Fiscal Year 2018-19 Needs-Based Plan & Budget

Commonwealth of Pennsylvania

Office of Children, Youth and Families

NEEDS-BASED PLAN AND BUDGET NARRATIVE TEMPLATE
Budget Narrative Template

The following pages provide a template for counties to use to complete the narrative portion of the Fiscal Year (FY) 2018-19 Needs-Based Plan and Budget (NBPB). All narrative pieces should be included in this template; no additional narrative is necessary. Detailed instructions for completing each section are in the NBPB Bulletin, Instructions & Appendices. As a reminder, this is a public document; using the names of children, families, office staff, and Office of Children, Youth and Families (OCYF) staff within the narrative is inappropriate.

The budget narrative is limited to a MAXIMUM of 50 pages, excluding charts, Special Grants Request Forms, and Independent Living (IL) Documentation. All text must be in either 11-point Arial or 12-point Times New Roman font, and all margins (bottom, top, left, and right) must be 1 inch. Any submissions that exceed the maximum number of pages will not be accepted.

Note: On the following page, once the county inserts its name in the gray shaded text, headers throughout the document will automatically populate with the county name. Enter the county name by clicking on the gray shaded area and typing in the name.
Philadelphia

NBPB
FYs 2017-18 and 2018-19
Section 2: NBPB Development

2-1: Executive Summary

Submit an executive summary highlighting the major priorities, challenges, and successes identified by the county since its most recent Needs-Based Plan and Budget (NBPB) submission. The summary should include any widespread trends or staffing challenges which affect the county child welfare and juvenile justice service delivery, particularly those which impact all outcome indicators. The juvenile justice summary should provide an overview of Juvenile Justice System Enhancement Strategy (JJES) efforts, including any general data or trends related to Youth Level of Service (YLS) domains and risk levels. Counties should highlight areas related to population changes, findings of Quality Service Reviews (QSRs), Child Family Service Reviews (CFSR) case reviews and annual licensure, and other critical events of the past year that will have impact on the county’s planning for FY 2017-18 and in their planning for FY 2018-19.

REMINDER: This is intended to be a high-level description of county strengths, challenges and forward direction. Specific details regarding practice and resource needs will be captured in other sections of the budget submission.

- County may attach any County Improvement Plan (CIP) for detail and reference attachment.
- Counties participating in the CFSR may attach any CFSR reports from the federal Online Monitoring System (OMS) and reference attachment.
- Juvenile Probation Office (JPO) Executive Summary components can be discussed under separate heading at the discretion of the county.
- Child Welfare Demonstration Project (CWDP) counties need only to provide responses not captured in their Initial Design and Implementation Report Update (IDIR-U).

Executive Summary

Child Welfare Services

DHS continues to move forward with a systemwide transformation called “Improving Outcomes for Children” or “IOC.” The transformation is based on the principle that a community neighborhood approach to the delivery of child welfare services will positively impact the safety, permanency, and well-being of children and families. The four goals of IOC are:
- More children and youth maintained safely in their own homes and communities.
- More children and youth achieving timely reunification or other permanence.
- A reduction in the use of congregate care.
- Improved children, youth, and family functioning.

Our top priority is to continue to implement strategies to achieve the four goals of IOC. Below, please find a summary of the current successes, challenges, and priorities of DHS.

Successes:

During Fiscal Year 2016-17, DHS saw several systemwide successes related to achieving the four goals of IOC. Specifically,
- As of June 30, 2017, 46% of children and youth in placement are living with kin. This is the highest percentage ever. At the very beginning of IOC in March of 2013, only 32% of those in placement lived with kin. Additionally, out of all the children and youth in placement that live in family-based settings, 55% are with kin.
Currently 56% of children and youth in foster and kinship care live within five miles of their home. In 2012, this measurement was only at 46%. Additionally, currently 82% of children and youth living in foster and kinship care live within ten miles from their home of origin.

The numbers of permanencies continue to grow. In FY 2016-17, there were 2,002 children and youth who left placement for a permanent home, an increase of 150 children and youth, or eight percent from the FY 2015-16 total. The increase was led mainly by the number of children and youth adopted, which spiked to 627 from 487 the year before, an increase of 140, or 29%.

The number and percentage of youth living in group homes and institutions has dropped significantly since the inception of IOC. As of June 30, 2017, 12% of children in placement live in a group home or institution setting, down from 23% in June 30, 2012.

During FY 2016-17, DHS fully integrated the DHS and CUA work under one division at DHS called “Child Welfare Operations”. This Division, led by Deputy Commissioner Kimberly Ali, is primarily focused on achieving the four goals of IOC with an overall goal of shrinking the number of children, youth, and families in the child welfare system. During FY 2016-17, leadership at all levels of the CUAs began to meet regularly to focus on consistent practice and enhanced training. Partnering with DHS University, Child Welfare Operations implemented a program called “Supervising for Excellence” which addresses issues raised in previous state inspections.

Also, during FY 2016-17, in an effort to hold our providers more accountable and to create a more transparent system, we created a scorecard to measure the performance of our CUAs. During FY 2017, DHS collected baseline data for the CUAs in areas such as: safety assessment, single case planning, court compliance, family assessment, permanency, finance, and governance. This baseline data will be published in September of 2017. Quarterly reviews of the Providers will be conducted during Fiscal Year 2018. Beginning in Fiscal Year 2019, a yearly scorecard, which ranks the CUA agencies, will be published publicly. As part of the ongoing monitoring, DHS will offer targeted technical assistance to the CUAs with respect to any weaknesses that are identified. DHS will also partner with CUAs to share best practices with others. Simultaneously, we created a contingency plan, which includes a Request for Proposal process, should we need to replace any CUA. Finally, our work with the CUA Scorecard will serve as a foundation towards moving to a performance-based contracting system.

Finally, due to our ability to fund the salaries of the CUA Case Managers at a ratio of 11 families to 1 case manager, we are pleased to share that caseload sizes at the CUAs are finally stabilizing. As of June 30, 2017, the average case load across the CUAs is 11.6 and reunification rates at the CUAs have improved.

**Challenges:**

Despite the many successes during the past fiscal year, the Philadelphia Child Welfare System continues to face several challenges. Referrals to our Hotline and Investigations continue to rise. In FY 2016-17, referrals to the Philadelphia DHS Hotline increased 14% FY 2015-16. Philadelphia DHS expects the number of investigations to increase in FY 2017-18 by approximately six and one half percent, consistent with an average annual increase between five percent and six and one half percent. Since FY 13, investigations have increased by a total of approximately 6,000 investigations. In order to address these challenges, we are reorganizing and increasing the staffing at our Hotline to include field screening units, whose primary function would be to conduct secondary field screens with a goal of diverting families from the child welfare system. We are also exploring the use of the RED Team System, an evidence-based model aimed at placement diversion.
We are pleased to share that since FY 2016, after showing three prior years of rapid growth, the number of children in placement has stabilized. As of June 30, 2016 there were 5,932 children and youth in out-of-home placement. After reaching 6,032 children and youth in placement July 5, 2017, the number has decreased as of July 31, 2017 to 5,999 children and youth in placement. Our goal for FY 2017-18 is to reduce the number of children and youth in care by 500. We will continue to use strategies such as requiring management approvals for all placements, increased use of targeted prevention services both before and during investigations, and focused and timely reunification and permanency services to reduce the placement population.

Although we have had much success in decreasing the number of children or youth who spent the night in the Child Care Room at 1515 Arch Street, this issue continues to be a challenge. In order to eliminate the use of the Child Care Room for overnight stays, we will be increasing the number of emergency foster care homes, as well as increasing the number of existing shelter slots by 16 beds. Additionally, the Division of Performance Management and Technology is conducting a data analysis to examine potential trends and patterns in the demographic and case information of the children who have spent the night in the Child Care Room. This information will be compared to the availability of emergency foster homes and other placement resources. DHS will utilize the analysis to identify policies, management strategies, case work practice and resources that can further reduce and ultimately eliminate the need for children and youth to spend the night in the Child Care Room.

Priorities:
Our top priority is to safely reduce the size of the child welfare system in Philadelphia. To do this, we are implementing a multipronged strategy designed to do the following:
- Reduce the number of families accepted for service.
- Safely move children, youth, and families to timely reunification and other permanencies.

To accomplish this work, DHS’s Child Welfare Operations (CWO) and Community Based Prevention Services Divisions will work closely to ensure that services are linked to risk and safety and that the primary focus is always on safe case closure. We will continue to build an array of prevention services designed to safely keep children and youth in their own homes and communities and divert them from placement, while at the same time hold Providers accountable for their performance. Finally, we will work to implement the specific recommendations from the IOC evaluation conducted by the Child Welfare Practice Group.

Improving child welfare practice
- Continuing efforts began in the last fiscal year to reduce the size of the system by re-designing front end decision-making, increasing access to targeted prevention services designed to divert families from the formal child welfare system and support safe case closure.
- Providing high level social work practice and transfer of learning support for social work assessment, planning, and decision-making for families with complex needs such as caregivers with intellectual disabilities or complex medical needs.
- Requiring administrator or above approval for all placement decisions, which include a review of all less intensive, less intrusive interventions.
- Mandating referrals to Family Finding and Accurint for children and youth in foster care and not with kin.
Increased roll out of Rapid Permanency Reviews to target children and youth with long stays in the child welfare system.

Convening Workgroups to examine practice at different points in the life of a case, and revise practice and policy to support consistent efforts that move children, youth, and families towards timely safe case closure.

Continuing Supervising for Excellence training for both DHS and CUA Supervisors.

DHS respectfully requests funding in the following areas to support its efforts to achieve its goals. Please note that the items listed below are highlights of our request and are not all inclusive.

- Funding for increased services designed to divert high-risk children, youth, and families when they come to the attention of the Hotline and do not have safety threats.
- Funding for increased emergency shelter beds to eliminate the use of the Child Care Room overnight.
- Funding to serve the increased number of families affected by substance abuse who require intensive case management services in accordance with federal mandate (CAPTA).
- Funding to hire additional Case Managers for truancy services with a goal of refocusing this service to enhance our ability to divert young people from the formal child welfare system.
- Funding to enhance Family Empowerment Services (FES) in the highest utilization areas.
- Funding to develop an Extended Integrated Assessment Unit with cross-systems experience in the area of child welfare, behavioral health, substance abuse, and intellectual disability. The purpose of this unit would be to assist with the complex assessment, intervention, planning, and service needs of children, youth, and families with family functioning concerns impacted by multiple factors such as substance use, cognitive limitations, developmental challenges, mental illness, and intellectual disabilities.
- Funding for enhanced training to support CWO staff and our Providers in improved child welfare practice.
- Three additional LSI paralegals and an increase in the SWAN allocation to take into account increased utilization in providing timely permanency and seeking permanency for older youth.
- Funding for two additional supervising attorney positions and five additional Child Welfare Unit legal assistants, to support the work of the new attorneys in the Child Welfare Unit and the enhanced work completed by the unit.

DHS respectfully re-requests funding for the following items to support its efforts in achieving its goals:

- Funding to reduce CUA caseload ratios to 10:1.
- Funding to increase the administrative rate for Specialized Behavioral Health resource home care to levels commensurate with the work required and with the levels paid throughout the state.
- Funding to increase the per diem for General Foster Care administrative and maintenance rates and to encourage recruitment and retention.
- Funding to increase administrative rates to support Resource Parent Recruiters.
- Funding for emergency foster care to eliminate the use of the Child Care Room overnight.
- Funding to expand Family Finding in order to provide services earlier in the process to help reduce the need to accept families for service, to identify kin as a resource, and to help
provide timely permanency for children and youth, and to reduce waiting times for the service.

- Funding to support Family Court in making the best informed decisions regarding safety in custody matters, protecting children and youth involved in custody matters, and preserving families.

**Juvenile Justice Services (JJS)**

Although the nature of Juvenile Justice Services is somewhat different from those of child welfare, the goals and priorities parallel those of CWO and IOC:

- Safely reducing the number of youth removed from their communities; safely reducing the number of youth being placed.
- Reducing the length of stay for those youth who are placed.
- Reducing reliance on institutional placement for youth who require placement.
- Reducing recidivism through strong reintegration services, improved youth competencies and family functioning.

The programs and priorities of Juvenile Justice Services address maintaining community safety, while at the same time providing appropriate services to youth so that they are less likely to re-offend, and so that they have positive alternatives. DHS continues to work collaboratively with the Court and the Juvenile Probation Office (JPO) to accurately assess the level of risk posed by delinquent youth to the community so that the appropriate level of services can be provided; to make alternatives to detention available, for both male and female youth who do not pose a risk to the community that requires detention; to provide support services that help prevent re-entry; and to make data-driven decisions.

Philadelphia County continues to make strides in its efforts to improve juvenile justice through the Juvenile Justice System Enhancement Strategies (JJSES).

During the FY 2016-17, the JPO continued to focus on JJSES implementation activities including work on Graduated Response, an evidence-based practice to increase a juvenile’s compliance with court-ordered probation conditions and decrease out of home placement. In September 2016, four staff members attended the case plan forum. A field test occurred with two JPOs November 14, 2016 through January 30, 2017; a pilot program with one JPO per district began April 1, 2017 and will continue through August 30, 2017, and includes a draft case plan developed by the Workgroup. In May 2017, Philadelphia participated in the statewide Graduated Response Forum and staff from Philadelphia County continue to participate on the statewide Graduated Response Committee.

The Graduated Response Workgroup in conjunction with consultant Dr. Naomi Goldstein continues to meet one to two times per week to develop the final drafts of policy, intervention options, and behavioral definitions. Dr. Goldstein, a Stoneleigh fellow from Drexel University, has 15 years of experience working in the field of adolescent brain development. Through Dr. Goldstein’s partnership with the Pennsylvania Commission on Crime and Delinquency (PCCD) and the Pennsylvania Council of Chief Probation Officers, she provides assistance to other counties in Pennsylvania around the work of incentivizing positive behaviors in youth. With Dr. Goldstein’s input, Philadelphia County created several matrices designed to guide Juvenile Probation Officers in monitoring compliance with court-ordered conditions for juveniles, implementing sanctions, and awarding incentives. An incentive matrix, incorporating tangible incentives such as SEPTA tokens and gift cards, was created based on responses from various youth focus groups. Given that in Philadelphia roughly one in four families are at or below the National Poverty Line, these small incentives have an enormous impact on some of the families...
served, and may be tied to compliance with court-ordered conditions. Philadelphia is requesting funding to support the incentives associated with the graduated response model.

Use of the Post-Adjudication Evening Reporting Center (Post-ERC), while still relatively new in Philadelphia, has resulted in considerable positive feedback from our stakeholders, chief among them the youth participants, their parents, and our judiciary. Due in large part to the diligence of our collaboration with the Provider, NET, prior to the program’s roll-out, we were able to obtain both input and buy-in from our judiciary. This ensured that, once established, there would be adequate utilization to sustain the model. To date, the program remains a very viable, lower cost alternative to placing youth in long-term placement, and is typically at or near full capacity of 20 youth per cohort. Program length is six months and GPS monitoring is a requirement of participation. We would like to expand our use of this alternative to placement in FY 2018-19. As the average cost of residential placement continues on the rise at about $270 per day, the approximate $100 per diem associated with use of the Post-ERC makes it a wise and cost-effective investment. More importantly, research shows keeping youth at home in their own communities produces better outcomes than sending them to remote, out-of-home facilities. Through participation in the Post-ERC, young people are able to maintain strong connections to their families and to important community resources. At the same time, they receive robust evidence-based programming, meaningful community service opportunities, and the remedial academic supports which move them closer towards the attainment of high school diplomas. Expansion of the Post-ERC is anticipated to include additional costs for leasing a site, hiring, training and certifying staff in evidence-based interventions, and ramping up the program so it is prepared to serve the first cohort of 20-25 youth. Philadelphia is requesting funding to support this expansion. Given the very positive performance of our existing provider, rather than issue an RFP for a new vendor, Philadelphia will explore with NET whether they could facilitate the operation of an additional Center. The projected opening for the new Center would be near the end of FY 2018.

The continued use of GPS monitoring, in lieu of placement or detention, as a component of the ERCs, allows the Court to remain consistent with the Balanced and Restorative Justice (BARJ) principles of youth accountability and community protection. Currently, approximately 240 youth per day are monitored with GPS products and services. Using key product features and staff dedicated to respond to alarms and violations 24 hours a day, seven days a week, Philadelphia Juvenile Probation is recognized as having one of the best GPS programs nationwide. In 2016, 1,374 youth were monitored by the GPS program; over 700 were monitored in their communities as an alternative to detention. Further aligned with alternative to detention strategies, youth committed to Philadelphia’s ERC are also placed on GPS monitoring. The combination of both comprehensive programs has evolved to be the Court’s most intensively supervised Alternative to Detention program.

Despite having issued a Request for Proposals (RFP) in FY 2015-16 for residential programming for females, we did not award such a contract due to trends that clearly indicated such programming would not be sustainable at this time. Many of the females currently in our system are sent to existing Provider programs, among them, a State secure facility, a private secure facility, and an open program outside of the Philadelphia area.

In August 2013, Philadelphia adopted the Pennsylvania Detention Risk Assessment Instrument (PaDRAI), an instrument designed to standardize the detention decision-making process, and has continued its use in guiding detention decisions for new arrests since that date. In August 2016, the JDAI coordinator ran a report, reviewed data, and provided an initial report.
Development of the report led to additional detention assessment reports being created and currently being field tested in Philadelphia. Reviewing the report quarterly helped identify reasons for overrides (i.e., parental refusal) which allowed the workgroup to develop creative strategies to address those reasons.

The Philadelphia Juvenile Justice Services Center (PJJSC), our secure detention facility, is fully licensed, having satisfied all of the requirements established by the Bureau of Human Services Licensing authority during our annual inspection in FY 2016-17.

The PJJSC is also fully compliant with the requirements of the Prison Rape Elimination Act (PREA), having completed a successful audit during our April 4-6, 2017 inspection.

We continue to experience ongoing success with the School Police Diversion program. Since its inception in May 2014, the program has diverted 1,467 school arrests, 437 of which were in FY 2016-17. The Intensive Prevention Services (IPS) to which youth in the program are often referred, continue to effectively support young people with avoiding additional encounters with the juvenile justice system and improving behaviors while at school. Currently, an evaluation is being completed of IPS as part of the diversion service array in the School Police Diversion program.

Early analysis shows that less than five percent of the youth who have gone through the program commit new offenses in schools that result in their arrest.

- During FY 2017-18, we seek to expand the program both to ensure adequate coverage in the Southwest Philadelphia region and to begin including summary retail theft as another category of offenses for which a Philadelphia youth's case may be diverted. The West-Southwest area of the city is currently covered by a single Provider. That Provider’s program is limited to serving just 50 youth at a time, and there are waiting lists for the service. The Department intends to issue an RFP for an additional Provider to cover this area of the city, eliminating waiting lists and ensuring timely delivery of services to young people in those communities needing it. Youth with summary retail theft is being added as a category to the diversion program in response to an effort led by former Deputy Commissioner of the Philadelphia Police Department, Kevin Bethel. The focus of the effort is to establish a pre-arrest diversion program that affords youth who commit summary retail thefts the opportunity to avoid a criminal arrest record and the associated negative impact on their future. A memorandum of understanding will be circulated to the leaders at the Philadelphia Police Department, Philadelphia Department if Human Services, Philadelphia District Attorney's Office, and the Defender Association of Philadelphia for their review and signatures, after which we anticipate the inclusion of these approximately 300 youth annually in the program. Additional funding is sought to include the costs of serving these youth as well as the youth in the Southwest community who might otherwise be placed on waiting lists.

As part of our ongoing Juvenile Detention Alternatives Initiative (JDAI) work, DHS authorized an independent team of system and content experts to conduct a JDAI Facility Assessment of the PJJSC. This team underwent a full day training in November 2015, conducted by the Center for Children's Law and Policy. The standards in the instrument used to complete the assessment pertained to areas most likely to impact the health, safety, and legal rights of youth held in detention. Some of the standards included were not strictly required by case law or statutes, but represented best professional practices to protect the health, safety, and legal rights of detained youth. From this assessment came numerous recommendations, among them, that of
developing a video orientation to institutional rights, rules, and procedures. DHS will seek to contract for creation of this video in FY 2017-18 and seeks funding to do so.

There was sufficient utilization to sustain the use of Family Group Decision Making (FGDM) in FY 2015-16, resulting from the Juvenile Justice System’s earnest efforts to make use of this evidence-based model.

A major component of JJSES is that decisions are driven by data. Philadelphia JJS, the JPO, and the Court continue to work collaboratively to address the need for quality data and appropriate statistical analysis for all system stakeholders.

DHS is requesting funding in the following areas to support its efforts in achieving its goals:

- Full funding of Youth Detention Counselor staffing positions at the Philadelphia Juvenile Justice Services Center to meet staffing ratios during all shifts as mandated by the State and Court Order and to meet security needs during transportation, intake, activities, etc.
- Funding to support Graduated Response incentives.
- Funding to expand the successful post-adjudication Evening Reporting Center to an additional center to safely serve more youth in their communities at a lower cost than residential placement.
- Funding to contract for development of a video orientation to institutional rights, rules, and procedures of detained youth.
- Funding to expand the School Police Diversion program to include youth who have summary retail theft as an offense, and to increase utilization to reduce or eliminate waiting lists for this service.
- Funding to replace the current 30 year old inventory tracking system which is degrading and no longer supported with a new inventory system, including the initial purchase, annual maintenance fee for data storage, technical assistance, and software upgrades.

2.2a&b: Collaboration Efforts and Data Collection Details

- Respond to the following questions.

- Summarize activities related to active engagement of staff, consumers, communities, and stakeholders. Identify any challenges to collaboration and efforts toward improvement.

  Internally, DHS Executive Cabinet meets weekly for Divisional status updates, discussion around areas of focus or concern, and assignment of tasks and deadlines. Act 33 recommendations are discussed at this table and assigned to Executive staff for action when necessary.

  Each Philadelphia DHS Division holds regular staff meetings. In 2016, DHS restructured to clearly establish the Children and Youth Division and the CUAs as components of one system of child welfare and child protective services in Philadelphia. The Division of Child Welfare Operations (CWO) was created, led by a single Deputy Commissioner, with three Operating Divisions: Front-end Operations, DHS Ongoing Services and Child Well-being Operations, and Improving Outcomes for Children Operations. The Child Welfare Operations Deputy Commissioner and the Operations Directors hold a monthly meeting for DHS and CUA Supervisors, jointly. Additionally, there is a monthly meeting with DHS Administrators and CUA Case Management Directors, chaired by CWO Operations Directors and a monthly meeting with DHS Directors and CUA Directors.
Finally, the Commissioner and Executive Staff meet monthly with the CUA CEOs. DHS and CUA management have various internal all-staff meetings.

Additional collaborative meetings include the Children’s Roundtable, the Commissioner’s quarterly meetings with advocates, and meetings with youth advocates.

Act 33 reviews are held on the first and third Fridays of each month if there are cases that require review. The City’s Chief Medical Examiner, Dr. Sam Gulino, chairs Philadelphia’s Act 33 Team. The multidisciplinary team consists of representatives from the Medical Examiner’s Office, City of Philadelphia Law Department, Pennsylvania Department of Human Services, Philadelphia Department of Human Services, St. Christopher’s Hospital, Children’s Hospital of Philadelphia, Philadelphia District Attorney’s Office, Philadelphia Police Department - Special Victims Unit, School District of Philadelphia, Philadelphia Department of Public Health, and Women Against Abuse. The Philadelphia DHS leadership as well as the entire DHS chain of responsibility for the case being reviewed are also required to attend.

CUAs are required to have a Community Advisory Board whose purpose is to advise the particular CUA as to how it is or is not immersing itself in the community, what the specific needs of the community are, and how the CUA can help address them, among other things. Their membership is made up of community members and community businesses owners, school principals, and prominent leaders in the community. These meetings occur monthly.

CUAs are also required to have a minimum of three Parent Cafes a month. These Cafes have been very successful and well attended by community members, both DHS involved and not, and are only one type of the many community engagement activities planned by individual CUAs (or jointly by CUAs) that have taken place throughout Philadelphia.

In June 2016, DHS was an active participant in the City of Philadelphia’s 100-day Street Homelessness Challenge, assisted by Rapid Results Institute, and incorporating participants from all levels and across systems. As a result, DHS is prioritizing children, youth, and families in the following groups:

- Inadequate or lack of housing for families working towards family reunification.
- Families who lack adequate housing which leads to DHS involvement, although parents have the protective capacities to care for their children.
- Families living in poor to uninhabitable conditions and have active dependency challenges.
- Older youth who age out of DHS without reaching permanency or self-sufficiency.
- LGBTQ youth who lack family support and sustainability.

The Philadelphia Department of Human Services, as part of the Health and Human Services in the Managing Director’s Office, also collaborates with our sister departments such as Philadelphia Department of Public Health and the Department of Behavioral Health and Intellectual disAbilities. Through this collaboration, DHS works to ensure service support for the City’s most vulnerable populations.

There are a myriad of other workgroup collaborations including practice improvement workgroups, Domestic Violence, CBH, the School District of Philadelphia, CASA, the
Sexual Abuse Collaboration with the DA’s Office, the children’s hospitals, and the Philadelphia Children’s Alliance.

DHS, along with the support of the Annie E. Casey Foundation was instrumental in kick-starting a Philadelphia Foster Care Association. The Association had its first meeting in June of 2015 and now meets monthly. It provides a support and information network for resource parents (kinship and foster).

Finally, the Community Oversight Board (COB) was established by Mayor Street on June 14, 2007 via Executive Order. In a successive Executive Order, Mayor Michael Nutter re-established and continued the COB as has the current Mayor Jim Kenney. The creation of the COB was one in a series of recommendations made by the Child Welfare Review Panel (CWRP) established by Mayor Street in 2006. The COB continued to focus on monitoring of the CWRP recommendations being addressed through implementation and operationalization of the Improving Outcomes for Children (IOC) system transformation. The COB continued to assess whether additional reforms are necessary to increase DHS’ ability to improve the safety, permanency, and well-being of children, youth, and families; advise DHS on the development of the Child Welfare Operations (CWO) Services Plan and Budget Estimate; and make recommendations regarding operations, programs, and policies of the CWO. The morning session of these meetings was open to the public. The last meeting of the COB took place on June 30, 2017. The members made the decision that they had achieved their primary purpose since the COB was established, and are recommending to the Mayor that that particular body be dissolved. The Department will work with the Managing Director’s Office to recommend an appropriate new structure utilizing outside experts to continue to help DHS to meet its goals.

This year there was continued collaboration among the Department’s Juvenile Justice Services Division, Juvenile Probation, the Defender Association, District Attorney’s Office, and other stakeholders in the continued implementation of several core strategies of the Juvenile Detention Alternatives Initiative (JDAI). Together, for example, we worked to develop a video which is now used to help educate youth and families about the court process. The release of the video occurred in November, 2016 and has already generated lots of positive feedback from youth and families.

The Juvenile Probation Office is routinely represented at the monthly Court and Community Services Planning Group chaired by the DHS Director of Court and Community Services. These meetings represent an opportunity to communicate across systems news about important developments in the field, information about resources available for serving the Philadelphia’s juvenile justice population, and discussions about systematic challenges and solutions.

The DHS/JJS leadership team attends and actively participates in the monthly Youth Review Meeting, chaired by the Deputy Chief of Juvenile Probation and co-chaired by the Deputy Commissioner. These meetings include participation by line JPOs, DHS/CWO and CUA representatives, Defender Association, the District Attorneys’ Office, CBH, and others, and serve as opportunities for collaboration on specific cases as well as systemic challenges.
The JDAI Collaborative Board, co-chaired by the Administrative Judge of Family Court and the Commissioner, serves as another opportunity for collaboration among juvenile justice stakeholders. The group convenes twice annually to review our JDAI progress and to decide upon future innovations to further support the initiative’s success.

