavioral challenges; and (3) linkages to recovery-fostering supports.

- Access to Recovery Program Accomplishments: The Access to Recovery (ATR) Program was an $11 million, four-year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). This grant provided uninsured or underinsured adults struggling with alcohol or drug challenges with an array of options and choices to obtain clinical and enhanced recovery support services. Over the course of 4 years, concluding in December 2014, this project served 11,648 people, surpassing the goal of 10,705. The ATR initiative succeeded in reducing levels of homelessness among this population by 63.1% and increasing substance use abstinence by 30%. Additionally, 30.9% of participants achieved their personal goals related to education or employment.

STAFFING

Staff Demographics (as of January 23, 2015)

	Full-Time Staff			*Executive Staff*	
	Male	**Female**		**Male**	**Female**
	African-American	African-American		African-American	African-American
Total	32	136	*Total*	3	2
% of Total	13.0%	56.0%	*% of Total*	37.0%	25.0%
	White	White		White	White
Total	25	32	*Total*	2	1
% of Total	10.0%	13.0%	*% of Total*	25.0%	12.0%
	Hispanic	Hispanic		Hispanic	Hispanic
Total	5	5	*Total*	0	0
% of Total	2.0%	2.0%	*% of Total*	0.0%	0.0%
	Asian	Asian		Asian	Asian
Total	2	3	*Total*	0	0
% of Total	1.0%	1.0%	*% of Total*	0.0%	0.0%
	Other	Other		Other	Other
Total	1	2	*Total*	0	0
% of Total	1.0%	1.0%	*% of Total*	0.0%	0.0%
	Bi-lingual	Bi-lingual		Bi-lingual	Bi-lingual
Total	5	5	*Total*	0	0
% of Total	2.0%	2.0%	*% of Total*	0.0%	0.0%
	Male	Female		Male	Female
Total	65	178	*Total*	5	3
% of Total	27.0%	73.0%	*% of Total*	62.0%	38.0%

	FY15 New Hires	
	Men	Women
Black	2	10
White	1	1
Hispanic	1	0
Asian	0	0
Other	0	0
Total	**4**	**11**

Two of the new hires are bilingual. The languages spoken are Spanish and Russian.

CONTRACTING

Philadelphia 21st Century Minimum Wage and Benefits Standards: DBHIDS contracts with over seventy agencies to provide a range of behavioral health services for children and adults across the City. Originally, fifteen contractors submitted requests for wage and/or benefit waivers pertaining to the new Standards. In dialogue with DBHIDS, twelve of the fifteen contractors subsequently achieved compliance and withdrew their waiver petitions. Ultimately, only three contractors pursued and were granted waivers based on rationales that included collective bargaining or training considerations. DBHIDS will continue to encourage and promote universal compliance with the new standards across our contract service network.

Minority/Women/Disability Provider Participation: Participation by minority and women in both leadership positions and workforce composition among DBHIDS non-profit contract service providers remains high. Specifically, 91.1% of the total workforce and 72.2% of executive staff of non-profit contract agencies are comprised of minority or female employees. It should also be noted that the number of contract providers with formal plans to promote diversity increased from 50% in FY13 to 65.8% in FY14.

M/W/DBE Participation on Large Contracts
FY15 For Profit Contracts

Vendor	Service Provided	Amount of Contract	RFP Issue Date	Contract Start Date	Ranges in RFP	% of M/W/DBE Participation Achieved	$ Value of M/W/DBE Participation	Total % and $ Value Participation - All	Living Wage Compliant ?
Kids & Family	IDS/EI	$1,325,000	4/18/14	7/1/15	MBE: 0-0%	0%	$0		Yes
					WBE: 0-0%	0%	$0	0%	
					DSBE: 0-0%	0%	$0	$0	
Goldstar Rehabilitation	IDS/EI	$1,748,000	4/18/14	7/1/15	MBE: 20-35%	0%	$0		Yes
					WBE: 20-35%	0%	$0	0%	
					DSBE: 0-0%	0%	$0	$0	
Sunshine Therapy Club (1)	IDS/EI	$1,208,000	4/18/14	7/1/15	MBE: 0-0%	0%	$0		Yes
					WBE: 0-0%	0%	$0	0%	
					DSBE: 0-0%	0%	$0	$0	
Sunny Days (1)	IDS/EI	$736,000	4/18/14	7/1/15	MBE: 0-0%	0%	$0		Yes
					WBE: 0-0%	0%	$0	0%	
					DSBE: 0-0%	0%	$0	$0	
Resilient Business Solutions	Database/System Administration	$610,000	TBD	7/1/15	MBE: 10-15%	0%	$0		Yes
					WBE: 10-15%	100%	$610,000	100%	
					DSBE: 0-0%	0%	$0	$610,000	

(1) Woman-owned noncertified provider

M/W/DBE Participation on Large Contracts
FY15 Non Profit Contracts

Vendor	Service Provided	Amount of Contract	RFP Issue Date	Contract Start Date	Ranges in RFP	% of M/W/DBE Participation Achieved	$ Value of M/W/DBE Participation	Total % and $ Value Participation - All	Living Wage Compliant?
Resources for Human Development	Mental Health	$17,623,028	N/A	7/1/15	MBE:	0%	$0		Yes
					WBE:	0%	$0	0%	
					DSBE:	0%	$0	$0	
NHS Philadelphia	Mental Health	$11,862,179	N/A	7/1/15	MBE:	0%	$0		Yes
					WBE:	0%	$0	0%	
					DSBE:	0%	$0	$0	
Horizion House	Mental Health	$6,050,355	N/A	7/1/15	MBE:	0%	$0		Yes
					WBE:	0%	$0	0%	
					DSBE:	0%	$0	$0	
Mental Health Association of Southeastern PA	Mental Health	$6,404,036	N/A	7/1/15	MBE:	0%	$0		Yes
					WBE:	0%	$0	0%	
					DSBE:	0%	$0	$0	
COMHAR	Mental Health	$4,736,002	N/A	7/1/15	MBE:	0%	$0		Yes
					WBE:	0%	$0	0%	
					DSBE:	0%	$0	$0	

Resources for Human Development:	Minority or Female
Workforce	84.50%
Executive	44.40%
Board	60.00%
Citizens Acting Together Can Help:	
Workforce	74.00%
Executive	65.00%
Board	52.00%

NHS Philadelphia:	Minority or Female
Workforce	93.20%
Executive	61.00%
Board	17.30%
Mental Health Assoc of Southeastern PA:	
Workforce	73.00%
Executive	46.70%
Board	75.50%

OTHER BUDGETARY IMPACTS

FEDERAL AND STATE (WHERE APPLICABLE)
See the aforementioned detail in DBHIDS Challenges section (1st and 3rd paragraphs).

OTHER
Not applicable.

DEPARTMENT OF PUBLIC HEALTH
FISCAL YEAR 2016 BUDGET TESTIMONY
APRIL 29, 2015

EXECUTIVE SUMMARY

DEPARTMENT MISSION AND FUNCTION

Mission: To protect and promote the health of all Philadelphians and to provide a safety net for the most vulnerable.

Description of Major Services: The Philadelphia Department of Public Health (PDPH) is comprised of thirteen divisions that provide the infrastructure and programming for disease prevention, food safety, environmental health and health care services. PDPH also works with a broad network of community, hospital, academic and business partners throughout Philadelphia and the Delaware Valley to make Philadelphia a healthier place to live, work and play.

PROPOSED BUDGET HIGHLIGHTS/FUNDING REQUEST

Budget Highlights: The FY16 Proposed Budget for PDPH is on par with the FY15 Current Projection.

	Class	FY14 Actual	FY15 Current Projection	FY16 Proposed Budget	FY16-FY15 Change	FY16-FY15 Percent Change
General	100	43,438,286	50,107,392	50,298,254	190,862	0.4%
	200	60,457,774	60,113,510	59,953,424	(160,086)	-0.3%
	300/400	5,413,266	5,490,768	5,490,768	0	0.0%
	800	500,000	500,000	500,000	0	0.0%
	Total	109,809,327	116,211,670	116,242,446	30,776	0.0%
	Positions	659	762	781	0	0.0%
Other*	100	15,840,284	18,065,976	20,416,740	2,350,764	13.0%
	200	206,966,479	214,318,437	212,394,523	(1,923,914)	-0.9%
	300/400	2,233,976	1,670,779	1,782,279	111,500	6.7%
	800	1,628,948	2,220,355	2,865,555	645,200	29.1%
	Total	226,669,687	236,275,547	237,459,097	1,183,550	0.5%
	Positions	169	231	231	0	0.0%
All	**100**	**59,278,570**	**68,173,368**	**70,714,994**	**2,541,626**	**3.7%**
	200	**267,424,254**	**274,431,947**	**272,347,947**	**(2,084,000)**	**-0.8%**
	300/400	**7,647,242**	**7,161,547**	**7,273,047**	**111,500**	**1.6%**
	800	**2,128,948**	**2,720,355**	**3,365,555**	**645,200**	**23.7%**
	Total	**336,479,014**	**352,487,217**	**353,701,543**	**1,214,326**	**0.3%**
	Positions	**828**	**993**	**993**	**0**	**0.0%**

* Other Funds includes: County Liquid Fuels Tax Fund, Special Gasoline Tax Fund, Healthchoices Behavioral Health Fund, Hotel Room Rental Tax Fund, Grants Revenue Fund, Community Development Fund, Car Rental Tax Fund, Housing Trust Fund, Water Fund, Water Residual Fund, Aviation Fund, and Acute Care Hospital Assessment Fund.

Staff Demographics Summary (as of December 2014)

	Total	Minority	White	Female
Full-Time Staff	830	608	222	584
Executive Staff	23	10	13	13
Average Salary - Executive Staff	$135,520	$123,302	$133,816	$124,221
Median Salary - Executive Staff	$107,693	$107,587	$107,693	$102,477

Employment Levels (as of December 2014)

	Budgeted	Filled
Full-Time Positions	992	830
Part-Time Positions	83	49
Executive Positions	25	23

Contracts Summary (*as of December 2014)

	FY10	FY11	FY12	FY13	FY14	FY15*
Total amount of contracts	$10,910,304	$20,721,079	$6,205,317	$6,258,257	$6,098,748	$6,221,700
Total amount to M/W/DBE	$100,471	$10,983,826	$929,425	$1,334,834	$2,392,181	$2,192,162
Participation Rate	1%	53%	15%	21%	39%	35%

PERFORMANCE, CHALLENGES AND INITIATIVES

DEPARTMENT PERFORMANCE (OPERATIONS)

Uninsured clinic visits: In FY14, the percentage of uninsured visits at the City's health centers was 49.6%, slightly lower than the 52.9% reported in FY13. There was a corresponding small increase in the percent of visits covered by Medicaid and private insurance. Patients without insurance are seen by a benefits counselor to review medical insurance options, and those counselors process applications to increase the number of insured individuals visiting the City's health centers. In recent years and continuing into the first two quarters of FY15, the percentage of uninsured patient visits has been relatively stable at approximately 50%. This indicates that the initial implementation of the Affordable Care Act implementation in Pennsylvania, which expanded access to private insurance coverage under the Federal exchange program, had a minimal impact on levels of insurance coverage among PDPH patients and that potential impacts of Medicaid expansion, which went into effect in January 2015, are yet to be seen.

Restaurant inspections: PDPH aims to inspect Risk Category 1 food establishments (establishments that prepare food and serve it for immediate consumption) at intervals of 12 months and has focused efforts to reduce this interval from a high of 17.6 months in 2011 to 14.6 in FY14. In prior years, the long hiring cycle for sanitarians contributed to long-term vacancies and difficulty in meeting the interval goal for inspections. New approaches to hiring have recently reduced the number of sanitarian vacancies and the length that those vacancies are open, decreasing the time to fill sanitarian positions from 245 days in 2011 to 180 days as of the second quarter of FY15.

HIV infections: The number of case reports of newly diagnosed HIV infections dropped by 16.9% (119 fewer cases) from FY13 to FY14. The 585 cases reported in FY14 remain well below FY08 levels of 1,438, reflecting progress in preventing new HIV infections during this period. During the first half of FY15, there were 327 cases, a 3.8% increase over the same time period in FY14 which is believed to be related to fluctuations in staffing and improvements in the timeliness of reporting rather than a true increase in cases.

Medical Examiner's Office: Since FY12, the Medical Examiner's Office has focused on increasing the percentage of final reports for homicides that are completed within 60 days, both to improve its service and to comply with standards set by the National Association of Medical Examiners. In FY14, 96.5% of all homicide autopsy reports were completed within the 60 day period. This percentage dropped in the first half of FY15 due to physician vacancies in the Pathology Unit. Recruiting efforts and increased pay rates helped address this issue and new staff will start in the fourth quarter of FY15 and the first quarter of FY16.

Immunizations: The percent of children 19-35 months of age with complete immunizations was 78%. 4% higher in FY14 compared to FY13. During the first half of FY15, 85% of children had complete immunizations, a 9% increase over the same time period in FY14. For measles vaccine, 95.9% of children 19-35 months of age have received one or more doses, which is higher than both the state and national levels.

Performance Measure	FY08	FY13	FY14	FY14-FY13 Change	FY14 Q1-Q2	FY15 Q1-Q2	FY15-FY14 Q1-Q2 Change	FY15 Goal	FY16 Goal
Percentage of visits uninsured	52.1%	52.9%	49.6%	-6.2%	54.0%	51.7%	-4.4%	50.0%	48.0%
Inspection interval for category 1 food establishments (months)	N/A	17.2	14.6	-15.4%	11.9	13.5	13.5%	13.0	12.0
Total number of newly diagnosed HIV case reports	1,438	704	585	-16.9%	315	327	3.8%	600	600
Homicides having final autopsy report completed within 60 days	80.0%	95.0%	96.5%	1.6%	97.5%	90.5%	-7.2%	95.0%	95.0%
Children 19-35 months with complete immunizations 4:3:1:3:3:1	N/A	75.0%	78.0%	4.0%	78.0%	85.0%	9.0%	78.0%	87.0%

DEPARTMENT CHALLENGES

- Hiring: PDPH faces multiple challenges in filling vacant positions in a timely manner. This reflects the spectrum of capacities PDPH requires, including multiple technical specialties, a competitive hiring marketplace, dependence on federal grants, the large number of highly experienced staff retiring under the DROP program, and the length of time required to navigate internal hiring procedures. PDPH's goal is to fill positions as quickly as possible. To this end, PDPH continues to review and improve the department's hiring procedures in consultation and collaboration with OHR, promote succession planning in all divisions, and conduct various recruiting activities. In addition, as part of the work towards achieving public health accreditation, in FY14 PDPH developed a new workforce development plan. The reduction in time to fill vacant sanitarian positions and improve the competiveness of pathologists salaries are examples of the results of these efforts.
- Rapid evolution of health information technologies: Advances in health information technologies present tremendous opportunities and challenges for the field of public health, in general, and for PDPH. More timely, complete, and accurate data about the health of clinic patients and, more broadly, the population of Philadelphia, will enable PDPH to improve services and programs. But, to take full advantage of this opportunity will require ongoing enhancements to PDPH's information technology infrastructure, the capacity to manage and make effective use of data in rapidly developing information technology environments, and a data-savvy workforce.
- Health Center Appointment Availability: As of March, 2015, all eight health centers had new and return pediatric appointments available within one month. More than half of the health centers have appointments for adult care within two months of request, and almost all have appointment availability within three months. These wait times are, on average slightly longer than wait times a year ago, and reflect reduced access due to implementation of the Electronic Health Record (EHR). This includes expected slow-downs required for physician, nursing, and clerical/administrative staff training, acclimation to new work procedures, and time needed to transfer paper records into the EHR. New adult patient appointment availability at Health Center 10 has the longest wait time, which currently averages around five months. The long wait for an adult appointment is attributed to the scarcity of other health care options in Northeast Philadelphia. As clinic staff becomes increasingly familiar with the use of the EHR, PDPH anticipates that the EHR will lead to improvements in efficiency.

ACCOMPLISHMENTS & INITIATIVES

Ebola Response: In the summer of 2014, PDPH, as the lead department responsible for the ongoing prevention and control of communicable diseases within the County, began enhancing Ebola readiness by updating preparedness plans, issuing health guidance to providers and the community, and coordinating with City agencies, hospital emergency directors, infection control specialists, the federal Centers for Disease Control & Prevention (CDC), the Pennsylvania State Health Department and other response partners. The Department also worked with the West African community in Philadelphia to educate, support, and meet the needs of newly-arriving persons.

In October 2014, at the request of the CDC, PDPH began daily monitoring of all persons newly arrived to Philadelphia from one of the affected West African countries for signs and symptoms of possible Ebola Viral Disease. Between October 2014 and March 2015, PDPH followed 453 individuals. This represents approximately 5% of the total arriving in the US. PDPH has been in daily contact with each of these individuals for 21 days following their departure from an affected country, including weekends and holidays. Each visit or phone contact involved collecting the person's temperature and a review of their health status to assure that they remained well. Nine patients required more intensive investigation, including physician evaluation and diagnostic testing, and all nine persons were determined to have other reasons for their illness; none were found to have Ebola Viral Disease. While media attention has waned, the outbreak is not over and PDPH will continue to monitor the situation.

Chronic Disease Prevention & the Decline in Smoking and Obesity Rates in Philadelphia: Smoking and obesity are the largest contributors to preventable illness and premature death in the United States. Through the *Get Healthy Philly* initiative, funded through City general funds and state and federal grants, PDPH has spearheaded an innovative citywide effort to address tobacco use, poor diet, and physical inactivity in partnership with other City agencies and non-governmental organizations. Interventions have focused on making the healthy choice the easier choice in schools, workplaces, communities, and health care settings.

Because of *Get Healthy Philly* and other initiatives at the local, state, and federal levels, smoking in Philadelphia has declined by 30% among youth since 2007 and by 15% among adults since 2008. In addition, childhood obesity rates have decreased by 6.3% since the 2006-07 school year, including substantial reductions among racial/ethnic minorities. Get Healthy Philly has been recognized by national and international media outlets and public health organizations as a model for how local governments can improve the health of their communities. Key *Get Healthy Philly* interventions have included:

- Creating food and fitness standards for all City-funded afterschool programs;
- Developing the largest healthy corner store network in the U.S.;
- Implementing a mass media campaign highlighting the links between sugary drink consumption, obesity, and diabetes in children;
- Extending smoke-free rules to all City parks, recreation centers, and playgrounds;
- Launching multiple rounds of hard-hitting media campaigns to encourage tobacco cessation; and
- Supporting the passage of laws to prevent tobacco sales to minors, limit sales and use of e-cigarettes, and increase the price of conventional cigarettes by $2.00 per pack.

In 2015, Get Healthy Philly will assist college and universities, public housing communities, and behavioral health facilities to implement smoke-free policies. This will protect students, residents, and patients from secondhand smoke exposure, reduce asthma exacerbations and the risk of fire, and motivate more Philadelphians to quit smoking.

In 2015, Get Healthy Philly will launch the first-ever local media campaign to encourage physical activity by highlighting real Philadelphians exercising in free and low-cost ways. The campaign will be titled—"Make Philly Your Gym!" and will be supported through federal funds from the CDC.

Lastly, Get Healthy Philly will further its partnerships with hospitals and clinical providers to improve the quality of care for Philadelphia adults affected with hypertension (38%) and diabetes (16%). Through a four-year $11.2 million grant from the Center for Disease Control, PDPH will work with 40 primary care practices that serve 350,000 patients to implement a series of quality-of-care improvement initiatives, including optimal use of electronic health records, team-based chronic disease management, aggressive identification of undiagnosed patients, home-based blood pressure monitoring, and better linkages between clinical practices and community resources.

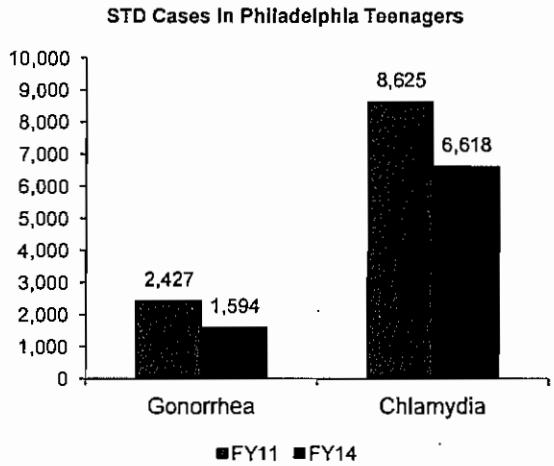
Electronic Health Records: As of March 2015, PDPH completed the installation of the practice management and medical record components of an Electronic Health Record (EHR) at all eight neighborhood health centers operated by PDPH. While the transition to the use of an EHR has resulted in temporary slow-downs in service as noted above, the use of EHR will improve clinical outcomes for patients, improve integration of health services across the City's clinics, provide a knowledge base for public health policy, and improve reporting to disease and immunization monitoring systems. Adoption of the EHR will bring PDPH into compliance with federal Medicaid and Medicare requirements. EHR program management staff is also working with the Department's Division of Disease Control to streamline and automate various functions supporting care services at the sexually transmitted diseases and tuberculosis clinics and to upgrade disease monitoring activities in accordance with national standards. The next phase of development will include implementation of service utilities, including connections to the Public Health Laboratory, development of required data-analysis utilities for performance management and quality improvement monitoring, creation of an online patient portal, and development of capacities to exchange information with area providers who provide referral, inpatient, or emergency department services for PDPH patients. The project was funded largely through hospital tax funds with supplementary grants.

Improvements in Primary Care Services: Progress continues on the joint venture between the City and the Children's Hospital of Philadelphia (CHOP) to provide health care to South Philadelphia adults and children in a unique arrangement that will allow the City to expand its provision of dental care, mammography, prenatal care and a wide range of other children's and adult health care services. The venture relocates two existing clinics: one, a pediatric primary care practice in South Philadelphia owned by CHOP, and, the other, PDPH Health Center 2. The new facility, being constructed by CHOP, will co-locate the two clinics, a City recreation center, and the South Philadelphia branch of the Free Library. The new multi-function center will allow the City and CHOP to create a complex that offers clinical care, wellness, prevention, and literacy services to improve health outcomes for children and adults. Under the

agreement, CHOP and other philanthropic sources will fully fund the construction of the complex (estimated at $42 million), and the City will charge CHOP a nominal fee to lease the land. Outfitting City facilities (health center, library, recreation center) will be funded by the City, CHOP, and other philanthropic sources, with the City contribution consisting of $1.8 million in the FY16 capital budget and $2 million already budgeted in the capital budget from FY13 and FY14. CHOP and City officials hosted a ceremonial groundbreaking in September 2014. The City hopes to open the health center, library and recreation center by February 2016.