DHS/JJS actively participates in the Systems of Care work being lead by the City’s Department of Behavioral Health and Intellectual disAbilities (DBHIDS), collaborating with family members and youth who are or have been the recipients of our services. Additionally, we have established a collaborative relationship with the Office of Addiction Services (OAS) such that their “Engaging Males of Color” (EMOC) initiative provides monthly wellness sessions to the youth in our custody at the Philadelphia Juvenile Justice Services Center (PJJSC). The goal of the program is to improve the health status of males of color by increasing behavioral health literacy and access to resources and services. The program also seeks to reduce stigma and known disparities and build system capacity in order to sustain wellness.

See also the collaborative efforts described below.

- Describe the process utilized in gathering input from contracted service providers in determining service level needs, provider capacity, and resource identification for inclusion in the budget.

See information about integrated CUA and DHS meetings in response above regarding activities related to active engagement. Meetings sometimes result in issuance of Interim CUA Guideline Revisions, which are then incorporated in the general CUA Guidelines, which have been expanded and revised since originally issued in January of 2013.

The DHS Contracts and Finance Division meet a minimum of monthly with CUA Fiscal Officers and also has separate meetings with individual CUAs for budget reconciliation.

The CUAs have joined collaboratively to meet with resource home subcontractors and subcontractors of higher levels of care in order to understand the challenges of service delivery and placement identification for children and youth. DHS and SERO join in these meetings when requested to help resolve issues that have arisen. The CUA collaboration, in partnership with DHS, SERO, and OCYF, is also in the process of producing a “unified contract” and scopes of service for all subcontractors to alleviate any confusion for those subcontractors who have contractual relationships with multiple contractors and confusion about roles and responsibilities.

The Commissioner and other Executive level staff from Philadelphia DHS meet monthly with the Administrative Judge of Family Court, Supervising Judge of Family Court, and the Chief JPO, when necessary. Again, these meetings are action-oriented and focused on resolving systemic issues.

The Deputy Commissioner for Juvenile Justice Services is a member and active participant of the Juvenile Justice subcommittee for the County Criminal Justice Advisory Board (CJAB), a local planning and problem solving group, co-chaired by the Administrative Judge of Family Court and the Chief of the Juvenile Probation Office.
These meetings serve as another opportunity to collaborate with key stakeholders around improvements to Philadelphia’s juvenile justice system.

Identify data sources used in service level, needs assessment, and plan development.

<table>
<thead>
<tr>
<th>Resource</th>
<th>Data Collected</th>
<th>Date of Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>US Census Bureau, American Community Survey</td>
<td>Population, Poverty statistics, Age Distributions</td>
<td>2015</td>
</tr>
<tr>
<td>FACTS / FACTS²</td>
<td>General Indicators, Ongoing Services, JPO Services, Placement Data, Demographics, Native American Status, Fostering Connections questions (Aging Out), Shared Case Responsibility FY 16, APPLA data, Investigations, Days of Care.</td>
<td>July 2017</td>
</tr>
<tr>
<td>DHS IT data extract FACTS / FACTS²</td>
<td>Act 91 and Board Extensions</td>
<td>July 2017</td>
</tr>
<tr>
<td>Hornby Zeller Data Package</td>
<td>Population Flow, Prospective Permanency and Re-entries</td>
<td>July 2017</td>
</tr>
</tbody>
</table>

Describe the process utilized within the county to select the data sources identified.

Use of data from the Hornby-Zeller Data Package is required by the Needs Based Plan and Budget Guidelines and Narrative Template. The U.S. Census is DHS’s usual source of population and poverty data. Cognos queries of the new Data Warehouse are used to access most of the remaining data items listed in the table above. The remaining data is extracted directly from the servers using programmers to draw down the data.

Describe how the data used was analyzed, including who was involved in the process. Include any challenges identified through the process specific to data quality, availability, and/or capacity toward analysis.

The Data Analytics Unit (DAU) in the Performance Management and Technology Division (PMT) is responsible for the quantitative data analysis of service trends and for projections. DHS data analysis and trend projection was conducted using a three year simple moving average method. In addition, service trends and projections will be presented to Philadelphia DHS, JPO, and Family Court leadership for review and for input on how programmatic priorities might impact service trends.

Challenges
Since the Data Warehouse was lost in December 2014, the relative ease and flexibility of accessing and analyzing data was severely constrained. Philadelphia DHS has built an interim, functional Warehouse that has allowed an accelerated rate of data report production for CUAs and DHS. The CUAs and DHS are now able to receive reports that allow managers to track and manage performance on a regular basis. Concurrently, DHS is building a new, state-of-the-art Data Warehouse, which will be operational in October 2017 and will allow DHS to conduct more sophisticated data analytics to inform enhancements in system practice and performance.
Philadelphia’s current case management system, using FACTS2 and ECMS, is not yet fully integrated. Placement and billing information is housed in Legacy FACTS, an antiquated mainframe application. DHS has begun development of the Integrated Case Management System (ICMS), which will enable full integration of multiple child welfare practice data sources, easy user navigation, and user-based data management and reporting capabilities. The first phase of the ICMS roll out is scheduled for January 2019.

Given historical data collection and cleaning challenges at DHS, AFCARS reports still contain too many errors. DHS is working on interim strategies to reduce errors and expects that errors will be eliminated or minimized after the migration of Legacy FACTS in Winter of FY2017-18.

 Counties may attach Implementation Team membership, CWDP Advisory Team member, or similarly named stakeholder group list to supplement these responses. With these attachments, counties will not need to identify each stakeholder group who collaborated with the plan development unless not specifically identified in the attachment.

See Attachments for the Philadelphia COB Members and the Child Welfare Demonstration Project (CWDP) Implementation Team.

### 2.3 Program and Resource Implications

**NOTE:** Do not address the initiatives in Section 2.3 unless requested below; address any resource needs related to all initiatives by identifying and addressing within the ADJUSTMENT TO EXPENDITURE request.

#### 2-3e. Five-Year Child and Family Services Plan (CFSP) – Reporting Requirements

To assist in state reporting of Indian Child Welfare Act (ICWA) compliance, counties are asked to respond to the following questions:

- Provide the total unduplicated number of Native American/Alaskan Native children/youth who received in-home child welfare services from the county during the period July 1, 2016–June 30, 2017.

  In FY 2016-17, 13 Native American/Alaskan Native children received in-home services.

- Provide the total unduplicated number of Native American/Alaskan Native children/youth who were in foster care through the county during the period July 1, 2016–June 30, 2017.

  For the Native American/Alaskan Native children/youth in foster care, provide the total number who resided in any one of the following placement settings during the period **July 1, 2016–June 30, 2017**:
  - Non-relative foster care:
  - Relative foster care:
  - Pre-adoptive home:
  - Trial home visit:
  - Residential:
  - Runaway status:
  - Supervised independent living:
In FY 2016-17, 11 Native American/Alaskan Native children and youth received dependent placement services, and two Native American/Alaskan Native children and youth received delinquent placement services.

- Of the children/youth identified as Native American/Alaskan Native, note the following:
  - Number of children/youth confirmed to be members of a federal and state recognized tribe:
  - Names of tribes for which children/youth were confirmed to be members:
    - Yavapai-Apache Nation in Camp Verde, AZ.

- For any of the children/youth identified as Native American/Alaskan Native, were proceedings requested and transferred to the jurisdiction of the tribe? If yes, provide the number of children/youth impacted and the tribe(s) to which jurisdiction was transferred.
  - Not Applicable. In-home services are being provided.

- If the county made active efforts to prevent the breakup of the Indian family when parties sought to place a child/youth in foster care or for adoption, note any specific efforts made that the county believes should be highlighted.
  - Not Applicable. In-home services are being provided.

To assist in reporting related to ongoing monitoring of implementation of Act 91 of 2012, counties are asked to respond to the following questions:

- For the period, July 1, 2016-June 30, 2017, provide the number of youth who turned age 18 and elected to remain dependent and under court jurisdiction.
  - For the period, 299 youth turned age 18 and elected to remain dependent and under court jurisdiction.

- For the period, July 1, 2016–June 30, 2017, provide the unduplicated number of youth who exited care within 90 days of turning age 18 or any time after turning age 18 who requested resumption of dependency jurisdiction.
  - For the period, nine youth who exited care within 90 days of turning age 18 or any time after turning age 18 requested and were granted resumption of dependency jurisdiction.
  - For the period July 1, 2016 - May 2017, 101 unduplicated young adults inquired into resumption of jurisdiction. Of those, 41 youth met the baseline criteria. Only 16 youth submitted documentation of eligibility. For youth who are interested in resumption, but who do not follow through, the DHS Act 91 Re-entry team make outreach efforts to the youth and to the youth’s AIC coach to encourage the youth to follow through and meet with DHS Re-entry staff.

- Of the five criteria required to meet the definition of a child for a youth over age 18, which ones are primary drivers for eligibility for youth remaining or returning to care?
School attendance and employment continue to be the primary drivers of eligibility for the youth who return to care.

All information provided by counties regarding the above requested information will be aggregated into statewide numbers for public reporting in the CFSP/Annual Progress and Services Report (APSR).

2-3f. Rate Methodology Task Force

- Describe the process by which private providers communicate their needs for the Implementation Year and upcoming budget year.

  Generally, Providers are focused on the implementation year. Philadelphia DHS is in contact with all Providers through regular communications and meetings. Upon receipt of tentative award letters, sent out between March and May, Providers are asked to submit budgets for the upcoming fiscal year. Providers are expected to communicate their needs through this process, and can contact DHS at any time to discuss needs.

- Describe the contract negotiation process, specifically addressing when negotiations take place.

  **CUA contracts.** CUA contracts are negotiated through a separate annual process that takes place between April and early August. CUAs are asked to submit budget proposals for the upcoming year to cover staffing, administrative, operating, and indirect costs. (As of FY 2017-18, placement maintenance funds have been removed from CUA budgets.) Philadelphia DHS Finance staff review each submission for allowability per the City’s cost principles and the Department’s fiscal guidelines, current and past year actuals, and for general reasonableness. Additionally, CUAs reach out, as needed, for budget adjustments during the contract year.

  **Professional services contracts.** Generally, these budgets are determined through an RFP process, then rolled forward for the subsequent four fiscal years, at which point they must go through a new RFP and budget and scope-setting process. However, at any time during this period, Providers are welcome to submit requests for increases to their contracts. These are reviewed and decided on a case-by-case basis, but generally approved if need is demonstrated. Professional service contract budgets are reviewed for adherence to the City’s cost principles.

  **Per diem (placement maintenance) contracts.** These amounts are generated by a financial projection developed for Philadelphia DHS by The PFM Group. This model estimates days of care by Provider for upcoming years using current rates, placement data, and a randomization element. These contracts are initially executed by the end of the first quarter of any fiscal year with every attempt made to have them executed by the end of July. The per diem rates are set through an RFP process and are sized to cover the cost of care for each client. Over the course of the year, Philadelphia DHS monitors utilization of these contracts and amends them up or down as necessary.

  When a Provider requests a per diem rate change, Philadelphia DHS completes a review to determine if the requested rate allows the Provider to cover the costs of delivering the service in question, and it compares with rates given to Providers who
offer a similar service. The following information for the two most recent fiscal years is reviewed:

- Roster of Personnel (including names, positions, salaries, fringe benefits, and hours charged to the program).
- Budget of Detailed Operational Costs.
- Budget of Child Direct Expenses.
- Administrative Cost (listing in detail all indirect costs).
- Full and Estimated Occupancy Rates.
- Computation of specific costs for services and occupancy rate, with calculation of requested per diem rate.
- If applicable, detailed subcontractor costs for the program.
- If applicable, maximum OCYF approved Title IV-E rate.

The Commissioner makes the final decision based on a recommendation provided by the Deputy Commissioner for Finance. Prior performance of a Provider is factored into the ultimate recommendation to the Commissioner. Over the course of FY 2017-18, the Department intends to develop a more formalized rate increase review process with integrated performance and financial data.

- Explain how increases/decreases in private providers’ costs of doing business are captured in the NBPB.

The County’s submission captures the sum of all private Providers’ costs. Actuals are included in the quarterly Act 148 invoices. Agreed upon rate changes, or other changes with financial implications (e.g., a scope change for additional or different services), are incorporated as an implementation year adjustment. The Department finalizes Provider budgets by early August to ensure that any changes are incorporated by the NBPB submission deadline.

2-3k. Use of Another Planned Permanent Living Arrangement (APPLA)

- Provide the number of youth over age 16 with a primary and/or secondary goal of APPLA as of June 30, 2017.

As of June 30, 2017, 495 youth aged 16 and older have a primary or secondary goal of APPLA.

- Provide the number of youth under age 16 with a primary and/or secondary goal of APPLA as of June 30, 2017.

As of June 30, 2017, 12 youth under age 16 have a primary or secondary goal of APPLA. These cases will be reviewed in September to ensure appropriate goals for these minors using Accurint and Family Finding resources when necessary.

- Provide any demographics and characteristics of children under age 16 with a primary or concurrent goal of APPLA along with the rationale used to establish or maintain the goal of APPLA for these children. Provide specific action steps toward establishment of an appropriate permanency goal for each child to be established at the next permanency hearing. Identify resources needed to achieve permanency for these children.
Philadelphia DHS is committed to achieving permanency for all youth, and has continued to reinforce that expectation via Family Team Conferences, Integrated Staff Meetings between DHS and the CUA, Training, and in our Practice Discussions. Specifically, our Family Team Conferencing staff facilitates Teamings at least quarterly, to review the permanency goal for children and youth to ensure the appropriateness of the goal. The Teaming staff assist the case management team with developing a plan to move the child or youth to permanency.

- **Describe what practice changes the agency has made towards eliminating the use of APPLA as a goal for youth under age 16.**

  The Department will continue to consistently communicate to staff the importance of achieving permanency for all children and youth. Supervisory oversight is the key to achieving good practice outcomes; therefore, DHSU and CWO meet monthly with CUA and DHS Supervisors, during the Supervisory Excellence Series, to address our areas of improvement and to reinforce good social work practice. Ongoing Data lists are reviewed to ensure that APPLA is not being utilized for children under the age of 16. Ongoing Administrative reviews of Children with the Goal of APPLA continue to occur to ensure that it is an appropriate Goal.

- **Provide any demographics and characteristics of youth age 16 or older with a primary or concurrent goal of APPLA.**

  Children with a goal of APPLA frequently have:
  - Complex mental health issues that include multiple inpatient hospitalizations as well as RTF placements.
  - Special medical or Intellectual disAbilities that require 24 hour care.
  - Extreme Behavioral Issues
  - Unresolved trauma and abandonment issues that cause the youth to reject permanency.
  - Histories of multiple placements

  - What inventory/array of services does your county currently have available to support moving older youth towards permanency and permanent connections?

    - **Services offered through the Achieving Independence Center (AIC) are critical in our efforts to support our older youth, and they are as follows:**
      - Life skills training including daily living skills, money management, self-care, personal and social development.
      - Mentoring.
      - Family Planning.
      - Housing assistance.
      - Educational Support Services.
      - Job readiness training.
      - Hands-on Job training program in hospitality and food service.
      - Computer Certification.

    - **We work closely with our Community Behavioral Health (CBH) partners to ensure that young people receive the services necessary to support them in achieving permanency.**
- Group Decision making, via our Family Team and Family Group Decision Making Conferences, to develop a comprehensive, individualized plan for the youth.
- SWAN Services such as: Child Specific Recruitment and Child Preparation Services.

  - Of those services that your county has available, what services does your county use to move older youth towards permanency and permanent connections?

All listed services are used to achieve permanency for young people, however, the services are individualized according to the needs of the youth. Behavioral Health Supports as well as referrals to SWAN services are critical in addressing the conflicting feelings that prevent young people from accepting a permanency goal.

  - What services does your county need to achieve permanency and permanent connections for these older youths? Please address both gaps in services as well as any issues around capacity to deliver these services.

Older youth need specialized resource parents who are able to provide the necessary supports to stabilize youth while in placement rather than being placed in congregate care. Additionally, parents are in need of housing resources to support reunification. Finally, we need an increased capacity for in-home behavioral health supports that will assist with the transition of youth to a permanent family.

  - What are the steps you intend to take toward establishment of an appropriate permanency goal for each child by their next permanency hearing?
    - Continue to team the youth through Family Team Conferences or Older Youth Reviews to ensure that permanency is achieved.
    - Referrals to SWAN for Child Specific Recruitment and Child Preparatory Services.
    - Ongoing partnering with Community Behavioral Health regarding the needs and appropriateness of the services received by young people.

- Describe any systemic issues and technical assistance needs.
  - Increased diversion at the Front End to ensure that older youth only enter the formal Child Welfare System for abuse and neglect.
  - Development of flexible services that are tailored to needs of young people and support their move to permanency.

2-3l. Educational Success and Truancy Prevention
- Describe the impact Every Student Succeeds Act (ESSA) has had on the agency.

In response to ESSA mandates, DHS created a dedicated unit within the Education Support Center to troubleshoot, advocate, streamline support, and be a centralized point of contact for LEAs, both Philadelphia county and out-of-county, and within DHS.
Implementation of ESSA has increased awareness of the need for educational stability. The ESSA unit is alerted every time a child or youth enters placement, and Child Welfare Operations staff are consulted regarding whether a Best Interest Determination conference needs to be held. The requirement to maintain children and youth in their schools of origin has resulted in fewer educational disruptions that children and youth experience when there is a transition in their placement. In addition, the implementation of ESSA is strengthening and fostering better relationships between child welfare and education agencies. However, training across all systems is necessary to ensure that child welfare staff and other stakeholders are informed and understand the new ESSA provisions.

The main negative effect is that Investigation and Case Management staff need to transport children and youth to school until School District transportation is implemented, such as re-routing a School District bus. This has an impact on staff’s primary role of investigations or case management.

- Has your agency successfully completed collaborative transportation plans for youth in foster care with local education agencies? Yes_ X__ No____  
  - If no, explain why.

- Provide the number of school districts in the county and how many the county children and youth agency (CCYA) has agreements with.

Philadelphia DHS has agreements with the SDP and 20 charter school LEAs. Philadelphia DHS partnered with the School District of Philadelphia’s acting Foster Care Liaison to make diligent outreach efforts to the Foster Care Liaisons from all of the charter school LEAs in Philadelphia; 20 of the 85 charter schools responded.

- Briefly describe any planned use of funds in FY 2017-18 related to implementation of ESSA.

Philadelphia is requesting funds for supplemental transportation to cover the period between when a child or youth is placed and when School District of Philadelphia transportation is implemented, and situations in which School District buses cannot be re-routed to transport a DHS-committed child or youth to school. Philadelphia anticipates beginning use of supplemental transportation in the second half of FY 2017-18. See response regarding barriers, below.

- Briefly describe any planned use of funds in FY 2018-19 related to implementation of ESSA.

See response above regarding use of funds in FY2017-18. Funds will be used for supplemental transportation in FY 2018-19.

- Provide the number of children who attended their home school district under ESSA in FY 2016-17.

For the period April 3, 2017 through June 30, 2017, Philadelphia DHS tracked 96 children and youth who came into care, or whose placement was disrupted, who
received a BID consultation, and who continued to attend their home school district under ESSA. Until recently, DHS was not able to track these changes. DHS now has the ability to track every BID conference, whether the outcome is that the student remains in the school of origin, whether transportation is necessary, and what type. More data will be available for next year’s submission.

Provide the number of children who required partial or full county support of transportation costs to attend their home school district under ESSA in FY 2016-17.

During the period, April 3, 2017 through June 30, 2017, 90 children and youth required transportation to continue attending their school of origin; 33 of these children and youth were transported by DHS Child Welfare Operations staff or a resource caregiver. This has been a cost fully paid for by Philadelphia DHS.

Describe any barriers your agency has encountered during implementation of ESSA and/or technical assistance needs the agency has related to these provisions.

While Philadelphia DHS and the School District of Philadelphia have a strong collaborative partnership in the implementation of ESSA, and there have been many positive strides, transportation concerns continue to present a significant challenge. Philadelphia DHS is proposing to issue an RFP to engage a supplemental transportation service which can be accessed immediately, a particular necessity for children and youth placed after hours or on an emergency basis. See Education Support Services: Transportation for Education Stability and Continuity under 3-4 Program Improvement Strategies for additional information.

In the early stages of implementation of the provisions of ESSA, there have been several additional barriers identified:
- Some LEAs have not identified a Foster Care Liaison point of contact. As a result, outreach has proven difficult, and there is inconsistent messaging regarding the Best Interest Determination (BID) meeting.
- LEAs do not have the ability to hold BID meetings during the summer months, so there is a backlog of children and youth for whom BID meetings need to be held.
- There are some communication and role confusion issues which affect:
  - Meeting timelines as outlined in the ESSA regulations due to LEA non-responsiveness or differences in interpretation of the ESSA guidance.
  - Providing transportation support aides for children and youth with special needs.
- Training regarding the ESSA guidance and requirements has not yet reached all stakeholders.
- Transportation between counties has not been consistent.
- Court orders that are not consistent with ESSA agreements between DHS and the LEAs.
- School transfers prior to BID conference, particularly when a child or youth is placed out of county.

2-3m. Housing

Provide, if available, a breakdown of costs for housing (rent, rental deposits, mortgage), housing supports (utility bills, utility deposits, household items, etc.), and those associated with hotels and other alternative housing, by funding stream, for FY 2016-17.
<table>
<thead>
<tr>
<th>Housing Grant</th>
<th>Independent Living Grant</th>
<th>Act 148</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expense</strong></td>
<td># Families Served</td>
<td># Children and Youth Served</td>
</tr>
<tr>
<td>1. Actual Housing- Mortgage, Emergency Housing, Rent, Rental Security Deposits</td>
<td>N/A – DHS Housing Grant funds do not cover direct housing expense.</td>
<td></td>
</tr>
<tr>
<td>2. Housing Supports- (such as Utility Bills, Utility Deposits, Household Items [furniture, appliances, etc.])</td>
<td>N/A – DHS Housing Grant funds do not cover direct housing expense.</td>
<td></td>
</tr>
<tr>
<td>Combination of #1 and #2 above</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.3q. Appointment of Counsel in Contested Termination of Parental Rights (TPR) hearings
- Provide the number of contested TPR hearings for children and youth in FY 2016-17.

There were 368 contested TPR hearings.

- Provide the number of contested TPR hearings for children and youth in FY 2015-16.

There were 359 contested TPR hearings.

- In the cases above, was counsel, in addition to the GAL, appointed?

It is estimated that counsel was appointed in 72 cases in addition to the GAL. Since the Supreme Court case requiring separate appointment came down the week of March 27, 2017, there have been at least 72 contested Goal Change/Termination hearings. Philadelphia Dependency Court has decided, since the Supreme Court case was published, to appoint a separate Child Advocate on all the contested Goal Change/Terminations (GCTs). Therefore, we estimate that at least 72 Child Advocates were appointed in addition to the GALs already appointed.
Section 3: General Indicators

3-1: County Fiscal Background

- Counties that exceeded their Act 148 allocation, resulting in an overmatch situation, in FY 2016-17 should describe the practice and fiscal drivers that impacted the county’s level of resource need. Address the impact the FY 2016-17 program and spending history had on the projected utilization of the allocation and additional resource needs for FY 2017-18.

  See response below.

- Counties that did not spend all their Act 148 allocation in FY 2016-17 should describe the practice(s) that impacted the county’s level of resource need and address any projections for underspending in FY 2017-18.

At the point of the submission of the NBPB, Philadelphia DHS had submitted three quarters of invoices to the Commonwealth. Through three quarters, Philadelphia DHS has used 72% of its allocation. The percent of expenditure for “Institutional Placement” and “Administration” are similar to the overall expenditure level, using 77% and 72% of their allocation, respectively. The categories of “In-home and Intake” and “Community-based Placement”, however, are on opposite sides of the total expenditure level. In-home and Intake has used 64% of its allocation, while Community-based Placement has used 83% of its allocation. This is a result of Improving Outcomes for Children and the Community Umbrella Agencies finally coming entirely online and the corresponding shift in responsibilities.

Projecting out Q4 and the entirety of FY2016-17 expenditures, it appears that Philadelphia will spend 1.75% less than its total allocation. Specifically, Philadelphia will use 98.26% of its Act 148 allocation and end up in undermatch by about $6.5 million. Although Community-based Placement is using 112% of its allocation, In-Home and Intake is only using 90% of its allocation. Institutional Placement and Administration are using 99% and 97%, respectively.

It is difficult to compare FY2016-17 expenditures to FY2015-16 expenditures because there is no real relation between cost centers from these two years. As Improving Outcomes for Children moves out of implementation, spending and the cost centers associated with that spending, should settle down and become more consistent.

We believe underspending is being driven by the following two factors: the number of children and youth in DHS care has remained consistent throughout the fiscal year; and DHS has put every effort into keeping children and youth with their kin, or at least in the same community. This has reduced placement costs, a continued goal in FY2017-18.

In FY 2017-18, DHS has a goal of reducing the number of children and youth in the Child Welfare system by 500 individuals. This goal will hopefully see placement costs continue to decline, however, there is a tradeoff of increasing Community-based Prevention Services costs and services to divert children, youth, and families from the system.
Address any other changes or important trends that will be highlighted as a resource need through an ADJUSTMENT TO EXPENDITURE submission.

In FY 2017-18 and FY 2018-19, Philadelphia DHS continues to focus on resources needed to achieve the goals of IOC, reduce the size of the system, safely divert children, youth, and families from the system and from out-of-home placement, and help children and youth achieve safe, timely permanency. Practice supports, such as improved training and consulting capacity and supplemental transportation for children and youth to implement provisions of ESSA, are also being requested. Philadelphia also continues to work to eliminate the use of the Child Care Room and is requesting resources needed to do so. Finally, DHS is requesting resources needed to enhance successful services for delinquent youth and address critical staffing and infrastructure needs for the Philadelphia Juvenile Justice Services Center and mandated child welfare services.

Implementation year adjustments for FY 2017-18 will reflect the actual cost of providing continuing and new vital services. Philadelphia DHS is requesting full-year funding in FY 2017-18 for previously approved FY 2016-17 requests, such as increased per diem rates for Foster Care and Specialized Behavioral Health, and adding new legal staff.

An adjustment to account for the skyrocketing costs of liability insurance for Philadelphia’s ten CUAs will be reflected as a resource need through an adjustment as well as anticipated hiring and separations, both agency-wide and specifically at the Philadelphia Juvenile Justice Services Center (PJSC). Additional requests will be submitted for related critical supporting infrastructure, vehicle, and systems replacements.

Additional non-program needs which will be reflected as adjustments include:
Vehicle Replacement: Currently, Philadelphia DHS needs approximately 76 cars on a daily basis to respond to reports and the need for emergency placements, conduct visits, respond to non-case emergencies, and perform administrative responsibilities. Almost half of the 81 vehicles assigned to the agency for use by staff are dedicated to the Hotline and to Investigations’ E-day Units to respond to reports. Six vehicles are reserved for use in emergencies not directly related to a case, or for use by Executive staff. Because of the average age of the vehicles, and increased usage, approximately 20 vehicles are out of service each day receiving preventive maintenance or repairs, and five to ten vehicles are being assessed for current drivability. This leaves only 20-25 vehicles available each day for distribution to staff for all other purposes. The DHS Transportation unit receives approximately 35-40 vehicle requests each day, so there is a daily waitlist.

Lack of sufficient vehicles adversely affects the ability of staff to respond in a timely manner and make efficient use of their time. It also affects the children, youth, and families we serve who may have to wait for placement or have delayed Worker visits due to lack of vehicles. Philadelphia DHS is requesting funding to replace 15 aging vehicles from our current fleet with 15 new minivans. Newer vehicles are better equipped, require less maintenance, have improved safety systems, produce fewer emissions, and are more fuel-efficient. Please see budget adjustment narrative for more detail about this need.
HR System: Philadelphia DHS is requesting funding as part of the IT grant to purchase and implement an off-the-shelf system to replace and consolidate the multiple systems now used to track employee relations events and incidents. Replacing will provide the opportunity to improve HR staff productivity, reduce operational complexity and increase internal controls by enabling standardization and automation of business processes. It will also better support the DHS’s decision-making by providing a complete and comprehensive set of reporting and workflow tracking tools that allow for increased visibility and accountability through alerts, triggers, canned, and ad-hoc reports. It may additionally help reduce the need for additional HR administrative staff. See IT grant narrative for additional information.

PLEASE NOTE: Capture any highlights here that are not addressed in the Program Improvement Strategies narrative (Section 3-4)

3-2a. Intake Investigations
Insert the Intake Investigations Chart (Chart 1).
3-2a. **Ongoing Services**

Insert the Ongoing Services Chart (Chart 2).

![Ongoing Services Chart](image1)

<table>
<thead>
<tr>
<th>Year</th>
<th>Children</th>
<th>Family</th>
<th>Children Placed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>11,365</td>
<td>6,120</td>
<td>6,106</td>
</tr>
<tr>
<td>2013/14</td>
<td>12,784</td>
<td>6,547</td>
<td>6,445</td>
</tr>
<tr>
<td>2014/15</td>
<td>15,630</td>
<td>7,594</td>
<td>7,396</td>
</tr>
<tr>
<td>2015/16</td>
<td>17,641</td>
<td>8,334</td>
<td>8,345</td>
</tr>
<tr>
<td>2016/17</td>
<td>16,819</td>
<td>8,025</td>
<td>8,650</td>
</tr>
<tr>
<td>FY 2017/18</td>
<td>16,697</td>
<td>7,984</td>
<td>8,130</td>
</tr>
<tr>
<td>FY 2018/19</td>
<td>17,052</td>
<td>8,114</td>
<td>8,375</td>
</tr>
</tbody>
</table>

3-2a. **JPO Services**

Insert the JPO Services Chart (Chart 3).

![JPO Services Chart](image2)

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Children</th>
<th>Community Based Placement</th>
<th>Institutional Placements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>5,508</td>
<td>479</td>
<td>2,055</td>
</tr>
<tr>
<td>2013/14</td>
<td>5,018</td>
<td>372</td>
<td>1,869</td>
</tr>
<tr>
<td>2014/15</td>
<td>4,442</td>
<td>348</td>
<td>1,703</td>
</tr>
<tr>
<td>2015/16</td>
<td>3,994</td>
<td>294</td>
<td>1,530</td>
</tr>
<tr>
<td>2016/17</td>
<td>3,637</td>
<td>257</td>
<td>1,572</td>
</tr>
<tr>
<td>FY 2017/18</td>
<td>4,024</td>
<td>300</td>
<td>1,602</td>
</tr>
<tr>
<td>FY 2018/19</td>
<td>3,885</td>
<td>284</td>
<td>1,568</td>
</tr>
</tbody>
</table>
3-2b. Adoption Assistance

Insert the Adoption Assistance Chart (Chart 4).

![Adoption Assistance Chart]

<table>
<thead>
<tr>
<th>Year</th>
<th>Assistance Added</th>
<th>Assistance Ended</th>
<th>Total Days of Care (DOC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>395</td>
<td>526</td>
<td>1,867,179</td>
</tr>
<tr>
<td>2013/14</td>
<td>474</td>
<td>539</td>
<td>1,849,128</td>
</tr>
<tr>
<td>2014/15</td>
<td>428</td>
<td>238</td>
<td>1,869,482</td>
</tr>
<tr>
<td>2015/16</td>
<td>471</td>
<td>544</td>
<td>1,949,824</td>
</tr>
<tr>
<td>2016/17</td>
<td>559</td>
<td>413</td>
<td>1,914,709</td>
</tr>
<tr>
<td>FY 2017/18</td>
<td>486</td>
<td>559</td>
<td>1,911,338</td>
</tr>
<tr>
<td>FY 2018/19</td>
<td>505</td>
<td>543</td>
<td>1,925,290</td>
</tr>
</tbody>
</table>

3-2c. Subsidized Permanent Legal Custody (SPLC)

Insert the SPLC Chart (Chart 5).

![SPLC Chart]

<table>
<thead>
<tr>
<th>Year</th>
<th>Receiving Care, First Day</th>
<th>Assistance Added</th>
<th>Assistance Ended</th>
<th>Total Days of Care (DOC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>1,829</td>
<td>150</td>
<td>318</td>
<td>634,192</td>
</tr>
<tr>
<td>2013/14</td>
<td>1,661</td>
<td>172</td>
<td>262</td>
<td>595,557</td>
</tr>
<tr>
<td>2014/15</td>
<td>1,571</td>
<td>106</td>
<td>248</td>
<td>539,445</td>
</tr>
<tr>
<td>2015/16</td>
<td>1,429</td>
<td>155</td>
<td>384</td>
<td>493,035</td>
</tr>
<tr>
<td>2016/17</td>
<td>1,200</td>
<td>159</td>
<td>266</td>
<td>414,599</td>
</tr>
<tr>
<td>FY 2017/18</td>
<td>1,093</td>
<td>140</td>
<td>299</td>
<td>482,360</td>
</tr>
<tr>
<td>FY 2018/19</td>
<td>1,241</td>
<td>151</td>
<td>316</td>
<td>463,331</td>
</tr>
</tbody>
</table>
3-2d. Out-of-Home Placements: County Selected Indicator
Insert charts related to out-of-home placements where trends are highlighted (Charts 6-22).

**Chart 6: Traditional Foster Care - Dependent**

![Traditional Foster Care (Non-kinship) Dependent chart](image)

**Chart 7: Traditional Foster Care - Delinquent**

![Traditional Foster Care (Non-kinship) Delinquent chart](image)
3-2d. Out-of-Home Placements: County Selected Indicator

Insert charts related to out-of-home placements where trends are highlighted (Charts 6-22).

Chart 8: Reimbursed Kinship Care – Dependent

![Chart 8: Reimbursed Kinship Care – Dependent]

Chart 9: Reimbursed Kinship Care – Delinquent

![Chart 9: Reimbursed Kinship Care – Delinquent]
3-2d. Out-of-Home Placements: County Selected Indicator

Insert charts related to out-of-home placements where trends are highlighted (Charts 6-22).

**Chart 10: Total Foster Family Care – Dependent**

![Chart 10: Total Foster Family Care – Dependent](image)

**Chart 11: Total Foster Family Care – Delinquent**

![Chart 11: Total Foster Family Care – Delinquent](image)
### Chart 12: Non-reimbursed Kinship Care - Dependent

<table>
<thead>
<tr>
<th>Year</th>
<th>Receiving Care, First Day</th>
<th>Assistance Added</th>
<th>Assistance Ended</th>
<th>Total Days of Care (DOC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2013/14</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2014/15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2015/16</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2016/17</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>FY 2017/18</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>FY 2018/19</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

### Chart 13: Non-reimbursed Kinship Care - Delinquent

<table>
<thead>
<tr>
<th>Year</th>
<th>Receiving Care, First Day</th>
<th>Assistance Added</th>
<th>Assistance Ended</th>
<th>Total Days of Care (DOC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2013/14</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2014/15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2015/16</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2016/17</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>FY 2017/18</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>FY 2018/19</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Chart 14: Alternative Treatment Dependent

<table>
<thead>
<tr>
<th>Year</th>
<th>Receiving Care, First Day</th>
<th>Assistance Added</th>
<th>Assistance Ended</th>
<th>Total Days of Care (DOC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>25</td>
<td>54</td>
<td>49</td>
<td>12,561</td>
</tr>
<tr>
<td>2013/14</td>
<td>30</td>
<td>21</td>
<td>21</td>
<td>13,365</td>
</tr>
<tr>
<td>2014/15</td>
<td>30</td>
<td>36</td>
<td>29</td>
<td>10,565</td>
</tr>
<tr>
<td>2015/16</td>
<td>37</td>
<td>30</td>
<td>34</td>
<td>10,346</td>
</tr>
<tr>
<td>2016/17</td>
<td>33</td>
<td>48</td>
<td>62</td>
<td>9,343</td>
</tr>
<tr>
<td>2017/18</td>
<td>19</td>
<td>38</td>
<td>27</td>
<td>10,085</td>
</tr>
<tr>
<td>2018/19</td>
<td>30</td>
<td>39</td>
<td>39</td>
<td>9,925</td>
</tr>
</tbody>
</table>

Chart 15: Alternative Treatment Delinquent

<table>
<thead>
<tr>
<th>Year</th>
<th>Receiving Care, First Day</th>
<th>Assistance Added</th>
<th>Assistance Ended</th>
<th>Total Days of Care (DOC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2013/14</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2014/15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2015/16</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2016/17</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2017/18</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2018/19</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Chart 16: Dependent Community Residential

<table>
<thead>
<tr>
<th>Year</th>
<th>Receiving Care, First Day</th>
<th>Assistance Added</th>
<th>Assistance Ended</th>
<th>Total Days of Care (DOC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>467</td>
<td>685</td>
<td>741</td>
<td>157,519</td>
</tr>
<tr>
<td>2013/14</td>
<td>411</td>
<td>532</td>
<td>583</td>
<td>144,948</td>
</tr>
<tr>
<td>2014/15</td>
<td>360</td>
<td>461</td>
<td>429</td>
<td>137,545</td>
</tr>
<tr>
<td>2015/16</td>
<td>392</td>
<td>487</td>
<td>484</td>
<td>146,872</td>
</tr>
<tr>
<td>2016/17</td>
<td>395</td>
<td>685</td>
<td>683</td>
<td>142,318</td>
</tr>
<tr>
<td>FY 2017/18</td>
<td>397</td>
<td>544</td>
<td>547</td>
<td>143,909</td>
</tr>
<tr>
<td>FY 2018/19</td>
<td>395</td>
<td>572</td>
<td>580</td>
<td></td>
</tr>
</tbody>
</table>

Chart 17: Delinquent Community Residential

<table>
<thead>
<tr>
<th>Year</th>
<th>Receiving Care, First Day</th>
<th>Assistance Added</th>
<th>Assistance Ended</th>
<th>Total Days of Care (DOC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>161</td>
<td>292</td>
<td>326</td>
<td>63,129</td>
</tr>
<tr>
<td>2013/14</td>
<td>127</td>
<td>202</td>
<td>212</td>
<td>46,250</td>
</tr>
<tr>
<td>2014/15</td>
<td>117</td>
<td>187</td>
<td>202</td>
<td>43,158</td>
</tr>
<tr>
<td>2015/16</td>
<td>102</td>
<td>136</td>
<td>148</td>
<td>32,208</td>
</tr>
<tr>
<td>2016/17</td>
<td>90</td>
<td>136</td>
<td>155</td>
<td>28,270</td>
</tr>
<tr>
<td>FY 2017/18</td>
<td>71</td>
<td>153</td>
<td>136</td>
<td>34,545</td>
</tr>
<tr>
<td>FY 2018/19</td>
<td>88</td>
<td>142</td>
<td>133</td>
<td>31,674</td>
</tr>
</tbody>
</table>
Chart 18: Supervised Independent Living Dependent

<table>
<thead>
<tr>
<th>Year</th>
<th>Receiving Care, First Day</th>
<th>Assistance Added</th>
<th>Assistance Ended</th>
<th>Total Days of Care (DOC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>184</td>
<td>195</td>
<td>158</td>
<td>89,290</td>
</tr>
<tr>
<td>2013/14</td>
<td>221</td>
<td>92</td>
<td>152</td>
<td>80,837</td>
</tr>
<tr>
<td>2014/15</td>
<td>161</td>
<td>62</td>
<td>137</td>
<td>52,383</td>
</tr>
<tr>
<td>2015/16</td>
<td>86</td>
<td>86</td>
<td>36</td>
<td>32,165</td>
</tr>
<tr>
<td>2016/17</td>
<td>136</td>
<td>105</td>
<td>88</td>
<td>54,797</td>
</tr>
<tr>
<td>2017/18</td>
<td>153</td>
<td>84</td>
<td>112</td>
<td>46,448</td>
</tr>
<tr>
<td>2018/19</td>
<td>125</td>
<td>92</td>
<td>79</td>
<td>44,470</td>
</tr>
</tbody>
</table>

Chart 19: Supervised Independent Living Delinquent

<table>
<thead>
<tr>
<th>Year</th>
<th>Receiving Care, First Day</th>
<th>Assistance Added</th>
<th>Assistance Ended</th>
<th>Total Days of Care (DOC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>52</td>
<td>57</td>
<td>74</td>
<td>14,248</td>
</tr>
<tr>
<td>2013/14</td>
<td>35</td>
<td>63</td>
<td>58</td>
<td>14,155</td>
</tr>
<tr>
<td>2014/15</td>
<td>40</td>
<td>46</td>
<td>54</td>
<td>13,566</td>
</tr>
<tr>
<td>2015/16</td>
<td>32</td>
<td>46</td>
<td>49</td>
<td>12,272</td>
</tr>
<tr>
<td>2016/17</td>
<td>29</td>
<td>29</td>
<td>40</td>
<td>7,932</td>
</tr>
<tr>
<td>2017/18</td>
<td>18</td>
<td>40</td>
<td>32</td>
<td>11,257</td>
</tr>
<tr>
<td>2018/19</td>
<td>26</td>
<td>38</td>
<td>35</td>
<td>10,487</td>
</tr>
</tbody>
</table>
Chart 20: Juvenile Detention

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Receiving Care, First Day</td>
<td>88</td>
<td>99</td>
<td>126</td>
<td>109</td>
<td>115</td>
<td>177</td>
<td>134</td>
</tr>
<tr>
<td>Assistance Added</td>
<td>3,111</td>
<td>2,321</td>
<td>2,247</td>
<td>2,107</td>
<td>1,994</td>
<td>2,116</td>
<td>2,072</td>
</tr>
<tr>
<td>Assistance Ended</td>
<td>3,100</td>
<td>2,294</td>
<td>2,264</td>
<td>2,101</td>
<td>1,932</td>
<td>2,159</td>
<td>2,076</td>
</tr>
<tr>
<td>Total Days of Care (DOC)</td>
<td>38,240</td>
<td>38,600</td>
<td>45,031</td>
<td>36,635</td>
<td>46,279</td>
<td>42,648</td>
<td>41,854</td>
</tr>
</tbody>
</table>

Chart 21: Dependent Residential Services

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Receiving Care, First Day</td>
<td>481</td>
<td>483</td>
<td>443</td>
<td>437</td>
<td>414</td>
<td>393</td>
<td>415</td>
</tr>
<tr>
<td>Assistance Added</td>
<td>549</td>
<td>415</td>
<td>397</td>
<td>441</td>
<td>732</td>
<td>523</td>
<td>565</td>
</tr>
<tr>
<td>Assistance Ended</td>
<td>547</td>
<td>455</td>
<td>403</td>
<td>464</td>
<td>753</td>
<td>502</td>
<td>556</td>
</tr>
<tr>
<td>Total Days of Care (DOC)</td>
<td>174,337</td>
<td>162,029</td>
<td>154,383</td>
<td>159,731</td>
<td>151,954</td>
<td>155,356</td>
<td>155,680</td>
</tr>
</tbody>
</table>
Chart 22: Delinquent Residential Services

<table>
<thead>
<tr>
<th>Year</th>
<th>Receiving Care, First Day</th>
<th>Assistance Added</th>
<th>Assistance Ended</th>
<th>Total Days of Care (DOC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>974</td>
<td>1,579</td>
<td>1,669</td>
<td>339,016</td>
</tr>
<tr>
<td>2013/14</td>
<td>884</td>
<td>1,327</td>
<td>1,476</td>
<td>311,448</td>
</tr>
<tr>
<td>2014/15</td>
<td>735</td>
<td>1,052</td>
<td>1,143</td>
<td>255,172</td>
</tr>
<tr>
<td>2015/16</td>
<td>644</td>
<td>797</td>
<td>821</td>
<td>220,220</td>
</tr>
<tr>
<td>2016/17</td>
<td>620</td>
<td>1,136</td>
<td>1,240</td>
<td>189,791</td>
</tr>
<tr>
<td>FY 2017/18</td>
<td>516</td>
<td>995</td>
<td>918</td>
<td>221,728</td>
</tr>
<tr>
<td>FY 2018/19</td>
<td>593</td>
<td>976</td>
<td>930</td>
<td>210,580</td>
</tr>
</tbody>
</table>

3-2e. Aging Out

Insert the Aging Out Chart (Chart 23).

Chart 23: Aging Out

<table>
<thead>
<tr>
<th>Year</th>
<th>Have Permanent Residence</th>
<th>Have Source of Income Support</th>
<th>Have Life Connection</th>
<th>Number of Children Aging Out</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>159</td>
<td>101</td>
<td>131</td>
<td>269</td>
</tr>
<tr>
<td>2013/14</td>
<td>182</td>
<td>140</td>
<td>186</td>
<td>249</td>
</tr>
<tr>
<td>2014/15</td>
<td>172</td>
<td>141</td>
<td>181</td>
<td>248</td>
</tr>
<tr>
<td>2015/16</td>
<td>170</td>
<td>120</td>
<td>179</td>
<td>271</td>
</tr>
<tr>
<td>2016/17</td>
<td>125</td>
<td>93</td>
<td>137</td>
<td>270</td>
</tr>
<tr>
<td>FY 2017/18</td>
<td>156</td>
<td>118</td>
<td>166</td>
<td>263</td>
</tr>
<tr>
<td>FY 2018/19</td>
<td>150</td>
<td>110</td>
<td>161</td>
<td>268</td>
</tr>
</tbody>
</table>
### 3-2f. General Indicators

Insert the complete table from the *General Indicators* tab. **No narrative** is required in this section.

#### 3-2: General Indicators

<table>
<thead>
<tr>
<th>County Number:</th>
<th>51</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class</td>
<td>1</td>
</tr>
</tbody>
</table>

**Philadelphia County**

#### 3-2a. Service Trends

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intake Investigations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td>18,212</td>
<td>19,528</td>
<td>20,229</td>
<td>25,977</td>
<td>27,499</td>
<td>24,568</td>
<td>26,014</td>
<td>51.0%</td>
</tr>
<tr>
<td>Family</td>
<td>14,127</td>
<td>14,922</td>
<td>18,028</td>
<td>19,597</td>
<td>20,613</td>
<td>19,413</td>
<td>19,874</td>
<td>45.9%</td>
</tr>
<tr>
<td><strong>Ongoing Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td>11,365</td>
<td>12,784</td>
<td>15,830</td>
<td>17,614</td>
<td>18,871</td>
<td>16,997</td>
<td>17,052</td>
<td>48.0%</td>
</tr>
<tr>
<td>Family</td>
<td>6,120</td>
<td>6,547</td>
<td>7,594</td>
<td>8,334</td>
<td>8,025</td>
<td>7,984</td>
<td>8,114</td>
<td>31.1%</td>
</tr>
<tr>
<td>Children Placed</td>
<td>6,106</td>
<td>6,445</td>
<td>7,396</td>
<td>8,345</td>
<td>8,650</td>
<td>8,130</td>
<td>8,375</td>
<td>41.7%</td>
</tr>
<tr>
<td><strong>JPO Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Children</td>
<td>5,508</td>
<td>5,018</td>
<td>4,442</td>
<td>3,994</td>
<td>3,637</td>
<td>4,024</td>
<td>3,885</td>
<td>-34.0%</td>
</tr>
<tr>
<td>Community Based Placement</td>
<td>479</td>
<td>372</td>
<td>348</td>
<td>294</td>
<td>257</td>
<td>300</td>
<td>284</td>
<td>-48.3%</td>
</tr>
<tr>
<td>Institutional Placements</td>
<td>2,055</td>
<td>1,869</td>
<td>1,703</td>
<td>1,530</td>
<td>1,572</td>
<td>1,602</td>
<td>1,568</td>
<td>-23.5%</td>
</tr>
</tbody>
</table>

#### 3-2b. Adoption Assistance

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adoption Assistance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receiving Care, First Day</td>
<td>5,245</td>
<td>5,114</td>
<td>5,049</td>
<td>5,239</td>
<td>5,166</td>
<td>5,312</td>
<td>5,239</td>
<td>-1.5%</td>
</tr>
<tr>
<td>Assistance Added</td>
<td>395</td>
<td>474</td>
<td>428</td>
<td>471</td>
<td>559</td>
<td>486</td>
<td>505</td>
<td>41.5%</td>
</tr>
<tr>
<td>Assistance Ended</td>
<td>526</td>
<td>539</td>
<td>238</td>
<td>544</td>
<td>413</td>
<td>559</td>
<td>543</td>
<td>-21.5%</td>
</tr>
<tr>
<td>Total Days of Care (DOC)</td>
<td>1,867,179</td>
<td>1,849,128</td>
<td>1,869,482</td>
<td>1,949,824</td>
<td>1,914,709</td>
<td>1,911,338</td>
<td>1,925,290</td>
<td>2.5%</td>
</tr>
</tbody>
</table>

#### 3-2c. SPLC

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Subsidized Permanent Legal Custodianship</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receiving Care, First Day</td>
<td>1,829</td>
<td>1,661</td>
<td>1,571</td>
<td>1,429</td>
<td>1,200</td>
<td>1,083</td>
<td>1,241</td>
<td>-34.4%</td>
</tr>
<tr>
<td>Assistance Added</td>
<td>150</td>
<td>172</td>
<td>106</td>
<td>155</td>
<td>159</td>
<td>140</td>
<td>151</td>
<td>6.0%</td>
</tr>
<tr>
<td>Assistance Ended</td>
<td>318</td>
<td>262</td>
<td>248</td>
<td>384</td>
<td>266</td>
<td>299</td>
<td>316</td>
<td>-16.4%</td>
</tr>
<tr>
<td>Total Days of Care (DOC)</td>
<td>634,192</td>
<td>595,557</td>
<td>539,445</td>
<td>493,035</td>
<td>414,599</td>
<td>482,360</td>
<td>463,331</td>
<td>-34.6%</td>
</tr>
</tbody>
</table>
### 3-2d. Placement Data

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Traditional Foster Care (non-kinship) - Dependent</th>
<th>Traditional Foster Care (non-kinship) - Delinquent</th>
<th>Reimbursed Kinship Care - Dependent</th>
<th>Reimbursed Kinship Care - Delinquent</th>
<th>Foster Family Care - Dependent</th>
<th>Foster Family Care - Delinquent (Total of 2 above)</th>
<th>Non-reimbursed Kinship Care - Dependent</th>
<th>Non-reimbursed Kinship Care - Delinquent</th>
<th>Alternative Treatment Dependent</th>
<th>Alternative Treatment Delinquent</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>1,668</td>
<td>8</td>
<td>1,307</td>
<td>2,975</td>
<td>8</td>
<td>25</td>
<td>0</td>
<td>0</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>2013/14</td>
<td>1,858</td>
<td>8</td>
<td>1,381</td>
<td>3,239</td>
<td>8</td>
<td>30</td>
<td>0</td>
<td>0</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>2014/15</td>
<td>2,072</td>
<td>6</td>
<td>1,716</td>
<td>3,788</td>
<td>6</td>
<td>37</td>
<td>0</td>
<td>0</td>
<td>37</td>
<td>37</td>
</tr>
<tr>
<td>2015/16</td>
<td>2,287</td>
<td>5</td>
<td>2,339</td>
<td>4,626</td>
<td>5</td>
<td>51</td>
<td>0</td>
<td>0</td>
<td>51</td>
<td>51</td>
</tr>
<tr>
<td>2016/17</td>
<td>2,308</td>
<td>3</td>
<td>2,865</td>
<td>5,173</td>
<td>3</td>
<td>65</td>
<td>0</td>
<td>0</td>
<td>65</td>
<td>65</td>
</tr>
<tr>
<td>Projected FY 2017/18</td>
<td>2,317</td>
<td>1</td>
<td>2,775</td>
<td>5,092</td>
<td>1</td>
<td>80</td>
<td>0</td>
<td>0</td>
<td>80</td>
<td>80</td>
</tr>
<tr>
<td>FY 2018/19</td>
<td>2,304</td>
<td>3</td>
<td>2,660</td>
<td>4,964</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>% Change</td>
<td>-38.4%</td>
<td>-62.5%</td>
<td>-119.2%</td>
<td>-73.9%</td>
<td>-124.1%</td>
<td>-62.5%</td>
<td>0</td>
<td>0</td>
<td>-62.5%</td>
<td>-62.5%</td>
</tr>
</tbody>
</table>
### Dependent Community Residential

<table>
<thead>
<tr>
<th>Receiving Care, First Day</th>
<th>Assistance Added</th>
<th>Assistance Ended</th>
<th>Total Days of Care (DOC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philadelphia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY 2018-19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent Community</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receiving Care, First Day</td>
<td>467</td>
<td>411</td>
<td>360</td>
</tr>
<tr>
<td>Assistance Added</td>
<td>685</td>
<td>532</td>
<td>461</td>
</tr>
<tr>
<td>Assistance Ended</td>
<td>741</td>
<td>583</td>
<td>429</td>
</tr>
<tr>
<td>Total Days of Care (DOC)</td>
<td>157,519</td>
<td>144,948</td>
<td>137,545</td>
</tr>
</tbody>
</table>

### Delinquent Community Residential

<table>
<thead>
<tr>
<th>Receiving Care, First Day</th>
<th>Assistance Added</th>
<th>Assistance Ended</th>
<th>Total Days of Care (DOC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philadelphia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY 2018-19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent Community</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receiving Care, First Day</td>
<td>161</td>
<td>127</td>
<td>117</td>
</tr>
<tr>
<td>Assistance Added</td>
<td>292</td>
<td>202</td>
<td>187</td>
</tr>
<tr>
<td>Assistance Ended</td>
<td>326</td>
<td>212</td>
<td>202</td>
</tr>
<tr>
<td>Total Days of Care (DOC)</td>
<td>63,129</td>
<td>46,250</td>
<td>43,158</td>
</tr>
</tbody>
</table>

### Supervised Independent Living Dependent

<table>
<thead>
<tr>
<th>Receiving Care, First Day</th>
<th>Assistance Added</th>
<th>Assistance Ended</th>
<th>Total Days of Care (DOC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philadelphia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY 2018-19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervised Independent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living Dependent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receiving Care, First Day</td>
<td>184</td>
<td>221</td>
<td>161</td>
</tr>
<tr>
<td>Assistance Added</td>
<td>195</td>
<td>92</td>
<td>62</td>
</tr>
<tr>
<td>Assistance Ended</td>
<td>158</td>
<td>152</td>
<td>137</td>
</tr>
<tr>
<td>Total Days of Care (DOC)</td>
<td>69,290</td>
<td>80,837</td>
<td>52,383</td>
</tr>
</tbody>
</table>

### Supervised Independent Living Delinquent

<table>
<thead>
<tr>
<th>Receiving Care, First Day</th>
<th>Assistance Added</th>
<th>Assistance Ended</th>
<th>Total Days of Care (DOC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philadelphia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY 2018-19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervised Independent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living Delinquent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receiving Care, First Day</td>
<td>52</td>
<td>35</td>
<td>40</td>
</tr>
<tr>
<td>Assistance Added</td>
<td>57</td>
<td>63</td>
<td>46</td>
</tr>
<tr>
<td>Assistance Ended</td>
<td>74</td>
<td>58</td>
<td>54</td>
</tr>
<tr>
<td>Total Days of Care (DOC)</td>
<td>14,248</td>
<td>14,155</td>
<td>13,566</td>
</tr>
</tbody>
</table>

### Juvenile Detention

<table>
<thead>
<tr>
<th>Receiving Care, First Day</th>
<th>Assistance Added</th>
<th>Assistance Ended</th>
<th>Total Days of Care (DOC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philadelphia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY 2018-19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Juvenile Detention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receiving Care, First Day</td>
<td>88</td>
<td>99</td>
<td>126</td>
</tr>
<tr>
<td>Assistance Added</td>
<td>3,111</td>
<td>2,321</td>
<td>2,247</td>
</tr>
<tr>
<td>Assistance Ended</td>
<td>3,100</td>
<td>2,294</td>
<td>2,264</td>
</tr>
<tr>
<td>Total Days of Care (DOC)</td>
<td>38,240</td>
<td>38,600</td>
<td>45,031</td>
</tr>
</tbody>
</table>

### Dependent Residential Services

<table>
<thead>
<tr>
<th>Receiving Care, First Day</th>
<th>Assistance Added</th>
<th>Assistance Ended</th>
<th>Total Days of Care (DOC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philadelphia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY 2018-19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent Residential</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receiving Care, First Day</td>
<td>481</td>
<td>483</td>
<td>443</td>
</tr>
<tr>
<td>Assistance Added</td>
<td>549</td>
<td>415</td>
<td>397</td>
</tr>
<tr>
<td>Assistance Ended</td>
<td>547</td>
<td>455</td>
<td>403</td>
</tr>
<tr>
<td>Total Days of Care (DOC)</td>
<td>174,337</td>
<td>162,029</td>
<td>154,383</td>
</tr>
</tbody>
</table>

### Delinquent Residential Services

<table>
<thead>
<tr>
<th>Receiving Care, First Day</th>
<th>Assistance Added</th>
<th>Assistance Ended</th>
<th>Total Days of Care (DOC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philadelphia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY 2018-19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delinquent Residential</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receiving Care, First Day</td>
<td>974</td>
<td>884</td>
<td>735</td>
</tr>
<tr>
<td>Assistance Added</td>
<td>1,579</td>
<td>1,327</td>
<td>1,052</td>
</tr>
<tr>
<td>Assistance Ended</td>
<td>1,669</td>
<td>1,476</td>
<td>1,143</td>
</tr>
<tr>
<td>Total Days of Care (DOC)</td>
<td>339,016</td>
<td>311,448</td>
<td>255,172</td>
</tr>
</tbody>
</table>

### 3-2e. Aging Out Data

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Aging Out</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Children Aging Out</td>
<td>269</td>
<td>249</td>
<td>248</td>
<td>271</td>
<td>270</td>
<td>263</td>
<td>268</td>
<td>0.4%</td>
</tr>
<tr>
<td>Have Permanent Residence</td>
<td>159</td>
<td>182</td>
<td>172</td>
<td>170</td>
<td>125</td>
<td>156</td>
<td>150</td>
<td>-21.4%</td>
</tr>
<tr>
<td>Have Source of Income Support</td>
<td>101</td>
<td>140</td>
<td>141</td>
<td>120</td>
<td>93</td>
<td>118</td>
<td>110</td>
<td>-7.9%</td>
</tr>
<tr>
<td>Have Life Connection</td>
<td>131</td>
<td>186</td>
<td>181</td>
<td>179</td>
<td>137</td>
<td>166</td>
<td>161</td>
<td>4.6%</td>
</tr>
</tbody>
</table>
3-2g. through 3-2i. Charts

Insert up to three additional charts that capture the usage and impact of prevention, diversion and/or differential response activities. Each chart should be pasted on a separate page.