Additionally, renovation plans are underway to reconfigure space at Health Center 10 to increase capacity. The renovations include adding four additional examination rooms and an elevator to the facility, as well as replacement of windows. These renovations are expected to start later this year.

Reduced Rate of Adolescent Sexually Transmitted Diseases (STDs): In response to rising rates of STDs among adolescents in Philadelphia, in 2011, the PDPH launched a teen sexual health campaign. As a part of this campaign, PDPH promoted a custom-labeled Philadelphia condom (The Freedom Condom); expanded the number, location, and type of venues providing free condoms to teens; implemented a mail-order program for condoms; promoted condom use and access through public high schools; and developed a social media presence for the campaign. As a result of the multi-faceted adolescent STD prevention campaign, the epidemic of teen STDs in Philadelphia has waned. Cases of Chlamydia in teens, which had been steadily increasing since 2007, declined 23% from FY11 to FY14 (8,625 cases in FY11 declined to 6,618 cases in FY2014). Gonorrhea, which had shown a 52% increase in adolescent case counts from 2009 to 2011, declined by 34% among teens from FY11 to FY14 (2,427 cases in FY11 declined to 1,594 cases in FY14).



HIV Prevention and Services: Expansion of Testing, Partner Notification, Pre-Exposure Prophylaxis and Linkage to Care: Research suggests that people infected with HIV who are unaware of their status contribute disproportionately to ongoing HIV transmission in the community. When people learn they are infected, they take steps to protect their own health and prevent HIV transmission to others. The sooner an infected individual is diagnosed and linked to care, the more quickly levels of HIV virus can be reduced through medication, decreasing the likelihood of subsequent transmission. As the national HIV/AIDS strategy has focused on ensuring high-risk individuals are tested and if HIV positive, linked to medical care, so has the work of the AIDS Activities Coordinating Office (AACO).

- HIV Testing: Since being designated one of 25 jurisdictions that received CDC funding for expanding HIV testing in 2007, AACO has implemented HIV testing programs in major hospital emergency departments, collaborated with the Philadelphia Prisons System to implement HIV testing of inmates at intake, and worked closely with community partner organizations to target community-based HIV testing among populations most at risk. Significant investment is also being made to encourage routine HIV testing in all clinical care settings. In calendar year 2008, AACO provided 62,295 HIV tests through its network of funded testing sites; the number of tests has nearly doubled to 115,852 in calendar year 2014 and is expected to meet or exceed that number in 2015.
- Partner Notification: The goal of partner services is to notify confidentially persons regarding their possible exposure to infection(s) so that they may access testing and treatment. For FY16, PDPH aims to identify 40 new cases of HIV infection through partner notification services and to link 90% of those to medical care.
- Pre-Exposure Prophylaxis (PrEP): is a new tool for HIV prevention. PrEP is an antiretroviral medication, which if taken daily, significantly reduces HIV infection among adult men and women who are at risk through sex or injection drug use. AACO is coordinating outreach and education to increase the number of medical care providers who prescribe PrEP and raise community and provider awareness. AACO will also be evaluating PrEP implementation. With funding from the CDC Foundation and Gilead Sciences, PDPH is currently conducting a PrEP implementation study at the Strawberry Mansion Health Center where 50 patients are currently enrolled, of whom about half are men who have had sex with men. Although any person who is a candidate for PrEP may join the study, the goal is to enroll 300 women and heterosexual men.

- Retention in Care: Philadelphia is one of three jurisdictions to receive funding from the CDC to demonstrate a cost-effective model for improving retention in HIV medical care for persons who have fallen out of care. This project, Philadelphia Cooperative Agreement Re-Engagement Controlled Trial (CoRECT) is expected to be funded at $2.3 million over the 5-year project period. CoRECT is a collaboration between two PDPH divisions- AACO and the Division of Disease Control (DDC) - and will work with six HIV clinics in the City of Philadelphia, which include Ryan White-funded, private, Federally Qualified Health Center, and Veterans Administration facilities. CoRECT will evaluate whether patients who are enrolled in the active intervention arm are more likely to achieve viral load suppression within 12 months of the study compared with those receiving usual services. CoRECT is in a first year planning phase and will scale up in the second and third years.
- HIV/STD Prevention in African American Men Who Have Sex With Men: Based on the success of the *Take Control Philly* campaign in educating adolescents about STDs, PDPH plans to launch *Do You Philly*, a campaign for African American young men who have sex with men (YMSM) who are at increased risk of HIV/STDs. *Do You Philly* will provide resources to reduce sexual risk taking, decrease barriers to testing, combat stigma surrounding LGBT issues, and empower these young men to make healthy decisions. A major component of the *Do You Philly* program will be its website, which will include education about HIV/STDs, screening, and treatment and prevention. It will include information on pre-exposure prophylaxis (PrEP), non-occupational post-exposure prophylaxis (nPEP) and where to access free condoms. A condom mailing program and at-home testing for HIV, gonorrhea, and Chlamydia will also be offered through the website.

Achieved High Adolescent Vaccination Coverage Rates: Philadelphia's rate of vaccination coverage for adolescents has steadily increased since 2008. The CDC has presented the PDPH with the Adolescent Vaccination Coverage Award annually since inception of the award. By 2013, Philadelphia had exceeded targets established by Healthy People 2020 (national standards from the U.S. Department of Health & Human Services) by achieving immunization rates of 89% for adolescent vaccination with Tdap (tetanus-diphtheria-acellular pertussis), 95% for Varicella (chickenpox), and 91% for MenACWY (meningococcal disease) among 13-15 year olds. In addition, Philadelphia vaccination coverage with Human Papillomavirus (HPV) is one of the highest in the nation with more than three-quarters of girls 13-15 years of age having initiated the HPV vaccination series in Philadelphia, and nearly one-half having received all three doses of the series. For boys, more than 70% have received at least one dose of HPV vaccine, while 37% have completed the series.

Reduced Health and Safety Hazards in Homes of Children with Asthma: The PDPH *Healthy Homes Healthy Kids (HHHK)* Program provides comprehensive services to prevent and correct significant health and safety hazards in homes of children with difficult to control asthma who are patients at St. Christopher's Hospital for Children in Philadelphia. These children have frequent emergency room visits and hospitalizations, with attendant high medical costs, along with significant numbers of missed school days that hinder their academic progress.

The program takes a comprehensive approach that involves removing asthma triggers in the home and helping caregivers and family members adopt healthier behaviors and improve medication adherence in collaboration with their medical providers. The results have been extremely encouraging: in the first two years of the program, the 117 enrolled children reported having fewer hospitalizations, emergency room visits, and office visits, and missed school days after the *HHHK* interventions. The average cost per household is $3500. In January, 2015 we expanded the program to serve asthmatic children receiving clinical care in two of the city's ambulatory health centers.

Public Health Accreditation: PDPH has been working to obtain Public Health Accreditation by 2015. Accreditation is a new national process by which local, tribal and state public health agencies assess and document their ability to provide public health services. The Public Health Accreditation Board (PHAB), an independent non-governmental agency, has developed a set of 300+ standards within ten broad categories of "essential public health functions" to serve as benchmarks for accreditation. While public health accreditation is not currently required, federal agencies, such as the CDC, will likely require accreditation within the next five years as a condition of grant awards. This will be critical for PDPH because many of its programs are made possible by grants from CDC other federal agencies.

Over the last several years, PDPH has taken a series of steps towards accreditation, including developing a citywide Community Health Assessment,[1] a department-wide five-year Strategic Plan,[2] and a stakeholder-driven Community

[1] Community Health Assessment (http://www.phila.gov/health/pdfs/CHA%20slides_52114_revised.pdf)

Health Improvement Plan.[3] These documents provide a roadmap for how governmental and non-governmental organizations will address the most pressing public health challenges of the future. PDPH submitted its final accreditation application in January 2015, is scheduled for an accreditation site visit in July 2015, and anticipates achieving accreditation by fall 2015.

Air Quality Improvements: Pending final EPA certification, Philadelphia County currently meets the National Ambient Air Quality Standards (NAAQS) set by the Environmental Protection Agency (EPA) for the most critical pollutants which affect health, with the exception of the ozone air standard.

The EPA has chosen Philadelphia as one of five recipients in the country for the Village Green Air Monitoring Station Grant award. The Village Green Air Monitoring Station is a low-cost, solar-powered modular air monitor, which will help educate Philadelphians about the impact of street-level air pollution on health. The station measures small particulate matter (PM2.5) and ozone, as well as local wind speed, wind direction, temperature, and humidity, while operating on solar and wind power. It was installed on the sidewalk near Independence Mall on March 5, 2015 and formally dedicated on April 21, 2015.

Safer and More Efficient Food Standards: PDPH's Environmental Health Services (EHS) continues its efforts to become more business friendly by streamlining its business processes and standardizing practices. All of EHS's services fees are now available for payment online. Through E-pay, a payment service which allows businesses and individuals to pay departmental fees online, EHS is able to significantly reduce processing time needed for payments, which results in faster service. In addition, the division, working jointly with the Department of Licenses and inspections, has completed three manuals to help new food businesses comply with rules and regulations: Opening a Stationary Food Business; Opening a Mobile Food Business and Farmers Market Sponsor's Operating Guide.

EHS also implemented an Enhanced Uniformity training program in order to ensure that food establishment inspections are conducted in a consistent manner. The Enhance Uniformity training will increase accuracy and uniformity in inspection results; enhance food safety by ensuring sanitarians do not miss risk factor violations; improve the Department's credibility with the food businesses it regulates; reduce violations; and improve compliance at food establishments.

Measles: While much of the country has been experiencing an outbreak of measles related to a California theme park, Philadelphia has managed to remain measles-free. This is a testament to the high childhood immunization rates that are maintained among our City's children. Measles vaccination rates, measured as a single dose of MMR vaccine for children 19-35 months of age, is 95.9%, surpassing levels in the rest of Pennsylvania (92.8%) and the nation (91.9%). Receipt of the recommended two doses of MMR is 87% at the time of Kindergarten entry, and 96% at time of 7th grade entry.

Philadelphia Nursing Home: For the period of November 2014 through February 2015, The Centers for Medicare & Medicaid Services (CMS) designated the Philadelphia Nursing Home as a Five-Star Quality facility—the highest rating. CMS created the Five-Star Quality Rating System to provide consumers, their families, and caregivers with an easy way to understand nursing home quality and make meaningful distinctions between high and low performing nursing homes. The rating system features an Overall Quality Rating of one to five stars based on facility performance for three types of measures: findings from health inspections, staffing, and quality measures.

Healthier Families: In September 2014, the Health Resources Services Administration (HRSA) awarded PDPH's Maternal, Child and Family Health (MCFH) division a Level 3 Healthy Start award which is granted to selected jurisdictions to provide program services locally, as well as Healthy Start leadership and mentoring at regional level. The focus of Healthy Start is to reduce disparities in infant mortality. In 2012, the overall infant mortality rate in Philadelphia was 10.1 per 1,000 live births. For white non-Hispanic women the rate was 4.9 and for black, non-Hispanic women the rate was 15.6. Since 2007, the infant mortality rate has ranged from a high of 11.4 to a low of 9.3 in 2011. Though we are making progress in Philadelphia, the racial disparities in infant mortality are unacceptable.

[2] Health Department Strategic Plan (http://www.phila.gov/health/pdfs/PDPHStrategicPlan_52114_final.pdf)
[3] Community Health Improvement Plan (http://www.phila.gov/health/pdfs/PhilaCommunityHealthImpPlan_52814_final.pdf)

The PDPH Healthy Start program is working to reduce disparities in infant mortality by improving women's health before, during and after pregnancy; and, strengthening family resilience by addressing the effects of early trauma that result in significant health disparities. The PDPH Healthy Start program will provide services to 1,000 pregnant women, new mothers and their infants annually for five years, in the target community of West and Lower North Philadelphia. To further strengthen family resilience, PDPH Healthy Start is developing the Healthy Start Father Initiative with a designated Men's Support Services Coordinator who will support fathers and partners of PDPH Healthy Start program participants. In addition, the PDPH Healthy Start will use its two decades of experience and expertise to further improve the capacity of providers citywide to care for women suffering from perinatal depression through the Philadelphia Perinatal Depression Institute.

STAFFING

The budget will support 781 full-time positions in the General Fund, 185 in the Grants Fund, and 17 in the Acute Care Hospital Assessment Fund. As of December 2014, 241 full or part time employees are bilingual or trilingual with fluency in 50 languages, ranging from Spanish (the most common) to Swahili to Gujarati.

The department's workforce is 732% minority (56.8% African American; 4.1% Hispanic; 9.1% Asian; and 3.2% Other race/ethnicity) and 70.4% female. Executive staff is 41.7% minority (20.7% African American and 20.7% Asian) and 56.5% female. Staff hired from 7/1/14 through 12/15/14 are 72.54 minority (47.0% African American; 7.8% Hispanic; 15.6% Asian; and 2.0% Other ethnicity) and 60.8% female. Of these new hires, 31.3% speak 10 different languages.

Staff Demographics (as of December 2014)

	Full-Time Staff			*Executive Staff*	
	Male	**Female**		**Male**	**Female**
	African-American	African-American		African-American	African-American
Total	99	373	*Total*	2	3
% of Total	11.9%	44.9%	*% of Total*	8.7%	13.0%
	White	White		White	White
Total	94	128	*Total*	6	7
% of Total	11.3%	15.4%	*% of Total*	26.1%	30.4%
	Hispanic	Hispanic		Hispanic	Hispanic
Total	11	23	*Total*	0	0
% of Total	1.3%	2.8%	*% of Total*	0.0%	0.0%
	Asian	Asian		Asian	Asian
Total	27	48	*Total*	2	3
% of Total	3.3%	5.8%	*% of Total*	8.7%	13.0%
	Other	Other		Other	Other
Total	15	12	*Total*	0	0
% of Total	1.8%	1.4%	*% of Total*	0.0%	0.0%
	Bi-lingual	Bi-lingual		Bi-lingual	Bi-lingual
Total	155	86	*Total*	1	3
% of Total	18.7%	10.4%	*% of Total*	4.3%	13.0%
	Male	Female		Male	Female
Total	246	584	*Total*	10	13
% of Total	29.6%	70.4%	*% of Total*	43.5%	56.5%

CONTRACTING

M/W/DBE Participation on Large Contracts
FY15 Contracts

Vendor	Service Provided	Amount of Contract	RFP Issue Date	Contract Start Date	Ranges in RFP	% of M/W/DBE Participation Achieved	$ Value of M/W/DBE Participation	Total % and $ Value Participation - All	Living Wage Compliant?
eClinical Works	EHR Implementation	$8,131,873	6/29/09	3/28/11	MBE: 10-15%	100%	$8,131,873		Yes
					WBE: 5-10%	0%	$0	100%	
					DSBE: Best Efforts	0%	$0	$8,131,873	
Alpha Medical Group	Radiology Services	$1,390,662	6/7/13	7/1/13	MBE: Best Efforts	0%	$0		Yes
					WBE: Best Efforts	100%	$1,390,662	100%	
					DSBE: Best Efforts	0%	$0	$1,390,662	
Walgreen Eastern Co., Inc.	HIV Medications	$1,287,636	3/11/14	6/30/14	MBE: Best Efforts	0%	$0		Yes
					WBE: Best Efforts	0%	$0	0%	
					DSBE: Best Efforts	0%	$0	$0	
General Healthcare Resources	Nursing Services	$652,311	5/30/13	7/1/13	MBE:	0%	$0		Yes
					WBE: 1-5%	0%	$0	0%	
					DSBE:	0%	$0	$0	
MEE Productions, Inc.	Media Campaign	$415,000	8/15/12	1/20/13	MBE: 10-15%	100%	$415,000		Yes
					WBE: 10-15%	0%	$0	100%	
					DSBE:	0%	$0	$415,000	

OTHER BUDGETARY IMPACTS

FEDERAL AND STATE (WHERE APPLICABLE)

- Dependence on state and federal grants: Many of PDPH programs are dependent on external funds. This includes state and federal funds, with federal funds coming to PDPH directly or via the state depending on the funding strategy of various federal programs. This is both an opportunity and challenge. The opportunity, of course, is that these funds enable services and innovation. The challenge is that grant-funded programs operate typically on 3-5 year budget cycles, might not be sustainable for longer periods, are susceptible to cuts in federal or state budgets, or to changes in federal or state allocation strategies.

OTHER

Not applicable.

DEPARTMENT OF HUMAN SERVICES
FISCAL YEAR 2016 BUDGET TESTIMONY
APRIL 29, 2015

EXECUTIVE SUMMARY

DEPARTMENT MISSION AND FUNCTION

Mission: To provide and promote safety, permanency and well-being for children at risk of abuse, neglect and delinquency.

Description of Major Services: The Department of Human Services (DHS) is responsible for investigating reports of child abuse and neglect. In addition, through contracts with social service agencies, DHS provides a wide range of prevention services, in home safety and non safety services, foster care, other placement services and juvenile justice services. DHS is also responsible for operating the Philadelphia Juvenile Justice Services Center. DHS' primary goal is to strengthen and stabilize families.

PROPOSED BUDGET HIGHLIGHTS/FUNDING REQUEST

Budget Highlights: The total FY16 Proposed Operating Budget is slightly lower (0.1%) than the FY15 Current Projection. The increase since FY14 is related to the increase in the number of children in placement.

Fund	Class	FY14 Actual	FY15 Current Projection	FY16 Proposed Budget	FY16-FY15 Change	FY16-FY15 Percent Change
General	100	22,776,786	23,817,687	24,637,310	819,623	3.4%
	200	76,267,118	77,931,501	76,779,935	(1,151,566)	-1.5%
	300/400	979,940	1,027,501	1,312,076	284,575	27.7%
	Total	100,023,844	102,776,689	102,729,321	(47,368)	0.0%
	Positions	382	451	449	(2)	-0.4%
Other*	100	104,669,472	111,014,684	116,949,046	5,934,362	5.3%
	200	375,934,050	458,262,753	451,172,464	(7,090,289)	-1.5%
	300/400	2,567,388	2,015,178	2,707,544	692,366	34.4%
	Total	483,170,910	571,292,615	570,829,054	(463,561)	-0.1%
	Positions	1,182	1,390	1,390	0	0.0%
All	**100**	**127,446,258**	**134,832,371**	**141,586,356**	**6,753,985**	**5.0%**
	200	**452,201,168**	**536,194,254**	**527,952,399**	**(8,241,855)**	**-1.5%**
	300/400	**3,547,328**	**3,042,679**	**4,019,620**	**976,941**	**32.1%**
	Total	**583,194,753**	**674,069,375**	**673,558,375**	**(510,929)**	**-0.1%**
	Positions	**1,564**	**1,841**	**1,839**	**(2)**	**-0.1%**

* Other Funds includes: County Liquid Fuels Tax Fund, Special Gasoline Tax Fund, Healthchoices Behavioral Health Fund, Hotel Room Rental Tax Fund, Grants Revenue Fund, Community Development Fund, Car Rental Tax Fund, Housing Trust Fund, Water Fund, Water Residual Fund, Aviation Fund, and Acute Care Hospital Assessment Fund.

Staff Demographics Summary (as of December 2014)

	Total	Minority	White	Female
Full-Time Staff	1,535	1,290	245	1,114
Executive Staff	36	26	10	24
Average Salary - Executive Staff	$102,551	$102,977	$101,445	$102,524
Median Salary - Executive Staff	$98,751	$98,651	$98,851	$98,751

Employment Levels (as of December 2014)

	Budgeted	Filled
Full-Time Positions	1,841	1,535
Part-Time Positions	0	0
Executive Positions	37	36

Contracts Summary (*as of December 2014)

	FY10	FY11	FY12	FY13	FY14	FY15*
Total amount of contracts	$70,502,519	$66,736,765	$11,675,627	$10,981,264	$13,075,473	$7,361,090
Total amount to M/W/DBE	$2,692,510	$2,222,120	$3,780,081	$4,134,509	$3,880,931	$1,921,091
Participation Rate	4%	3%	32%	38%	30%	26%

PERFORMANCE, CHALLENGES AND INITIATIVES

DEPARTMENT PERFORMANCE (OPERATIONS)

Performance Trends: Based on the point-in-time data, the dependent placement population has been increasing since FY14, and slightly less than one third of dependent children in care have been in care for more than two years. The rise in the dependent placement population is a negative trend that DHS hopes to address through the Improving Outcomes for Children (IOC) system transformation where the primary goal is to maintain children at home in their own communities (more information on IOC can be found in the Accomplishments & Initiatives section below). The FY16 goal for the dependent placement population reflects the negative trend of a larger dependent placement population due to new child welfare laws that expand the definition of child abuse and the definition of a perpetrator, as well as increase the number of mandated reporters and the penalties for failure to report. Additionally, the number of children discharged to all types of permanency dropped when compared between the first half of FY14 to the first half of FY15, another negative trend that DHS hopes to reverse through the IOC's secondary goal to increase permanencies. The FY16 goal has been adjusted to reflect this negative trend. The percent of discharges to adoption increased slightly from the first half of FY14 compared to the first half of FY15, a positive trend that DHS hopes to maintain in FY16. The percent of permanency discharges to reunification dropped between the first half of FY14 and the first half of FY15 meaning that fewer children are returning to their families, a negative trend. DHS hopes to increase permanency discharges to reunification to 65% in FY15 and FY16. The percentage of children in congregate care placement (group or institutional level care) has decreased, a positive trend for DHS. The level of approval for new congregate care placements has been raised to ensure that the placement setting is the most appropriate. Data for the first two quarters of FY15 also shows that the number of children in out-of-state dependent placement remained stable, a positive trend for DHS. The majority of these children were in care with extended family through kinship care, and they were able to maintain familial connections instead of residing in out-of-state congregate care. The number of youth in delinquent placement decreased between the first half of FY14 compared to the first half of FY15, another positive trend. This may indicate that prevention services, alternative treatment services and diversion programs are providing resources for youth who do not pose threats to public safety.