At this time, DHS does not have the capability to produce reports that measure the full impact of our prevention, diversion and differential response services because our Prevention Services data system is completely separate from our Child Welfare data system. To measure impact, we need to match data on children, youth, and families who experienced both systems.

See 2-2b Data Collection Details for information on the development of the Integrated Case Management System (ICMS) that will integrate Prevention Services with formal Child Welfare Services to give DHS a more holistic picture of how our Prevention Services impact our Child Welfare systems. The first phase of the ICMS roll out is scheduled for January 2019. We will be able to monitor:
- The outcomes of children, youth, and families who were subjects of abuse and neglect reports and referred to a Prevention service instead of being accepted for child protective services.
- The impact of Prevention Services for families at-risk for child welfare involvement who were successfully diverted through a Prevention program.

Chart Analysis for 3-2a. through 3-2i.

**NOTE:** These questions apply to both the child welfare and the juvenile justice agencies

☐ Discuss any highlighted child welfare and juvenile justice service trends and describe factors contributing to the trends in the previous charts.

It appears that the strategies implemented to focus on accept for service decisions and increasing permanency are producing positive results. It is anticipated that continuation of targeted strategies and other initiatives (e.g., Rapid Permanency Reviews and Prevention Realignment) should help further reduce the growth in the number of children, youth, and families receiving services.

Service Trends:
Despite continued growth in referrals and investigations, trends in ongoing services, cases accepted for service, CWO children served, CWO families served, and dependent foster care placements have stabilized in the last fiscal year. Numbers are projected to remain consistent in the next two fiscal years.

The number of new referrals accepted for investigation continues to increase at a rate of six and a half percent. Investigations are projected to increase by six percent next year.

Comparing data from this year’s submission with last year’s submission helps to illustrate that numbers of children and youth served is stabilizing even though there was an increase over the last five years. Between FY 2011-12 and FY 2015-16, the percentage and number of children served increased by 59% or 6,577 children and youth. However, from FY 2012-13 to FY 2016-17, the percentage and number of children and youth served increased by 48% or 5,454 children and youth.
Five-year trends show that there has been a substantial increase in Adoption subsidies (42%), while also seeing a sizable decrease in the termination of both Adoption (-21.5%) and Permanent Legal Custodianship subsidies (-16%). The five year trends have also shown a decrease in the Total Days of Care of Permanent Legal Custodianship (-35%). Findings from DHS’s monitoring of permanency rates for FY 2016-17 show 2,002 children and youth left placement for a permanent home, an overall increase of 8% from FY 2015-16. While Reunification continues to be the primary outcome at 62%, Adoptions saw an increase by 29% over the previous fiscal year, which is consistent with the five-year trends found in the General Indicators data. Note: the permanency numbers here reflect those children discharged to permanency during the FY 2016-17 and were pulled from FACTS/FACTS2 Data Warehouse.

Dependent Placement Trends:
Although investigations and the use of foster family care as a placement setting have increased, most ongoing placement services have either decreased or stabilized because of systemic changes implemented by DHS. Additionally, the number of days in care has increased, but is projected to stabilize in the next two fiscal years due to ongoing implementation of targeted permanency strategies and front-end initiatives designed to reduce entries in placement.

Despite the surge in the number of children in placement, DHS has been successful in its use of the least restrictive placement settings by placing more children in family-like settings. Over the five-year reporting period, there was a 74% increase in the number of children and youth in Foster Family Care. From FY 2015-16 to FY 2016-17, there was a 12% increase in number of youth in Foster Family Care. Overall, the annual average growth rate from FY 2011-12 to FY 2016-17 for children in Foster Family Care has been 15%. Of the children and youth placed in foster family care, placement in Kinship Care increased substantially more than in non-kin foster family care. Reimbursed Kinship Care has seen a 119% increase from FY 2012-13 to FY 2016-17, while non-Kin Traditional Foster Family Care has only seen a 38% increase. Traditional Foster Care has remained stable since FY 2014-15, and is expected to remain consistent for the next two fiscal years.

In addition, there was a 15% decrease in the use of Dependent Community Residential placement (group home placements) and a 14% decrease in the use of Dependent Residential Services (institutional placements).

Juvenile Delinquent Trends:
See response to JJS services below

Discuss any important trends that may not be highlighted.

An analysis conducted by the Division of Performance Management and Technology (PMT) of investigations and accept for services data showed that the accept-for-service rate increased dramatically between FY 2012-13 and FY 2013-14, continuing to increase through FY 2014-15, before decreasing to 15% in FY 2015-16, and remaining at 15% for FY 2016-17.

While Philadelphia has seen a dramatic reduction in violence over the past decade, the accessibility of deadly weapons has continued to plague cities and states across the country. There has been an 18 percent increase in homicide victims this year, compared
Philadelphia

with the same point in time last year, and gun assaults are up by more than 4%, according to recent reports. While juveniles are not exclusively responsible for these increases, some are contributors. And while gun violence can happen anywhere, it disproportionately affects those communities in which families are at a higher risk for involvement with formal child welfare services or juvenile justice services. The Philadelphia DHS Deputy Commissioner of Juvenile Justice Services is co-chairing the Social Services and Opportunities subcommittee of the newly created Special Committee on Gun Violence Prevention and will have a voice in whatever innovations come from the think tank that the City is convening. Philadelphia is respectfully requesting funding to support development and implementation of the recommendations for preventing gun violence that are applicable to children, youth, and families at risk for involvement in child welfare or juvenile justice services.

- Identify the impact of established Shared Case Responsibility (SCR) practices within the county.

In FY 2016-17, DHS served 707 youth identified as SCR, down from 943 in FY 2015-16. A youth can enter an SCR status multiple times throughout the life of their involvement with the Department. Shared Case Responsibility provides an opportunity to provide a wider array of services to youth who are under probation supervision and have child welfare, or dependency issues. SCR ensures that appropriate services are provided to address all identified needs. In accordance with Philadelphia DHS policy, DHS and the Philadelphia Juvenile Probation Office actively work together to achieve permanency for Shared Case Responsibility youth. SCR youth in dependent placements are part of the Permanency strategy detailed in the Program Improvement Strategies section of the Narrative.

- Describe what changes in agency priorities or programs, if any, have contributed to changes in the number of children and youth served or in care and/or the rate at which children are discharged from care.

The size of our system appears to have finally stabilized. The following priorities and programs had been put in place and, we believe, have contributed to this:

**Child Welfare**

- **Child Welfare Demonstration Project (CWDP)** - DHS, in partnership with the Community Umbrella Agencies (CUAs) and the City’s Community Behavioral Health (CBH), continues to move forward on the three components of the CWDP: engagement, assessment, and Evidence-Based Practices (EBPs). The component that has had the most effect on changes in the number of children and youth served or in care or the rate at which children and youth are discharged from care is the engagement component.

DHS and the CUAs continue to engage families and stakeholders in Family Team Conferences (FTC) to support the four goals of IOC. There has been an increased focus on enhancing the quality of the conferences and focus has shifted from implementation to refinement of the engagement process. Data from the state-led CWDP family engagement evaluation indicate that Philadelphia has maintained a high degree of fidelity to the intended FTC model. Philadelphia DHS continues to work on ensuring quality participation in the FTCs by families and their informal supports.
Philadelphia

- Conduct Permanency Reviews - In partnership with Casey Family Programs, in 2015 DHS began conducting a case-by-case analysis of children and youth who had been in care two plus years to address barriers to permanency. Case reviews were extended to youth with court-identified goals of APPLA, and then to children and youth with finalized adoptions but whose cases had not been closed. Growing out of this intensive permanency review, DHS, continuing to partner with Casey Family Programs, developed and began implementing the Rapid Permanency Review process to eliminate barriers for families that are close to reaching permanency. Please see Program Improvement Strategies for implementation update and plans for full system roll-out.

- Rightsizing Congregate Care – See response to question regarding county’s use of congregate care.

- Efforts to increase use of kinship - Full implementation of IOC has had a positive effect on the use of kin as resource homes for children and youth who need out-of-home care. Family outreach and engagement is an integral part of the CUAs’ work under IOC. Additionally, DHS revised policy, consistent with regulations and PaDHS guidance, in order to promote use of kinship resource homes. Efforts to increase use of kinship resource homes also include encouraging application for waivers of non-safety related licensing requirements, and use of Family Finding, and Accurint. See Program Improvement Strategies for more detail on use of Family Finding to increase kin resources available to children and youth.

- Use of SWAN services - The use of SWAN services as part of Philadelphia’s strategy to improve timely permanency has created a demand for SWAN Services. Philadelphia DHS will continue to reach out to the Achieving Independence Center for referrals for Child Specific Recruitment, Child Prep, and Child Profiles for older youth with a goal of APPLA. Philadelphia also continues to encourage case managers to request SWAN services for children and youth who have been in care for six months or longer.

- “Closing the Loop” meetings - Meetings held to brainstorm and provide technical assistance to CUAs to support improved performance. These meetings are related to the roll-out of the CUA Scorecard.

- Administrative review process required for placement - A policy and process has been put in place requiring conference with and approval by an Administrator or above prior to seeking orders removing a children or youth from their home. The consultation must include a discussion regarding the dependency issues and explore less restrictive resources that will ensure safety prior to removing children and youth. CWO staff are encouraged to familiarize themselves with available resources and alternatives to removal, such as emergency family shelters when family conditions are due to environmental factors and there are no other dependency issues.
Philadelphia

Juvenile Justice Services

Though the numbers of arrested youth in Philadelphia for whom petitions were filed continues to decline as it has over the course of the past several years, it has not translated into a decrease in our use of secure detention. Detention numbers have remained steady or have increased over the previous fiscal year, and lengths of stay have increased. The Juvenile Justice System Enhancement Strategy (JJSES), the Juvenile Detention Alternatives Initiative (JDAI), and other strategies have had an impact on risk, responsivity, and overall recidivism. The Philadelphia Juvenile Justice System is committed to address criminogenic factors through diversionary programs at the front end, adequate reintegration on the back end, the use of assessments at critical junctures, and developing a graduated approach as part of Stage 3 of the JJSES model. The use of Graduated Response has contributed to fewer youth being placed and more being referred to community-based programming. See Program Improvement Strategies and the Executive Summary for more detail regarding Graduated Response.

- Increased Census at the Philadelphia Juvenile Justice Services Center (PJJSC) - We saw a slow but steady incline in case processing from 15.18 days in the first quarter of 2016 to 17 days by the first quarter of 2017. If lengths of stay continue to increase at the current pace, we will reach an average 18.5 days length of stay by the end of this calendar year. Also, an increased percentage of youth were held out of detention hearings; the percentage increased from 35.11% to 62.2% between January 2016 and the end of the year. Detention decisions are made at the discretion of the assigned hearing detention officer and informed by PaDRAI scores. In some cases, the youth’s assigned judge decides that the youth not be released subsequent to apprehension or surrender. Finally, one of our community-based detention shelters closed, with the loss of 20 beds for youth who must otherwise be placed in secure detention, and our remaining community-based detention Provider reduced the numbers of beds available for our use during this same period.

- Youth Level of Service - In July 2014, Philadelphia’s Youth Level of Service (YLS) policy was restructured in line with recommendations of the Juvenile Court Judges Commission such that the initial YLS assessment is conducted prior to adjudicatory hearings. Identifying the risk and needs of youth in the early stages has allowed for structured decision making at critical junctures in the Juvenile Justice System.

- Pennsylvania Detention Risk Assessment Instrument (PaDRAI) - Philadelphia, as one of the State’s pilot sites for the Annie E. Casey Foundation’s Juvenile Detention Alternatives Initiative (JDAI), has been using the PaDRAI since August 2013 to implement the JDAI core strategy of objective decision-making processes. The design and implementation of the PaDRAI provides an objective admissions tool, has resulted in a more fair and consistent admissions policy, and is aligned with the Balanced and Restorative Justice principles as well as the JJSES for Pennsylvania. The PaDRAI is conducted at the time of arrest on all new arrests in Philadelphia, and has been built into the Juvenile Case Management System (JCMS), so that it is used consistently. Results from local data analysis support the utilization of the PaDRAI; the low discretionary override rate is consistent with both the findings of the Validation Study and JDAI literature regarding adherence to indicated decisions and buy-in by intake interviewers.
Global Position System (GPS) Monitoring - The use of GPS monitoring provides efficient alternatives to detention and alternatives to placement within the juvenile justice system. See Executive Summary for details.

Post-Adjudication Evening Reporting Center (ERC) - The ERC is directly aligned with Balanced and Restorative Justice Principles of community safety through GPS monitoring and prevention of re-arrest, accountability through required attendance, and competency development through extensive programming. See Executive Summary for details.

Data-informed decisions - A very important priority for the Juvenile Justice System, as stated in the Executive Summary, is to have quality data, information sharing, and appropriate statistical analysis for all stakeholders across the system because data-informed decisions are a core component of JDAI.

Are there any demographic shifts which impact the proportions of children and youth in care (for example, are younger children making up a larger proportion of admissions than in years past)?

In a five year comparison, shown below, the percent of children and youth over age ten in placement decreased from 56% of the children and youth on 06/30/2012, to approximately 46% on June 30, 2017. Youth 13 years of age and older represented 47% of the children and youth in care on June 30, 2012 and 34% of the population on June 30, 2017. It is notable that, while the total number of youth in care aged 13 years and older increased, the number of youth residing in a congregate care settings decreased. We are placing fewer youth into group homes and institutions, even while the system has experienced rapid and significant growth in placements.

### Children & Youth in Dependent Placement on 06/30/2017

<table>
<thead>
<tr>
<th>Placement Type</th>
<th>0 to 4</th>
<th>5 to 9</th>
<th>10 to 12</th>
<th>13 to 17</th>
<th>18 to 21</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kinship Care</td>
<td>1002</td>
<td>753</td>
<td>386</td>
<td>495</td>
<td>133</td>
<td>2769</td>
</tr>
<tr>
<td>Foster Care</td>
<td>804</td>
<td>637</td>
<td>306</td>
<td>445</td>
<td>123</td>
<td>2315</td>
</tr>
<tr>
<td>Group Home</td>
<td>9</td>
<td>5</td>
<td>9</td>
<td>276</td>
<td>66</td>
<td>365</td>
</tr>
<tr>
<td>Institution</td>
<td>0</td>
<td>7</td>
<td>27</td>
<td>265</td>
<td>45</td>
<td>344</td>
</tr>
<tr>
<td>SIL</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>126</td>
<td>129</td>
</tr>
<tr>
<td>Zero Rate CUA</td>
<td>26</td>
<td>16</td>
<td>8</td>
<td>23</td>
<td>5</td>
<td>78</td>
</tr>
<tr>
<td>Emergency Shelter</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>46</td>
<td>6</td>
<td>53</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1841</strong></td>
<td><strong>1418</strong></td>
<td><strong>737</strong></td>
<td><strong>1553</strong></td>
<td><strong>504</strong></td>
<td><strong>6053</strong></td>
</tr>
<tr>
<td>Age Range</td>
<td>30.4%</td>
<td>23.4%</td>
<td>12.2%</td>
<td>25.7%</td>
<td>8.3%</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Children in Care Age 13 and over</th>
<th>Number</th>
<th>2057</th>
</tr>
</thead>
<tbody>
<tr>
<td>As % of total in placement</td>
<td>34.0%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Children in Congregate Care</th>
<th>Number</th>
<th>762</th>
</tr>
</thead>
<tbody>
<tr>
<td>As % of total in placement</td>
<td>12.6%</td>
<td></td>
</tr>
</tbody>
</table>
Philadelphia

<table>
<thead>
<tr>
<th>Placement Type</th>
<th>0 to 4</th>
<th>5 to 9</th>
<th>10 to 12</th>
<th>13 to 17</th>
<th>18 to 21</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kinship Care</td>
<td>502</td>
<td>303</td>
<td>117</td>
<td>253</td>
<td>101</td>
<td>1276</td>
</tr>
<tr>
<td>Foster Care</td>
<td>582</td>
<td>369</td>
<td>212</td>
<td>333</td>
<td>145</td>
<td>1641</td>
</tr>
<tr>
<td>Group Home</td>
<td>2</td>
<td>7</td>
<td>7</td>
<td>343</td>
<td>80</td>
<td>439</td>
</tr>
<tr>
<td>Institution</td>
<td>0</td>
<td>6</td>
<td>33</td>
<td>380</td>
<td>61</td>
<td>480</td>
</tr>
<tr>
<td>SIL</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>11</td>
<td>157</td>
<td>168</td>
</tr>
<tr>
<td>Zero Rate CUA</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Emergency Shelter</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>37</td>
<td>2</td>
<td>41</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1086</strong></td>
<td><strong>685</strong></td>
<td><strong>371</strong></td>
<td><strong>1357</strong></td>
<td><strong>546</strong></td>
<td><strong>4045</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Children in Care Age 13 and over</th>
<th>Number</th>
<th>As % of total in placement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1903</td>
<td>47.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Children in Congregate Care</th>
<th>Number</th>
<th>As % of total in placement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>960</td>
<td>23.7%</td>
</tr>
</tbody>
</table>

- Describe the county’s use of congregate care – provide an overview description of children/youth placed in congregate care settings and describe the county’s process related to placement decisions.

As of June 30, 2017, Philadelphia’s use of congregate care was 12.6%, down from 23.7% on June 30, 2012 and below the national average of 13%. DHS will continue to pursue its successful efforts to reduce the use of congregate care, and to make judicious use of congregate care as a stop-gap measure for emergency placements while appropriate, less restrictive settings are located so that children and youth do not stay overnight in the Department’s Child Care room.

Two processes in place continue to be successful in reducing use of congregate care settings and improving outcomes for youth: the Commissioner's Approval Process and clear guidelines for the use of this level of care. It continues to be a DHS priority to increase the use of resource home care, particularly kinship care, for children and youth needing care. This priority is being pursued by increasing resource home recruiting, increasing the per diem rate for resource home parents, and issuing a policy that supports the practice of requiring Accurint Searches and Family Finding for any child or youth who is not placed in kinship care. While the Department has utilized Expedited Permanency Meetings (EPMs) in the past as a strategy to reduce the reliance on congregate care, the EPMs will no longer be a teaming meeting that is separate from the Family Team Conferences (FTCs). Instead, the promising practices of the EPMs will be incorporated in the FTCs.
Philadelphia

How has the county adjusted staff ratios and/or resource allocations (both financial and staffing, including vacancies, hiring, turnover, etc.) in response to a change in the population of children and youth needing out-of-home care? Is the county’s current resource allocation appropriate to address projected needs?

Child Welfare Operations

- Child care room strategy.
  - Increase the number of emergency resource home beds - Philadelphia DHS is diligently working to eliminate the use of overnight stays in the Child Care Room. In order to do this, the county has implemented the following changes:
    - Philadelphia DHS currently has 60 emergency foster care resource beds available, with the beds almost filled to capacity. DHS is working on expanding the emergency foster care resource bed capacity to at least have 85 available beds.
    - As of June 26, 2017, DHS has centralized the responsibility to secure all placements through the Central Referral Unit (CRU) division at DHS. Exploration of kin relatives will have to be completed prior to the child and/or youth entering placement.
    - DHS has established a list of emergency foster care parents that is updated daily and provided to the after-hours staff as well as to the on-call directors.
    - If there is a child or youth in jeopardy of spending the night in the child care room, the emergency foster care providers will be contacted.
    - The emergency foster care rate for foster parents is $112.53 for children ages 0-12 and $122.53 for children over the age of 13. The rate includes a mandatory per diem maintenance payment of $50 to the emergency resource parent.
      - The expectations of all foster parents are to address the child or youth’s daily needs including but not limit to: behavioral and physical health as well as their educational needs.
      - This service is provided for up to 10 business days, special permission from the Commissioner is needed if the placement will be beyond 7 days, and its use is closely monitored by DHS staff.
  - Increase the number of emergency shelter beds - In addition to increasing the number of emergency foster care resources, DHS is also expanding emergency group home shelter beds by an additional 16 (8 female and 8 male beds). This RFP will be issued during the Summer of 2017.
  - Continue to have tight controls on use of the room.

- Administrative review process required for placing children and youth in out of home care.
  
  See also Prevention Realignment in Program Improvement Strategies for additional placement diversion strategies.

- Efforts to increase use of kinship.
  
  See Program Improvement Strategies for more detail on use of Family Finding to increase kin resources available to children and youth.

- Reduce CUA CM caseloads.

- Transition of staff from OSR to Front-end, Adoptions, Teaming, and CUA practice supports.

The Ongoing Service Region currently has 23 Social Work Services Managers (Workers) assigned to the section, and they are responsible for 240 families. Approximately 50% of the 240 families that are being case managed by these Workers
Philadelphia

are due to the Department’s inability to transfer the cases to the CUAs. The barrier to transferring the cases was due to waiting for the Specialized Behavioral Health Scope of Services and rate to be finalized. The Scope and the rate were effective, July 1, 2017; therefore, the Department will begin to transfer the cases to the CUAs. As the cases are transferred to the CUAs, the Workers will transfer to other sections in the Department to support the goals of IOC.

- Reduce Solicitor caseloads.
  See Program Improvement Strategies for support for the work of the new Solicitors and enhanced work provided by the Philadelphia Law Department related to permanency.
- Implement revised Family Service Plans and Child Permanency Plans that include mandatory concurrent planning goals, objectives, and actions for cases that are managed by the DHS side of Child Welfare Operations.
- Implement annual credit checks for youth age 14 and older.
- Rapid Permanency Reviews.
  See Program Improvement Strategies for implementation update and plans for full system roll-out.
- Resource capacity – increase and stabilize – see response in 3-1 County Fiscal Background.
- Increase use of permanency supportive services – SWAN.
  See response above to question regarding describing changes in agency priorities or programs, if any, which have contributed to changes in the number of children and youth served or in care and/or the rate at which children are discharged from care. See also use of SWAN services for older youth in the Independent Living Services grant narrative under 4-3b. Permanency and Older Youth Initiative.
- Use Prevention Services to stabilize and support permanency and reduce re-entry.
  See Prevention Realignment in Program Improvement Strategies for use of Prevention Services to support permanency.

Juvenile Justice
- PJJSC Staffing - The PJJSC is required to meet specific staffing ratios during all shifts as mandated by the State and Court Order, and to meet security needs during transportation, intake, activities, etc. With the current census and existing staffing levels, these ratios can only be fully met through the use of overtime, including mandatory overtime. The PJJSC census has increased 13.4% compared to Fiscal 2016. The average daily population can be misleading in understanding the staffing needs of the Center on a daily basis which drives overtime costs both voluntary and mandated. The Fiscal 2017 average daily census was 115.7 compared to 100.23 for Fiscal 2016. However, over the last quarter of Fiscal 2017 the Center had the following census above the Fiscal average: ten days at 120 youth; 27 days at 130 youth; 54 days at 140 youth; 28 days at 150 youth; and three days at 160 youth. The higher census causes a strain on mandated staffing ratios. Mandated overtime has been a major factor contributing to the ability to retain new Youth Detention Counselor staff at the PJJSC. **DHS is requesting full funding for Youth Detention Counselor positions in order to reduce dependency on overtime, particularly mandated overtime.** It is anticipated that this will increase the quality of care by reducing the number of hours worked by a fatigued workforce, and assist in retention of new Youth Detention Counselors.
Philadelphia

Additionally, see the programs and priorities included in the Program Improvement Strategies section and in response to the question regarding changes in agency priorities or programs that affect numbers of children and youth receiving services, in care, or the rate of discharge from care.

3-4 Program Improvement Strategies

Counties may opt out of completing all or parts of this section if the information in captured in a:

- CWDP CCYAs IDIR-U and the plan is submitted as an attachment; or
- Phase I – VI Continuous Quality Improvement (CQI) CCYAs County Improvement Plan (CIP) and the plan is submitted as an attachment; or
- County’s formalized strategic plan (child welfare and/or juvenile justice) and the plan is submitted as an attachment.