Performance Measure	FY08	FY13	FY14	FY14-FY13 Change	FY14 Q1-Q2	FY15 Q1-Q2	FY15-FY14 Q1-Q2 Change	FY15 Goal	FY16 Goal
Dependent placement population (as of the last day of the quarter)	5,740	4,291	4,473	N/A	4,375	4,894	N/A	4,500	4,800
Number of children discharged to permanency (All Types)	2,140	1,229	1,221	-0.7%	649	478	-26.3%	1,300	1,100
Percent of permanency discharges to adoption	16.6%	28.6%	31.8%	11.3%	30.2%	32.5%	7.5%	32.0%	35.0%
Percent of permanency discharges to Reunification	66.7%	62.7%	59.7%	-4.8%	61.3%	57.4%	-6.3%	65.0%	65.0%
Percent of dependent children in care more than two years (as of the last day of the quarter)	32.3%	29.4%	31.5%	N/A	31.3%	30.0%	N/A	30.0%	35.0%
Congregate Care population: percent of children in care (as of the last day of the quarter)	25.5%	21.7%	19.1%	N/A	20.1%	14.5%	N/A	14.0%	13.0%
Dependent out-of-state population (as of the last day of the quarter)	143	51	45	N/A	44	41	N/A	45	45
Delinquent placement population (as of the last day of the quarter)	1,657	1,155	952	N/A	1,023	857	N/A	950	900

N/A - Rate of change cannot be calculated as these measures are point-in-time and some children may be counted in both periods.

DEPARTMENT CHALLENGES

FY15 was a pivotal year for the Department of Human Services. During this year, DHS opened five new Community Umbrella Agencies (CUAs). Additionally, we saw large increases in calls to the hotline, number of investigations, cases accepted for service and placements. Specifically, we saw the following growth:

- Hotline calls increased 68% when comparing February 2014 to February 2015
- Investigations are projected to be up 13% between FY14 and FY15
- The total number of active cases is up by 46% when comparing February 2014 to February 2015
- Placements are up 18% when comparing February 2014 to February 2015

DHS is continuously monitoring this growth and the potential fiscal impact. As DHS moves towards the final implementation stages of IOC, the goal is to stabilize the system. DHS is working on strengthening and expanding its hotline and investigation sections. Additionally, DHS has increased the ability to provide technical and practice assistance to the CUAs. DHS is focusing on keeping children safely in their own homes and communities and is working diligently to achieve permanency for children who have remained in the placement system.

ACCOMPLISHMENTS & INITIATIVES

Improving Outcomes for Children (IOC): The IOC system transformation is based on a belief that a community neighborhood approach with clearly defined roles between county and provider staff will positively impact safety, permanency, and well-being of the children and families that are involved with DHS. IOC is a single case management system in which a family will have one case manager who is responsible for the provision of ongoing services. Previously, several social workers may have provided services to one family and as a result, there was little coordination of those services. Under the new system, because one social worker is accountable for the entire family, needed services are expected to be better recognized, coordinated and delivered through strong community partnerships. The case manager will be employed by a Community Umbrella Agency (CUA) that is located in the community where the family lives. Under IOC, the City is divided the City into 10 geographic regions with one CUA assigned to each region. IOC is designed for families to receive their services in the community whenever possible.

The four goals of IOC are:

1. More children and youth maintained safely in their own homes and communities;
2. More children and youth achieving timely reunification or other permanence;
3. A reduction in the use of congregate care; and
4. Improved children, youth, and family functioning.

IOC began in July 2012 with the selection of the first two CUAs to be based in the 25th and 24th/26th police districts. During FY13, DHS began the transition of cases to the CUAs and all ten CUAs were open as of FY15. During the remainder of FY15 and the first half of FY16, DHS will focus on finalizing the full implementation of IOC with all cases expected to be transferred to the CUAs by the end of December 2015. All new cases accepted for service by the Department are currently transferred to the Community Umbrella Agencies for ongoing service delivery. As of February 2015, our CUAs are servicing over 3000 families. Our goal is to keep children in their own communities. In fact, approximately 46% of the children placed in non-kinship foster care through the CUAs, are placed within 5 miles from their home. When fully implemented, IOC is designed to decrease placement and improve the number of reunifications and other permanencies.

Reduction of Congregate Care and Out of State Placements: Since FY08, the percentage of youth in congregate care – both group homes and institution settings – has decreased from approximately 22.5% to approximately 14.5%. To reduce reliance on congregate care placements, DHS has increased the use of youth driven teamings (where youth are able to bring their support network to the table and play an active role in driving the planning process) to re-connect young people with the people in their own natural networks. DHS instituted a Commissioner approval process, which requires the Commissioner to sanction the use of congregate care placement. Additionally, between 2008 and the end of calendar year 2014, children living in non-relative out of state placements decreased approximately 90%.

Juvenile Justices Services Center: In April of 2013, DHS opened the Philadelphia Juvenile Justices Services Center, a state of the art detention center for youth in Philadelphia. At a cost of $110 million, the new center is located at the intersection of 48th Street and Haverford Avenue. The 166,000 square foot facility is a LEED (Leadership in Energy and Environmental Design) certified building. Among its many outstanding attributes is a state-of-the art school area with ten classrooms, two full courtrooms, a fully outfitted gymnasium, a healing garden, and outdoor running track. The new center will offer an array of services to young people detained there, among them medical and dental services, education, recreational programming and court services.

Philadelphia Safety Collaborative: In August of 2013, DHS opened the Philadelphia Safety Collaborative with the Philadelphia Police Department, the District Attorney and Philadelphia Children's Alliance. The Collaborative is designed to integrate the investigative process for incidents of sexual and physical abuse. The purpose of this collaborative is to reduce the trauma for victims and their families. During calendar year 2014, the Philadelphia Safety Collaborative served 3,056 children.

Family Conferencing: In FY16, DHS will continue to implement Family Team Conferencing. These conferences are designed to provide the family with a voice in the child welfare process. Family Team Conferences occur throughout the life of a case at key decision making points, including safety and permanency decisions, child or youth placement moves, changes in service, routine review intervals, and case closings. Family Team Conferences are children and youth centered, family focused structured meetings. Attendees include: parents, youth 12 years of age or older, any supports identified by the parents or youth including family members, and friends, community resources, the CUA and DHS staff, other child, youth, and family serving agencies, and other professionals involved including counsel for parents, children and youth, if they have been identified. Since January of 2013, DHS has held over 6,000 conferences. DHS will continue to hold Family Team Conferences for all families accepted for service and assigned to the CUAs.

International Recognition: DHS was the recipient of the 2013 United Nations Public Service Award, Second Place, for improving the delivery of public services in the European and North American region. More than 600 organizations from 82 countries submitted applications for a United Nations Public Service Award. DHS is one of 47 organizations to be recognized and the only North American entity selected for the 2013 United Nations Public Service Award. The award recognized the transformation of DHS over the past six years, including the implementation of its Improving Outcomes for Children system transformation, a groundbreaking, family-centered neighborhood-based approach to child welfare. The structural and programmatic reforms by DHS have been instituted to increase accountability, improve processes and enhance child welfare and well-being.

STAFFING

DHS currently has 1,S35 full time staff. Of this number, 1,290 are minority and 1,114 are female. DHS continues to maintain a very diverse workforce.

Of the full time non-executive staff, 58.2% is African American females and 19.3% is African American males. 2.5% of non-executive staff is Hispanic females and 1.1% is Hispanic males. 1.2% of the non-executive staff is Asian American females and 0.7% is Asian American males.

The DHS Executive Team is also very diverse. 47.25% of the team is African American females and 22.2% are African American males. The Executive team is also 66.7% female and 33.3% male.

DH5 also has 77 bilingual employees.

Of the new hires in FY15, 26 are African American, 10 are White, 2 are Asian and 1 is bilingual.

Staff Demographics (as of December 2014)

	Full-Time Staff			*Executive Staff*	
	Male	**Female**		**Male**	**Female**
	African-American	African-American		African-American	African-American
Total	297	894	*Total*	8	17
% of Total	19.3%	58.2%	*% of Total*	22.2%	47.2%
	White	White		White	White
Total	93	152	*Total*	3	7
% of Total	6.1%	9.9%	*% of Total*	8.3%	19.4%
	Hispanic	Hispanic		Hispanic	Hispanic
Total	17	38	*Total*	0	0
% of Total	1.1%	2.5%	*% of Total*	0.0%	0.0%
	Asian	Asian		Asian	Asian
Total	10	19	*Total*	0	0
% of Total	0.7%	1.2%	*% of Total*	0.0%	0.0%
	Other	Other		Other	Other
Total	4	11	*Total*	1	0
% of Total	0.3%	0.7%	*% of Total*	2.8%	0.0%
	Bi-lingual	Bi-lingual		Bi-lingual	Bi-lingual
Total	29	47	*Total*	1	1
% of Total	1.9%	3.1%	*% of Total*	2.8%	2.8%
	Male	Female		Male	Female
Total	421	1,114	*Total*	12	24
% of Total	27.4%	72.6%	*% of Total*	33.3%	66.7%

M/W/DBE Participation on Large Contracts
FY15 Contracts

Vendor	Service Provided	Amount of Contract	RFP Issue Date	Contract Start Date	Ranges in RFP	% of M/W/DBE Participation Achieved	$ Value of M/W/DBE Participation	Total % and $ Value Participation - All	Living Wage Compliant?
Vision Quest	Placement	$14,734,218	5/10/12	7/1/12	MBE: 20%-25%	23.60%	$3,477,576		
					WBE: 20%-25%	0.00%	$0	23.6%	Yes
					DSBE: 0	0.00%	$0	$3,477,576	
Mid-Atlantic	Placement	$10,862,437	6/5/12	7/1/12	MBE: 20%-25%	0.00%	$0		
					WBE: 20%-25%	0.18%	$19,600	0.18%	Yes
					DSBE: 0	0.00%	$0	$19,600	
First Home Care	Placement	$3,969,610	6/5/12	7/1/12	MBE: 20%-25%	0.57%	$22,674		
					WBE: 20%-25%	0.47%	$18,574	1.1%	Yes
					DSBE: 0	0.03%	$1,278	$42,526	
Cornell Abraxas	Placement	$2,379,831	5/10/12	7/1/12	MBE: 20%-25%	0.00%	$0		
					WBE: 20%-25%	0.00%	$0	0.0%	Yes
					DSBE: 0	0.00%	$0	$0	
Eastern Software	Technology	$2,093,350	4/17/12	7/1/12	MBE: 25%-30%	13.85%	$290,000		
					WBE: 20%-25%	16.00%	$335,000	29.9%	Yes
					DSBE: 0	0.00%	$0	$625,000	

OTHER BUDGETARY IMPACTS

FEDERAL AND STATE (WHERE APPLICABLE)

If funding from the federal or state government decreased, the City would be required to increase its proportionate share of dollars to purchases services. It is critical that DHS maximizes dollars from the federal and state government in light of the rising number of reports, families being accepted for services and children in placement.

DHS is continuing to monitor placement numbers as they relate to the Department's ability to drawn down Title IVE dollars under the Child Welfare Demonstration Project's cap.

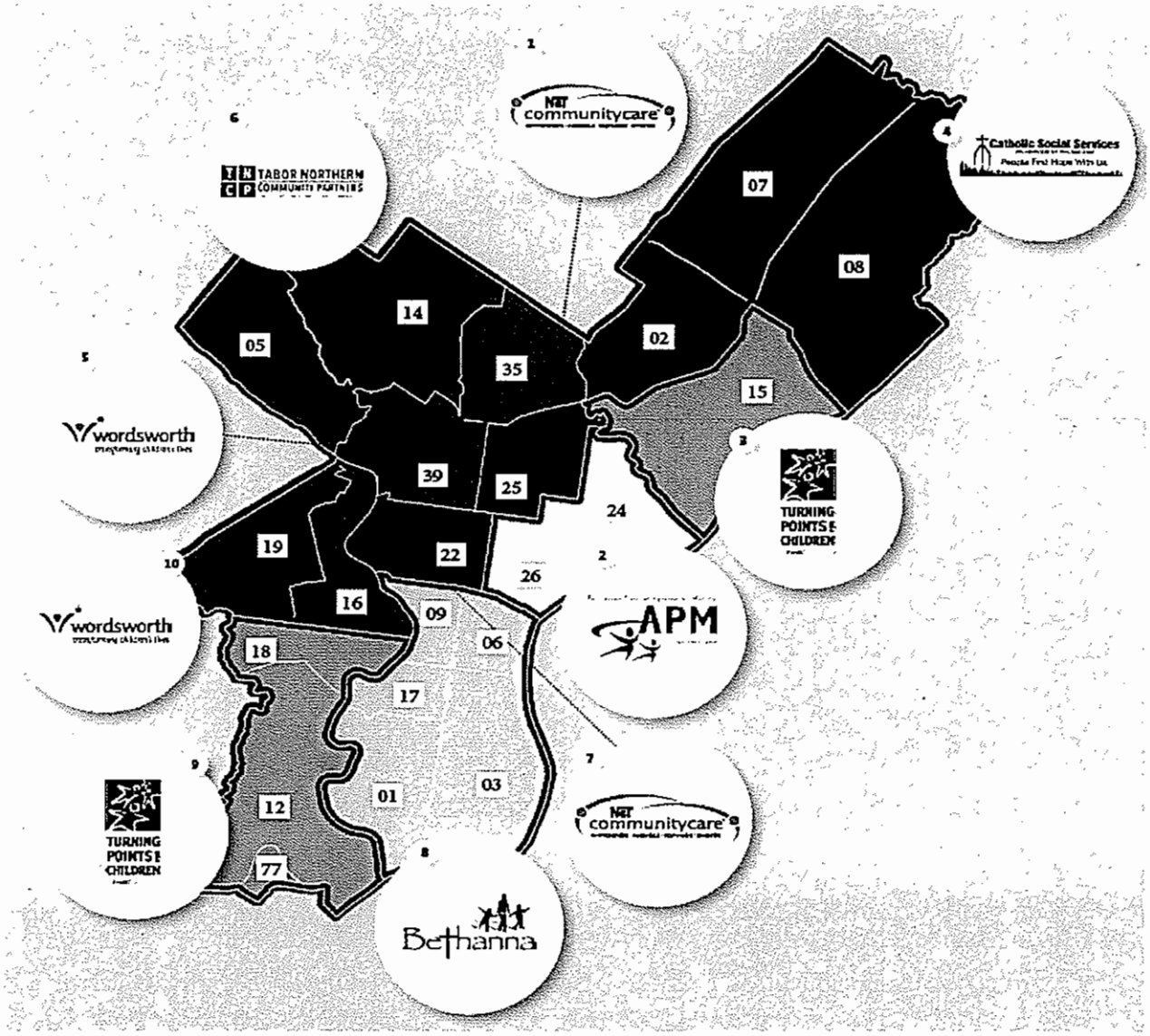
Finally, as DHS is under the Needs Based Budgeting process, DHS also continuously monitors ther need for additional state dollars and will work with the Pennsylvania Department of Human Services to request additional dollars if necessary.

OTHER

DHS continues to monitor the impact of the sweeping reforms to the Child Protective Services Law that went into effect in January of 2015. These new laws expanded the definition of child abuse as well as widened the definition of who can be a perpetrator. In addition, the new laws increased the number of mandated reporters and the penalty for not reporting. DHS has begun to and expects to see further increases in the number of reports and investigations as a result of this widened definition of child abuse and who can be a perpetrator. As part of IOC, DHS is strengthening and expanding its investigative sections. In order to ensure quality practice for those cases that are accepted for service, DHS has increased focus on providing technical assistance to the CUAs. DHS placed DHS staff on site at the CUAs to work with and mentor the CUA case managers and supervisors. Additionally, DHS continues to monitor and evaluate providers to ensure quality practice for the children and families that DHS serves.

OTHER RELEVANT DATA AND CHARTS

Below is a map of all ten CUA locations throughout the city.



Region	Community Umbrella Agency (CUA)
Eastern North Philadelphia: 25th Police District	NorthEast Treatment Centers (NET)
Eastern North Philadelphia: 24th and 26th Police Districts	Asociación Puertorriqueños en Marcha (APM)
Lower Northeast: 15th Police District	Turning Points for Children
Far Northeast: 2nd, 7th, and 8th Police Districts	Catholic Social Services
Logan/Olney: 35th and 39th Police Districts	Wordsworth
Northwest Philadelphia: 5th and 14th Police Districts	Tabor Northern Community Partners
North Central Philadelphia: 22nd Police District	NorthEast Treatment Centers
South Philadelphia: 1st, 3rd, 6th, 9th, 17th Police Districts	Bethanna
Southwest Philadelphia: 12th, 18th, and 77th Police Districts	Turning Points for Children
Mantua, Overbrook, Wynnefield: 16th, 19th Police Districts	Wordsworth

OFFICE OF SUPPORTIVE HOUSING
FISCAL YEAR 2016 BUDGET TESTIMONY
APRIL 29, 2015

EXECUTIVE SUMMARY

DEPARTMENT MISSION AND FUNCTION

Mission: To help individuals and families move towards independent living and self-sufficiency in safe and stable housing. The Office of Supportive Housing fulfills this mission through Philadelphia's Homeless Continuum of Care and the Riverview Home, which is a state, licensed Personal Care Home that provides housing to low income elderly and disabled persons. OSH is also responsible for the policy, planning and coordination of the City's response to homelessness.

Description of Major Services: The Office of Supportive Housing (OSH) is charged with planning and implementing the City of Philadelphia's support and services to residents who are experiencing homelessness and whenever possible to prevent homelessness. OSH balances diverse needs, capturing as many resources and tools as possible and directing them to multiple subpopulations. OSH does its work always in partnership with other city departments, the Commonwealth and the Federal government, as well as over 50 non-profit corporations and advocacy groups. OSH provides direct support to emergency housing, as well as a wide array of services including transitional and supportive housing to individuals, couples and families.

PROPOSED BUDGET HIGHLIGHTS/FUNDING REQUEST

Budget Highlights: The FY16 General Fund proposed allocation is slightly higher than the FY15 Current Projection to account for employee salary increases as a result of union contract settlements. The total FY16 Proposed Operating budget for OSH is on par with the FY15 Current Projection.

Fund	Class	FY14 Actual	FY15 Current Projection	FY16 Proposed Budget	FY16-FY15 Change	FY16-FY15 Percent Change
General	100	7,877,851	8,263,759	8,281,213	17,454	0.2%
	200	36,866,677	36,586,621	36,586,621	0	0.0%
	300/400	340,878	344,127	344,127	0	0.0%
	500	30,899	32,421	32,421	0	0.0%
	Total	45,116,305	45,226,928	45,244,382	17,454	0.0%
	Positions	154	159	159	0	0.0%
Other*	100	395,640	614,129	710,423	96,294	15.7%
	200	28,501,815	45,022,629	44,956,142	(66,487)	-0.1%
	300/400	976,701	887,489	887,489	0	0.0%
	Total	29,874,156	46,524,247	46,554,054	29,807	0.1%
	Positions	9	12	12	0	0.0%
All	**100**	**8,273,491**	**8,877,888**	**8,991,636**	**113,748**	**1.3%**
	200	**65,368,492**	**81,609,250**	**81,542,763**	**(66,487)**	**-0.1%**
	300/400	**1,317,579**	**1,231,616**	**1,231,616**	**0**	**0.0%**
	500	**30,899**	**32,421**	**32,421**	**0**	**0.0%**
	Total	**74,990,461**	**91,751,175**	**91,798,436**	**47,261**	**0.1%**
	Positions	**163**	**171**	**171**	**0**	**0.0%**

* Other Funds includes: County Liquid Fuels Tax Fund, Special Gasoline Tax Fund, Healthchoices Behavioral Health Fund, Hotel Room Rental Tax Fund, Grants Revenue Fund, Community Development Fund, Car Rental Tax Fund, Housing Trust Fund, Water Fund, Water Residual Fund, Aviation Fund, and Acute Care Hospital Assessment Fund.

Staff Demographics Summary (as of December 2014)

	Total	Minority	White	Female
Full-Time Staff	164	138	26	119
Executive Staff	16	13	3	9
Average Salary - Executive Staff	$88,427	$87,366	$93,027	$93,554
Median Salary - Executive Staff	$86,111	$83,600	$97,731	$93,150

Employment Levels (as of December 2014)

	Budgeted	Filled
Full-Time Positions	171	164
Part-Time Positions	0	0
Executive Positions	16	16

Contracts Summary (*as of December 2014)

	FY10	FY11	FY12	FY13	FY14	FY15*
Total amount of contracts	$2,854,086	$4,276,757	$4,026,492	$4,518,015	$4,183,400	$3,629,928
Total amount to M/W/DBE	$472,260	$880,773	$1,469,777	$1,709,346	$1,167,480	$1,092,480
Participation Rate	17%	21%	37%	38%	28%	30%

PERFORMANCE, CHALLENGES AND INITIATIVES

DEPARTMENT PERFORMANCE (OPERATIONS) Emergency housing (shelter) served an average of 1,500 single individuals and 450 families every night in FY15. During the winter months of December 1 through March 31 an average of 450 additional emergency housing beds were available. This support is critical to persons who might otherwise be on the streets.

The number of households receiving financial assistance to prevent homelessness increased from 610 to 676 (10.8%) from FY13 to FY14. Starting in the second quarter of FY14, OSH used Housing Trust Funds and also received Community Services Block Grant (CSBG) Funds from the Mayor's Office of Community Empowerment and Opportunity to provide prevention services. In the second quarter of FY15, OSH received additional CSBG funds and is already serving more than twice the number of households in the first half of FY15 relative to the same period in FY14. Through the second quarter of FY15, 374 persons have received assistance to prevent them from experiencing homelessness.

In concert with the City's 10 Year Plan to End Homelessness, a plan created in 2005, OSH implemented the Mayor's Homeless Housing Strategy, which included a commitment to provide housing opportunities for homeless individuals and families. Since the end of the Federal American Recovery and Reinvestment Act (ARRA) funding of $23.million from 2009 – 2012, to provide Prevention, Rapid Re-Housing and Housing Stabilization services there has been a dramatic decrease in the numbers of families and persons assisted to prevent homelessness and to move out of homelessness into permanent housing. The ARRA funding was approximately $7 million per year whereas the FY14 Federal allocation was $2.8 million. Rapid re-housing is the practice of focusing resources to help households (individuals and families) to quickly move out of homelessness and into permanent housing and reduce the amount of time experiencing homelessness. Participants receive financial assistance to move back into the community and housing stabilization services which is a type of case management focused on helping participants to maintain their housing, such as managing the household budget, making timely rent and utility payments and being a good tenant and neighbor. OSH continues to seek and utilize all available local, state and federal homeless rapid re-housing funding and assure that residents in Emergency and Transitional Housing are able to connect with all mainstream benefits for which they qualify and connect them to resources and opportunities to increase their skills, education and income. The number of households receiving assistance is lower for the first two quarters of FY14 because the performance measures only represent new households whereas the majority of recipients of rapid re-housing assistance at that time were already housed and receiving ongoing rental assistance. In the first two quarters of FY15, OSH was able to move 272 households out of emergency housing into transitional housing and end homelessness for 174 households. In FY16, OSH will continue to provide short to medium term financial assistance and housing stabilization services to households residing in emergency or transitional housing. The goals and service for upcoming rapid re-housing and prevention services are contingent on expected grant funding and capturing of other supportive housing resources in FY16.

In addition to rapid re-housing, OSH provides Continuum of Care permanent supportive housing units. OSH serves as the collaborative applicant for Continuum of Care funding through HUD. The Continuum of Care (CoC) program is designed to focus community commitment on the goal of ending homelessness and providing funding for new and ongoing efforts to quickly re-house homeless individuals and families and promote self-sufficiency among individuals and families experiencing homelessness. In FY14, OSH completed 509 Transitional Housing Placements. Placements for the first and second quarters of FY15 are slightly higher than those quarters in FY14 (265 in FY14 and 272 in FY15). More than 80% of those who leave Transitional Housing enter permanent housing. OSH is on track to meet the FY15 placement goal of 505.

Performance Measure	FY08	FY13	FY14	FY14-FY13 Change	FY14 Q1-Q2	FY15 Q1-Q2	FY15-FY14 Q1-Q2 Change	FY15 Goal	FY16 Goal
Households provided financial assistance to prevent homelessness	336	610	676	10.8%	181	374	106.6%	675	N/A*
Households provided financial assistance to end homelessness	N/A	291	135	-53.6%	59	174	194.9%	155	N/A*
New permanent supportive housing units for people experiencing homelessness (Non-Philadelphia Housing Authority)	76	180	59	-67.2%	0**	0**	N/A	100	100
Number of transitional housing placements	435	539	509	-5.6%	265	272	2.6%	505	520

*Dependent on grant funding received during year.

** Per HUD, numbers are reported 1x/year at the end of the fiscal year

DEPARTMENT CHALLENGES

- Philadelphia's homeless strategies are recognized nationally as very productive and effective. However, the need for affordable housing, coupled with high levels of poverty and unemployment continue to have a direct impact on the numbers of individuals and families in particular that consistently present at our front door. More and more low –income and poor citizens turn to the homeless system to meet their housing needs. On any given day, OSH is operating at or near full capacity. On average, 30 families present daily at the Appletree Family Intake Center. The OSH front door is the safety net for these families.
- The number of young mothers with one or two children is significant. Many of these young families are not characteristically homeless; many of them have never had a home, meaning they have never lived independently. They became a parent and/or young adult living with family, friends and "couch surfing" with a child in tow. These families thrive when there are supportive services and a healthy environment that builds accountability and key life skills of child care, healthy food and job skills. OSH is currently developing ways to provide appropriate housing options with increased collaboration.

ACCOMPLISHMENTS & INITIATIVES

Increased Homeless Housing: Between 2008 and 2014, the overall Philadelphia homeless housing inventory increased by 80% (from 3,047 to 5,500) through local and federal McKinney-Vento Act-funded construction, rehabilitation and leased units, including units through the City's partnership with the Philadelphia Housing Authority. To date, through this partnership, 2,103 individuals and 1,601 families have moved into permanent housing. In addition, through the 2013 HUD Continuum of Care Program, the City was awarded $29.8 million for continuing and new housing for individuals and families experiencing homelessness, including 80 newly funded permanent housing units. The decrease in non-PHA permanent supportive housing units in FY14 was due to delays in the receipt of grant funding and in agencies securing development funding. The FY15 Quarter 1 and 2 numbers are not available at this time as per HUD, they are reported once per year at the end of the fiscal year. OSH expects to meet the FY 15 goal of 100 new units.

Homelessness Prevention: OSH will continue to work to prevent homelessness of individuals and families already housed by providing financial assistance with delinquent rent and/or utilities or security deposits to re-locate to more affordable housing and providing financial assistance to prevent mortgage foreclosure. The FY16 goal is contingent upon the amount of funding received from federal and/or state sources.

Expansion of Beds for Victims of Domestic Violence: The number of beds for women and children experiencing domestic violence were expanded, as well as community-based services for Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual (LGBTQIA) and gender minority individuals experiencing domestic violence. In FY14, the City provided $3 million for Domestic Violence services to double the number of emergency housing beds (from 100 to 200) for women and children experiencing domestic violence. In addition, OSH expanded community-based services to serve LGBTQIA and gender minority victims of domestic violence.

In FY15 to date, Carol's Place (the new 100 bed shelter operated by Women Against Abuse (WAA)) has served 349 people (151 adults and 198 children). An additional $200,000 provided through transfer ordinance will support child

care/children's programming onsite. A Domestic Violence (DV) specialist funded to assist at OSH intake has provided support and services to 223 unique adult consumers during FY15 to date. The DV hotline collaboration between Congreso, Lutheran Settlement House, Women in Transition and WAA, funded in part through OSH, has fielded more than 9,000 calls from victims in FY1S. In FY16, OSH will support the implementation of the Citywide Coordinated Response to Domestic Violence, which builds on the successful efforts of law enforcement to increase and improve efforts to address DV by engaging the City's social service departments and other key stakeholders in the collaborative effort.

Ending Veteran Homelessness: In Philadelphia, 9% of adults experiencing homelessness were Veterans per the 2014 U S Conference of Mayor's Hunger and Homelessness Report. Since August 2013 through March 2015, the City and partners, including the Veterans Administration (VA), the Public Housing Authority (PHA) and non-profits, ended homelessness for 862 veterans. Philadelphia has been designated one of 10 Dedicating Opportunities to End Homelessness (DOEH) communities by HUD and the US Interagency Council on Homelessness. Philadelphia used a diversity of housing strategies, as well as data-based analytic tools to project gaps and identify housing resources to close the gaps and end chronic and veteran homelessness. In addition, Philadelphia participated in the Rapid Results Institute sponsored by Community Solutions to build a local team to end veteran homelessness. This is leading to new housing commitments and processes to ensure that veterans are identified, targeted, and offered housing solutions more quickly. OSH is now developing a new partnership with HUD/VA with new resources to Support Service for Veterans Families (SSVF) and a total of 460 rental subsidies.

With an estimated 500 veterans in need of housing, adequate resources from the VA, and the continuing commitment from the partners to collaborate, OSH is now working with the Philly Vets Home team for a final push to meet Mayor Nutter's goal to end veteran homelessness in 2015.

Permanent Supportive Housing Clearinghouse: In 2012, OSH, in concert with Health & Opportunity, developed an initiative to consolidate the housing resources of the social service departments in the City. With this effort, there is a streamlined, single point of access to permanent supportive housing. This eliminates duplicative efforts and the cost of maintaining multiple access points, promotes coordination between housing and services, and assures that all available housing resources and partnerships for supportive housing are captured and not lost. Resources are dedicated to households served by the Health & Opportunity social service cluster who have both a services and a housing need, including individuals and families with mental illness, chronic substance abuse and related health disabilities, as well as those who are homeless or at the highest risk of homelessness. This initiative now includes access to 8 programs and to date 3,055 individuals and families have been housed.

Infant Screening Protocol: Mothers who reside in emergency housing with infants 0-4 months of age are now supported to develop strong, healthy babies with the development of new infant protocols and services. An Infant care nurse weighs infants 0-4 months every two weeks for up to 16 weeks to track growth and development and parents receive assistance with locating and connecting to a primary care provider for regularly scheduled well child appointments. In FY14, 39 infants were screened, and to date, 59 infants were screened in FY15. In addition, all children in Emergency Housing receive an immunization screening.

Facility Improvements: In the FY16 OSH proposed Capital Budget, $1.0 million is recommended for capital improvements at the Woodstock Family Residence, Stenton Family Manor, Our Brother's Place (single males) and the Riverview Home. This funding is for infrastructure improvements such as fire alarm system upgrades, door replacements, installation of emergency generators, HVAC upgrades and facade and shower room renovations

Development of New Permanent Supportive Housing Resources: OSH is now in a feasibility stage of initiating new partnerships at a local and national level to create 100 units of permanent supportive housing annually. These would be new units in addition to other permanent supportive housing unit creation. Potential strategies to accomplish this goal include providing incentives to improve the housing stock owned by small and minority landlords and property owners, as well as, faith-based partners, to join OSH with a commitment to supportive housing units. A specific partnership with private and other City agencies is assessing the potential for building new models of supportive housing for veterans and young families.

STAFFING

OSH has hired 4 new employees since the beginning of FY15: 3 are African-American males and one is and Asian female.

Staff Demographics (as of December 2014)

Full-Time Staff

	Male	Female
	African-American	African-American
Total	34	84
% of Total	20.7%	51.2%
	White	White
Total	8	18
% of Total	4.9%	11.0%
	Hispanic	Hispanic
Total	1	9
% of Total	0.6%	5.5%
	Asian	Asian
Total	1	2
% of Total	0.6%	1.2%
	Other	Other
Total	1	6
% of Total	0.6%	3.7%
	Bi-lingual	Bi-lingual
Total	3	11
% of Total	1.8%	6.7%
	Male	Female
Total	45	119
% of Total	27.4%	72.6%

Executive Staff

	Male	Female
	African-American	African-American
Total	6	4
% of Total	37.5%	25.0%
	White	White
Total	1	2
% of Total	6.3%	12.5%
	Hispanic	Hispanic
Total	0	3
% of Total	0.0%	18.8%
	Asian	Asian
Total	0	0
% of Total	0.0%	0.0%
	Other	Other
Total	0	0
% of Total	0.0%	0.0%
	Bi-lingual	Bi-lingual
Total	0	3
% of Total	0.0%	18.8%
	Male	Female
Total	7	9
% of Total	43.8%	56.3%

CONTRACTING

M/W/DBE Participation on Large Contracts
FY15 Contracts

Vendor	Service Provided	Amount of Contract	RFP Issue Date	Contract Start Date	Ranges in RFP	% of M/W/DBE Participation Achieved	$ Value of M/W/DBE Participation	Total % and $ Value Participation - All	Living Wage Compliant?
Food Management Services d/b/a Linton's Management	Food service for the Riverview Home	$712,527	4/20/12	7/1/12	MBE 10-15%	0%	$0	0	Yes
					WBE: 10-15%	0%	$0	0%	
					DSBE:	0%	$0	$0	
US Facilities	Maintenance services at 6 City-Supported Emergency Housing Facilities	$663,250	4/19/13	7/1/13	MBE: 5 -10%	100%	$663,250	$663,250	Yes
					WBE: 5-10%	0%	$0	100%	
					DSBE:	0%	$0	$0	
Core Care Food Services	Food service Families Foreward/Phila/ Kirkbride Campus	$600,334	4/9/13	7/1/13	MBE: 5 -15%	0%	$0	0	Yes
					WBE: 5-15%	0%	$0	0%	
					DSBE:	0%	$0	$0	
Darlene Morris	Emergency Housing & Support Services to homeless families	$415,000	3/17/14	7/1/14	MBE:	0%	$0	$415,00	Yes
					WBE:	100%	$415,00	100%	
					DSBE:	0%	$0	$0	
Social Solution Global Inc.	Customization/ ongoing support for HUD mandated HMIS database	$400,000	1/29/13	10/1/13	MBE: 10-15%	8%	$32,000	$32,000	Yes
					WBE: 10-15%	0%	$0	8%	
					DSBE:	0%	$0	$0	

OTHER BUDGETARY IMPACTS

FEDERAL AND STATE (WHERE APPLICABLE)

Philadelphia will receive a small increase in Emergency Solutions Grant (ESG) funds ($250K) to support rapid re-housing rental assistance. Nationally, there are increases in the Continuum of Care Homeless Assistance Program funding. However locally, there is a $ 3.5M reduction in HOME, CDBG and HOPWA funds that are critical HUD funding that supports housing development and rehabilitation.

The proposed State funding is favorable in the Homeless Assistance Program (HAP), Human Services Development Program (HSDF), State Food Purchase Program (SFPP), resulting in as much as a $ 600K increase overall if passed by the legislature.

OTHER IMPACTS

Per the December 2014 U S Conference of Mayor's Report on Hunger and Homelessness, the main causes of homelessness in Philadelphia among families with children are: lack of affordable housing; eviction; and, poverty. Among unaccompanied individuals, the main causes of homelessness are: lack of affordable housing; substance abuse and lack of needed services; and, poverty.

City Council of
Philadelphia

Philadelphia School-Based Family Service Centers

A Roadmap to Support Academic and Economic Outcomes for Philadelphia Students & Families

Contents

References

[10] United States Census Bureau. *American Community Survey, 2012.* Median Income In The Past 12 Months (Table S1903), Philadelphia County.
Available online: http://factfinder2.census.gov

[11] United States Census Bureau. *American Community Survey, 2012.* Median Income In The Past 12 Months (Table S1903), Pennsylvania State.
Available online: http://factfinder2.census.gov

[12] United States Census Bureau, *American Community Survey, 2005-2012.* Poverty Status In The Past 12 Months (Table S1701), Philadelphia County.
Available online: http://factfinder2.census.gov

[13] National Center for Education Statistics. *Average National Assessment of Educational Progress (NAEP)* mathematics and reading scale score.
Available online: http://nces.ed.gov

[14] Pennsylvania Department of Education. *Yearly Reports: % Students Eligible for Free and Reduced Lunch, 2005-2013.* Available online: http://www.portal.state.pa.us/portal/server.pt/community/national_school_lunch/7487

[15] United States Census Bureau: *State and County QuickFacts.* Data derived from Population Estimates, American Community Survey.
Available online: quickfacts.census.gov

[16] United States Census Bureau. *American Community Survey, 2009.* Linguistic Isolation (Table S1602), Philadelphia County.
Available online: http://factfinder2.census.gov

[17] School-Based Health Alliance. *About School-Based Health Centers.* Available online: http://www.sbh4all.org/site/c.ckLQKbOVLkK6E/b.7528935/k.84EA/About_SBHCs.htm

Letter From Philadelphia City Council

Education is one of the fundamental components of helping children reach their full potential. Yet, a child's ability to succeed academically is not solely determined by access to quality teachers and plentiful books. Research continues to show that academic performance is linked to one's health, income, safety, and other social factors. Communities around the country have embraced this notion and transformed schools into places that both educate and promote healthy students, families, and communities.

School-Based Family Service Centers (SBFSCs) are based on full-service community school models that are currently supporting 1.5 million students in 3,000 schools across 150 municipalities nationwide. Full-service community schools are built on partnerships between school and communities that integrate academics, youth development, family support, and health care. These community schools are designed to remove barriers to student academic and socioeconomic success.

This innovative model for education also seeks to strengthen families by customizing the services offered at each school to match the specific needs of each neighborhood.

Through listening to each neighborhood about the services that would most help them, SBFSCs will become far better equipped to promote comprehensive child and family wellness.

School-Based Family Service Centers in Philadelphia will adopt an innovative approach to education by integrating health and social services for children and their families within schools themselves, and in so doing align the interrelated goals of providing quality education, nutrition, healthcare and other services essential for student, family, and community wellness.

By enabling Philadelphia schools to coordinate multiple services in one location, essential care will become far easier to access, thereby increasing the likelihood that children and parents will have the tools they need to reach their full academic and economic potential.

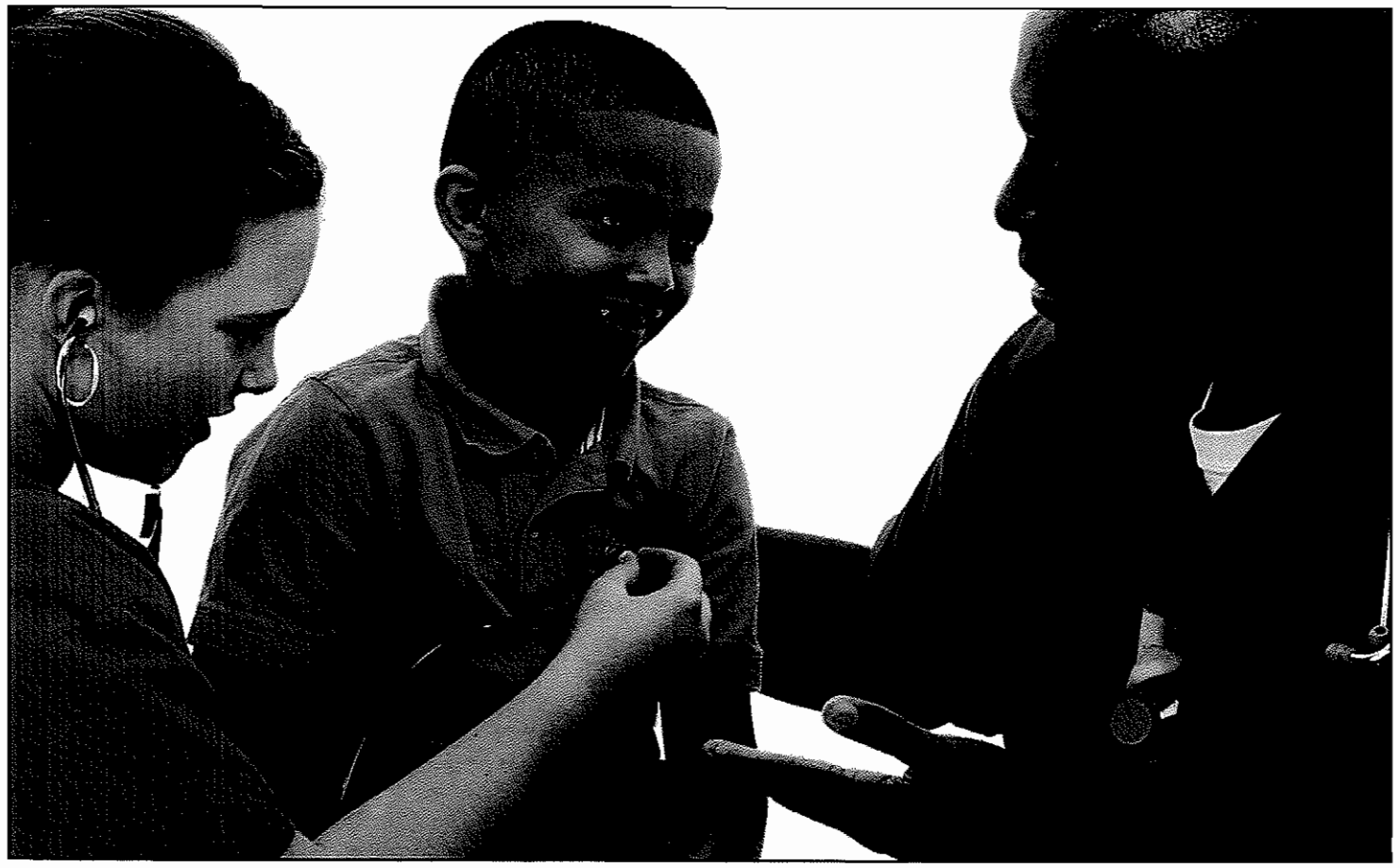
Introduction

Over the last decade, research on full-service community school outcomes has consistently shown:

- Strong increases in academic performance, college enrollment rates, access to preventative health services, and parental involvement; and
- Substantial decreases in dropout rates, chronic absenteeism, and disciplinary actions.

The inspiration for launching School-Based Family Service Centers (SBFSC) is simple: we can better prepare Philadelphia's children for academic success by simultaneously improving their physical, emotional, and social well-being.

School-Based Family Service Centers are a more efficient and effective use of taxpayer money than traditional schools. Children will have better educational outcomes because their health, nutrition, and behavioral needs are all being addressed simultaneously.



References

[1] Philadelphia Department of Public Health. Community Health Assessment, May 2014. Available online: http://www.phila.gov/health/pdfs/CHAreport_52114_final.pdf

[2] Philadelphia Department of Public Health (2011). *Philadelphia Youth in Crisis: Adolescents and Sexually Transmitted Infections.* Available online: http://www.phila.gov/health/pdfs/Adolescents%20and%20STIs.pdf

[3] Centers for Disease Control and Prevention (CDC). 1991-2013 *High School Youth Risk Behavior Survey Data.* Available online: http://nccd.cdc.gov/youthonline/

[4] Substance Abuse Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality, *National Survey on Drug Use and Health,* 2005 and 2006 to 2010 (Revised March 2012).

[5] School District of Philadelphia, Office of School Safety. *Violent Crime Index District Wide, Year to year Comparison Report.* Available online: https://webapps.philasd.org/news-files/pr-files/Violent_Crime_Table.pdf

[6] Pennsylvania Department of Education. *Dropout Data and Statistics,* 2011-2012. Available online: http://www.education.state.pa.us/portal/server.pt/community/dropouts/7396

[7] United States Census Bureau: State and County QuickFacts. Data derived from Population Estimates, *American Community Survey.* Available online: quickfacts.census.gov

[8] Pennsylvania Department of Education, Bureau of Assessment and Accountability. *District Report Card, Philadelphia City School District, 2011-2012.*

[9] United States Bureau of Labor Statistics (2014). *Local Area Unemployment Statistics Information and Analysis.* Pennsylvania and Philadelphia. Available online: www.bls.gov/LAU.