Counties must identify the areas for improvement that are the focus of CIPs, IDIR-U, or other strategic plans, including those in response to the CFSR findings that are in planning stages or under implementation in FY 2017-18 and FY 2018-19 that address both child welfare and juvenile justice populations.

Counties must select a minimum of three Outcome Indicator charts that are relevant to their identified Program Improvement Strategies. County JPOs should also include charts relevant to their program improvement strategies. Counties participating in the federal CFSR case reviews may elect to substitute federal safety, permanency, and well-being outcomes evaluated during the review as their identified areas of improvement and reference data available in the reports provided through the CFSR Online Monitoring System (OMS).

Counties who are below the national standard for re-entry must select an area of improvement.

- CWDP counties must select Outcome Indicators that are reflective of targeted outcomes of their Demonstration Project design.
Philadelphia

Population Flow*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>30-Sep-12</td>
<td>1,903</td>
<td>1,747</td>
<td>1,959</td>
<td>2,016</td>
<td>2,443</td>
<td>2,267</td>
<td>2,317</td>
<td>1,991</td>
<td>1,658</td>
<td>1,357</td>
</tr>
<tr>
<td>31-Mar-13</td>
<td>1,891</td>
<td>1,673</td>
<td>1,742</td>
<td>1,738</td>
<td>2,381</td>
<td>1,542</td>
<td>1,866</td>
<td>2,533</td>
<td>1,714</td>
<td>1,504</td>
</tr>
<tr>
<td>30-Sep-13</td>
<td>4,490</td>
<td>4,551</td>
<td>4,727</td>
<td>4,965</td>
<td>5,105</td>
<td>5,768</td>
<td>6,217</td>
<td>5,749</td>
<td>5,813</td>
<td>5,666</td>
</tr>
<tr>
<td>31-Mar-14</td>
<td>6,036</td>
<td>5,850</td>
<td>6,095</td>
<td>6,295</td>
<td>6,725</td>
<td>6,941</td>
<td>7,645</td>
<td>7,855</td>
<td>7,184</td>
<td>6,993</td>
</tr>
<tr>
<td>30-Sep-14</td>
<td>395,656</td>
<td>393,874</td>
<td>393,874</td>
<td>392,704</td>
<td>392,704</td>
<td>392,618</td>
<td>392,618</td>
<td>392,618</td>
<td>392,618</td>
<td>392,618</td>
</tr>
<tr>
<td>31-Mar-17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Numbers may vary from year to year to do data drift as per conversation with Hornby-Zeller on 07/11/2017. The numbers are small and do not affect the overall percentages and/or trends.
## Permanency Data:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>31-Mar</td>
<td>30-Sep</td>
<td>31-Mar</td>
<td>30-Sep</td>
<td>31-Mar</td>
<td>30-Sep</td>
<td>31-Mar</td>
<td>30-Sep</td>
<td>31-Mar</td>
<td>30-Sep</td>
</tr>
<tr>
<td><strong>Philadelphia</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total in Care 24+ Months</td>
<td>1,128</td>
<td>1,137</td>
<td>1,135</td>
<td>1,219</td>
<td>1,327</td>
<td>1,410</td>
<td>1,420</td>
<td>1,524</td>
<td>1,646</td>
<td>1,592</td>
</tr>
<tr>
<td>Discharges to Permanent Home</td>
<td>394</td>
<td>371</td>
<td>363</td>
<td>363</td>
<td>455</td>
<td>458</td>
<td>437</td>
<td>606</td>
<td>733</td>
<td>642</td>
</tr>
<tr>
<td>Percent</td>
<td>34.93%</td>
<td>32.63%</td>
<td>31.98%</td>
<td>29.78%</td>
<td>34.29%</td>
<td>32.48%</td>
<td>30.77%</td>
<td>39.76%</td>
<td>44.53%</td>
<td>40.33%</td>
</tr>
<tr>
<td><strong>Class 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total in Care 24+ Months</td>
<td>1,128</td>
<td>1,137</td>
<td>1,135</td>
<td>1,219</td>
<td>1,327</td>
<td>1,410</td>
<td>1,420</td>
<td>1,524</td>
<td>1,646</td>
<td>1,592</td>
</tr>
<tr>
<td>Discharges to Permanent Home</td>
<td>394</td>
<td>371</td>
<td>363</td>
<td>363</td>
<td>455</td>
<td>458</td>
<td>437</td>
<td>606</td>
<td>733</td>
<td>642</td>
</tr>
<tr>
<td>Percent</td>
<td>34.93%</td>
<td>32.63%</td>
<td>31.98%</td>
<td>29.78%</td>
<td>34.29%</td>
<td>32.48%</td>
<td>30.77%</td>
<td>39.76%</td>
<td>44.53%</td>
<td>40.33%</td>
</tr>
<tr>
<td><strong>Southeast Region</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total in Care 24+ Months</td>
<td>1,718</td>
<td>1,721</td>
<td>1,706</td>
<td>1,758</td>
<td>1,892</td>
<td>2,009</td>
<td>2,019</td>
<td>2,092</td>
<td>2,192</td>
<td>2,152</td>
</tr>
<tr>
<td>Discharges to Permanent Home</td>
<td>556</td>
<td>563</td>
<td>577</td>
<td>557</td>
<td>656</td>
<td>652</td>
<td>651</td>
<td>814</td>
<td>948</td>
<td>855</td>
</tr>
<tr>
<td>Percent</td>
<td>32.36%</td>
<td>32.71%</td>
<td>33.82%</td>
<td>31.68%</td>
<td>34.67%</td>
<td>32.45%</td>
<td>32.24%</td>
<td>38.91%</td>
<td>43.25%</td>
<td>39.73%</td>
</tr>
<tr>
<td><strong>Statewide</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total in Care 24+ Months</td>
<td>4,286</td>
<td>3,970</td>
<td>3,921</td>
<td>3,806</td>
<td>3,757</td>
<td>3,800</td>
<td>3,740</td>
<td>3,717</td>
<td>3,817</td>
<td>3,816</td>
</tr>
<tr>
<td>Discharges to Permanent Home</td>
<td>1,540</td>
<td>1,359</td>
<td>1,457</td>
<td>1,375</td>
<td>1,396</td>
<td>1,363</td>
<td>1,383</td>
<td>1,473</td>
<td>1,626</td>
<td>1,559</td>
</tr>
<tr>
<td>Percent</td>
<td>35.93%</td>
<td>34.23%</td>
<td>37.16%</td>
<td>36.13%</td>
<td>37.16%</td>
<td>35.87%</td>
<td>36.98%</td>
<td>39.63%</td>
<td>42.60%</td>
<td>40.85%</td>
</tr>
</tbody>
</table>

*Numbers may vary from year to year to do data drift as per conversation with Hornby-Zeller on 07/11/2017. The numbers are small and do not affect the overall percentages and/or trends.*
Philadelphia
**Philadelphia**

**CFSR Measure 1.4**
*Of all children reunified during the previous year, what percent re-entered care within 12 months of the discharge to reunification?*

| County: | Total Reunifications | 30-Sep | 31-Mar | 30-Sep | 31-Mar | 30-Sep | 31-Mar | 30-Sep | 31-Mar | 30-Sep | 31-Mar | 30-Sep | 31-Mar | 30-Sep | 31-Mar |
|---------|----------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| Philadelphia | 1,891 | 1,728 | 1,628 | 1,604 | 1,577 | 1,652 | 1,627 | 1,395 | 1,361 | 1,320 | 30-Sep | 31-Mar | 30-Sep | 31-Mar | 30-Sep | 31-Mar |
| Re-Entries within 12 months | 867 | 786 | 758 | 756 | 744 | 749 | 601 | 716 | 708 | 602 | 867 | 786 | 758 | 756 | 744 | 749 | 601 | 716 | 708 | 602 | 867 | 786 | 758 | 756 | 744 | 749 | 601 | 716 | 708 | 602 |
| Percent | 45.85% | 45.49% | 46.56% | 47.13% | 47.18% | 45.34% | 36.94% | 51.33% | 52.02% | 45.61% | 45.85% | 45.49% | 46.56% | 47.13% | 47.18% | 45.34% | 36.94% | 51.33% | 52.02% | 45.61% |

| Class: | Total Reunifications | 30-Sep | 31-Mar | 30-Sep | 31-Mar | 30-Sep | 31-Mar | 30-Sep | 31-Mar | 30-Sep | 31-Mar | 30-Sep | 31-Mar | 30-Sep | 31-Mar | 30-Sep | 31-Mar | 30-Sep | 31-Mar | 30-Sep | 31-Mar | 30-Sep | 31-Mar | 30-Sep | 31-Mar | 30-Sep | 31-Mar | 30-Sep | 31-Mar | 30-Sep | 31-Mar |
|---------|----------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| Philadelphia | 1,891 | 1,728 | 1,628 | 1,604 | 1,577 | 1,652 | 1,627 | 1,395 | 1,361 | 1,320 | 30-Sep | 31-Mar | 30-Sep | 31-Mar | 30-Sep | 31-Mar | 30-Sep | 31-Mar | 30-Sep | 31-Mar | 30-Sep | 31-Mar | 30-Sep | 31-Mar | 30-Sep | 31-Mar | 30-Sep | 31-Mar |
| Re-Entries within 12 months | 867 | 786 | 758 | 756 | 744 | 749 | 601 | 716 | 708 | 602 | 867 | 786 | 758 | 756 | 744 | 749 | 601 | 716 | 708 | 602 | 867 | 786 | 758 | 756 | 744 | 749 | 601 | 716 | 708 | 602 | 867 | 786 | 758 | 756 | 744 | 749 | 601 | 716 | 708 | 602 | 867 | 786 | 758 | 756 | 744 | 749 | 601 | 716 | 708 | 602 | 867 | 786 | 758 | 756 | 744 | 749 | 601 | 716 | 708 | 602 |
| Percent | 45.85% | 45.49% | 46.56% | 47.13% | 47.18% | 45.34% | 36.94% | 51.33% | 52.02% | 45.61% | 45.85% | 45.49% | 46.56% | 47.13% | 47.18% | 45.34% | 36.94% | 51.33% | 52.02% | 45.61% | 45.85% | 45.49% | 46.56% | 47.13% | 47.18% | 45.34% | 36.94% | 51.33% | 52.02% | 45.61% | 45.85% | 45.49% | 46.56% | 47.13% | 47.18% | 45.34% | 36.94% | 51.33% | 52.02% | 45.61% | 45.85% | 45.49% | 46.56% | 47.13% | 47.18% | 45.34% | 36.94% | 51.33% | 52.02% | 45.61% |

Despite work on correcting coding errors in AFCARS data, the rates provided in the Hornby-Zeller data package continue to differ from data produced by Philadelphia DHS. As in past submissions, to maintain consistency in reporting out progress on the program improvement strategies, Philadelphia DHS will use its own data count of children and youth who entered and exited any dependent placement and who re-entered dependent care.
Case Activity FY Year-to-Date*

<table>
<thead>
<tr>
<th></th>
<th>Cases Open for CWO Service on 5/31</th>
<th>Total Case Closures</th>
<th>Total Cases Accepted for Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY15</td>
<td>6,208</td>
<td>2,011</td>
<td>2,878</td>
</tr>
<tr>
<td>FY16</td>
<td>6,131</td>
<td>2,628</td>
<td>2,688</td>
</tr>
<tr>
<td>FY17</td>
<td>5,957</td>
<td>2,389</td>
<td>2,597</td>
</tr>
</tbody>
</table>

*Through May 31

Cases Accepted for Service and Closed by Month

Accept for Services and Case Closures FY16 through FY17 - May

Numbers are different than NBB last year as these numbers go until May 31st of each year
### Children Receiving In-Home Services

<table>
<thead>
<tr>
<th></th>
<th>31-May-16</th>
<th>31-May-17</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHS</td>
<td>59</td>
<td>85</td>
<td></td>
</tr>
<tr>
<td>CUA</td>
<td>4,101</td>
<td>4,022</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>4,160</td>
<td>4,107</td>
<td>−1%</td>
</tr>
</tbody>
</table>

### Children Receiving Placement Services

<table>
<thead>
<tr>
<th></th>
<th>31-May-16</th>
<th>31-May-17</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHS</td>
<td>1,033</td>
<td>567</td>
<td></td>
</tr>
<tr>
<td>CUA</td>
<td>5,057</td>
<td>5,484</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>6,090</td>
<td>6,051</td>
<td>−1%</td>
</tr>
</tbody>
</table>

Numbers are different than NBB last year as these numbers go until May 31st of each year.

### Children Discharged to Permanency, FY13 - FY17 through 3/31

<table>
<thead>
<tr>
<th></th>
<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
<th>FY16</th>
<th>FY17*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reunification</td>
<td>810</td>
<td>887</td>
<td>950</td>
<td>1252</td>
<td>913</td>
</tr>
<tr>
<td>Adoption</td>
<td>142</td>
<td>121</td>
<td>88</td>
<td>482</td>
<td>467</td>
</tr>
<tr>
<td>PLC</td>
<td>370</td>
<td>379</td>
<td>378</td>
<td>118</td>
<td>104</td>
</tr>
</tbody>
</table>

**Legend:**
- Reunification
- Adoption
- PLC
Philadelphia
Percentage of Children that reentered placement within one year of reunification

\[
\begin{array}{cccc}
\text{FY12} & \text{FY13} & \text{FY14} & \text{FY15} \\
N=143 & N=137 & N=121 & N=146 \\
15.2\% & 17.0\% & 14.0\% & 16.2\% \\
\end{array}
\]

*FY16 data includes only those children who were reunified between July 1, 2015 and March 31, 2016 to allow for a full year to elapse from the reunification date.

Counties do not need to provide a separate response for each area of Program Improvement Strategy but rather discuss the county’s identification, planning, and implementation efforts.

- If you have not submitted a formalized plan as an attachment, please describe the priority areas of program improvement that are underway within your county. Discuss the connection of your priority areas to the OCYF priority areas that have been identified.

See CWDP IDIR-U, CWDP semi-annual progress report, attached.

In addition to the use of engagement, assessment, and evidence-based practices as part of the CWDP, DHS is continuing to pursue the set of strategies specified in last year’s submission based on priority areas of improvement.

CWO: There are four priority areas for improvement to achieve the core goals of IOC, as described in the Executive Summary. The strategies used to address these goals will, additionally, address Philadelphia’s re-entry rate being higher than the national average.

Supporting safe reduction in accept for service
- Establish field screening units to conduct secondary screening with the goal of diverting families from the system.

Recent revisions to Pennsylvania’s Child Protective Services law have led to increases in the number of referrals coming into the DHS Hotline, part of DHS Information, Assessment, and Referral Services (IARS), the number of reports accepted for investigation, and the number of investigations that have been accepted for service.
Because General Protective Service reports with three- or seven-day response times typically involve service assessment or provision on non-protective service concerns, IARS is developing a secondary screen-out section to divert some of these referrals to non-protective community and DHS prevention services, prior to assignment for investigation. Child Protective Service reports and General Protective Service reports with “immediate” and “24-hour” response times will automatically be accepted for investigation because there are concerns about safety apparent based on the allegations.

- Establish an Extended Integrated Assessment Unit (EAU) providing high level cross-systems experience to assist with the complex assessment, intervention, planning, and service needs of children, youth, and families with family functioning concerns.

To safely divert families with multiple complex needs that are reported to the Hotline, the Department is requesting funding to develop a unit of licensed Social Workers with cross-systems expertise to conduct higher level, more comprehensive social work assessments, beyond what can be captured through the current safety assessment process. These assessments will help identify those families who can be safely diverted to other service systems and supports, including behavioral health, intellectual disabilities, entitlements (such as SSI, the Consolidated Waiver, etc.), and physical health care services. In cases where there are current service providers, the teaming will bring together those service providers to engage them in developing a different treatment and service plan that would enhance the services, again diverting from unnecessary child welfare involvement. For families that need child protective services, such an extended assessment would also drive and better support development of a comprehensive plan to safely divert children and youth from placement, ensure placement with kin, achieve permanency in a timely manner, and decrease the length of time a case is open for services.

Similar to the already established DHS Nursing and Psychology Units, the EAU would have specific criteria that would prompt the involvement of this unit to conduct home visits with the family and complete an extended assessment. Criteria will include when safety assessments have determined that there are biopsychosocial factors that may impact the safety and well-being of children and youth. The EAU will complete a deeper analysis that assesses the environmental milieu, family interaction, processing of information, and attachment between family and household members when there are concerns that family functioning is impacted by multiple factors such as: substance abuse, cognitive limitations, developmental challenges, mental illness, and intellectual disabilities.

Currently, there is only one person, the Director of Integrated Clinical Consultation for DHS, who completes about 11 visits a week. However, the number of families who are impacted by the factors, described above, far exceed 11 visits a week. Therefore the creation of a unit of eight licensed Social Workers is necessary to address the need. The licensed Social Workers will have cross-systems experience in the area of child welfare, behavioral health, substance abuse, and intellectual disability. See Budget Adjustment Narrative for more detail on the criteria and the types of cases that will receive an extended assessment.

- Implement a RED team process to assist accept for service and diversion decision-making.
Philadelphia

The RED team process is a structured decision-making framework for collaborative practice that provides a standardized method of assessing reports of alleged child maltreatment. The simple structure supports critical thinking, applied knowledge, collaborative practice, comprehensive assessment, and inclusion. It is informed by a consultation and information sharing framework that includes harm/danger, risk statements, complicating factors, safety, strengths/protective factors, the purpose/focus of consultation and, ultimately, next steps. Initial implementation of the RED team process will be supported by Casey Family Programs. Philadelphia respectfully requests funding to subsequently sustain the process.

- Ensure a sufficient array of Prevention services that are directly focused on maintaining children and youth in their own homes and communities, safely diverting children and youth from placement, and supporting families so that children and youth do not re-enter care.

Prevention Realignment and Development of the Prevention Diversion Service Array

During FY 2016-17, Philadelphia DHS continued Prevention Service Re-Alignment as part of its strategy to divert children, youth and families from formal child welfare services, support safe, timely permanency, and safe case closure.

Throughout the year, DHS continued implementation of the recommendations included in the “Prevention IOC Alignment Report.” See attached.

- “Anchor” prevention programs, focused on the communities with the highest Accept for Service and Poverty rates, are now used during investigations to inform safety assessment, provide safety services for safety plans, and serve as program alternatives for families at risk but with no safety threats. See attached list of Anchor program categories.

- All Anchor program performance standards and scopes of service have been revised to ensure alignment with IOC goals. The standards and scopes now reflect expectations that the programs will have an impact on accept for service rates, out-of-home placements, and re-entry rates. The Department has been working closely with all the Prevention Providers to ensure that they are able to develop internal systems to evaluate their success in reducing accept for service rate, out-of-home placements, and re-entry rates.

Baseline Data for Prevention Re-Alignment

<table>
<thead>
<tr>
<th>Investigations &amp; AFS Rates, FY13 - FY16</th>
<th>FY14</th>
<th>FY15</th>
<th>FY16</th>
<th>FY17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investigations</td>
<td>14,922</td>
<td>17,949</td>
<td>19,597</td>
<td>20,613</td>
</tr>
<tr>
<td>Investigations on Cases Not Already Open</td>
<td>13,661</td>
<td>14,965</td>
<td>16,116</td>
<td>17,345</td>
</tr>
<tr>
<td>Cases AFS*</td>
<td>2,417</td>
<td>2,893</td>
<td>2,428</td>
<td>2,617</td>
</tr>
<tr>
<td>AFS Rate**</td>
<td>18%</td>
<td>19%</td>
<td>15%</td>
<td>15%</td>
</tr>
</tbody>
</table>
Philadelphia

*The accept for service numbers relate directly to the number of investigations with report dates that fall within the year shown. They do not reflect the total number of cases accepted for service during the year, as some cases accepted for service during the period shown will be related to investigations from the previous year.

**AFS rates are determined by dividing the number of cases accepted for service by the number of investigations on cases that were active at the time of the report.

### Initial Out of Home Placements

<table>
<thead>
<tr>
<th>FY</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2014</td>
<td>1473</td>
</tr>
<tr>
<td>FY 2015</td>
<td>1891</td>
</tr>
<tr>
<td>FY 2016</td>
<td>1823</td>
</tr>
<tr>
<td>FY 2017</td>
<td>1730</td>
</tr>
</tbody>
</table>

From FY 2016 to FY 2017, there was a five percent decrease in the total number of children experiencing a first time out of home placement.

#### Reentry into Foster Care

The data on reentry into foster care shown below is one of the federal indicators used to measure state child welfare systems performance on permanency. This particular indicator is a measure of the stability of reunification. Included in the reunification numbers are those children and youth discharged to the care of a relative. Excluded are those children and youth discharged to relatives who were granted PLC or Guardianship.

| Table 1: Of all children who were discharged from foster care to reunification in the 12-month period shown what percentage re-entered foster care in less than 12 months from the date of discharge? |
| --- | --- | --- |
| # Reunifications | FY 2014 | 888 | FY 2015 | 921 | FY 2016 | 1,277 |
| # Reentered Placement within 12 Months | 149 | 172 | 199 |
| 12 Month Reentry Rate $^1$ | 16.8% | 18.7% | 15.6% |

The Department will continue its Prevention Realignment implementation efforts and will focus on the following steps in the upcoming fiscal year:

- Further develop Anchor programs including Family Empowerment Services, Truancy services, several diversion case management programs, and Education Support Services to meet the particular needs of the communities served and provide additional options for service intervention outside of the formal child welfare system.

---

$^1$ Nationally, the median 12 month reentry rate is 12% (Federal Fiscal Year 2013), according to the *Child Welfare Outcomes 2010-2013: Report to Congress*, published in February 2016.
Philadelphia

- Continue to develop individual program methodology for measuring program success with desired outcomes specified. This includes referral, engagement, utilization, and retention strategies.

- Focus on data collection and Quality Assurance processes to assure accountability for prescribed services and ensure continued internal assessment of program goals and objectives.

- Partner with Community Umbrella Agencies to ensure community connections and collaborations so as to adequately serve children, youth and families in their respective regions.

In support of the Department’s efforts to maintain children and youth in their own homes and communities, and safety divert families when possible, DHS’s Community Based Prevention Division will be implementing the following new or expanded programs.

**Family Empowerment Services**

As part of the further development and enhancement of Family Empowerment Services (FES) to divert families from formal child welfare services and reduce re-entry rates, DHS proposes to pilot expansion of the service delivery model of two of its FES programs to include an integrated “Family Support Center.” The pilot will replicate a model that is currently in use in Allegheny County to successfully reduce the number of families accepted for service in their formal child welfare system. (See attached evaluation of the program’s implementation in Allegheny County.) The proposed enhancement will serve as a “one stop shop” community prevention home for families that are receiving prevention case management services. The first two centers will be operated by two existing FES providers who will expand their current program and additional services into family service centers. The location of the centers will be determined by the region with highest accept for service rate. To identify high-risk communities, DHS will utilize geographic information system (GIS) mapping software that will emphasize regions with the highest concentration of child welfare activity by analyzing its hotline reports, investigation, and accept for service activity by geography over a period of time.

In FY 2016-17, eight FES Providers serviced 1,212 families across the city. We expect that the expansion, due to its presence in these high risk communities and its expansion of services, will touch an additional 300 families or a 25% increase in services in the first year followed by 375 total families served in the second year.

CBPS leadership is collaborating with PMT’s evaluation team to develop an evaluation design and methodology to measure the program. The design and methodology is in development, but we expect to assess the intervention by utilizing both quantitative and qualitative data collection methods. Following a similar approach to the evaluation conducted in Alleghany County, the evaluation would include outcomes in the following domains: Family Engagement, Connection to Social Service, and Diversion from Formal Child Welfare Services. PMT will use FY 2018-19 as the baseline year to measure Child Welfare Activity in selected service regions. DHS expects that between July 1, 2018 and June 30, 2019 the two service centers will have served 300 additional families. DHS will complete its initial evaluation of year 1 by September 30, 2019.

The Department respectfully requests funding for the cost of the two pilot Family Support Centers.
Diversion Case Management Programs
Substance Exposed Infants and their Families

Philadelphia DHS’s CAPTA services program delivers intensive diversion case management services to families affected by substance abuse in accordance with federal mandate. Consistent with the Department’s overall strategy, the primary goal of the CAPTA services program is to promote safe, stable, and nurturing relationships between caregivers and children that lead to family well-being. The program primarily serves:
- Women and their infants that have been reported to DHS as having been affected by exposure to an illicit substance at the time of the baby’s birth. The program also targets other children residing in the home.
- Families affected by substance use disorder who are in the investigation process with the Intake unit at DHS.

The program must expand to adjust to the rising numbers of referrals for CAPTA services. The current program is sized to serve 260 families during the fiscal year. The referrals for FY 2017 increased by almost 100% over FY 2016. In FY 2015-16, 278 referrals were made for CAPTA services; in FY2016-17, 544 referrals were made for these services. In FY 2016-17, 35% of children with CAPTA referrals, or 189 children, received Prevention Services; 86% of these children were diverted from formal Child Welfare Services. It is anticipated that the program will produce similar results with increased utilization.

Philadelphia DHS is requesting increased funding for CAPTA services to support increased utilization.

Diversion Truancy Case Management Services

As a result of Act 138 of 2016, which takes effect for the upcoming 2017-18 school year, there are new definitions of truant children and youth and an expectation of closer monitoring and follow-up of attendance. Truancy Case Management services are currently provided to children and youth who have certain minimum truancy levels, and who have been referred to Regional Truancy Court. In Philadelphia, if truancy does not improve at the Regional Truancy Court level, the family is referred to Family Court, and ultimately a report is made to the formal child welfare system.

Before the new definitions and requirements have become effective, we have already seen an increase in the number of children and youth referred to Regional Truancy Court, Family Court, and DHS for truancy. It is expected that these numbers will increase as a result of the new definitions. In Philadelphia, 7,667 children and youth received a Truancy Service in FY 2016-17. Of these, 6,142 children and youth, approximately 80%, did not enter the child welfare system while receiving a Truancy Service or within a year of the end of Truancy Service.

With the goal of diverting children, youth, and families, DHS proposes to expand the capacity of existing Providers to deliver case management services to address truancy before children and youth are referred to Court. **DHS requests funding to expand diversion Truancy Case Management services to include ten additional Case Managers who will be spread out across the Truancy Providers.** The ten Case Managers will specialize in Tier 1 Cases, supporting an estimated 2,100 new referrals.
Education Support Services: Transportation for Education Stability & Continuity
Consistent with the requirements of the federal Fostering Connections to Success and Increasing Adoptions Act of 2008, the Uninterrupted Scholar’s Act of 2013, and the Every Student Succeeds (“ESSA”) Act of 2015, children and youth who enter or move in foster care must remain in their schools of origin, unless it is determined not to be in their best interest. Children and youth who must change schools are required to be enrolled in their new school without delay. Philadelphia DHS has worked with the School District of Philadelphia (SDP) and local charter schools to establish and implement a protocol for sharing information, making best interest determinations, and transporting children and youth to school to support educational stability for children and youth in foster care.

Under the protocol, DHS, its CUAs, and placement Providers are responsible for transportation until the School District can provide the transportation, or in situations for which the School District does not provide transportation. There are times when children and youth must be placed in resource homes where the resource parent cannot transport the child or youth and there is no other resource, putting the burden on CUA or Provider staff for transportation. There are situations where CUA staff or other Provider staff are not assigned immediately, so a DHS Investigation Worker must transport the child or youth, cutting down on their ability to focus on completing quality investigations and assessments. There are also situations where it is not logistically feasible, or it takes a long time, to re-route buses to provide service.