Family Resources & Continuing Education

Social workers, knowledgeable about community-based resources, will link students and their families to relevant programs and services. Referrals will be based on needs identified during the student/family need assessment. Social workers will serve as case managers, not only making appropriate service referrals, but providing follow-up to ensure the student and the family are connected with service agents.

Providence, RI students who were in schools that were integrated with School-Based Family Service Centers in 2009 exhibited 55% fewer incidents of chronic absenteeism. The same students had a 97% attendance rate where their parents attended Family Literacy classes.

Services should include general social service assessment, referral, and guidance to access eligible public assistance and other programs that provide basic needs. These include: psychosocial risk assessments; nutrition counseling and assistance; housing placement; utilities subsidies, medical insurance; legal services; continuing education; tax benefits, employment services; child day care and elder care services; and substance abuse services.

Nonprofits and other non-governmental organizations can also use SBFSCs as a delivery vehicle for services that support students and families. For example, local community colleges and universities can help improve socioeconomic outcomes for families by offering English as a Second Language (ESL), GED, job training, and college readiness programs.

Why Does Philadelphia Need School-Based Family Service Centers?

In Philadelphia, 40% of school-age children (age 17 or younger) live in poverty—one of the highest rates in the nation. An estimated 30% of Philadelphia children live with a chronic disease like asthma – a statistic that does not include children who receive little or no medical care and therefore go undiagnosed or untreated. Many disadvantaged children are unable to learn because they lack essentials such as adequate food and basic healthcare. We cannot declare that we have fulfilled our moral duty by simply providing our City's children with desks, pencils, books, and teachers. These children need far more in order to have positive academic outcomes. Their families often also require support in order to have positive socioeconomic outcomes. We cannot declare that we have fulfilled our moral duty by simply providing our City's children with desks, pencils, books, and teachers. These children need far more in order to have positive academic outcomes. Their families often require support in order to have positive socioeconomic outcomes.

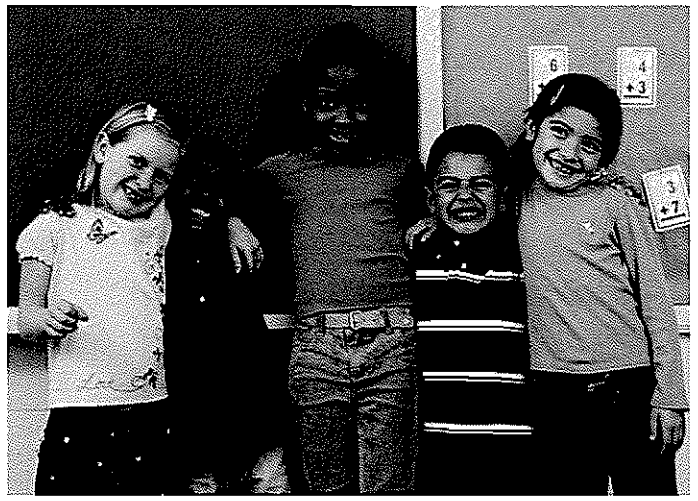
Between 2006 and 2011, all 51 Cincinnati Public Schools were transformed into School-Based Family Service Centers. Graduation rates soaring from 51% in 2000 to 82% in 2010. ***(details page 9)***

School-Based Family Service Centers will not only focus on the needs of students inside the school, they will also address their needs outside the school. Naturally, success will not be possible without active engagement from community groups that are already making important contributions inside many of our City's schools.

Demographic Context

More than half of Philadelphia's residents are racial and ethnic minorities, with Blacks comprising 44%, Hispanics making up 13% and Asians comprising 7% of the total population. Twelve percent are foreign born, and 21% speak a language other than English in the home. Seven percent of Philadelphia households are linguistically isolated. Linguistic isolation refers to a household in which all members over the age of 13 speak a non-English language and have difficulty with English. This demographic composition highlights the need to utilize culturally-competent, linguistically-appropriate providers in the delivery of health and social services to our city's diverse population.

Understanding the health, safety, educational, and socioeconomic challenges



students and their families face is impossible without ongoing community engagement happening at each SBFSC. Only then can we design comprehensive programs that effectively address the unique needs of every neighborhood's families. The proposed School-Based Family Service Centers (SBFSCs) will ensure Philadelphia students and families can access a full array of health and social services in the city in the most convenient, affordable manner possible.

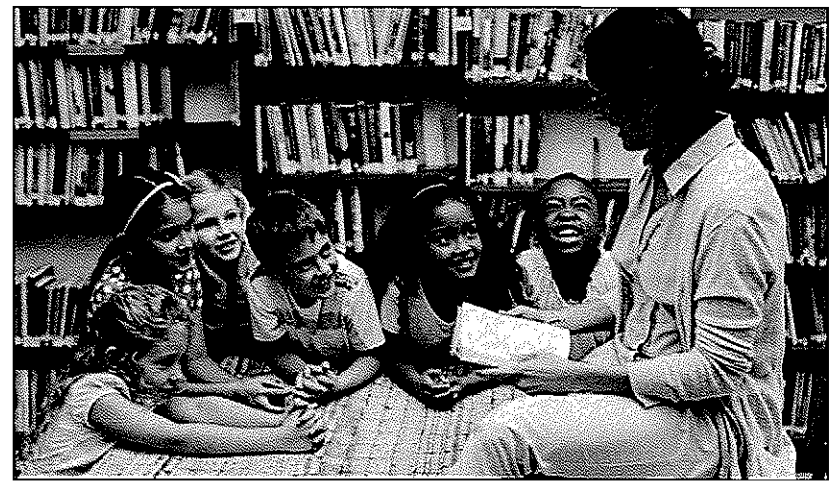
Economic Indicators

While trends in unemployment mirror that of Pennsylvania over the past decade, Philadelphia's unemployment rate has consistently surpassed that of the state. The median income ($35,386) is a fraction of the state's average ($51,230). Consistent with national trends, ethnic and minority groups have lower median incomes than whites. Families affected by unemployment and low wages are less likely to have health insurance, which compromises their access to healthcare services, places them at risk for poor health status, and increases the chances of chronic absenteeism.

More than one quarter of our residents (26.9%) live below the federal poverty line. The proportion of children 17 years and younger living in poverty is nearly 40%. Children raised in poverty face daily overwhelming challenges that undermine academic performance. Data from the National Assessment of Educational Progress show that more than 46% of average math scores and 40% of average reading scores across states are associated with child poverty rates.

Disparities in socioeconomic status are evident across the School District of Philadelphia (SDP). The proportion of SDP children who qualify for free lunch far surpasses the state average. Nearly three out of four children were eligible for free lunch in 2013. A growing body of data suggests less advantaged students are more likely to have behavioral problems at school and lower academic achievements than their more advantaged peers.

cleanings, oral health education and referrals to local dental treatment and specialty services off-site.



Early Childhood Programs

Early childhood education and Head Start preschool programs prepare children for transitioning into elementary school by building confidence and skills in each child. Parents benefit from the same programs as they help develop education readiness skills that support the child in preparation for their primary education experience. Further, when a preschool program is located in the school building, transition to kindergarten and primary grades is easier. The benefits to both children and families are long lasting

Before and After School Programs

Because there is not enough time in the school day for many children to acquire all the skills they need to succeed in today's educational system, before- and after-school programs provide an ideal space for extended learning opportunities. Schools that are open for longer hours before and after the school day, and where creative enrichment programs are provided, can help children achieve significant academic gains. Further, where the extended learning opportunities are integrated into the school's academic curriculum, after-school activities can reinforce and enrich what children learn each day. When the programs are extended over the summer, remediation and preparation learning can prepare the child for the following school year. These same programs also help children gain social skills and cultural experiences that lead to strong youth development.

Philadelphia's Shaw Middle School, which partners with the University of Pennsylvania to provide School-Based Family Services, saw suspensions decrease from 464 to 163 over a span of six years.

Services Provided Through School-Based Family Service Centers

All SBFSCs, through guidance from the Community Advisory Board (CAB), should perform needs assessments to determine medical and social services that families may be eligible for and to assist in accessing them through education and enrollment. Baseline services, which will be available either through direct service delivery or referral, are outlined below.

Medical & Health Education Services

Healthcare services should include services comparable to that provided by primary care providers (PCPs). Services will include wellness exams; episodic acute care, including diagnosis and treatment of illness and injury; immunizations; basic laboratory tests; and follow-up and coordination of care whenever appropriate. Additional services should also include education related to nutrition and physical activity, chronic disease management, pregnancy tests and counseling as appropriate, testing and treatment for sexually transmitted infections as clinically indicated, and referrals for specialty care or other needed services not provided onsite.

Behavioral Health Services

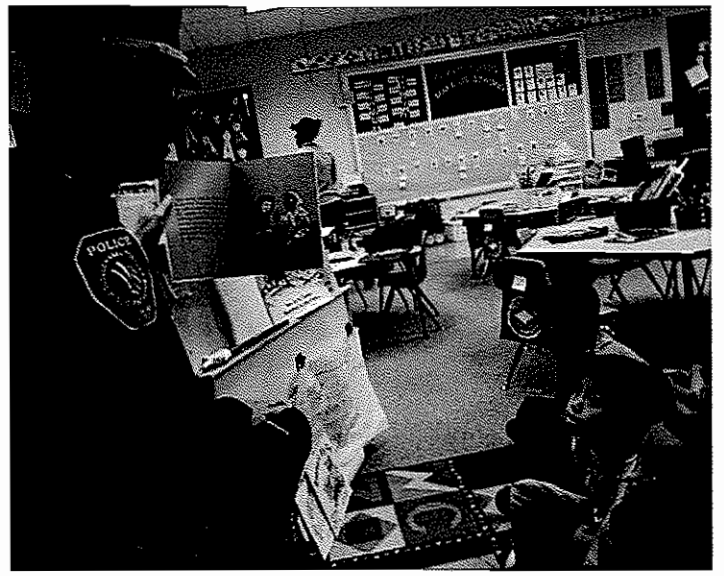
Behavioral health services should include age-appropriate, culturally competent screening and assessment to facilitate early identification of substance abuse, domestic/dating violence, and mental health disorders. Additional services should include mental health and substance abuse awareness and prevention education; individual, family and/or group therapy/counseling provided by a qualified staff person; crisis intervention/counseling; and case management/ client advocacy. Clients will be referred to a continuum of mental health services for medications, emergency psychiatric care, community support programs, substance abuse services, and inpatient and outpatient mental health programs.

Vision, Oral and Auditory Health Services

Oral health services should include oral health screenings, fluoride varnish, sealants, dental

Safety Indicators

Crime rates in Philadelphia are trending downward—a promising sign for our city's residents. Unfortunately, Philadelphia's crime rate still far surpasses the U.S. average, and violence is highly concentrated in a number of our neighborhoods. The effects of concentrated violence on youth can be seen in our schools every day.



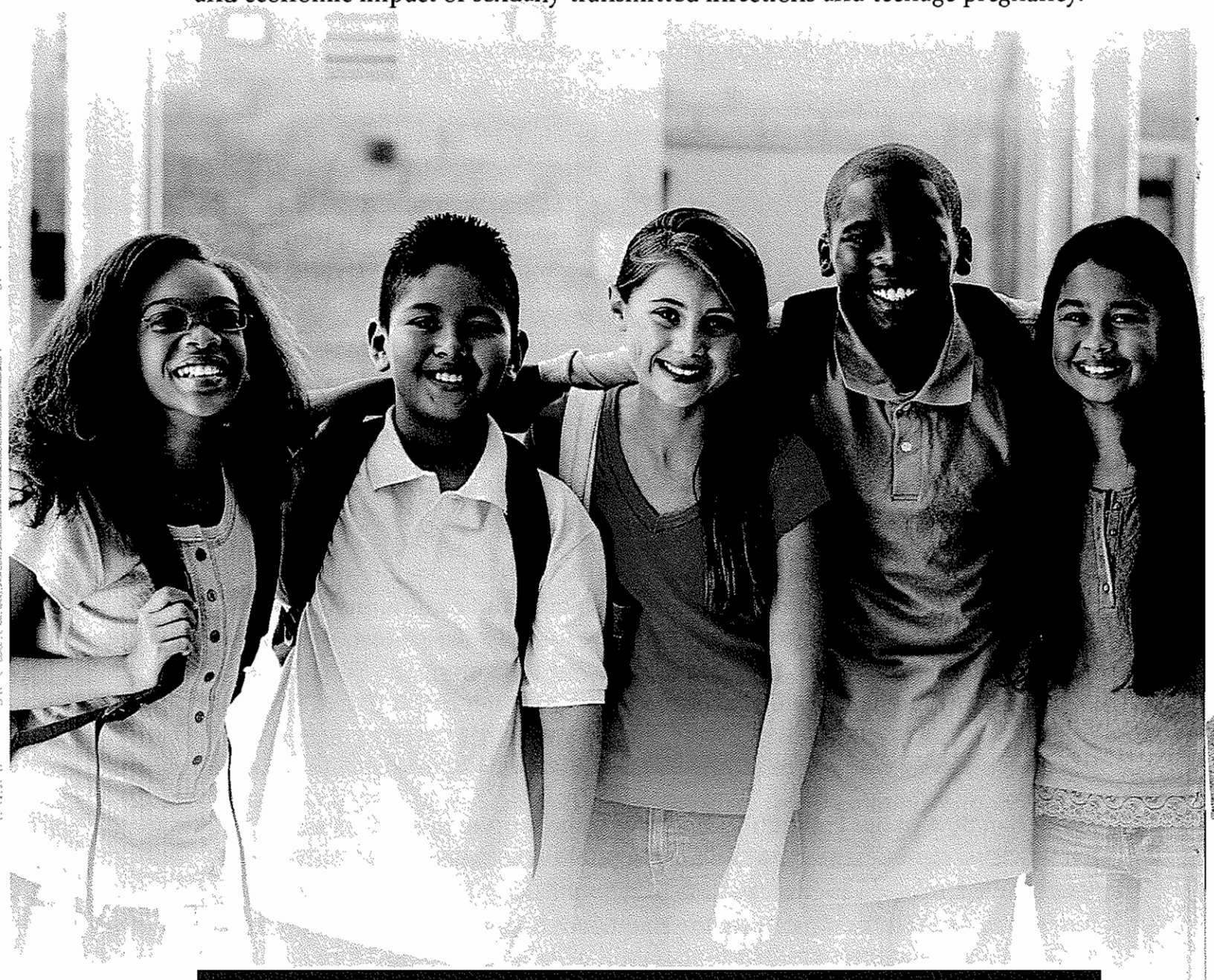
According to the 2013 Youth Risk Behavior Survey (YRBS), more than one third of Philadelphia youth were in a physical fight one or more times in the 12-month period preceding the survey. The proportion of youth who were in a physical fight on school property at least once during the year was double that of the U.S. average (16.2% versus 8.1%). A reported 2,756 violent incidents were reported at schools during the 2012-2013 academic year. Exposure to violence, including peer victimization and family and community violence, are damaging to our youth. Some studies suggest exposure to violence, directly or as witnesses, may be linked to poorer academic outcomes.

Health Indicators

More than 30% of our children who receive some form of medical care are living with a chronic disease. More than 30% of these children live with asthma. There is evidence that indicates access to school-based health programs reduces hospitalization rates and increases the number of days in school among children with asthma. One fifth of Philadelphia youth experience childhood obesity. School-based health services have been associated with increased physical activity and better nutrition.

Reproductive health indicators among Philadelphia youth are also cause for concern. The rates of chlamydia and gonorrhea among 15-19 year olds are 3.5 times and 3 times the national rate, respectively. Compared with the U.S. average, Philadelphia youth are more likely to report: having had sexual

intercourse prior to age 13 years; having had sexual intercourse with four or more persons during their lifetime; and not using any methods to prevent pregnancy during their last sexual encounter. Early and age-appropriate education, prevention and intervention programs can help mitigate the social and economic impact of sexually transmitted infections and teenage pregnancy.



In Philadelphia, the Sayre High School Class of 2007, whose students were provided school-based family services, achieved a 90% on-time graduation rate. Between 2007 and 2009, the rate of graduates enrolling in two-year or four-year college grew from 68% to 84%.
(details page 12)

Program Development

Community Advisory Boards

Each School-Based Family Service Center will establish, and receive guidance from, a local Community Advisory Board (CAB) that manages the ongoing community engagement process to identify the unique needs of the students and families at each SBFSC school. Additionally, CAB responsibilities include: managing community engagement; overseeing site-based coordination of activities; publishing a report card on service outcomes; and providing governing oversight. The CAB's membership should include representatives from the school staff, parents, students (if middle or high school), and community stakeholders. The CAB should also include healthcare and social service providers that support the school center, public agencies, post-secondary institutions, and local community-based organizations.

An Organizational Structure that Listens and Evolves

A Cabinet will be constituted with the purpose of establishing citywide programmatic policies and strategies to support operations of SBFSCs. The Cabinet will provide implementation guidance and interface with each Community Advisory Board to ensure the improvement of: student well-being, academic achievement, and family socioeconomic outcomes. Cabinet members will include representatives from the leadership team of participating groups including:

- Parents
- Educators & School Staff
- School District of Philadelphia
- Community Service Providers
- Philadelphia Department of Human Services
- Philadelphia Department of Public Health
- Philadelphia Housing Authority
- Philadelphia Office of Supportive Housing
- Philadelphia Mayor's Office
- Philadelphia City Council

Locating Services Where They Are Most Impactful

All services must be delivered in collaboration with Philadelphia public schools, parents, health and service providers, and appropriate community partners. Schools are the center of the community and shared resources lead to improved student learning, stronger families, and healthier communities. It is essential that SBFSCs be convenient to the students, siblings, and parents. This can best be achieved by establishing strong partnerships between communities and schools. When a service cannot be placed inside the school itself, it must be placed conveniently within the community or at another nearby SBFSC so transport does not create an additional barrier to access or utilization.

Alcohol and Substance Abuse

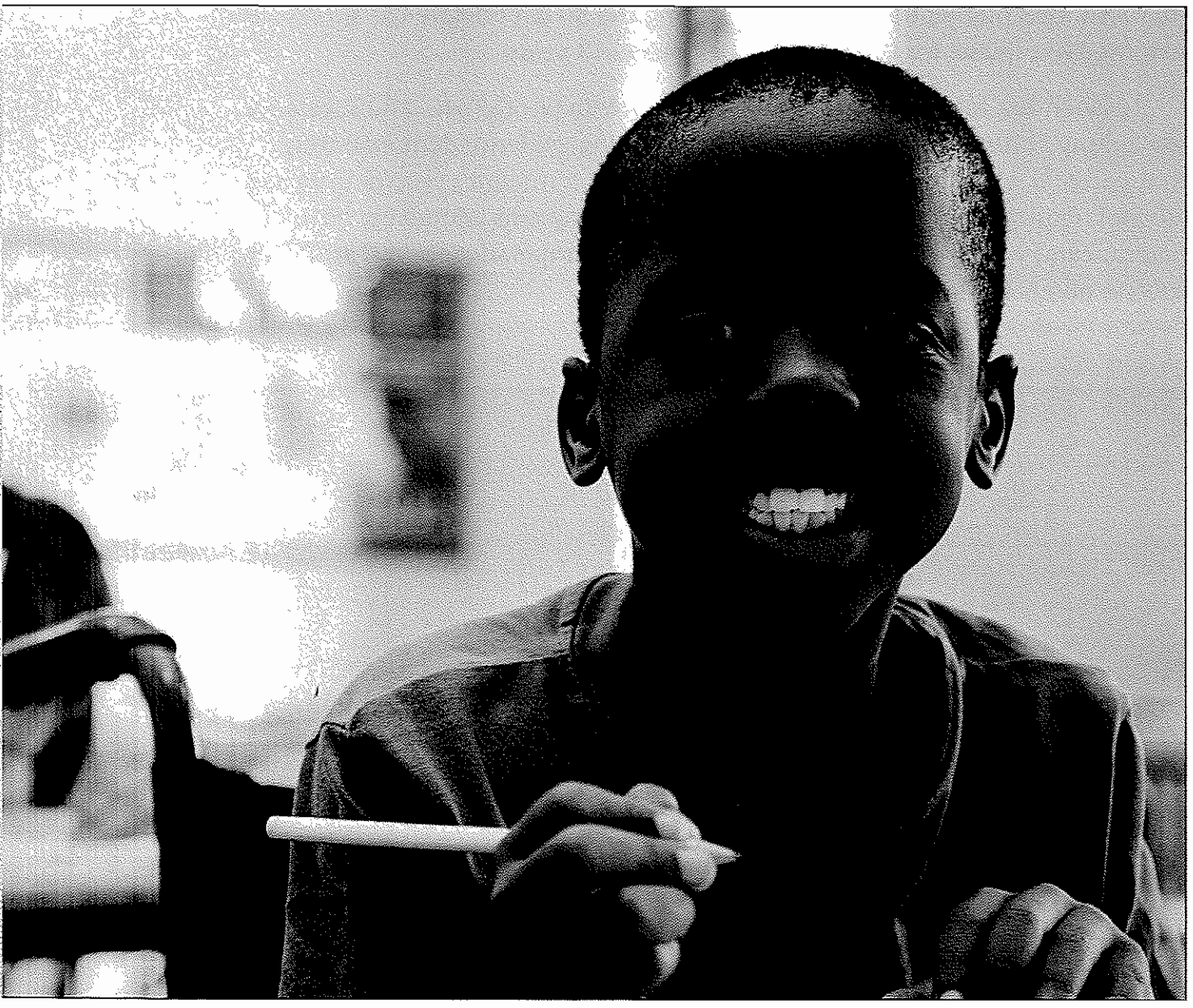
According to data from the National Survey on Drug Use and Health (NSDUH) for the Metropolitan Statistical Area (MSA) that includes Philadelphia, 16.6% of individuals aged 12 years or older used an illicit drug in the past year—surpassing both the state (13.6%) and national rates (14.7%). One tenth of the MSA residents were classified as having substance use disorder, and more than 25% of people in the MSA participated in binge alcohol use at least once during the past month. Data from Philadelphia's YRBS confirm alcohol and illicit drug use is a concern among Philadelphia's youth. One in four youth in our city report current alcohol or current marijuana use. One third of youth (33%) reported they had at least one drink of alcohol or had used marijuana at least once during the 30 days before the survey. Almost one fifth of youth (18.9%) had tried alcohol for the first time before age 13 years. One in four youth (25.1%) reported they had used marijuana at least once during the 30 days before the survey; 8% had tried marijuana for the first time before age 13 years.

Research has established an association between poor grades and substance use among young people. There is also compelling evidence demonstrating that parental substance or alcohol abuse increases a student's risk for drug and alcohol abuse and low educational attainment. Programs addressing both parental and youth substance-using behaviors are imperative for the academic success of our city's youth.

Academic Indicators

Philadelphia ranks first in the state for public school dropouts, with a rate that is more than triple that of the state average. One fifth of our city's residents do not have a high school diploma or its equivalent. Less than half of students scored proficient or above on math and reading—falling short of the 78% and 81% federal No Child Left Behind targets, respectively. Minority students and students from economically disadvantaged backgrounds fared worse.

At Carlin Springs Elementary School in Arlington, VA, 95% of parents are taking adult ESL (English as a Second Language) courses.



The design of community schools vary depending on the resources and needs of the local community. What Sayre and more robust community schools elsewhere in the country have in common are "broad participation by a wide range of providers, intensive coordination and collaboration between the school, its teachers and leaders, and outside partners, and the active engagement of the surrounding community."

Bundling City Services Under One Roof

Philadelphia has always had the tools necessary for transforming every district school into vibrant School-Based Family Service Centers. Now we have the will to make this a reality. Our City can reasonably achieve this ambitious goal through grouping together existing City services for children and families; service contributions from our City's world-class health and higher education institutions; and an experienced third-party responsible for coordinating care and measuring outcomes so we can track each student's wellness needs in real-time.

Philadelphians already contribute their tax dollars to countless child and family services each year. The question is not whether they should be giving more, but whether their tax dollars are being spent in the most intelligent way—and in a manner that reaches the largest percentage of those in need. Below are a handful of the ways in which local tax dollars are already enhancing the quality of life for children and families. School-Based Family Service Centers would simply bundle the high-quality work being done across the City and provide it in the most convenient location possible—schools.

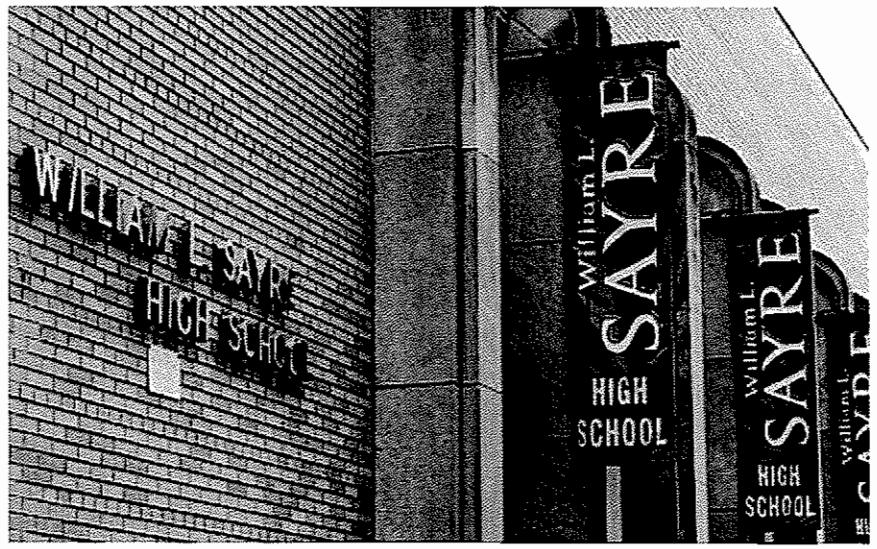
- Arts & Culture Programming
- Behavioral Health and Intellectual disAbility Services
- Child Care Funding
- Community College of Philadelphia Tuition Subsidies
- Youth Aid Diversion Panels
- Empowerment Zones
- Family Court
- Financial Literacy
- Free Library of Philadelphia
- GED & Job Training
- Juvenile Offender Support Services
- Language Access Training
- Parks & Recreation Department
- Public Defender's Office & Legal Services
- Public Health Clinics - Maternal, Child, and Family Healthcare
- School District of Philadelphia (Direct Funding)
- Social Services
- Supportive Housing Programs
- University Scholarships

A Case Study in Community Partnerships: Sayre High School

Philadelphia's Sayre High School is a living example of how engaged community stakeholders can transform the learning experience for public school students. While far from complete, the Sayre High School experience comes closest to reaching the ambitious goals of School-Based Family Service Centers.

Through a long-lasting partnership with the University of Pennsylvania, the public school offers an enhanced health sciences curriculum which features cross-collaboration with prominent university science faculty. In 2011, over 350 University of Pennsylvania students gained vital work experience at Sayre as 'co-learners' under the supervision of highly experienced, licensed care providers.

After listening to the needs of Sayre parents, the high school now stays open until 8 p.m. and offers free after-school mentoring and intensive support for college and career readiness.



A health center opened within Sayre High School in 2007. Funded through federal grants and a sustainable funding model, students and community members are provided convenient access to world-class doctors from the University of Pennsylvania. In addition, the school has a nutrition and garden program that offers job experience, healthy eating classes and more.

The work has paid off. According to the Annenberg Institute for School Reform at Brown University, "Sayre's first senior class of 80 students had a 90% graduation rate, and 56% enrolled in post-secondary education."

Sayre's science curriculum, a main focus of the partnership, focuses on hands-on inquiry and small group learning. A cohort of 10th graders from Sayre travel to the University of Pennsylvania's School of Medicine to gain real-world medical certifications, opening the door to immediate employment opportunities in various medical services professions.

Common Characteristics of Successful Community Schools

- Physically located in the school or proximate to school grounds
- Offer a comprehensive range of services that are customizable to meet specific needs of students and families
- Multidisciplinary team of care providers who work with educators, school nurses and social workers to deliver quality care that can be integrated with learning experience
- Offer services available to members of community in which school is located
- Have an advisory board consisting of community representatives, parents, service providers and school staff to provide planning and oversight to ensure services meet needs

The Cincinnati Story: How A Struggling School District Became A National Model

Experts consistently point to Cincinnati Public Schools' nationally recognized "Community Learning Centers" as one of the best models for community schools.

Key Components & Program Structure

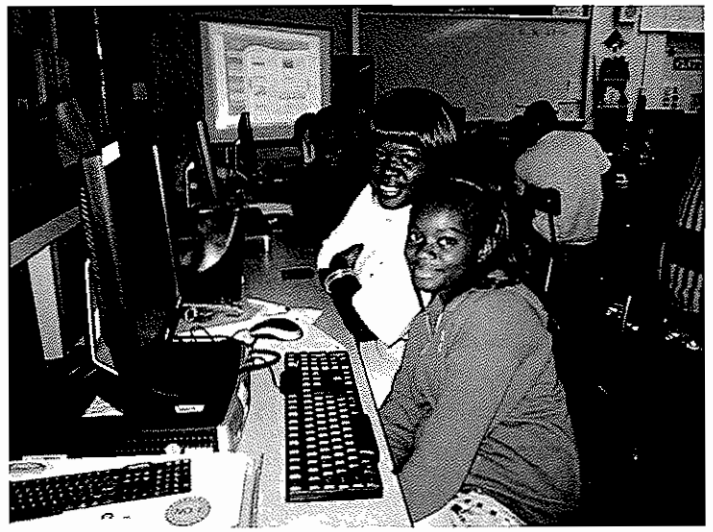
The Community Learning Center Institute is a non-profit that manages the administrative responsibilities of a citywide network of community schools "each with a set of financially self-sustaining, co-located community partnerships responsive to the vision and needs of each school and its neighborhood." The five core components of the Cincinnati model are:

1. A commitment to comprehensive, sustained community engagement to ensure service partnerships remain responsive.
2. Site-based governance that includes parents, educators, and community leaders that is charged with: establishing the unique vision for each school; steering the selection of community partners and care providers; and evaluating their performance.

3. Partnership networks comprised of care providers that provide equitable access to quality services in a manner that is financially sustainable and ensures district dollars remain dedicated to education.

4. Cross Boundary Leadership that knits together the partnership network leaders as a collaborative team to provide coordination and integration of interdisciplinary resources.

5. On-site Resource Coordinators in every school that interface with teachers and staff to provide the critical infrastructure at the site level to develop, integrate, and manage the community partnerships.



Highlighted Outcomes

With community learning centers as a central strategy for school and neighborhood improvement, Cincinnati Public Schools have:

- Become the highest performing urban district in Ohio for five consecutive years;
- Narrowed the achievement gap between black students and white students from 14.5% in 2003 to 1.2% by 2010;
- Raised high school graduation rates from 51% in 2000 to 81.9% in 2010;
- Established two co-located early childhood education centers, 20 school-based health centers, two dental clinics, and the first school-based vision center in the United States;
- Surpassed enrollment projections, in part because of middle class families returning to neighborhood schools; and
- Provided positive conditions for learning through hundreds of community partnerships, which brought millions of dollars in additional resources to the students and their families.

The Proposed Philadelphia Model

The proposed Philadelphia Model for School-Based Family Service Centers draws from the decades of experience in communities across the country where measurements of the effects on student's academic performance and wellness continue to inspire an increasing number of cities to follow their lead.

School-Based Family Service Centers (SBFSC) will adopt the major tenets of full-service community schools drawing from the best models from across the country. Additionally, a Community Advisory Board (CAB) will be formed at each SBFSC location to ensure every student and family member receives the high-quality services they need. Each CAB should include representation from that school's own parents, educators, school staff, service providers, and other community stakeholders. The Philadelphia model for SBFSCs aims to eventually provide convenient, affordable access to the following services at every District school across the City and include:

- Primary Health Clinics – Facilities that operate in school buildings, on school grounds or in the neighborhood using a multidisciplinary team of providers to care for the students, which will provide primary healthcare, dental care, vision care, behavioral health, counseling, and health education.
- Early Childhood Development Programs – Programs that provide services including all-day childcare, after-school care, family guidance, and similar means-tested programs.
- After School Programs – Programs that build on the effectiveness of schools by providing school-age children with academic and nonacademic support.
- Youth Development Programs – Youth programming that provides purpose-driven activities including mentoring, substance abuse counseling, physical activities, community service learning, and pre-employment training.
- Family Resources & Continuing Education Programs – Services for parents and guardians that help support the home on an ad hoc basis or through case management and can include: parenting education; literacy; career counseling and employment programs; tax education; General Education Development (GED) preparation; college readiness support; immigration information; housing, food, and clothing assistance; health services; and early child care.

PUBLIC TESTIMONY ON APRIL 29th

Name	Company	Phone #
Bob Previdi	Bicycle Coalition of Greater Philadelphia	267-235-8523
Waffiyyah Murry	Safe Routes Philly, Coordinator	
Sarah Stuart	Deputy Director Bicycle Coalition of Greater Philadelphia	
Hans Kersten	St. Christopher Hospital	
Judith Robinson	Citizen	215-765-9500
Jeannine Lisitski	Women Against Abuse, Executive Director	215-386-1280 ext. 105
Beth McConnell	PACDC	215-732-5829 x110
Margaret Cukoski	Pa Council of Children Youth and Family Svs.	267-787-5344
Charles Younger		267-528-9053
David Fair	Turning Point for Children	215-300-7886
Angel Rodriguez	APM	267-317-2298
Kelly Davis	Lutheran Settlement House	215-266-9436

Cindy Fortino

Rob Harrison Stenton Family

Testimony : Reduction in Funding of Safe Routes Program 4/29

"This is the decision I regret the most of my mayoral service". Mayor Nutter

These words were spoken by Mayor Nutter at the beginning of March in his last budget address. He was referring to libraries. In an attempt to reduce spending across the government he attempted to close 11 libraries based on incomplete information by well meaning members of his administration.

As we come into 2016 with the expectation of internal budget cuts at the Philadelphia Department of Public Health which will affect Safe Routes the words ring true for this program. The effect of $50,000 in cuts will be devastating to programming which will create hardship for those who can least afford it. As was found with the decision to close libraries there are nuances which are not being looked at with this decision.

- This cut in safe routes will also cost the lost of matching NHTSA funding.
- The communities that most need these services have no recourse to replace them

If we look at the Community Health Improvement Plan for 2014 - 2018, increasing physical activity is one of the priorities, specifically Chronic Disease related to Poor Diet and Physical Inactivity. Physical activity without parameters of safety is as unsafe as no physical activity.

Community Health Improvement Plan 2014-2018

Philadelphia Community Health Improvement Plan Summary of Priorities and Goals

Priority 3: Chronic Disease related to Poor Diet and Physical Inactivity

Goal 1 Increase access to healthy foods

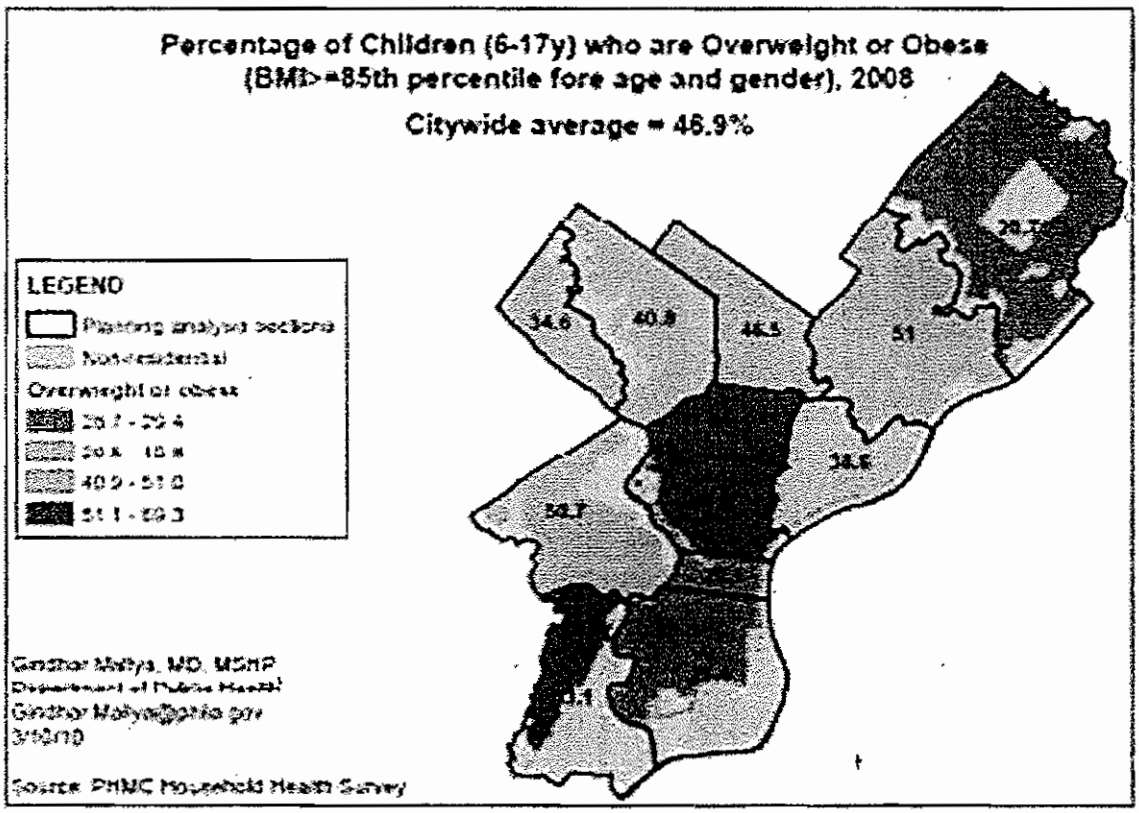
Goal 2 Increase physical activity among children and adults

Goal 3 Further the integration of nutrition and physical activity promotion with clinical practice

Goal 4 Improve knowledge of and access to evidence-based community resources

Although violent crime in the city has gone down over the years there still are dangers and concerns with children traveling to school. In the last few years 24 schools were closed which created additional travel in some communities. Safe Routes was a resource which was geared toward making that travel safer. Lea was one of the schoosl affected by those closings by having the Wilson school merge with it. Children had to travel past extremely busy streets and across some of the top 10 most traveled Septa routes. This created a danger for students and increased stress for parents. Safe Routes is a program whose mission is to lessen the safety issues with students traveling to school. It is also geared toward helping to train them in best practices of walking and riding which in turn directly affects their physical being.

Considering the fact that 54% of Philadelphia children aged 6 – 11 are overweight or obese with an outstanding 70% in North Philadelphia, this is more than just an issue but in fact a crisis. To take away a program which could directly affect change in those numbers is ill conceived especially considering the nominal cost of the program.



So as we look at budgets and what is important or not important, we must set priorities. With the Philadelphia Department of Public Health making children physical activity one of its priorities for 2014 - 2018 that is a great start. To cut a program from the budget which could economically facilitate this could be a decision which will in the future called ***"the decision I regret the most".***

So I ask for the health and safety of the children of Philadelphia that this funding be restored.

HENRY C. LEA & ALEXANDER WILSON MERGER

Student Travel and Safety Analysis

Student Safety Report

ANAYLYSIS OF STUDENT SAFETY

Safety Report

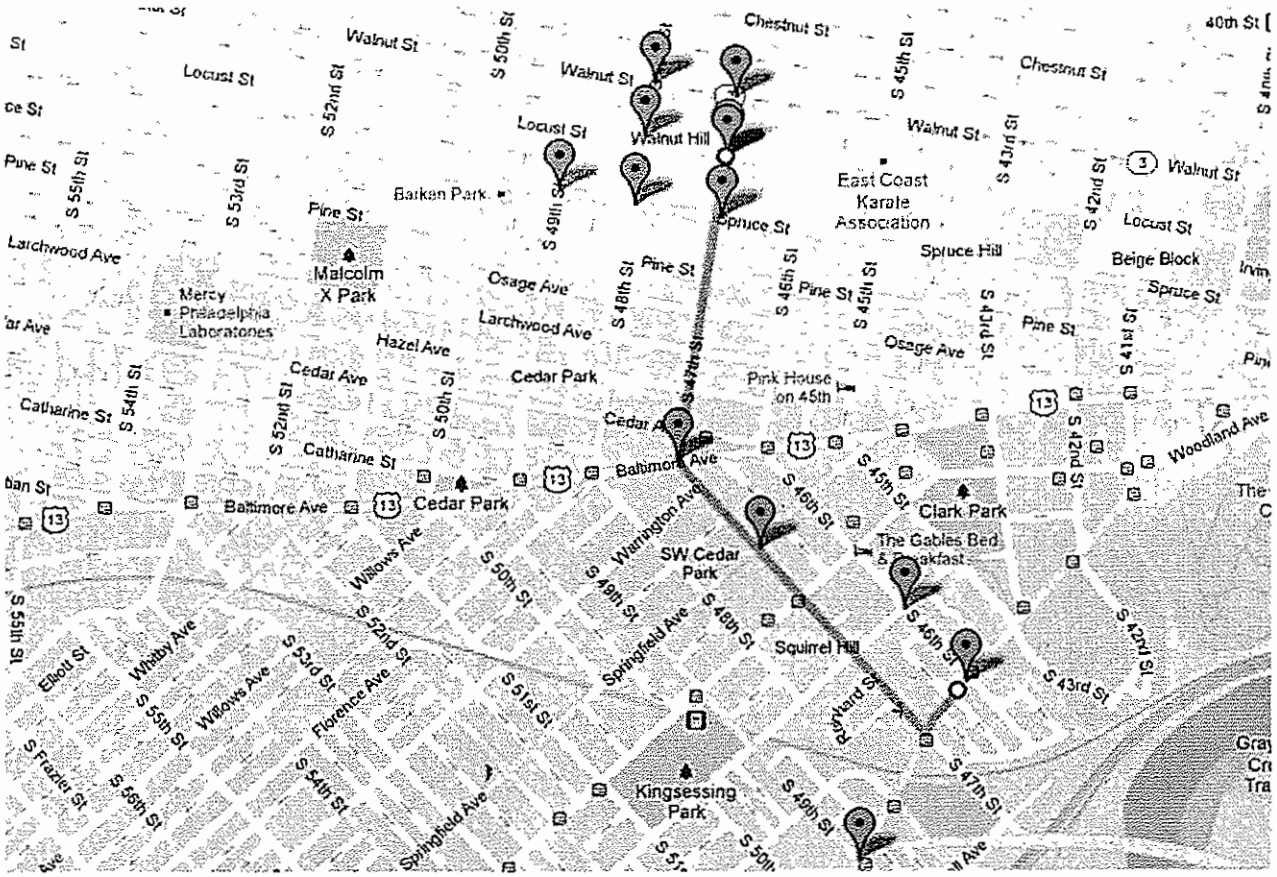
Lea Home School & Community Association

Working Together As One

INTRODUCTION

Due to budget cuts the School District of Philadelphia has determined that a number of schools had to be closed. Because of a number of factors the Alexander Wilson School was placed on this list and subsequently voted to be closed by the School Reform Commission. .Many of the population of Wilson does not meet the criteria for transportation services; determined by the district to be those students living 1.5 miles from the prospective school location. There are a total of 76 students who currently live beyond this cut off of 1.5 miles and are eligible for transportation services out of the 239 current population. Wilson is located exactly 1.02 miles from Lea with most of the current population living Southwest of the school and above Woodland Ave. This will require those who do not receive transportation services to walk a route which includes many busy thoroughfares and highly trafficked streets. Wilson's population consists of grades K through 6, and due to the age of students who will be required to walk or find other means of transportation this report will examine any factors which will lead to safety concerns for parents and students.