In support of educational stability, kinship placement, resource home recruitment, and efficient use of DHS Worker, and CUA and Provider staff time and energy, Philadelphia DHS is requesting funding for supplemental transportation services for eligible children and youth in placement. Funds would be used for immediate service for the time between placement and when School District of Philadelphia transportation begins and when the School District of Philadelphia is unable to provide transportation. Funding would also be used for cost sharing with the SDP when they would not normally provide transportation services, such as for children in kindergarten. Philadelphia DHS is intending to issue an RFP for these supplemental services. Based on our implementation to date, we estimate that this service will benefit at least 264 DHS children and youth per year.

Achieving Independence Center
To further strengthen service delivery to older youth, and work to improve their outcomes as they transition to adulthood, DHS is proposing to create a Youth Partnership Model of Service, similar to a model that is being successfully implemented in Allegheny County. The model employs a diverse group of young adults to act as advocates and mentors for youth who are involved with one or more of the child-serving systems. The young adult partners will have personal experience in receiving services from child welfare, juvenile justice, behavioral health, drug & alcohol, or homeless services or a combination of these areas. Their personal lived experiences give them credibility and lend to successful engagement of youth in planning and achieving success. Youth may be involved with child welfare, independent living, or juvenile probation. They will be coached, trained, and supervised so that they can use their experiences and their trainings to help
Philadelphia

collaborate with system partners to better engage and support young people as they navigate systems towards their goals.

The proposed service will enhance our existing Achieving Independence Center. The six core competencies of Independent Living would be addressed: Education and Training, Employment, Housing, Life Skills, Prevention and Wellness, and Supports and Permanent Connections. The expected outcome would be a successful transition from care that results in decreased homelessness, increased independent living skills, and success in reaching employment and education goals that allow older youth and young adults to sustain self-sufficiency. Based on current activity and enrollment at the AIC, this program is anticipated to be able to serve monthly approximately 600 youth ages 14 – 21 years. Philadelphia DHS respectfully requests funding to implement the Youth Partnership Model.

Finally, in an effort to address the need for housing for youth who have aged out of the system, but have requested the Court resume jurisdiction, DHS is requesting funding to create emergency housing assistance for youth prior to them being recommitted to DHS. Lack of adequate housing and lack of employment that pays a living wage are the two primary reasons that young adults seek to return to care. All 101 of the young adults who inquired about resumption of jurisdiction had housing as a main need.

- Use services, such as Family Finding or Family Group Decision Making, also used as case management tools, during the investigation period when Family Empowerment Services have been put in place to help stabilize the family and mitigate safety threats to potentially divert the family from being accepted for service.

- Working with and supporting Philadelphia Family Court in its decision making regarding the safety of children and youth involved in custody matters, and not currently accepted for service. As part of the continuing collaboration between DHS and Family Court to protect children and youth and to preserve families, DHS is working with the Court to ensure that the Court has adequate resources to inform its safety decision regarding children and youth involved in custody matters.

State law requires criminal history certifications in custody matters for all parties and their household members. If a party or household member has been convicted of or has pled guilty to one of the enumerated crimes, the Court, or a designee, is required to conduct an initial parenting capacity evaluation as to whether the person poses a threat of harm to the child or youth whose custody is being considered.

Supporting the Court in obtaining evaluations for custody proceedings is consistent with both PaDHS’s core goal to increase children and youth’s safety and safety of the community and Philadelphia DHS’s core IOC goals of more children and youth maintained safely in their own homes and communities and improved child, youth, and family functioning. These evaluations in custody matters can serve as a primary prevention measure by assessing the strengths, weaknesses, and general capacity of parents to meet their child or youth’s basic needs, and identifying the need for counseling and impediments to permanency. It may also identify any other individuals who should be evaluated before awarding custody of a child or youth because they
Philadelphia

may pose risk of harm. Further, it will support children and youth maintaining contact with both parents when there is no risk in doing so.

Parenting capacity evaluations are not covered by health insurance and, because they are completed by a third party, the fee cannot be waived for indigent parties as it is with custody filings or mental health evaluations by Court psychologists.

The Philadelphia Department of Human Services, in support and on behalf of the Philadelphia Family Court, is requesting funding for legally mandated parenting capacity evaluations when parties to a custody matter, or their household members, are found to have a record of one of the enumerated offenses and the Court deems it necessary to assess whether a risk of harm to the child or youth may exist if access to the child or youth is granted.

These parenting capacity evaluations will assist the Court in making a custody decision that 1) protects the safety of the child; 2) potentially preserves a child’s ability to remain with a parent or kin; 3) potentially reduces the number of children that would enter the formal child welfare system.

Supporting safe, timely permanency

- Safely diverting children and youth from out-of-home placement
  - Administrative approval process for all placements.
  - Providing Housing support to prevent placement of children and youth in homeless families and to support permanency when housing is the only issue.

Inadequate housing is a significant and pervasive barrier to family reunification in Philadelphia. Currently there are few housing options for DHS parents waiting for reunification. While DHS is an active partner with the Philadelphia Office of Homeless Services (OHS), what housing resources exist are scarce with eligibility criteria that exclude most DHS involved parents. Public Housing programs have lengthy waiting lists and OHS programs require residency in over-crowded shelters that are often forced to turn families away. Few of DHS parents seeking reunification reside in the shelters. Instead, they struggle to maintain housing in temporary arrangements including couch-surfing with friends and family, living in boarding houses or doubling or tripling up – all situations which are not adequate to permit family reunification. In the initial rapid permanency reviews conducted at DHS with Casey Family Programs, housing was a factor delaying family reunification in 40% of cases.

In response, DHS is seeking additional funding to create an innovative pilot project providing rental assistance and social service support to quickly rehouse and stabilize families in the community. The goal is to reduce the length of time children remain in out-of-home placement due to housing issues by providing families with a year of rental and social service assistance that allows them to successful reunite with their children and assume rent payments independently and maintain housing with their children once the subsidy ends. Through an RFP process nonprofit partners will: conduct housing search and housing placement for families; identify employment and training opportunities; provide monthly case management to ensure households create and follow a housing stabilization plan; and provide social services to ensure successful reunification.
The proposed program model is based on rapid rehousing, an evidence-based intervention with a variety of studies showing that households receiving rental support and social services avoid future homelessness at a rate of 75% to 90%.

In addition, program participants had better employment outcomes over time than those not in the program. While there are no studies evaluating the impact of this model on families seeking reunification, there is ample overlap with the needs of homeless families to anticipate success.

The cost of supporting a family for one year with rental assistance and social service support is $10,000 which is significantly less than the current annual cost of general foster care of between $25,000 and $48,000 a year. DHS is requesting funding to support a pilot project that will serve 15 families for a year of assistance for a total of $150,000 a year.

Since September 2016, DHS has benefited from the assistance of a Stoneleigh Foundation Senior Policy Fellow whose three-year fellowship is dedicated to addressing the impact of housing on out-of-home placement, delayed reunification and youth aging out of foster-care. She will plan and help monitor and evaluate the program.

- Safely moving children and youth to permanency in a timely manner by reducing barriers to permanency on both case and systemic levels.
  - Universal Accurint and Family Finding referral for all children and youth not placed with kin.
  - Supporting the work of the Solicitors in guiding cases through the court process toward permanency.

With the addition of the new attorneys, and most importantly the full implementation of IOC, the Philadelphia Law Department Child Welfare Unit (CWU) has reviewed its structure so that the Unit can evolve to serve the evolving needs of its client, Philadelphia DHS. As a result of that review, several needs have been identified.

The CWU’s current structure has existed since before IOC. Just as DHS has made leadership and organizational changes in support of the IOC System Transformation, the CWU needs to restructure its leadership and current organizational structure. Additional leadership positions in the CWU are needed to ensure qualitative oversight and management of the attorney’s work. This directly correlates with the quality of representation and ultimately outcomes including permanency and family stabilization for the children and youth served by DHS.

---


4 The annual cost of $25,000 is for a 13+ year old in general foster care and comprises what’s paid to the resource family, the agency’s overhead costs, and case management. If the youth requires a higher level of services such as specialized behavioral health (SBH), the cost is closer to $48k a year.
Philadelphia

The current management structure consists of a Chief and five supervisory level managers (Divisional Deputy City Solicitors). On average, the Divisionals are directly responsible for the work of 10 attorneys.

Based on the current structure, with the addition of ten new attorneys, the Divisionals would be indirectly responsible for over 2,400 cases. Additionally, they are responsible for the work of the attorneys that they supervise in defending challenges to the determinations of CPS reports at the Bureau of Hearings and Appeals and for preparing and redacting DHS/CUA case files for compliance with subpoenas and other requests to review. The number of request for records and record review has increased tremendously. In 2016, the CWU received over 1,750 requests for records, and the unit is on track to exceed that number of requests in 2017. Redacting and preparing records for review takes a great deal of the attorney’s time and requires management and oversight as well.

In addition, changes in the law enacted after the Sandusky case have tremendously increased the responsibilities of the CWU attorneys. The mandate of attorney approval prior to the determination of a CPS report has greatly increased the number of required consults. Consultations in the CWU are primarily handled by the Chief and the Divisionals.

The Chief is ultimately responsible for the quality and quantity of the work of all 50 attorneys, as well as the five Divisionals. To ensure a high quality of work, the responsibility for the attorney workloads and for administrative functions would be more effective if divided between two Chiefs.

Philadelphia is proposing a new structure that would include a Chief of Litigation and Appeals and a Chief of Administration and Specialty Practice, thereby allowing the work and level of responsibility, management, and oversight to be shared. Philadelphia would also like to add one additional Divisional Deputy City Solicitor to share the responsibility of direct supervision of the attorneys. Philadelphia respectfully requests funding for 2 additional leadership positions consisting of 1 additional Chief and 1 additional Divisional Deputy City Solicitor.

Philadelphia also needs to add legal assistants to support the work of the new attorneys hired as part of Philadelphia’s focused permanency efforts. CWU legal assistants do work that would otherwise have to be completed by attorneys, such as: drafting and filing the petitions that initiate a case in Court, preparing the Goal Change/Termination petitions that allow children and youth to be freed for adoption, and preparing the Permanent Legal Custodianship petitions that allow children and youth to achieve permanency through PLC.

Even with the ten additional attorneys, Solicitor caseloads are above those recommended by the ABA. Hiring legal assistants allows more efficient and cost effective use of attorney time as legal assistant salaries are approximately half that of attorney salaries. They keep the work moving forward, allow the attorneys to concentrate on aspects of the work that only attorneys can do such as preparing witnesses and trial strategy, formulating questions for direct and cross-examination, and litigating the case, and allow the attorneys to prepare themselves and their cases for court, which helps to reduce continuances.
Philadelphia

The Law Department currently assigns one legal assistant to two attorneys. To support the additional ten attorneys, Philadelphia respectfully requests funding to hire five additional CWU legal assistants.

- Rapid Permanency Reviews – eliminate barriers for families that are very close to reaching permanency.
  DHS, continuing to partner with Casey Family Programs, developed and began implementing the Rapid Permanency Review process to eliminate barriers for families that are close to reaching permanency. To date, the RPR Implementation Team completed three Pilot Phases with four CUAs and DHS, from November 2016 to March 2017. During the three Pilots, 250 children and youth were reviewed by trained review teams. Out of the 200 cases reviewed during Pilots One and Two, 26% have achieved permanency and 70% remain in placement. The data from Pilot Three (50 youth) will be complied with the support from Casey Family Programs. Action steps were identified during all of the reviews and approximately 80% of those action steps have been completed. The youth will continue to be monitored by DHS until all of the children and youth achieve permanency.

In January 2018, DHS will move towards a full system roll-out among all ten CUAs and DHS. The RPR Process will be incorporated into each organization’s permanency work, providing stakeholders with a consistent stream of feedback on what must be achieved to move “long-stayers” to permanency and what organizational and systemic barriers are delaying permanency. Processes have been identified to address the identified barriers with Executive Leadership at DHS and the CUAs as well as with System partners.

- Increase the use of permanency supportive services, such as SWAN.
  See use of SWAN services for older youth in the Independent Living Services grant narrative under 4-3b. Permanency and Older Youth Initiative.

- Use of prevention services to stabilize and support permanency to reduce re-entry.
  See Prevention Realignment write-up above for more detail as to use of prevention services to stabilize and support permanency.

Improve Practice and Monitoring capabilities.

- Supervising for Excellence training for DHS and CUA supervisors.
  Implemented by Child Welfare Operations and DHS University, designed to strengthen practice in critical areas such as safety assessment, case planning and permanency practice, this joint training addresses issues raised in our previous state inspections.

- Implementing the CUA Scorecard.
  The DHS Performance Management and Technology (PMT) Division will produce the new CUA Scorecard for the system. The CUA Scorecard includes nine domains of performance and sub-indicators for completion, quality, and timeliness in most of the domains. Most of the indicators are drawn from the Comprehensive Case File Review tool. The domains are: Case Planning, Safety Assessments, Visititation, Court Practice, Supervision, Children and Family Assessments, Permanency, Finance, and Leadership. See PMT Program Improvement Strategies attachment for more information regarding progress and plans, and for additional monitoring and evaluation improvements.
Philadelphia

- Re-centralizing the placement referrals.
- Re-centralizing subcontractor monitoring.
- See PMT Program Improvement Strategies attachment for more information regarding progress and plans.
- Integrating Performance Management and Information Technology as the new Division of Performance Management & Technology (PMT) to bring together core infrastructure functions. In October 2016, the new PMT division launched several key initiatives to improve and modernize how DHS collects and analyzes data, evaluates Providers, and utilizes modern technology to facilitate quality child welfare practice. These initiatives will continue to be developed, implemented, and enhanced in FY 2018 and FY 2019.
- Re-instating Performance-Based Contracting: See PMT Program Improvement Strategies attachment for more information regarding progress and plans.
- Data Analytics Modernization: PMT will identify data elements to be utilized for program delivery and outcome monitoring. See PMT Program Improvement Strategies attachment for more information regarding progress and plans.
- Specialized training for DHSU, in areas not covered by existing CWRC training, to support CWO staff and Provider in improved child welfare practice. DHSU’s scope of work has expanded to not only include providing technical assistance to Community Umbrella Agencies (CUA) but also to non-CUA provider partners who serve Philadelphia families, children and youth, and supporting providers in achieving safety, permanency and well-being. DHSU’s leadership will identify and assign DHSU Training Liaisons to providers based on service type (i.e., group home, residential and foster care). The Training Liaisons will be responsible to engage providers in regular meetings to provide information, consultation, and technical assistance and conduct training needs assessments (as needed) for the purposes of strengthening practice and cross-system collaboration. Therefore, DHS is making significant investments in building consulting capacity within the division. DHSU staff is being equipped to provide DHS and its partners with technical assistance to enhance organizational procedures and processes that support effective case consultations, case diversion, comprehensive assessments, and timely service linkages.

DHS is requesting a training budget to assist with DHS’ efforts to enhance professional development of child welfare staff in Philadelphia. The resources will be used to build additional expertise capacity which will deepen the knowledge base within DHSU and achieve greater success in improving outcomes for children. The funding will be used exclusively for DHSU staff in five main areas:
- Specialized training.
- Cross-jurisdictional learning and peer-to-peer consultation.
- Professional memberships and professional conferences to remain current with best approaches to staff and organizational development and learning.
- External expertise.
- Technical support for DHSU staff.

- Secure contracts with additional providers of forensic evaluations, psycho-educational evaluations, and cognitive capacity evaluations for children, youth, and adults in families that are receiving child welfare services. Philadelphia DHS currently has only one reliable provider for forensic evaluations and one provider for psycho-educational evaluations. This provider can only conduct psycho-educational evaluations for children and youth, not adults, and can only conduct them during the academic year.
Philadelphia

We cannot currently comply with court orders to conduct a psycho-educational evaluation during the summer. We do not have a contract with a provider to conduct cognitive capacity assessments for adults to determine their capacity to parent a child. There is only one provider to meet the volume for parental capacity evaluations and bonding evaluations. The availability and timeliness of these evaluations affects the timeliness of permanency planning and impacts child safety. Philadelphia DHS has initiated numerous efforts to secure qualified providers. However, the reimbursement rates that are offered are not competitive and constitute a barrier to successfully engaging providers. Rates have not been raised in approximately 18 years since DHS began contracting out for these services. **We respectfully request funding to offer competitive rates, so that we may obtain at least two additional providers for forensic evaluations and two licensed, school-certified psychologists with the ability to conduct child and adult cognitive capacity and psycho-educational evaluations year round.**

Juvenile Justice

Many reforms in Restorative Juvenile justice are directly geared towards making data-driven decisions, employing evidence-based practices, and focusing on the development of youth competencies.

Assessments and data-driven decisions

- Use of the Youth Level of Service assessment.
  See response to question regarding changes in agency priorities or programs that affect numbers of children and youth receiving services, in care, or the rate of discharge from care.
- Use of the Pennsylvania Detention Risk Assessment Instrument.
  See response to question regarding changes in agency priorities or programs that affect numbers of children and youth receiving services, in care, or the rate of discharge from care.

Placement and Detention Alternatives

- Graduated Response
  Philadelphia County has developed a Graduated Response approach for the Juvenile Probation Office. Graduated response utilizes the concept of incentives and sanctions or interventions, and is consistent with research showing that when an adolescent is consistently rewarded for positive behavior extrinsically, this assists in developing intrinsic rewards and changes behavior. The Graduated Response approach is directly aligned with the principles of Balanced and Restorative Justice (BARJ) and the Juvenile Justice System Enhancement Strategies (JJSES). The approach holds the youth accountable for their actions through competency development while maintaining community safety. Development of a structured response system also promotes consistency amongst staff, provides structured decision-making, and improves desired outcomes. See Executive Summary for additional information.

  The Graduated Response Approach will be implemented for juveniles within the community, once a juvenile is discharged from a residential facility. The juvenile will have the opportunity to receive incentives for compliance with court-ordered conditions. Incentives will be provided during a youth’s six to twelve month probation period. **In order to obtain tangible incentives for about 1,000 juveniles on**
Community probation, Philadelphia respectfully requests funding for the implementation year.

- Global Position System Monitoring
  See response to question regarding changes in agency priorities or programs that affect numbers of children and youth receiving services, in care, or the rate of discharge from care.

- Post-adjudication Evening Reporting Center
  See response to question regarding changes in agency priorities or programs that affect numbers of children and youth receiving services, in care, or the rate of discharge from care. The ERCs also support youth competency development.

- Describe the process undertaken to identify the areas of improvement for prioritization, including identifying data analysis utilized in defining the program need. Describe any analysis related to the county's outcome performance in comparison to comparable counties' and/or statewide performance and how these findings may have contributed to the identification of practices contributing to strong or weak performance.

See CWDP IDIR-U, CWDP Semi-annual progress report, attached.

CWO: The priority areas of improvement were identified last year based on analysis of data that showed an increasing system size, and evaluation of the areas that can be changed to most effectively address and reduce the size of the system and to achieve the goals of IOC. This year, with IOC having been fully implemented, the priority areas are being pursued with strategies that further operationalize the components of IOC.

JJS: The priority areas of improvement were chosen based on implementation of the components of JJSES, and the need to make data-driven, consistent decisions regarding intervention levels and services.

See Executive Summary for details regarding priorities in achieving both child welfare and juvenile justice goals.

- For each strategy identified, please address the following questions. It is recognized that the same responses may apply for multiple strategies. In those circumstances, please note as such, otherwise provide separate responses for distinct strategies as warranted.

For all questions below: See CWDP IDIR-U, CWDP Semi-annual progress report, attached.

- Describe how the strategies were selected as the approach that will successfully meet the challenge the agency is addressing.

  Strategies were selected based on: identified priorities; assistance from Casey and internal research to identify effective interventions; and input from internal and external stakeholders. Please see response above to the question requesting a description of the priority areas of improvement that are underway within the county. Additionally, please see the Executive Summary and responses to General Indicators Chart Analysis questions.
Philadelphia

Describe how the selected strategies fit within your county’s current organizational structure, existing service provider community, and align with agency mission and values.

Because DHS has moved beyond the implementation stage of IOC, and Children and Youth and CUA have been integrated as Child Welfare Operations, all of the strategies are designed to specifically work within the structure and with the goals of IOC, or include participation of the major system partners who could have the most influence on achieving the goals. Additionally, please see response above to the question requesting a description of the priority areas of improvement that are underway within the county, the Executive Summary, and responses to General Indicators Chart Analysis questions.

Describe resources needed by the CCYA and service providers to be able to successfully implement the strategy (including staffing, training needs, concrete needs etc.)

Please see response above to the question requesting a description of the priority areas of improvement that are underway within the county, the Executive Summary, and responses to General Indicators Chart Analysis questions. Additionally, please see responses in section 2-3 – Program and Resource Implications and section 3-1 – County Fiscal Background.

How will the county and service provider determine program efficacy or effectiveness? If the strategy is an Evidence-Based Program, how will fidelity to the model be assessed? Identify a measurable target for improvement and timeframes for evidence.

Philadelphia DHS’s Performance Management and Technology Division is responsible for monitoring and evaluation of programs. Improvements in monitoring and evaluation, and data analytics modernization are included as program improvement strategies. See PMT Program Improvement Strategies attachment for more information regarding progress and plans. Additionally, outcomes and benchmarks have been included in the Scopes of Services for Prevention programs.

If the program improvement strategy is an expansion of an existing service, describe the county and provider’s readiness to expand or duplicate the program.

Please see descriptions of individual strategies in the response above to the question requesting a description of the priority areas of improvement that are underway within the county.

What efforts are underway by the county and/or provider to determine capacity to implement and sustain program enhancements?

The strategies discussed in the responses above are elements intended to build a system which will lead to further improvement, as well as make the positive effect of existing efforts sustainable. Additionally, Philadelphia has identified additional resources needed to implement and sustain the changes that we believe will lead
Philadelphia

to progress toward meeting our goals. We are requesting the additional resources as identified.

☑ Briefly describe the current activities for each strategy. Include structural and functional changes made to accommodate the enhanced or new strategy.

Please see response above to the question requesting a description of the priority areas of improvement that are underway within the county, the Executive Summary, and responses to General Indicators Chart Analysis questions. See response to previous question.

☑ Briefly describe the status of engagement of staff who will be identifying children/youth/families for the practice.

See CWDP Semi-annual Progress Report, attached. See response above to the question requesting a description of the priority areas of improvement that are underway within the county, the Executive Summary, and responses to 2-2 – Collaboration, 2-3 – Program and Resource Implications, and the General Indicators Chart Analysis questions.

☑ Briefly describe the engagement of stakeholders who will be impacted by the enhanced programming.

See CWDP Semi-annual Progress Report, attached. See response above to the question requesting a description of the priority areas of improvement that are underway within the county, the Executive Summary, and responses to 2-2 – Collaboration, 2-3 – Program and Resource Implications, and the General Indicators Chart Analysis questions.

☑ Provide a description of the program set-up, including hiring and training of staff delivering the service.

Each individual strategy has a different timeframe for implementation. See response above to the question requesting a description of the priority areas of improvement that are underway within the county, the Executive Summary, and the General Indicators Chart Analysis questions.

☑ Identify the projected date that the referrals will begin for new services/programs.

Each individual strategy has a different timeframe for implementation. See response above to the question requesting a description of the priority areas of improvement that are underway within the county, the Executive Summary, and the General Indicators Chart Analysis questions.

☑ Identify the data elements to be utilized for program delivery and outcome monitoring.

As mentioned above and in the response to the question requesting a description of the priority areas of improvement that are underway within the county, data analytics modernization is one area of improvement being implemented in
Philadelphia

Philadelphia. This will include identification of data elements in addition to monitoring and evaluation improvements, such as the CUA Scorecard. See PMT Program Improvement Strategies attachment for more information regarding progress and plans. Additionally, outcomes and benchmarks have been included in the Scopes of Services for Prevention programs.
4-1a. Employee Benefit Detail

Submit a detailed description of the county’s employee benefit package for FY 2016-17. Include a description of each benefit included in the package and the methodology for calculating benefit costs.

OFFICE OF THE DIRECTOR OF FINANCE - ACCOUNTING BUREAU
Fringe Benefits Memo - FY 2017

To: All Departments, Boards, Agencies and Commissions
From: Josefine Arevalo, Director of Accounting (signed)
Subject: Fringe Benefit Costs - Fiscal Year Ending June 30, 2017
Date: March 15, 2017

Non-Uniformed Employees

The following fringe benefit costs for non-uniformed employees are effective as of July 1, 2016, and should be added to all Fiscal Year, 2017 costs which are chargeable to other city agencies, other governmental agencies and outside organizations:

<table>
<thead>
<tr>
<th>Municipal Pensions (Percentage of Employee’s Pension Wages)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan</td>
</tr>
<tr>
<td>L</td>
</tr>
<tr>
<td>M</td>
</tr>
<tr>
<td>Y</td>
</tr>
<tr>
<td>J</td>
</tr>
<tr>
<td>10</td>
</tr>
</tbody>
</table>

*Plan is optional for all employees except Register of Wills and DC 33 Guards.

Employee Disability

<table>
<thead>
<tr>
<th>Cost Per Employee Per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worker’s Compensation</td>
</tr>
<tr>
<td>Regulation 32 Disability</td>
</tr>
</tbody>
</table>
### Social Security / Medicare

<table>
<thead>
<tr>
<th>Calendar Year Earnings Covered</th>
<th>Effective Period</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Earnings not to exceed $117,000</td>
<td>07/01/16 - 12/31/16</td>
<td>6.20%</td>
</tr>
<tr>
<td>Gross Earnings not to exceed $127,200</td>
<td>01/01/17 - 06/30/17</td>
<td>6.20%</td>
</tr>
<tr>
<td>Unlimited Gross Earnings</td>
<td>07/01/16 - 12/31/16</td>
<td>1.45%</td>
</tr>
<tr>
<td>Gross Earnings (less than $200,000 annually)</td>
<td>01/01/17 - 06/30/17</td>
<td>1.45%</td>
</tr>
</tbody>
</table>

### Group Life Insurance

All full time employees except those hired as emergency, seasonal or temporary help.

<table>
<thead>
<tr>
<th>Employee Classification</th>
<th>Coverage</th>
<th>Cost per Employee Per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>D.C. 33 (except Local 159 B)</td>
<td>$25,000</td>
<td>$3.48</td>
</tr>
<tr>
<td>D.C. 33 Correctional Officer Classes of Local 159B</td>
<td>25,000</td>
<td>3.85</td>
</tr>
<tr>
<td>D.C. 47 (including Local 810 - Courts)</td>
<td>20,000</td>
<td>3.31</td>
</tr>
</tbody>
</table>

Exempt & Non-Rep employees & Common Pleas Court -

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Cost per Employee Per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Municipal (excluding Local 810, see above)</td>
<td>15,000</td>
</tr>
<tr>
<td>School Crossing Guards</td>
<td>15,000</td>
</tr>
</tbody>
</table>

### Employee Health Plans

These plans are available to all non-uniformed employees except emergency, seasonal, temporary and part time employees.