Current Locations of Crossing Guards



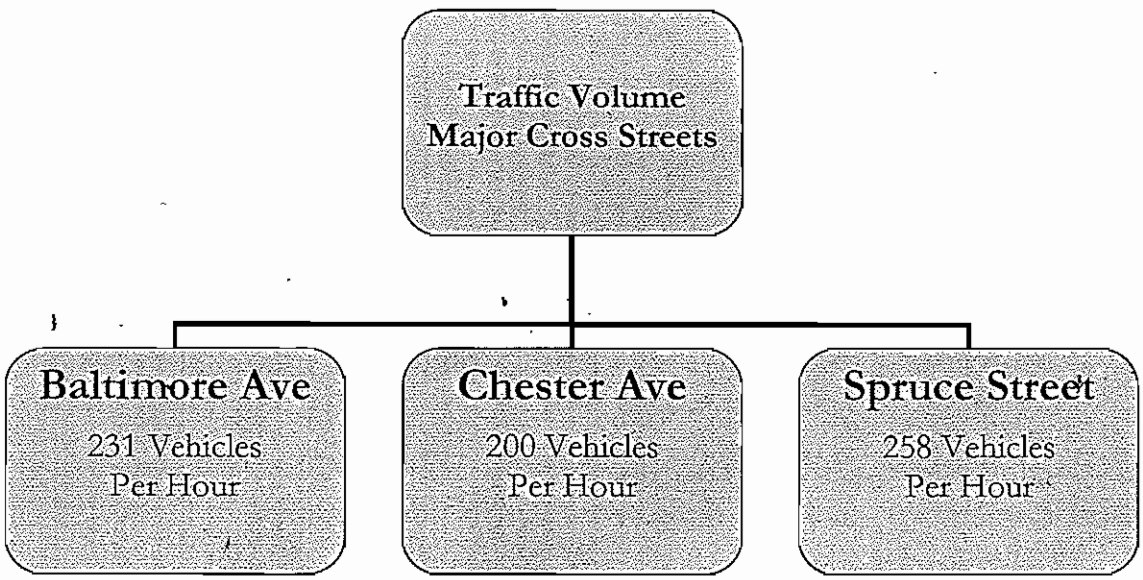
- The 18th Police Department was contacted to report on locations for Crossing Guards
- According to Officer Porter who oversees the guard force all crossing guards will continue at the same locations during the 2013 - 2014 school years. An analysis was requested to determine need for additional locations for Crossing Guards in area of Wilson School

High Traffic 2 Lane Thoroughfares - Wilson to Lea

- Woodland Ave
- Kingsessing Ave
- Chester Ave
- Springfield Ave
- Baltimore Ave
- Spruce Street

Low Traffic 2 Lane Thoroughfares - Wilson to Lea

- Cedar Ave
- Hazel Ave
- Larchwood Ave
- Osage Ave
- Pine Street



PENNDOT Data

2011

TRAFFIC VOLUME MAP

PUBLISHED NOVEMBER 2012

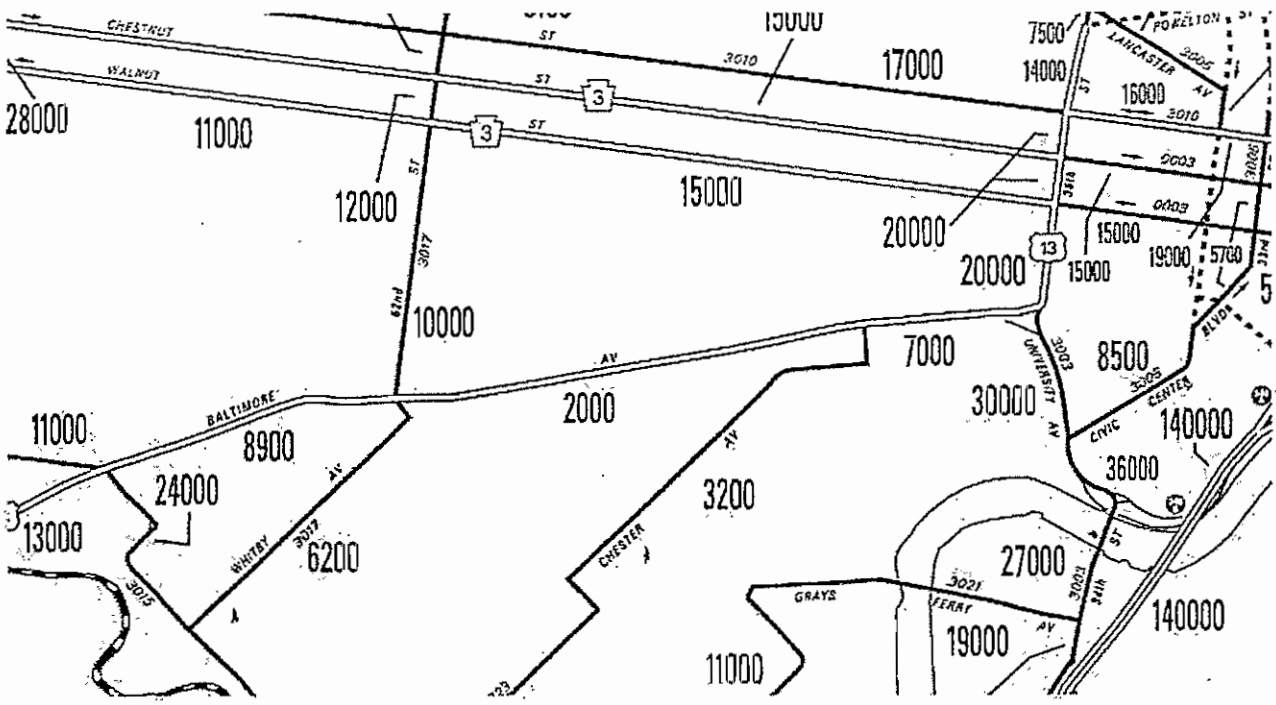
PHILADELPHIA COUNTY

PENNSYLVANIA

PREPARED BY THE

PENNSYLVANIA DEPARTMENT OF TRANSPORTATION

BUREAU OF PLANNING AND RESEARCH



- Traffic Volumes vary along route of travel for students but the average remains high for this region
- Four Trolley or Bus Routes will need to be crossed by students traveling to Lea from Wilson area
- Per Septa Data these routes are rated in their top 10 for usage by public transit customers

Route 13 Trolley
Chester Ave
Daily Avg Ridership
18,220
Ranking 9th

Route 11
Woodland Ave
Daily Avg Ridership
18,617
Ranking 6th

Route 42
Spruce Street
Daily Avg Ridership
11,911
Ranking 19th

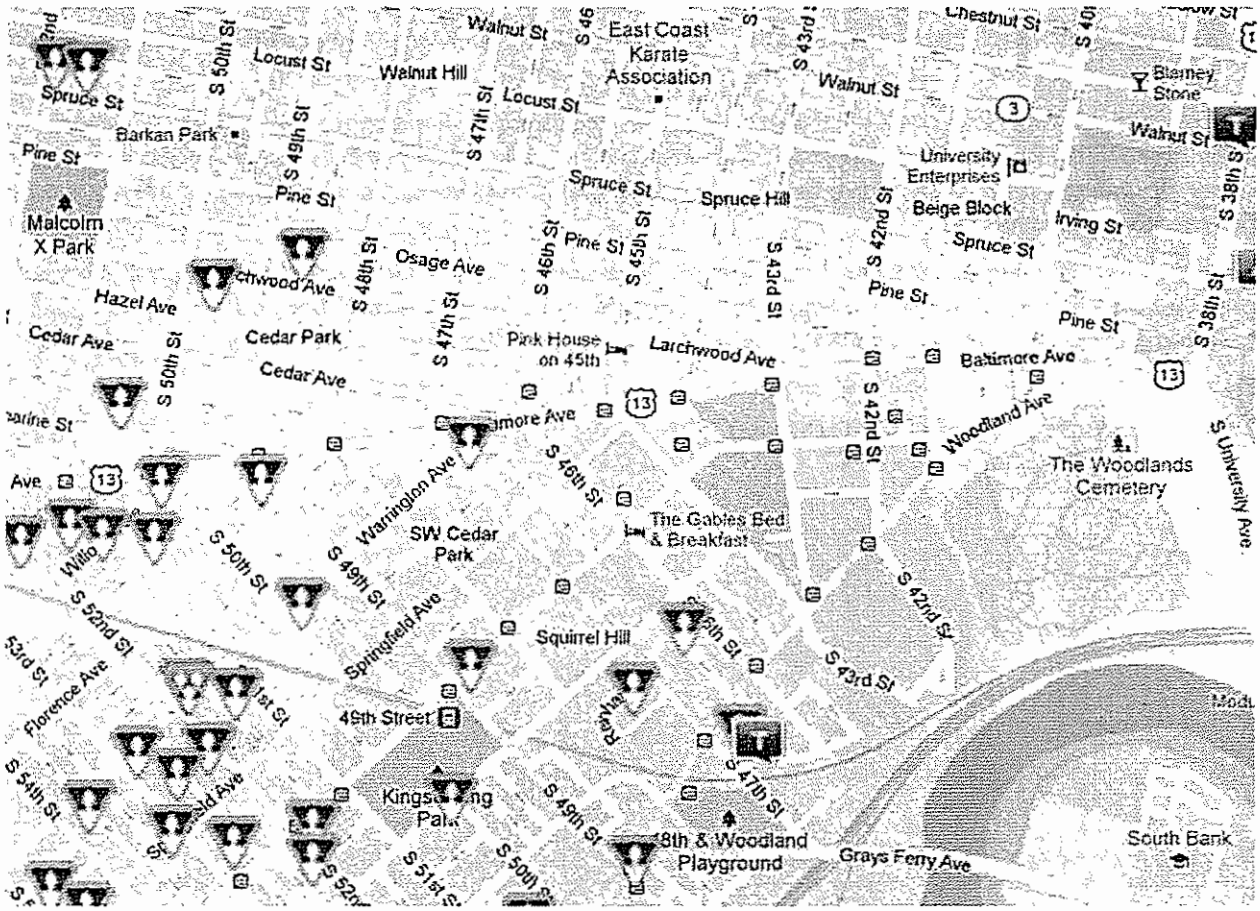
Route 34
Baltimore Ave
Daily Avg Ridership
18,889
Ranking 5th

Public Transportation Volume - Cross Streets

Three of the top 10 Septa lines, based on volume, transverse the route that students will travel to Lea from their current residences near the Wilson School. This creates a safety hazard for children traveling

SEPTA Data

Crime Data



Map listed above represents crime data for the region that encompasses Lea and Wilson.

LEGEND :

- Red Markers Represent Sex Offender Locations
- Orange Markers with multiple figures represent multiple Sex Offenders
- Blue Markers with a T represent Thefts

Steps Taken

1. **University City District:** Representatives from UCD were contacted to develop a plan for September 2013 to have Bicycle Ambassadors patrol the route determined most safe for travel by students.
2. **University of Pennsylvania Police:** Captain Fisher of Penn Police was requested to devise a plan for the coming school year to add patrols along the favored route to Lea to insure safety.
3. **Philadelphia Police 18th District:** Officer Porter was reported to concerning availability of additional Crossing Guards for Woodland Ave and Kingsessing Ave. Additional patrols were requested to insure safety of children, especially during the Winter when daylight declines, and periods when after school programs release students.
4. **Philadelphia Bicycle Coalition:** Safe Routes Walkability Survey was recently conducted of Lea population to determine routes students currently travel and a grant was procured to have PENNDOT do a complete analysis of travel routes for all students in September 2013.

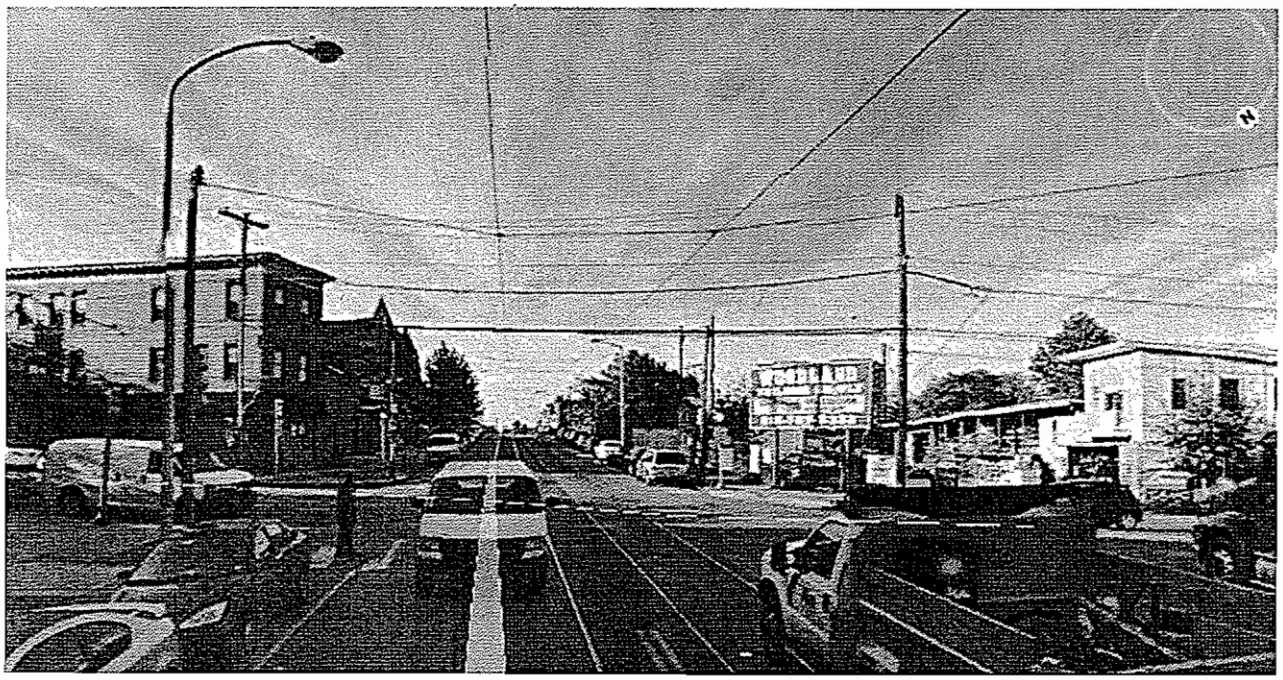
West Philadelphia Students Should Not Have to Resort to Third World Conditions to Get to School

Conclusions

Based on data accumulated of traffic volumes, and public mass transit route ridership numbers, there appears to be an imenent risk to the population of students who will be traveling to Lea from the Wilson vacinity. Steps must be taken to provide at the minimum a mode of safe transit from Woodland Ave and 46th Street; Wilson's current location, to Locust Street and 47th, Lea's address.

The safest walking route has been determined to be from 46th and Woodland Ave, North to Kinsessing Ave, Southwest to 47th Street, and taking 47th Street the remainder of the route to Lea. Due to the number of multiple intersections along Baltimore Ave this proves to be the most critial area for safety concerns on this path. It appears that 47th and Baltimore Ave is the safest location to cross Baltimore Ave due to a crossing guard being stationed there.

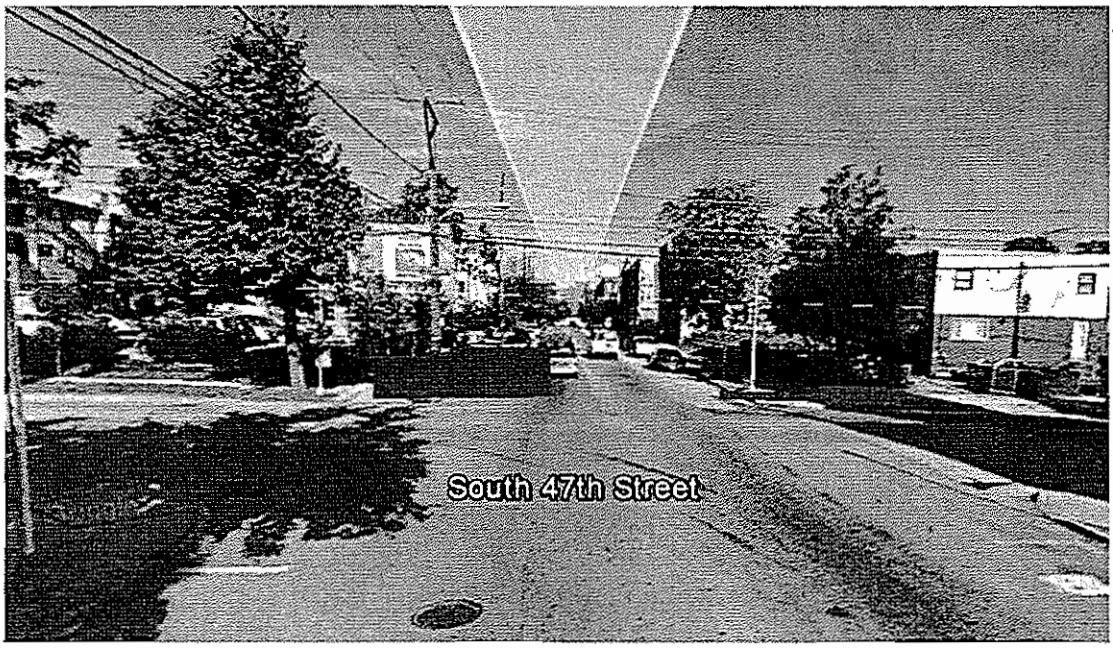
Photos of High Traffic Intersections



Woodland Ave looking East with 47th running North and South

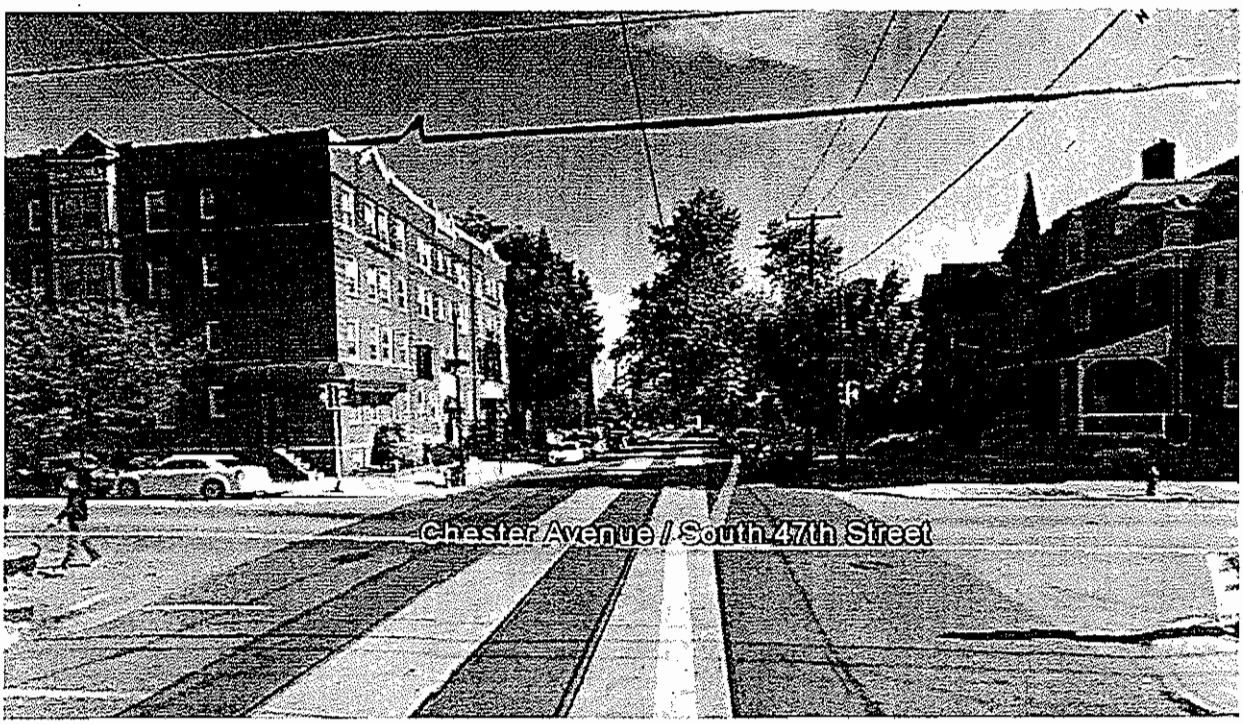
No Crossing Guard at this Intersection Crossing Guard at 46th and Woodland (Leanne)

Trolley Route 11 Runs along Woodland Ave - Septa's 6th Busiest Route



47th Street facing North with Kingsessing running across East to West

No Crossing Guard at this Intersection

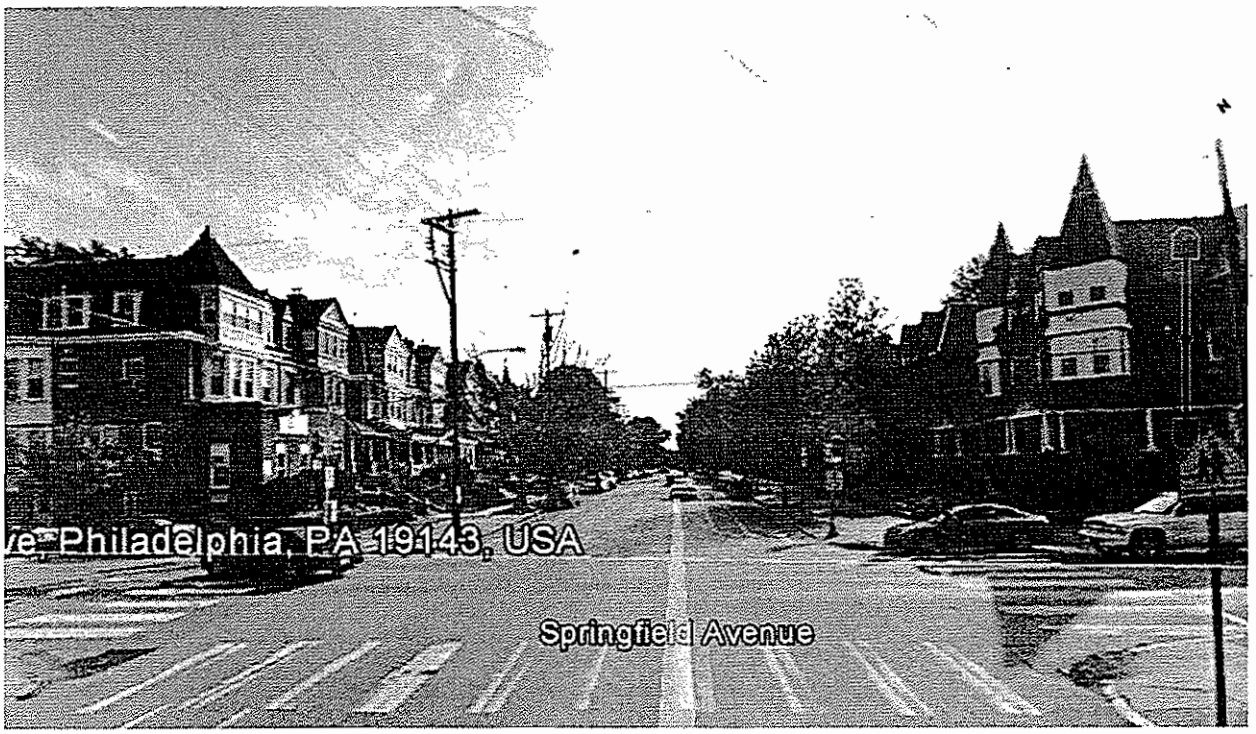


47th Street facing North with Chester Ave running across East to West

No Crossing Guard at this Intersection

200 Vehicles per hour travel this section of Chester Ave

Trolley Route 13 Travels along Chester Ave - Septa's 9th Busiest Route



Springfield Ave facing West with 47th Street running across North to South

Crossing Guard Located at this Intersection (April)

Francis de Sales Parochial School Located on this corner

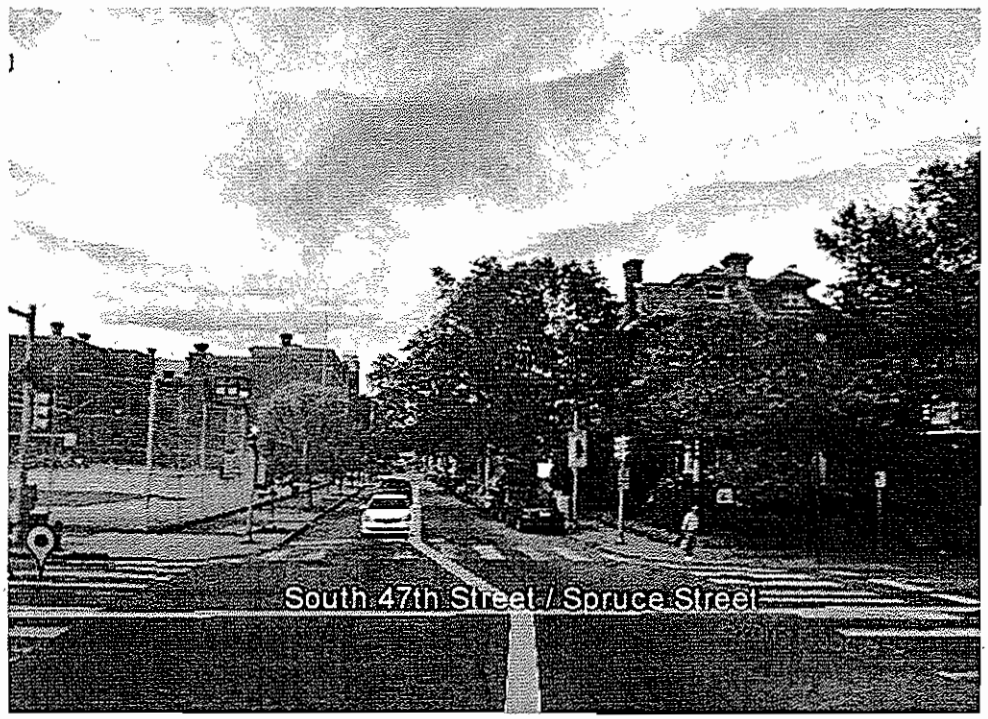
Baltimore Ave facing East with 47th running across North to South

Crossing Guard Located at this Intersection (Renee)

Intersection has a Island with creates traffic multiple traffic patterns

231 Vehicles per hour travel this section of Baltimore Ave

Trolley Route 34 Runs along Baltimore Ave - Septa's 5th Busiest Route

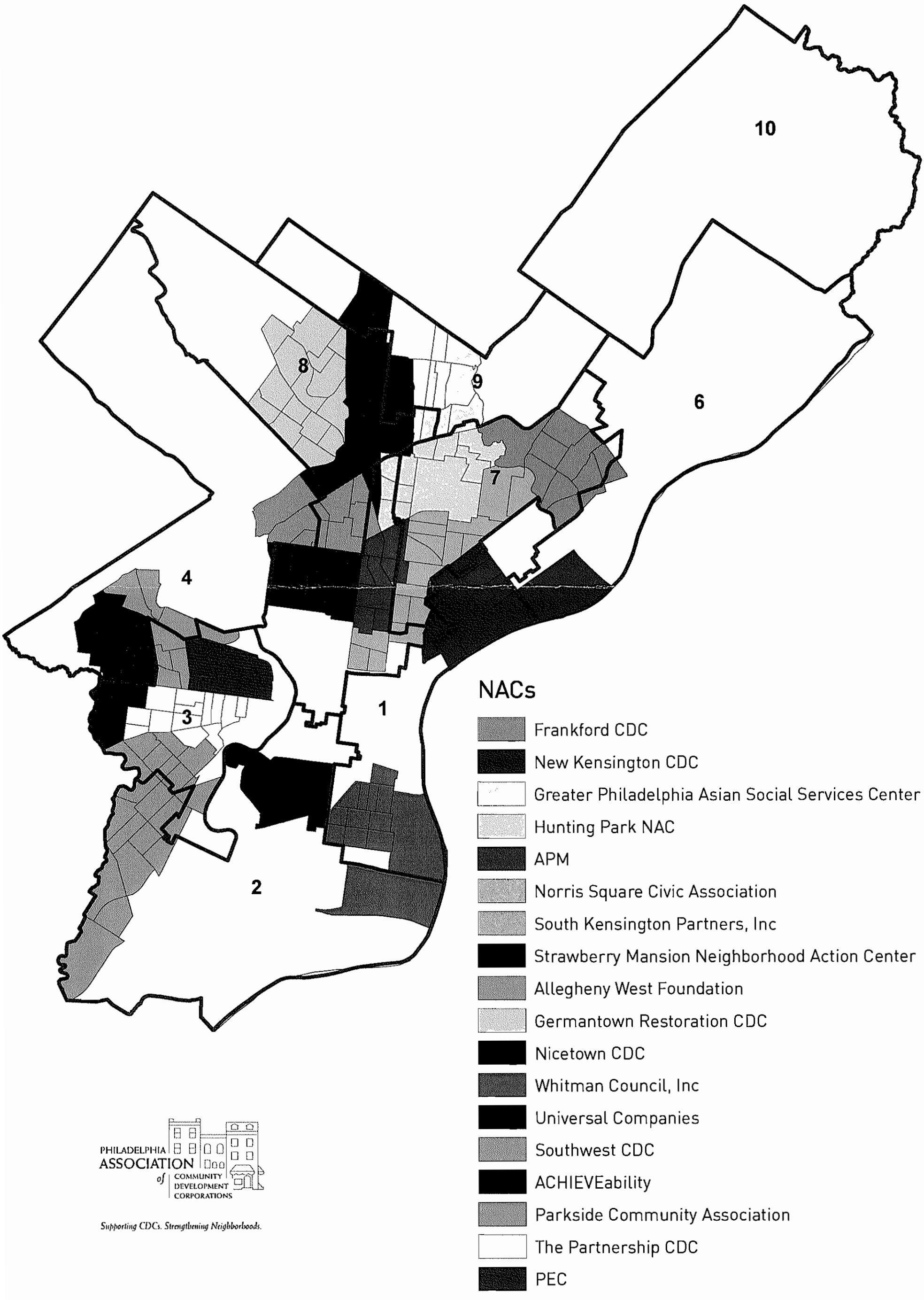


47th Street facing North with Spruce Street running across East to West

Crossing Guard located at this Intersection (Edna)

Bus Route 42 Runs along Spruce Street - Septa's 19th Busiest Route

Philadelphia's Neighborhood Advisory Committees by 2016 City Council District



PHILADELPHIA ASSOCIATION of COMMUNITY DEVELOPMENT CORPORATIONS

Supporting CDCs. Strengthening Neighborhoods.

Map created by Garrett O'Dwyer at PACDC using data provided by OHCD

PHILADELPHIA ASSOCIATION of COMMUNITY DEVELOPMENT CORPORATIONS

1315 Walnut Street, Suite 1600 | Philadelphia, PA 19107

www.pacdc.org PHONE 215.732.5829 FAX 215.732.5725

Supporting CDCs. Strengthening Neighborhoods.

Testimony on Bill No. 150164, FY16 Operating Budget of the City of Philadelphia
Presented to City Council's Committee of the Whole
April 29, 2015

Beth McConnell, Policy Director, Philadelphia Association of Community Development Corporations

Good evening and thank you for the opportunity to testify. My name is Beth McConnell, and I'm the Policy Director for the Philadelphia Association of Community Development Corporations (PACDC). PACDC is a membership association of more than 100 organizations, including 50 CDCs, which work to advance equitable development, revitalize Philadelphia's neighborhoods and improve quality of life for residents.

We are here to urge City Council to work with **the Nutter Administration to allocate an additional $1 million in General Funds in the FY16 City Budget to support neighborhood small businesses and commercial corridors including the Storefront Improvement Program (SIP), which would also free up $500,000 in federal funds to strengthen the NAC program.**

$535,000 in General Fund dollars are needed to fund the Storefront Improvement Program (SIP), which was transforming our neighborhood commercial corridors and boosting small businesses. SIP is an excellent example of how modest investments in our neighborhood corridors make a big impact. SIP provides matching grants to small businesses to help them fix up the facades of the properties they rent or own. Since 2009, more than 382 unsightly, outdated, blighted or uninviting storefronts have been transformed with new windows, doors, signs, paint, lighting or other features in every single Council district. These improvements have led to increases in foot traffic and sales, helped leverage other private investment on our corridors, and helped new small businesses just starting out achieve immediate success. This generates returns to the City in increases in sales, wage and business tax payments.

Unfortunately, the Philadelphia Department of Commerce was forced to unveil new guidelines for the program in December to comply with federal prevailing wage rules and related complex regulations. These new guidelines are threatening this dynamic, successful program: This month, the Tacony CDC had to cancel plans to improve 11 storefronts, other PACDC members report that contractors are declining to bid, and small business owners who wanted to access the program are not applying because of the impact of these new restrictions. In fact, SIP applications have dropped by more than half. While PACDC supports policies that ensure contractors are paid a fair wage for their work, the federal rules are overly burdensome for small businesses that are only spending a few thousand dollars, as well as neighborhood-based contractors that are losing out on potential work.

The only way to avoid the federal rules that threaten the program is to use another source of funding. ***If SIP were to be funded with local dollars and kept at level funding for the grants and support services, $535,000 in General Funds is needed.*** This would give the Commerce Department the flexibility to design rules for SIP that make sense for Philadelphia, as well as the flexibility to consider funding SIP projects on corridors that may not be eligible for CDBG funding but still face challenges and would benefit from a modest public investment. **It would also free up CDBG funds that were devoted to SIP to be re-directed to the Neighborhood Advisory Committee (NAC) program.** We want to thank Councilman Henon for leading the charge advocating to save SIP, and encourage other members of Council to join him.

We advocate that another $465,000 in General Funds be made available for the corridor management and corridor cleaning programs. Our commercial corridors are strongest when they have three ingredients: corridor managers that serve as advocates, organizers, marketers, planners and problem solvers; cleaning staff that keep the corridors free of litter and illegal dumping; and physical improvements that make the corridors attractive to potential shoppers and new businesses. In fact, many SIP applications come as a result of corridor managers recruiting multiple small businesses to participate, helping them find qualified contractors and fill out applications. Private investment is more likely to flow to our corridors if they are kept clean, and have staff dedicated to implementing a comprehensive revitalization strategy. But also due to federal funding cuts and restrictions on where CDBG funds can be spent, far too many of our neighborhood corridors lack managers and cleaning staff: only 19 out of more than 70 that are targeted for

support. ***An additional $465,000 in General Funds would allow the Commerce Department to boost investment in these critical programs to achieve more comprehensive revitalization of our corridors, and reach neighborhoads that are not CDBG eligible, yet still sorely lacking in investment.***

$500,000 is needed to stabilize the Neighborhood Advisory Committee (NAC) program, which is a critical community outreach tool. Neighborhood-based community organizations are absolutely vital in implementing strategies to attack poverty and improve the conditions of our neighborhoods. The NAC program provides a form of constituent service right in our neighborhoods, connecting residents with help to save their home from foreclosure or find an affordable home, keep the heat on, address food insecurity, find employment, and a myriad of other services. The NAC program also serves as a forum for resident engagement in planning and development decisions, and for organizing community clean-ups and neighborhood festivals to improve quality of life and connect neighbors with each other.

Resources from OHCD for the NAC program are among the only source of public or private funding for neighborhood-based organizing and outreach. Unfortunately, cuts in Philadelphia's federal CDBG allocation from Washington D.C. have led to significant cuts in the NAC program. The overall number of NACs has been reduced, leaving those that remain to do more with less: expand their service territories, serve more residents, and do it with less funding and less capacity. In 2014, OHCD funded 19 NACs with just over $1 million in CDBG funds to serve more than half a million residents. The NAC program is underfunded, under-capacity and unable to keep up with the growing demand for help from residents struggling with economic insecurity.

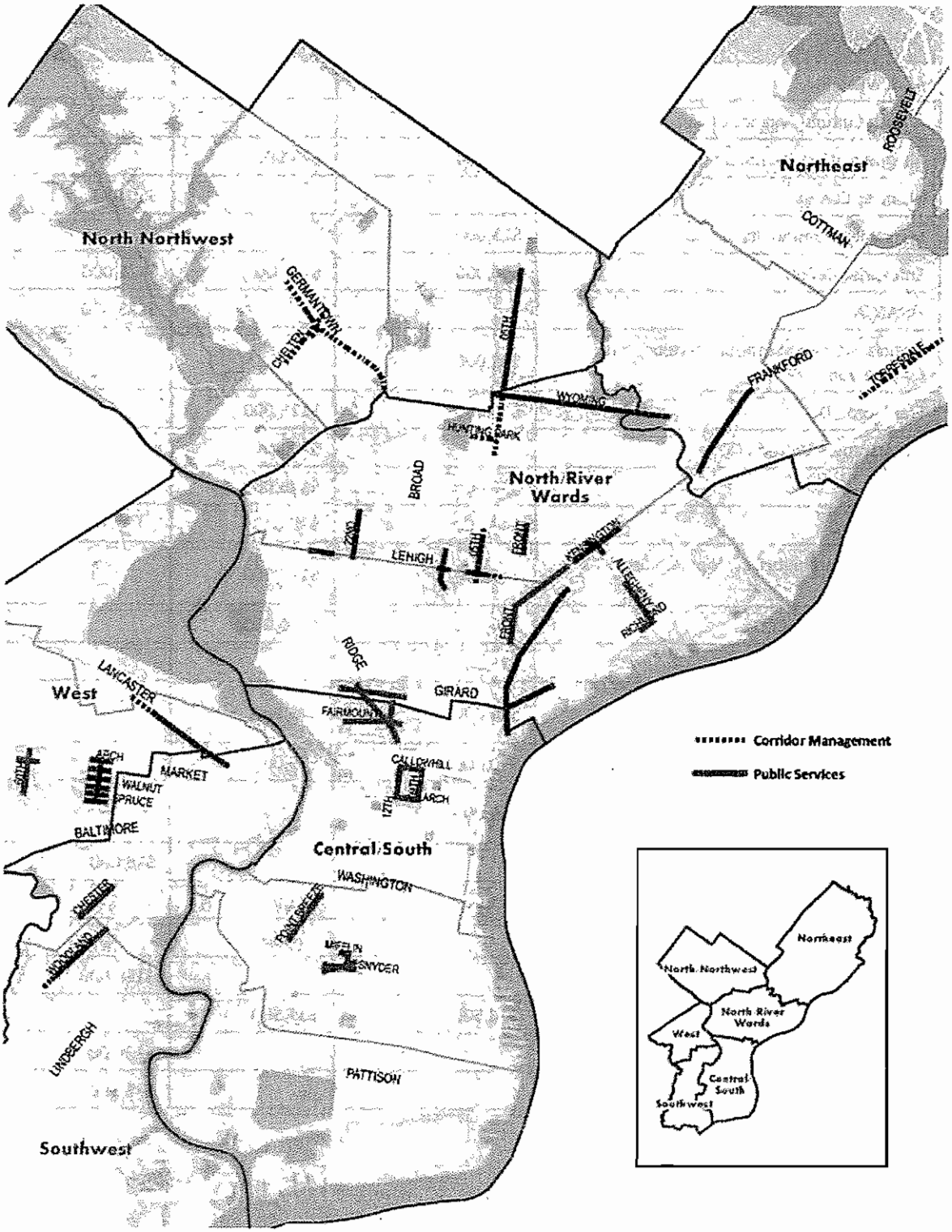
In the long run, the NAC program and other community groups need a total of $4 million annually to truly "scale up" and meet the needs of our residents. But just to meet the program's basic needs in FY16, $500,000 is needed to provide more adequate support to cover the program's basic costs, expand the program modestly to add a few more NAC programs, to provide training and technical support to NAC staff to help them share and implement best practices, and create a small pool of funds for innovative projects or services to support our neighborhoods. ***If General Fund Revenue was made available to fund the Storefront Improvement Program, then $500,000 of the federal***

CDBG funds freed up should be re-directed to stabilize the NAC program. We also want to thank Councilman Jones and Councilwoman Blackwell for hosting a briefing on the NAC program, which will be held next Thursday, May 7th at noon after Council's Stated Meeting, in the Caucus room, where you will hear from NAC leaders about their work.

In closing, I'd like to thank Council President Clarke and Councilwoman Blackwell for the recent and upcoming hearings to examine how Philadelphia can better meet the needs for affordable homes. We look forward to working with you over the summer to consider potential revenue sources to at least double resources for the Philadelphia Housing Trust Fund.

Thank you for the opportunity to testify.

Targeted Corridor Management and Public Services



Commerce Department Program Allocations for Year 41			
Organization	Public Services in Commercial Corridors	Targeted Corridor Management	Business Technical Assitance Program
ACHIEVEability	$27,500		
African Cultural Alliance of North America	$35,000		
Allegheny West Foundation	$30,000	$75,000	
Business Center			$50,000
Diversified Community Services	$25,000		
Enterprise Center	$50,000	$75,000	$125,000
FINANTA			$125,000
Francisville Neighborhood Development Corporation	$30,000		
Frankford CDC	$50,000	$125,000	
Germantown United CDC		$75,000	
HACE	$50,000	$125,000	
Impact CDC	$40,000	$75,000	
Korean Community Development Services Center	$40,000	$120,000	
New Kensington CDC	$75,000	$175,000	
Newbold CDC	$25,000		
Nueva Esperanza Housing & Economic Development Corp.	$35,000	$75,000	
People's Emergency Center CDC	$30,000	$75,000	
Philadelphia Chinatown Development Corporation	$56,000		
SCORE			$75,000
Southwest CDC	$35,000	$75,000	
Tacony CDC		$37,500	
UAC/Entrepreneur Works			$125,000
Village of Arts and Humanities	$28,500	$37,500	
Welcoming Center for New Pennsylvanians			$125,000
Women's Opportunities Resource Center			$75,000

Asociación Puertorriqueños en Marcha
APM
... for everyone

a health, human services and community development organization

Luz E. Lopez, M.S.
Board Chair

Nilda I. Ruiz
President & CEO

Good Evening esteemed Council Members,

I am Angel Rodriguez Vice President of Asociación Puertorriqueños En Marcha (APM). I am before you today in support of the allocation of an additional $1 million dollars in General Funds in the FY16 budget to support neighborhood small businesses and commercial corridors, which would also free up federal funds to strengthen the NAC program.

It is well documented that due to cuts to CDBG funds from Washington D.C. these successful programs are struggling and that complicated federal rules that restrict how and when the funds can be spent.

With $1 million dollars of General Fund revenue would allow these programs to continue to serve our neighborhood small businesses, commercial corridors and disadvantaged residents.

In particular the $500,000 dollars needed to stabilize a vital community outreach tool, the Neighborhood Advisory Committees is critical.

- The Neighborhood Advisory Committee program (NAC) provides a form of constituent service in our neighborhoods,
    - Connecting residents with help to save their homes from foreclosure
    - Find an affordable home,
    - Keep the heat on,
    - Address food insecurity and,
    - Find employment.
- The NAC programs are a forum for resident engagement:
    - In planning and development decisions,
    - For organizing community clean-ups and neighborhood festivals
    - And improve quality of life in our City of Neighborhoods.
- Our NAC program has also been a vehicle to leverage additional resources for our community residents such as:
    - Crime Prevention Programming
    - Lead & Healthy Homes Services
    - Energy Saving Initiatives
    - Basic Systems Repairs and,
    - Numerous Health initiatives addressing Asthma, Obesity, and Diabetes to name a few

Unfortunately, cuts in Philadelphia's federal CDBG allocation from Washington D.C. have led to significant cuts in the NAC program. The overall number of NACs has been reduced, leaving those that remain to do more with less: expand their service territories, serve more residents, and do it with less funding and less capacity. In 2014, OHCD funded 19 NACs with just over $1 million in CDBG funds to serve more than half a million residents.

The NAC program is underfunded, under-capacity and unable to keep up with the growing demand for help from residents struggling with economic insecurity.

In the long run, the NAC program and other neighborhood groups need $4 million to scale up, but $500,000 is needed for FY16 to restore some of the recent federal cuts. This would provide:

- More adequate support to cover the program's basic costs,
- Expand the program modestly to add a few more NAC programs,
- Provide training and technical support to NAC staff to help them share and implement best practices, and
- Create a small pool of funds for innovative projects or services to support our neighborhoods.

If General Fund Revenue was made available to fund the Storefront Improvement Program, then $500,000 of the federal CDBG funds freed up should be re-directed to stabilize the NAC program.

APM stands ready to work alongside City Council, the Administration, PACDC, and various intermediaries in this endeavor to improve the quality of life for the citizens of Philadelphia.