<table>
<thead>
<tr>
<th>Employee Classification</th>
<th>Cost Per Employee Per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>D.C. 33 (except Crossing Guards) and D.C. 47</td>
<td>$1,194.00</td>
</tr>
<tr>
<td>D.C. 33 School Crossing Guards 1</td>
<td></td>
</tr>
<tr>
<td>Head of Household</td>
<td>$1,194.00</td>
</tr>
<tr>
<td>Single</td>
<td>$597.00</td>
</tr>
</tbody>
</table>

Exempt & Non-Rep Personnel in City Administered Plans:

<table>
<thead>
<tr>
<th>Plan</th>
<th>Single</th>
<th>Single + one</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keystone HMO 2</td>
<td>$498.84</td>
<td>$923.94</td>
<td>$1,449.05</td>
</tr>
<tr>
<td>Personal Choice PPO 2</td>
<td>466.58</td>
<td>864.33</td>
<td>1,355.48</td>
</tr>
<tr>
<td>Dental PPO 3</td>
<td>29.36</td>
<td>54.32</td>
<td>85.15</td>
</tr>
<tr>
<td>Dental HMO 3</td>
<td>18.74</td>
<td>37.01</td>
<td>67.29</td>
</tr>
<tr>
<td>Optical 3</td>
<td>2.77</td>
<td>5.01</td>
<td>7.07</td>
</tr>
<tr>
<td>Prescription Plan 3</td>
<td>175.22</td>
<td>324.16</td>
<td>508.14</td>
</tr>
</tbody>
</table>

1. Health coverage is not provided for School Crossing Guards eligible for any other health plan from any employer.
2. Based on self-insured conventional rates for calendar year 2017
3. Based on fully insured premium rates for calendar year 2017
Unemployment Compensation

Employee Classification       Cost Per Employee Per Month
All non-uniformed employees          $7.69

Group Legal Services

Employee Classification       Cost Per Employee Per Month
D.C. 33 (except Crossing Guards & Local 1971) and D.C. 47          $15.00
D.C. 33 Local 1971                      15.00
School Crossing Guards                        3.50

Uniformed Employees

The following fringe benefit costs for all uniformed employees are effective as of July 1, 2016 and should be added to all Fiscal Year 2017 costs, which are chargeable to other city agencies, other governmental agencies and outside organizations:

Municipal Pensions
(Percentage of Employee’s Pension Wages)

<table>
<thead>
<tr>
<th>Plan</th>
<th>Employee Classification</th>
<th>Normal Cost</th>
<th>Unfunded Liability</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>Police hired before 7/1/1988</td>
<td>15.727%</td>
<td>831.841%</td>
<td>847.568%</td>
</tr>
<tr>
<td>B</td>
<td>Police hired on or after 7/1/1988</td>
<td>7.702%</td>
<td>7.728%</td>
<td>15.430%</td>
</tr>
</tbody>
</table>

Fire Plans:

<table>
<thead>
<tr>
<th>Plan</th>
<th>Employee Classification</th>
<th>Normal Cost</th>
<th>Unfunded Liability</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>Firefighters hired before 7/1/1988</td>
<td>15.745%</td>
<td>1115.318%</td>
<td>1131.063%</td>
</tr>
<tr>
<td>A</td>
<td>Firefighters hired after 7/1/1988</td>
<td>8.139%</td>
<td>6.816%</td>
<td>14.955%</td>
</tr>
</tbody>
</table>

Employee Disability

<table>
<thead>
<tr>
<th></th>
<th>Cost Per Employee Per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worker’s Compensation</td>
<td>$319.72</td>
</tr>
<tr>
<td>Regulation 32 Disability</td>
<td>$16.05</td>
</tr>
</tbody>
</table>

Social Security / Medicare

Uniformed employees do not contribute to the Social Security program. However, those uniformed employees hired after April 1, 1986 must pay the Medicare portion of the Social Security Tax at the following rate.

<table>
<thead>
<tr>
<th>Calendar Year Earnings Covered</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unlimited Gross Earnings</td>
<td>07/01/16 - 12/31/16 1.45%</td>
</tr>
<tr>
<td>Gross Earnings (less than $200,000 annually)</td>
<td>01/01/17 - 06/30/17 1.45%</td>
</tr>
</tbody>
</table>
## Group Life Insurance

All full time employees except those hired as emergency, seasonal or temporary help.

<table>
<thead>
<tr>
<th>Employee Classification</th>
<th>Coverage</th>
<th>Cost per Employee Per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police Uniformed Employees</td>
<td>$25,000</td>
<td>$9.21</td>
</tr>
<tr>
<td>Fire Uniformed Employees</td>
<td>25,000</td>
<td>18.25</td>
</tr>
<tr>
<td>Deputy Sheriffs</td>
<td>25,000</td>
<td>2.71</td>
</tr>
</tbody>
</table>

² Includes a fee of $5 per employee per month for administration of the Firefighters’ Trust Fund.

## Employee Health Plans

Uniformed personnel of the Police Department, Fire Department, Office of the District Attorney Investigatory Employees, and Regulation 32 (formerly Uniformed) Employees and Uniformed Deputy Sheriff classes are eligible for coverage in the uniformed health plans.

<table>
<thead>
<tr>
<th>Employee Classification</th>
<th>Cost Per Employee Per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uniformed Police Personnel, Office of the District Attorney Investigatory Employees &amp; Regulation 32 (formerly uniformed) Employees</td>
<td>$1,290.00</td>
</tr>
<tr>
<td>Uniformed Fire Personnel</td>
<td>1,619.64</td>
</tr>
<tr>
<td>Uniformed Deputy Sheriffs (Including D.O.P)</td>
<td>1,290.00</td>
</tr>
</tbody>
</table>

## Unemployment Compensation

<table>
<thead>
<tr>
<th>Employee Classification</th>
<th>Cost Per Employee Per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>All uniformed employees</td>
<td>$7.69</td>
</tr>
</tbody>
</table>

## Group Legal Services

<table>
<thead>
<tr>
<th>Employee Classification</th>
<th>Cost Per Employee Per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police Uniformed Employees</td>
<td>$31.00</td>
</tr>
<tr>
<td>Fire Uniformed Employees</td>
<td>26.00</td>
</tr>
<tr>
<td>Deputy Sheriffs</td>
<td>16.00</td>
</tr>
</tbody>
</table>
4-1b. Organizational Changes

- **Creation of the Division of Child Welfare Operations**
  In 2016, DHS restructured to clearly establish the Children and Youth Division and the CUAs as components of the same system of child welfare and child protective services in Philadelphia. The Division of Child Welfare Operations (CWO) was created, led by a single Deputy Commissioner, with three Operating Divisions: Front-end Operations, DHS Ongoing Services and Child Well-being Operations, and Improving Outcomes for Children Operations. These are each led by an Operations Director. All of the staff in these three Operating Divisions are considered Child Welfare Operations Staff. Additionally, Court Support Services have been moved back under Child Welfare Operations, after having been temporarily moved under CBPS while the restructuring and reorganization of CWO and CBPS took place. See Organizational Chart, attached, for details.

- **Expansion of Hotline Units**
  In order to relieve some of the pressure on the Investigation sections, the Hotline has taken on expanded responsibilities. In addition to the Hotline’s traditional functions, Hotline staff are completing secondary screen-outs to make sure that families that can be diverted from the system are, and only those reports that really meet the HGDM criteria are accepted for investigation or assessment. Hotline staff are also responsible for court-ordered placements that do not require new investigations because no new allegations have been made. To accommodate this increased workload, two new “afternoon” units were created consisting of two Social Work Supervisors and 16 Social Work Services Managers. The Department also expanded the after-hours Hotline units by an additional six Social Work Services Managers.

- **Reestablishment of the Community Based Prevention Services Division with a new Deputy Commissioner**
  In an effort to reduce the size and scope of the formal child welfare system, DHS reestablished the Community Based Prevention Services Division in 2017. Targeted prevention services will be available for at risk children, youth, and families to prevent system involvement, to divert families from being accepted for service, to support timely permanency, and to support safe case closure so that children, youth, and families do not re-enter the system. Under new leadership, CBPS has been restructured to include the Education Support Center and the Family and Youth Services section. The Domestic Violence Strategies Director position was created to help provide a coordinated response around the issue of Domestic Violence in the city, ensuring appropriate screening and referral for applicable services.

- **DHS University (DHSU)**
  In October 2016, the Department created the position of Chief Learning Officer, reporting directly to the DHS Commissioner, who is now responsible for the overall direction and management of DHS University (DHSU) in overseeing the learning and professional development needs of Philadelphia DHS through the delivery of training, technical assistance, consultation and ELearning curricula and supports. The CLO position is an executive cabinet position consistent with Commissioner Figueroa’s vision of DHSU as a professional learning center for Philadelphia Child Welfare
through the investment of continuous professional development of DHS’ staff, CUA staff and DHS Provider partners.

- **Integrating Information Technology with Performance Management and Accountability**
  Adequate data collection, analysis and reporting are essential to support practice improvement and accountability, and appropriate information technology is central to that function. Responsibility for IT was moved from the Administration and Management Division to Performance Management and Accountability (PMA). Division and Section names were changed to appropriately reflect the work; the Performance Management and Accountability Division became the Performance Management and Technology (PMT) Division, and the IT section became the Data and Technology section.

- **Restructuring of Finance and Movement of Fiscal Monitoring to PMT**
  In FY 2016-17, the Finance Division added a new Deputy Commissioner and began re-aligning its units to better reflect the needs of the Department. In order to create greater capacity, the Fiscal and Budget Team was divided into Fiscal Operations and Budget. Fiscal Operations is responsible for audits, petty cash, travel, and reimbursements; Budget is responsible for budget preparation and monitoring, state invoicing, reporting, and purchasing. The Fiscal Monitoring Unit (FMU), which had been responsible for monitoring CUAs, was also re-organized; the Performance Monitoring Unit was transferred to PMT and the financial monitoring functions were integrated into the Auditing Unit.

### 4-1c. Complement

- **Describe what steps the agency is taking to promote the hiring of staff regardless of whether staff are hired to fill vacancies or for newly created positions.**

  The DHS Human Resources (HR) Office meets monthly with each DHS Division to discuss and provide updates on all staffing matters including promotions and filling vacancies. Additionally, the HR Office meets with each Division to determine classification and hiring needs for each half of the fiscal year and works with the City of Philadelphia's Office of Human Resources to ensure that eligible lists with sufficient candidates are available.

- **Describe the agency’s strategies to address recruitment and retention concerns.**

  DHS's overall turnover is 8% which is low compared to that of the national average. In order to keep this number low, DHS has and will continue to participate in job fairs and classroom recruitment. DHS has implemented the following efforts regarding retention:

  - **Supervisory Training** - DHS University has enhanced training to both DHS and CUA supervisors by offering the Supervising for Excellence training, designed to strengthen practice in critical areas such as safety assessment, case planning, and permanency practice.
  - **Leadership Development** - DHS University has partnered with Performance Plus, Inc (PPI) to pilot a leadership development program offered to mid-level leaders at both DHS and CUA.
  - **Caseload Reduction** - DHS has increased funding to lower caseload size at the CUAs. The current average caseload size has decreased from 13 families per Case Manager.
Philadelphia

to 11 families. The reduction gives staff relief and allows them to better manage the work and provide better quality services to the children, youth, and families.

- Employee Recognition Program - the program has been redesigned to include employee of the month, crusader's award, years of service, and kudos.

<table>
<thead>
<tr>
<th>4-1d. Caseload Sizes</th>
</tr>
</thead>
<tbody>
<tr>
<td>For consistency across CCYAs, please determine average caseload size by dividing the total number of children or families served during the fiscal year by the number of Full-Time Equivalent (FTE) caseworkers in each unit. When determining FTEs, use the theoretical standard of 2,080 hours per year (8 hours per day * 5 days per week * 52 weeks per year). This standard does not include deductions for holidays, vacations, sick time, etc. Count each child and family in each stage of the case continuum. A child and family may appear more than once in each stage if multiple referrals are received over the course of the year.</td>
</tr>
</tbody>
</table>

- Provide the average caseload size for intake workers by family and by child during FY 2016-17.

During FY 2016-17, the average caseload size for DHS General and Specialty Intake Workers was 85.5 families, or 114.1 children and youth per Intake Worker.

- Provide the average caseload size for ongoing workers (i.e. cases accepted for service) by family and by child during FY 2016-17.

During FY 2016-17, the average caseload size for CUA Case Managers was 11.1 families, or 23.5 children and youth per Case Manager. The average caseload size for DHS Ongoing Services Workers was 15.2 families, or 30.3 children and youth per Worker.

- Describe any specialty units or positions that are case-carrying and provide the average caseload size by family and by child during FY 2016-17.

During FY 2016-17, the average caseload for DHS Adoptions Workers was 8.9 families, or 16.9 children per Adoption Worker.

DHS also assigns Permanency Workers to Adoptions cases that are with the CUAs. These cases are primarily the responsibility of the CUA Case Manager to continue visitation and case management. Once parental rights are terminated, DHS Permanency Workers are assigned to manage the adoptions process from Family Profiles to sealing the case once the adoption is finalized. These workers carry regular ongoing cases as well as CUA Permanency Cases. The average Permanency Worker caseload for FY 2016-17 was 30.1 families, or 51.5 children per Worker.

<table>
<thead>
<tr>
<th>4-1e. Audit Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>How are decisions regarding monitoring contracted service providers made?</td>
</tr>
</tbody>
</table>

Philadelphia DHS’s Audit Unit monitors contracted service Providers in three ways:

- Independent CPA audits of all contractors, which are reviewed by Philadelphia DHS audit staff.
- Random audits of agencies not required to submit full independent CPA audits.
Philadelphia

- Full cost, onsite annual audit of Community Umbrella Agencies (CUAs) by a specialized DHS internal audit unit due to their size, complexity, and critical importance to the Department.

☐ Does the CCYA use a risk-based assessment to determine the review schedule for all contracted service providers? Yes __X__ No____

☐ If so, what are the CCYAs considerations when determining risk? Ex: funding level and streams, number of children/families referred, staff turnover, time operating in Pennsylvania, changes in service delivery, bad press, audit findings, etc.

Philadelphia DHS determines risk level based on funding amount. Currently, there is a $300,000 funding threshold that triggers a mandatory independent CPA audit to be commissioned by the contractor. Audit Unit staff randomly audit agencies that are funded below the $300,000 threshold. Additionally, in the event that a contractor has raised concerns about fiscal matters, program or fiscal staff can request a field audit of that contractor.

☐ Is the review schedule formally documented? Yes __X__ No____

☐ Does the county utilize random sampling?

Yes, the county uses random sampling for contractors below the $300,000 threshold. Above the threshold, all Contractors are required to submit an annual independent CPA audit report to Philadelphia DHS.

☐ If so, how is the sample size determined?

Each sub-$300,000 contract is scheduled to be sampled once every three years, so the sample size is approximately 33% of these contracts each year.

☐ Are all contracted service providers monitored over a determined period in cases where random sampling is utilized? Yes __X__ No____

On a rotational basis over three years.

☐ Does the documentation include how monitoring will be completed and by whom? Yes __X__ No____

Philadelphia’s internal administrative process includes monitor tracking, assigning to an auditor, tracking the auditor’s progress, and requesting a plan of action from the agency. It is reviewed regularly by supervisory staff.

☐ How does the CCYA document that the review process is followed?

By the use of an audit log, audit correspondence to agencies, a desk review tool, and the use of DHS’s Audit Unit Policy & Procedures Manual.

☐ Does the documentation include response actions when issues are identified? Ex: a corrective action plan and timeline. Yes __X__ No____
Philadelphia

Through the desk review process, auditors will contact the agency to provide a plan of correction. Letters are kept on file.

☐ Does documentation exist to support these decisions? Yes ___X___ No____

☐ If so, does it detail any thresholds for non-inclusion that may limit who is monitored?

The audit threshold is incorporated in the collection and review process.

☐ How often is this process reevaluated?

Annually.

☐ How are decisions regarding which providers are determined to be sub-recipients made?

Philadelphia DHS uses the federal definition of sub-recipient from OMB Circular A-133 to determine which entities are considered sub-recipients.

☐ Highlight any overlapping findings/adjustments that exist in the most recent single audit report and Auditor General (AG) report.

The most recent reports cited here are the FY2014-15 City of Philadelphia Single Audit and the State AG Audit. Copies of each as well as responses from Philadelphia DHS can be provided upon request. Two common issues, internal controls and advance payments, are addressed in both audits.

☐ Provide a corrective action plan to address findings in the most recent single audit report, including what levels and types of controls will be strengthened and/or implemented to prevent repeat adjustments and findings in the current year.

Responses are summarized; full responses can be submitted upon request. As noted above, these responses pertain to FY2014-15.

Three of the five findings related to sub-recipient monitoring and accurate reporting of funding sources are on the Schedule of Federal Expenditures (SEFA). Since FY 2014-15, Philadelphia DHS and the City’s Finance Dept have been holding regular meetings, at which sub-recipient monitoring and SEFA preparation are regular agenda items. In addition, sub-recipients are now informed of their funding allocations by source (federal, state, and local funds), as per the audit’s recommendation. These changes have enabled more accurate reporting of federal program amounts in the SEFA.

One finding noted a failure to recover funds advanced to a sub-recipient. These funds were subsequently recovered. In addition, Philadelphia DHS has greatly curtailed the practice of advance payments, except in extreme circumstances approved by the Commissioner.

Finally, one finding noted that DHS is regularly late in submitting Act 148 invoices to OCYF. The addition of new fiscal staff, implementation of automated tools, and a stronger
Philadelphia

Focus on timely submissions is expected to significantly reduce these delays going forward.

☐ Provide a corrective action plan to address findings in the most recent AG report, including what levels and types of controls will be strengthened and/or implemented to prevent repeat adjustments and findings in the current year.

Note: The most recent completed Auditor General Fiscal Report for Philadelphia DHS is for the period July 1, 2008 – June 30, 2010. The Office of the Auditor General is currently conducting FY2010-11 through FY2013-14 audits. Given that six fiscal years have elapsed since the last report, most of the findings are no longer relevant, but are summarized here.

Philadelphia DHS no longer includes estimated costs on its CY 370 expenditure reports, and is only reimbursed for actual expenditures. This also applies to building occupancy costs. In addition, time studies are now regularly administered for all case-carrying staff at both DHS and its CUAs. The Department’s records retention policy was updated to align with that of the Commonwealth and to ensure that they are available for audits in future years.

Act 148 invoicing has been improved through the development and implementation of the Act 148 Performance Improvement Process. Additional process improvements are ongoing.

As noted above, advance payments have been greatly curtailed, primarily due to a reduction in the time needed by Philadelphia DHS and its contractors to enter into contracts at the beginning of each fiscal year.

Philadelphia DHS disagreed with the finding related to monitoring of contractors and subcontractors. The Department stands by its auditing and oversight procedures, which have been strengthened in the subsequent seven fiscal years.

4-3a. Special Grant Initiatives (SGI)

By agreement with the State, Special Grants Initiatives will be submitted with the Budget in the September 1, 2017 submission.

➢ Please review important SGI changes and highlights prior to completing this section.

Family Group Decision Making (FGDM) Additional Information Request
Please complete the questions below regarding FDGM implementation in FY 2016-17.

☐ Did your CCYA receive FGDM funds through SGI in FY 2016-17? Yes ____ No____

☐ If yes, was FGDM purchased or provided by CCYA staff?
  Purchased_____CCYA____

☐ Were there any instances of over-spending for a single FGDM conference (exceeding the $3,000 per conference limit)? Yes___ No___
If yes, provide details regarding why the overspending occurred and what other funds, if any, were used to fund the overspending.

Please complete the chart below with those SGI programs that the county will provide in FY 2017-18 and/or request funding for in FY 2018-19. Place an “X” in the FYs for which the CCYA is requesting funding. Identify the SGI category type and provide the full name of the program identified.

<table>
<thead>
<tr>
<th>FY 2017-18</th>
<th>FY 2018-19</th>
<th>SGI category (EBP, PaPP Dep, PaPP Del, Housing or ATP)</th>
<th>Program Name (use full program names, not acronyms)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Additional rows can be added as necessary

For the SGI programs identified in the above chart, the following charts and questions (Sections A-G) must be completed for EACH identified SGI program. For example, if you are requesting funding for five SGI programs, you would complete sections A-G separately for each of those five SGI programs.

BEGIN COPY

A. Program Implementation

- Was this program funded through the SGI in FY 2016-17? Yes___ No___
- Is the program being funded through the SGI in FY 2017-18? Yes___ No___
- Are SGI funds requested for this program in FY 2018-19? Yes___ No___
- If yes, what is the total amount being requested for FY 2018-19? $__________

B. FY 2017-18 Budget Revision Opportunity
CCYAs can request, at any time, a transfer of funds within the SGI categories of EBP, PaPP Dep, PaPP Del, Housing and ATP if the request does not result in an increased state allocation and
sufficient local matching funds are available. (See Appendix 5 in the NBPB Guidelines for additional information.)

CCYAs can use the NBPB submission as an opportunity to transfer funds for FY 2017-18. In the chart below, in the Special Grant Allocation block, insert the amount of your county’s current approved Special Grant amount for the program listed above for FY 2017-18. In the Budget Revision Amount block, input the amount to be increased or decreased to that allocation for FY 2017-18. The Revised Special Grant Allocation Request is the new total allocation your county is requesting for the program listed above for FY 2017-18.

Note: This section should only be completed if a transfer or revision of SGI funds is being requested. Otherwise, leave this section blank.

<table>
<thead>
<tr>
<th>Budget Year</th>
<th>Special Grant Program Allocation Amount</th>
<th>Budget Revision Amount</th>
<th>Revised Special Grant Allocation Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2017-18</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- If a budget revision was identified above, explain the need for this revision and what factors contributed to the decision to transfer funds between SGI programs?

C. Program Description and Outcomes

- Provide a description of the program, the population to be served and the anticipated impact to the children and families participating in the program. If requesting NFP funds, please document the anticipated/actual use of all NFP grant funds available through the Office of Child Development and Early Learning and the Maternal, Infant and Early Childhood Home Visiting Program.

- Is this program being implemented as a family engagement Evidence-Based Practice (EBP)? Yes ___ No ___

  - If yes, is this a Crisis/Rapid Response Team Meeting practice? Yes ___ No ___

- If the program is an EBP, provide the link to the website registry or program website used to select the model. If the program is not an EBP but there is a website resource that is available, please provide that website link.

- What assessment or data was used to indicate the need for the program and how this program will improve outcomes?

- How and by whom will this program be monitored to ensure program integrity or fidelity to the model (EBPs) and to determine if desired outcomes are being met?

D. Tracking Chart

The following chart must be completed for each year the program was funded through SGI. If the program was not funded through SGI during a specific year, then no data needs to be included for that year. The following is a description of each row in the chart:
Philadelphia

- **Row 1** refers to the specific population of children and/or families who will be served by this program (i.e. dependent youth ages 12-18; families with children in placement; families with children ages birth to five years old; any family served by children and youth services, etc.).
- **Row 2** is the actual number of referrals made to the program during the specified fiscal year. For FY 2017-18 and 2018-19, the anticipated number of referrals should be identified.
- **Rows 3 and 4** are the actual numbers of families and/or children who actively participated in services during the identified fiscal year. For FY 2017-18 and 2018-19, the anticipated number of families and/or children who will participate in services should be identified.
- **Row 5** is the total amount of SGI funds used for that program. These should be actual expenditures except for FY 2017-18 and 2018-19 which would identify anticipated expenditures.
- **Rows 6 and 7** should identify the number of children who were or will be referred to the program that are and are not eligible for medical assistance (the total of Rows 6 and 7 should equal Row 2);

- **Row 8** should include the full name (no acronyms) of the provider who will be delivering the program.

Complete the following chart for each applicable year

<table>
<thead>
<tr>
<th></th>
<th>FY 14-15 (actual #’s)</th>
<th>FY 15-16 (actual #’s)</th>
<th>FY 16-17 (actual #’s)</th>
<th>FY 17-18 (anticipated #’s)</th>
<th>FY 18-19 (anticipated #’s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Target Population</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td># of Referrals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Total # of Families Served</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Total # of Children Served</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Cost Per Year</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td># of MA Referrals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td># of Non-MA Referrals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Name of Provider</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

E. **Explanation of Tracking Chart**

- Please explain any underutilization or underspending of prior years’ grant funds. What tools or strategies have been implemented to ensure that all grant funds will be utilized moving forward?

- If no provider has been identified, what is the plan to identify and secure a provider?
NOTE: The following sections (F and G) were added to streamline the understanding and rational of SGI requests and to decrease the number of questions to the CCYAs during the NBPB review process.

F. FY 2017-18 Fiscal Description
Provide a fiscal description of how the SGI funds will be spent during FY 2017-18. This description could include, but is not limited to, the number of caseworkers and the amount of their salaries and benefits, the number and cost of fixed assets, cost of curriculum and training required, travel costs, etc. If the program is being delivered through a contract with a private agency, identify the costs that will be billed to the CCYA.

G. FY 2018-19 Fiscal Description
Provide a fiscal description of how the SGI funds are projected to be spent during FY 2018-19. This description could include, but is not limited to, the anticipated number of caseworkers and the amount of their salaries and benefits, the number and cost of fixed assets, cost of curriculum and training required, travel costs, etc. If the program is being delivered through a contract with a private agency, identify the costs that will be billed to CCYA. If a provider is not identified at the time of the NBPB submission, provide details on how the requested budget amount was calculated.

END COPY

4-3b. Permanency and Older Youth Initiative

Statewide Adoption and Permanency Network (SWAN)
☐ Please explain any over or under utilization of SWAN services in the prior year, i.e. explain any differences when comparing the SWAN allocation to actual spending.

For FY 2016-17, Philadelphia County’s Swan allocation was $7,074,500. Philadelphia made over 4,000 referrals for SWAN services, spending a total of $9,586,500, an over utilization of $2,512,000 in FY 2016-17.

The overutilization is due to systematic changes related to Improving Outcomes For Children and information sessions facilitated by DHS and Diakon, emphasizing the importance of SWAN services and their contribution to timely permanency for Philadelphia children and youth. As a result, referrals and request of SWAN services have increased drastically.

☐ Please explain any projected change in focus of utilization of SWAN services in FY 2018-19 compared to previous years as justification for the county’s FY 2018-19 allocation request.
Philadelphia

The increase in the utilization of SWAN Services is projected to continue well into the next fiscal year. The use of SWAN services as part of Philadelphia’s strategy to improve timely permanency has created a demand for these services that has resulted in an overutilization of SWAN allocation for FY 2015-16 and FY 2016-17. Philadelphia DHS will continue to reach out to the Achieving Independence Center for referrals for Child Specific Recruitment, Child Prep, and Child Profiles for older youth with a goal of APPLA. Philadelphia also continues to encourage case managers to request SWAN services for children and youth who have been in care for six months or longer. These efforts are expected to result in the continued increase in utilization.

☐ If requesting new or additional paralegal support, please explain why and what services/activities the requested paralegal(s) will perform.

Philadelphia is requesting funding to hire three additional LSI paralegals. These paralegals are directly involved in permanency work in Philadelphia according to their mandate per our Memorandum of Understanding with SWAN.

LSIs do the preliminary work on a case prior to the CWU Legal Assistant receiving it for composition of the statement of facts and filing of the actual permanency petition. This preliminary work includes retrieving the record, reviewing it to determine if all necessary documentation is in place, and generating the basic template of the petition, including all of the demographic information regarding the child, youth, and family as well as basic factual assertions in support of the request to change the goal, and in adoption cases, terminate parental rights. One of the major challenges in filing permanency petitions is the lack of birth certificates. LSI paralegals are specifically charged with identifying whether birth certificates are needed and ordering them in a timely manner so that permanency is not delayed. LSI paralegals also initiate searches for parents whose whereabouts are unknown. Their timely work in this regard also prevents unnecessary continuances in court and delays in permanency.

LSIs are also assigned to Accelerated Adoption Review Court (AARC), which currently has over 1,000 children and youth awaiting adoption. The LSI paralegals assist in preparing cases for Court by determining the status of child and family profiles and troubleshooting where there are delays in this area that can directly impact our ability to achieve finalization of adoptions. LSI paralegals also attend AARC and play a critical role in relaying Court Orders to the SWAN affiliates who are not present in Court and may not otherwise be aware of deadlines that the Court has imposed concerning profile composition.

Independent Living Services (ILS) Grant

NOTE: CCYAs should utilize the most recent IL site visit report to complete the ILS Grant template section.

NOTE: CCYAS must submit their written policy and procedures that address the administration of IL stipends as referenced in OCYF Bulletin #3130-14-01 titled “Youth Independent Living Services Guidelines” (under Direct Services, E. Support Services, page 29) as an attachment to their NBPB submission.
In the chart below, indicate the actual ILS Grant budget for FY 2017-18 and ILS Grant budget request for FY 2018-19.

<table>
<thead>
<tr>
<th></th>
<th>FY 2017-18 Budget</th>
<th>FY 2018-19 Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Budget Amount</td>
<td>$3,007,523</td>
<td>$3,493,046</td>
</tr>
</tbody>
</table>

Please explain any over or under utilization of the ILS Grant in the prior year, i.e. explain any differences when comparing the ILS allocation to actual spending.

N/A

Please explain any increase or decrease in the ILS Grant request for FY 2018-19.

An increase of $485,523 was requested last year, but not granted. This year, we are requesting the same amount. This amount will support a ten percent increase in the number of youth to be served plus expenditures related to implementing a new Youth Partner Initiative as well as related costs around housing (See Prevention Realignment in Program Improvement Strategies section.)

What is the projected total number of youth the county will serve through the ILS program in FY 2018-19?

The total number of youth served for 2016-17 was 2,991. We expect this to increase by ten percent to reflect ACT 91 Resumption of Jurisdiction youth and increased efforts to serve youth from the NYTD and Credit Report outreach process.

Does the county provide IL services in-house, contract with a provider for services, or both?

Philadelphia contracts with a provider for IL services.

If IL services are provided by the county, how many county caseworkers are assigned to provide IL services and what percentage of the budget is allocated to their salary? Do these caseworkers manage only ILS cases?

N/A

If IL services are provided through a contractor, provide the name of the provider(s) and the percentage of the ILS Grant budget that is allocated to that provider.

Valley Youth House (VYH) is the lead agency and receives 100% of the allocation.

What needs assessment does the county use to assess youth 14 and older?

The Ansell Casey Needs Assessment is the tool used.

What recommendations or action steps were identified in the most recent IL site visit report for the county to complete? How does the county plan to address those recommendations and action steps, and what assistance, if any, does the county need to address these issues?
Philadelphia

1. **Philadelphia DHS to continue efforts to increase awareness within the CUA Providers around IL Service provision**
   The role of the DHS AIC CUA Liaison was created. The ten CUA organizations were divided amongst DHS AIC staff whose responsibilities included: education with regards to ILS; outreach to CUA Life skills coaches and CUA youth mentors to assist in the recruitment effort for youth; engagement process with advertisements for a speakers bureau; and support to CUA/AIC staff with regards to problem resolution of barriers that could impede progress in the transition effort. A quarterly IL in-service is hosted at AIC for CUA, DHS and Provider Workers to educate them on the services of AIC and requirements of IL.

2. **Philadelphia DHS to assess challenges related to engaging youth around older youth services that are placed at a distance from the Achieving Independence Center**
   It has been noted that the depth of programming that is offered at the AIC would be hard to duplicate at the local CUA level. The current location of the center was chosen because it would be the most central point for youth across the city. Trainings have been offered to the CUA organizations to generate an understanding of the role that the AIC plays in the provision of ILS.

   Additional collaborative efforts are being utilized where the DHS/CUA Liaisons are collaborating with inter/intra agency partners to increase the level of knowledge regarding the scope of ILS. This would include: collaborative presentations to the CUAs regarding core service expectations; available resources; and coordination of the Youth Development Plan (YDP), Transition Plans, and DHS’s Single Case Plan.

   AIC has piloted a Youth Services Review which is an assessment of ILS services for Providers outside of Philadelphia County and the youths’ need in congregate care placements. The outcome of the review is communicated with the CUA Case Manager and Provider to address any concerns. The data from this pilot may suggest a need to implement mobile Life Skills teams under the auspices of the IL provider VYH.

3. **Achieving Independence Center to consider incorporating or strengthening any existing workshops that focus on Court Preparation as it relates to the challenges identified by youth during this review**
   Discussion with regards to best steps and review of existing workshops has occurred. The Young AIC workshops have expanded this topic to address preparation. We also partner with the Juvenile Law Center to host workshops around court preparation. The Youth Advisory Board continues to assist in peer education around Know Your Rights and court preparation. The Youth Fostering Change group through the Juvenile Law Center is also focused on better court preparation for court-involved youth. Lastly, the Older Youth Services Coordinator engages youth in mock presentations to prepare for court as well as utilizes the Youth Services Review tool for assessments.

☐ Did the county request Technical Assistance (TA) from the Pennsylvania Child Welfare Resource Center this past state fiscal year? Yes___No X__

☐ If so, what TA was requested?

☐ Do county ILS staff attend SWAN/IL quarterly meetings? Yes X___No___
Philadelphia

Staff from both DHS AIC and the IL Provider, Valley Youth House, attend the quarterly meetings.

☐ Does the county require IL contracted providers to attend SWAN/IL quarterly meetings? Yes_ X_ No__

☐ CCYAs should be referring older youth for SWAN services. Identify the number of youth age 14 and older who will be referred for SWAN services in FY 2017-18 and FY 2018-19.

Philadelphia will refer 275 youth age 14 and older. It has increased last year’s amount by ten percent. (See below.)

☐ How many youth ages 14 and older received SWAN services in FY 2016-17?

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Prep</td>
<td>216</td>
</tr>
<tr>
<td>Child Profile</td>
<td>34</td>
</tr>
<tr>
<td>Child Specific Recruitment</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total SWAN services</strong></td>
<td><strong>251</strong></td>
</tr>
</tbody>
</table>

☐ Explain how the county is meeting the federal annual credit reporting requirements for all youth in foster care age 14 and older.

DHS has established the National Youth and Transition Database (NYTD) and Credit Reporting Unit which will request credit reports annually for all youth in foster care age 14 and older. Signed agreements with all three credit reporting agencies have been completed and the unit encompasses a Supervisor, three Social Workers, and an Administrative Technician.

☐ Describe the county’s efforts to engage youth for successful completion of the National Youth in Transition Database (NYTD) Follow-up Survey (ages 19 and 21). For counties who report positive results, please include what strategies help with successful survey completion. For counties that have difficulties, indicate what barriers exist. Identify what assistance, if any, is needed.

The NYTD unit, comprised of a Supervisor, three Social Workers, and an Administrative Technician, was established and monitors this scope of work. Challenges due to the transitory nature of this population are being addressed though a more proactive outreach. This outreach includes soliciting assistance from provider agencies, seeking internal search assistance from the DHS liaison unit, forming relationships with youth while they are younger and still are in care, and educating youth and provider staff on the recruitment process.

☐ Identify the individual(s) who completed the ILS Grant template section and ILS Grant Budget Excel spreadsheets.
Philadelphia

<table>
<thead>
<tr>
<th>ILS Grant Section Completed</th>
<th>ILS Grant Budget Excel Spreadsheets Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: Syreeta Owen-Jones</td>
<td>Lief Erickson</td>
</tr>
<tr>
<td>Email: <a href="mailto:Syreeta.owen-jones@phila.gov">Syreeta.owen-jones@phila.gov</a></td>
<td><a href="mailto:Lief.erickson@phila.gov">Lief.erickson@phila.gov</a></td>
</tr>
</tbody>
</table>

☐ Identify the county’s primary contact or coordinator for each of the following initiatives (do not include the county administrator unless no other staff is available).

<table>
<thead>
<tr>
<th>IL Services</th>
<th>NYTD</th>
<th>Credit Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: Lester Goodman</td>
<td>Javier Aguero</td>
<td>Javier Aguero</td>
</tr>
<tr>
<td>Email: <a href="mailto:Lester.goodman@phila.gov">Lester.goodman@phila.gov</a></td>
<td><a href="mailto:javier.a.aguero@phila.gov">javier.a.aguero@phila.gov</a> <a href="mailto:javier.a.aguero@phila.gov">javier.a.aguero@phila.gov</a></td>
<td></td>
</tr>
</tbody>
</table>

4-3c. Information Technology

☐ Identify the Case Management System your county is using: ________________

Currently, Philadelphia DHS is in the process of developing a new case management system. In the meantime, DHS end users continue to work with multiple systems to perform various business functions. All automated case management functions are performed in the web-based FACTS² and Legacy Mainframe FACTS systems. This system is an inter-operable, real-time, standardized case management system that has been complemented with the continued development of the Electronic Case Management System (ECMS) within its current application and database structure. External providers, including CUA Case Managers (CUA CMs), utilize the web-based provider portal, DHSConnect, to perform various case-related functions. DHSConnect provides CUAs with access to FACTS2 and ECMS.

During the development of the new case management system, the following applications will continue to be utilized by both internal and external Users:

**Internal Philadelphia Department of Human Services Users**
- FACTS – Legacy Mainframe System – used for Placements, Juvenile Justice Services (JJS), and Fiscal-related functions.
- FACTS² – Web-Based System – used for Hotline, Investigation, and Intake-related functions, including automatic filing of Police Reports directly to the Philadelphia Police Department Special Victims Unit for those investigations requiring them.
- Electronic Case Management System (ECMS) (within FACTS²) – used for Case Management functions and Family Team Conferencing.

**Community Umbrella Agencies and External Provider Users**
- DHSConnect – Web Based Provider Portal – used to access the following web-based applications: FACTS²/ECMS, In-Home Protective Services (IHPS) Case Management, Ages and Stages, Family Group Decision Making, Rapid Service Response Initiative
Philadelphia

(RSRI), P-drive, FAST and CANS assessments, and the National Youth in Transition Database (NYTD).

Case Management Systems
In January 2016, IT collaborated with DHS and CUA staff to initiate a business process analysis and perform system and data analyses. Initially, the results of these analyses led Philadelphia DHS to embark on the development and implementation of a commercially available solution (Netsmart Evolv) to replace our existing application portfolio (FACTS, FACTS2, ECMS, DHS Connect applications). One year after launching the project, the team concluded that Netsmart’s My Evolv product would not be able to meet the needs of our business as initially intended without a significant and longer-term injection of additional human and financial resources to ensure that the system could be as comprehensive as initially scoped. Given our findings, we have modified our approach to embark on an internal, in-house build of the integrated case management system, utilizing an enhanced project team.

The main purpose of the project is to:
1. Develop a system that allows the City to collect, integrate, store, manage, and distribute information for Philadelphia’s child welfare system in an efficient, effective, and accurate manner; and
2. Develop a system that is user-friendly and efficient for the Philadelphia child welfare system and its partners in promoting safety, permanency, and well-being for children, youth, and families.

To accomplish this mission, Philadelphia DHS’s Data and Technology team is, and will continue to undertake work in five areas.

A. Integrated Case Management System

1. CONTINUING: Review other case management systems.
   • In FY 2016-17, Philadelphia DHS’ Development Team visited Montgomery and Allegheny Counties to review their ACYS and KIDS systems, respectively, and assess the feasibility of integrating or adapting components of other PA county child welfare case management systems into our integrated case management system.
   • In FY 2017-18, the team will continue visiting and learning about other systems in the state (including CAPS), as well as other case management systems with user-friendly, innovative, and responsive user interfaces.

2. CONTINUING: Migrate off the Legacy Mainframe.
   • In FY 2016-17, the team focused on analyzing what components of the mainframe needed to be updated and began collecting user requirements for each of these components. We also focused in identifying the human and physical resources needed to develop the integrated case management system.
   • In FY 2017-18, the migration work will focus on planning and implementing improvements, specifically around AFCARS data collection and reporting, revamping contract/services, enhancing invoicing and billing capability, addressing Title IV and CY61 concerns, upgrading natural GUI apps, and, enhancing data feed processes to other internal and external databases.
   • By the beginning of FY 2018-19, full migration will be completed.
3. **CONTINUING**: Enhance FACTS - CWIS Integration.
   - In FY 2016-17, the team focused many of its releases on ensuring seamless integration with the State’s system, including enhancing the re-evaluation and resend functionalities, adding reporter and secondary referral source management, ensuring data integrity between the two systems, and adding needed data fields to allow adequate data collection.
   - In FY 2017-18, we will focus on ensuring that we can effectively respond to CWIS 1.3 requirements.

4. **NEW**: Increase system integration and functionality
   - In FY 2017-18, the team will collect and plan user requirements for enhancements in the following areas:
     - Configurable dashboards.
     - Enhanced alerts and notification capability.
     - Visual relationships.
     - Easier navigation.
     - Transition to child-centric system.
     - Integration of all ECMS forms into the system.
     - Mobile support for all applications.
     - Browser Neutrality.
   - In FY 2018-19, the team will implement the plan for these enhancements.

5. **NEW**: Enhance User Interface
   - In FY 2017-18, the team will plan and collect user requirements for enhancements in the following areas:
     - Intuitive and user-tested navigation.
     - Enhanced child location.
     - Increased user configuration.
     - Ability for users to correct data.
   - In FY 2018-19, the team will implement the plan for these enhancements.

B. **Maintenance of Current Systems**

1. **CONTINUING**: Continue development to ensure current system maintenance and support.
   - In FY 2016-17, our development team focused on making major changes to the system that would allow DHS and CUAs to perform critical functions, many directed to ensuring enhanced operations, such as taking back Central Referral Unit functions, CWIS integration (as described above), and better capability for the Teaming Unit.
   - In FY 2017-18, we will be making continuous upgrades to our Legacy FACTS, FACTS 2, and ECMS systems. While we build the new integrated case management system, maintenance of these current systems will be critical to ensure the safety of children within our system and the ability of our caseworkers to serve them. It will also allow us to begin to integrate functionality requested by practitioners such as the ability to implement Performance-Based Contracting (PBC), track respite placements, enhance the contracting model with provider agencies, and track placements in real-time.

2. **CONTINUING**: Continue upgrading and support users’ hardware, software, and communications needs.
   - In FY 2016-17, with the coming of a new administration, many of our efforts focused on continuing to upgrade systems and computers for our staff, especially by providing
Philadelphia resources such as laptops and aircards to mobile staff so that they can better serve families.

- In FY 2017-18, a significant portion of the resources requested will be used to upgrade the operating systems of many of our workers (some of which are using Windows XP and Windows 2003 operating systems) and to build the capacity of all the new system staff, especially in the Hotline and Intake Units. We also plan to purchase tablets for our mobile and LAN team, so they are able to serve clients and users more effectively.
- In FY 2018-19, we will complete this phase of the hardware and software upgrades and plan for upgrades related to the new integrated case management system.

3. **NEW**: Enhance Asset Management.
   - In FY 2016-17, we began analyzing our asset management processes to assess its strengths and weaknesses and to develop a plan to ensure that we can account for, manage, and dispose of all hardware, software, and communications equipment effectively. As a part this plan, we also focused on retaining talent and purchasing software necessary to effectively manage assets. The first part of the implementation of this plan took place in late FY 2016-17, with a thorough audit of our hardware.
   - In FY 2017-18, we will continue to enhance our asset management process by launching a new asset management system. We plan to continue to track our hardware environment but will be placing special emphasis on software inventory and license compliance.

4. **NEW**: Enhance Help Desk Capability
   - In FY 2016-17, with the coming of a new administration, the decision was made to take back some of the functions Philadelphia DHS had relinquished to Philadelphia’s Office of Information Technology (OIT). This fiscal year, we began an incremental process of absorbing these functions to ensure no disruption to our users.
   - In FY 2017-18, we will be continuing to roll out a new and improved IT Help Desk and continue to work on the transition with OIT.

5. **NEW**: Human Resources Management System
   - Currently, Philadelphia DHS Human Resources uses a combination of databases, spreadsheets, and SharePoint lists to track employee relations, events, and incidents. Documenting, tracking, and reporting out is time-consuming and cumbersome. The County is requesting funding to purchase and implement an off-the-shelf system to replace and consolidate the multiple systems now used to track employee relations events and incidents. Replacing will provide the opportunity to improve HR staff productivity, reduce operational complexity and increase internal controls by enabling standardization and automation of business processes. It will also better support the decision-making by providing a complete and comprehensive set of reporting and workflow tracking tools that allow for increased visibility and accountability through alerts, triggers, canned and ad-hoc reports. It may additionally help reduce the need for additional HR administrative staff.

C. **Data Center Implementation**

1. **CONTINUING**: Develop and operationalize data center to ensure adequate server and networking capability.
Philadelphia

- In FY 2016-17, much of the resources requested in this area were designated toward the purchase of all the hardware and materials needed to build the center.
- In FY 2017-18, most resources will be invested in consultant and staff time needed to fully configure, run, and maintain the Center in optimal operation.
- In FY 2018-19, we will be working to optimize the center to ensure that all servers and associated software are in compliance. We will also work to ensure that we have sufficient capacity to respond to a growing network of users, especially the added capacity needed with the migration off the legacy mainframe system and the increased demands for adequate connectivity and data exchange with local, state, and federal partners.

D. New Data Warehouse Deployment

1. **CONTINUING**: Deploy new data warehouse that will house all the data contained within our multiple systems and serve as a source for all our reporting processes.
   - In FY 2016-17, most of the resources requested were utilized to contract with staff to design and build the data model for the warehouse.
   - In FY 2017-18, efforts will be focused on designing and implementing the dimensional layer of the data warehouse and reproducing all the reports that are needed at the local, state, and federal levels. Specifically, we will focus on revising the AFCARS reporting process, both from the perspective of correcting erroneous or missing data, as well as adjusting the system so that we are able capture the data that we are not currently capturing and reduce the levels of derivation that are currently needed to produce the report.
   - In FY 2018-19, efforts will focus on finalizing production of all reports in the BI layer of the data warehouse and beginning to implement the plan for predictive and prescriptive analytics.

E. Development of a new internal and external DHS websites

1. **NEW**: Build or renovate existing websites to improve communication. The DHS external website is outdated, difficult to navigate, contains multiple broken links and is not consistently branded. Currently, DHS requests any changes to its website through another City department, limiting flexibility and response time. The external website and the internal site will focus on user friendly design, actionable service links and will be built on a platform that allows DHS staff to make updates and changes as needed. The sites will be designed according to new standards set by the City’s Office of Open Data and Digital Transformation. DHS has hired a Website Project Manager to ensure we can implement the changes.

Provide the county’s approved staffing complement:

- Certified staff: _1,311_
- Staff not included in above certified number: 
- Other staff not included in certified who receive IT equipment and services – please identify the positions and the number in the position:
  - Position: ________________________ Number: ___
  - Position: ________________________ Number: ___
  - Position: ________________________ Number: ___
Philadelphia

☐ If requesting additional Mobile Computing Devices (Laptops or Tablets), provide a business justification for the number of devices exceeding the number of staff. The justification should include how the CCYA plans on using the devices and how the use of mobile devices is efficient, economical, and effective in carrying out workers’ responsibilities.

We do not anticipate that Philadelphia’s request to purchase mobile computing devices will exceed the number of staff. Most of the devices to be purchased will replace old and outdated devices. However, there are special units where staff may have more than one computer, because the availability of these devices ensures smooth operations. This may include some mobile staff that benefit from having a desktop computer in the office, as well as a tablet that they can take off-site. The other unit that may require multiple devices includes staff that are providing network and hardware/software support. Having a tablet will allow them to check tickets as they are on the floor without having to return to their cubicles. By FY 2018-19, we will phase out most desktop computers for Help Desk staff, who will primarily utilize tablets to carry to provide IT support.

☐ Indicate if your county is submitting a revised FY 2017-18 IT budget along with your FY 2018-19 IT Grant request. Yes_ X__No____

☐ Indicate if your county has the necessary contract language in all IT contracts to ensure compliance with federal and state regulations (see Appendix 6: Information Technology, Section III). Yes_ X__No____Do not have any contracts___

☐ Indicate if your county is requesting funding for ongoing or new development in FY 2018-19 that is not related to the statewide Child Welfare Information Solution (CWIS). Yes_ X__No____

☐ If yes, provide the following details:
  • Business Need - Describe the business need for the ongoing or new development;
  • High Level Requirements – Provide a description of the high-level business and technical requirements;
  • Project Cost Proposal – Provide the total costs for the development, as well as the total estimated project costs if the development is part of a larger project; and
  • Identify contracts associated with the development project.

As described above, Philadelphia DHS’s IT Department is embarking on the development of an integrated case management system. This project will deliver a better information management system and enable DHS to implement improved data management and IT infrastructure frameworks on an enterprise-level.

The purpose of the new integrated case management system is to efficiently, effectively, and accurately collect, integrate, store, manage, and distribute information for Philadelphia’s Child Welfare system. Upon complete implementation of the new case management solution,
Philadelphia
Philadelphia intends to retire the Legacy FACTS, FACTS2/ECMS, and DHSCConnect applications.

- High Level Requirements – Provide a description of the high-level business and technical requirements;
  - **User Friendly** - Browser neutral, provide a single point of entry for data, efficient and easy to use, stable (available 24 x 7 x 365), able to capture and retrieve reliable data, provide ticklers and dashboards, ensure system and data are easily accessible to end users.
  - **Supportive of the Philadelphia Child Welfare supports and services lifecycle to children, youth, and families** – Child-centric, supports common Philadelphia Child Welfare system language and processes, configurable to Philadelphia Child Welfare system supports and services lifecycle, seamlessly distributes information from multiple data sources to end users, sustainable (able to be maintained and/or modified by in-house resources), flexible to accommodate future changes to business needs and/or requirements, effectively interface with external information trading partners (e.g., State [CWIS], Social Security, Courts, etc.).
  - **Efficient and effective in supporting our information management architecture and infrastructure for transactional, reporting, and data analytics purposes** – Ensures that appropriate hardware, software, and network environment are setup and maintainable using in-house resources. Enables end users to efficiently collect required information. Maintains and assures the accuracy and consistency of data over its entire lifecycle, integrates and centralizes data from multiple data sources, accommodates current end-user capacity while anticipating and being able to accommodate an increase in end user capacity, captures data to support current reporting requirements (i.e., AFCARS), ensures data collected is relevant and useful - both technically and from a business perspective, and managed at the enterprise level.

- Project Cost Proposal – Provide the total costs for the development, as well as the total estimated project costs if the development is part of a larger project;
  - Total Cost for development – $1.5 million; overall project costs - $3 million.

- Identify contracts associated with the development project.
  - IT Vendor Contracts.
    - i. MFR Consultants, Inc.
    - ii. Resilient Business Solutions.
    - iii. CAI.
    - iv. MODIS.
    - v. FutureNet, Inc.

☐ Indicate if your county is entering or planning to enter an IT procurement in FY 2017-18 or FY 2018-19. Yes X No

☐ If yes, provide the following details:
  - Estimated dollar amount of the procurement;
Philadelphia

In FY 2017-18, we will enter an IT procurement in the amount of $11 million; in FY 2018-19, we will enter an IT procurement in the amount of $12 million.

- Type of procurement (Request for Proposals, Request for Quotation, sole source, etc.);

  FY 2017-18 – Sole source; FY2018-19 – IT Staff Augmentation RFP.

- If the county obtained the necessary state and federal approvals prior to initiating the procurement.

  We are waiting for FY 2017-18 IT Grant approval before initiating the procurement process. We will await FY 2018-19 Grant approval before initiating the RFP process.

- Indicate if your county has obtained required signatures for the CWIS Data Sharing Agreement and will submit along with your NBPB. Yes___No___

  Required signatures will be obtained as needed and included with the final submission.

- Provide any additional information that will assist in the review of changes to your FY 2017-18 IT budget or 2018-19 IT request.

4-4. Accurint

- Please identify the name and email addresses of the Accurint Administrator in your county and each Accurint User.

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Email address</th>
</tr>
</thead>
<tbody>
<tr>
<td>William</td>
<td>Gordon</td>
<td><a href="mailto:William.J.Gordon@phila.gov">William.J.Gordon@phila.gov</a></td>
</tr>
</tbody>
</table>

Current Accurint Users

<table>
<thead>
<tr>
<th>Shahodah Bohannon</th>
<th><a href="mailto:Shahodah.T.Bohannon@phila.gov">Shahodah.T.Bohannon@phila.gov</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Stephanie Davis</td>
<td><a href="mailto:Stephanie.A.Davis@phila.gov">Stephanie.A.Davis@phila.gov</a></td>
</tr>
<tr>
<td>Juanita Dennis</td>
<td><a href="mailto:Juanita.Dennis@phila.gov">Juanita.Dennis@phila.gov</a></td>
</tr>
<tr>
<td>Zachary Harris</td>
<td><a href="mailto:Zachary.Harris@phila.gov">Zachary.Harris@phila.gov</a></td>
</tr>
<tr>
<td>Alice Herbert</td>
<td><a href="mailto:Alice.Herbert@phila.gov">Alice.Herbert@phila.gov</a></td>
</tr>
<tr>
<td>Lelia Johnson</td>
<td><a href="mailto:Lelia.Johnson@phila.gov">Lelia.Johnson@phila.gov</a></td>
</tr>
<tr>
<td>Cara Mallon</td>
<td><a href="mailto:Cara.A.Mallon@phila.gov">Cara.A.Mallon@phila.gov</a></td>
</tr>
<tr>
<td>Renee Morgan</td>
<td><a href="mailto:Renee.G.Morgan@phila.gov">Renee.G.Morgan@phila.gov</a></td>
</tr>
<tr>
<td>Ja’Net Roberson</td>
<td>Ja’<a href="mailto:Net.Roberson@phila.gov">Net.Roberson@phila.gov</a></td>
</tr>
<tr>
<td>Mario Thomas</td>
<td><a href="mailto:Mario.T.Thomas@phila.gov">Mario.T.Thomas@phila.gov</a></td>
</tr>
<tr>
<td>Annie Thomason</td>
<td><a href="mailto:Annie.P.Thomason@phila.gov">Annie.P.Thomason@phila.gov</a></td>
</tr>
<tr>
<td>Paula Ward</td>
<td><a href="mailto:Paula.M.Ward@phila.gov">Paula.M.Ward@phila.gov</a></td>
</tr>
</tbody>
</table>
Philadelphia

Users to Be Added

<table>
<thead>
<tr>
<th>User</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fanny Burdine</td>
<td><a href="mailto:Fanny.Burdine@phila.gov">Fanny.Burdine@phila.gov</a></td>
</tr>
<tr>
<td>Kristin Shatz</td>
<td><a href="mailto:Kristin.Shatz@phila.gov">Kristin.Shatz@phila.gov</a></td>
</tr>
<tr>
<td>Rochelle Collins</td>
<td><a href="mailto:Rochelle.N.Collins@phila.gov">Rochelle.N.Collins@phila.gov</a></td>
</tr>
<tr>
<td>Chatel Washington</td>
<td><a href="mailto:Chatel.Washington@phila.gov">Chatel.Washington@phila.gov</a></td>
</tr>
<tr>
<td>Shirrell Seibert</td>
<td><a href="mailto:Shirrell.Seibert@phila.gov">Shirrell.Seibert@phila.gov</a></td>
</tr>
<tr>
<td>Satta Taylor</td>
<td><a href="mailto:Satta.Taylor@phila.gov">Satta.Taylor@phila.gov</a></td>
</tr>
<tr>
<td>Richard Wolfe</td>
<td><a href="mailto:Richard.C.Wolfe@phila.gov">Richard.C.Wolfe@phila.gov</a></td>
</tr>
<tr>
<td>April Coker-Elliott</td>
<td><a href="mailto:April.L.Coker-Elliott@phila.gov">April.L.Coker-Elliott@phila.gov</a></td>
</tr>
<tr>
<td>Lisa Mahoney</td>
<td><a href="mailto:Lisa.Mahoney@phila.gov">Lisa.Mahoney@phila.gov</a></td>
</tr>
<tr>
<td>Latiffany Perkins</td>
<td><a href="mailto:Latiffany.Perkins@phila.gov">Latiffany.Perkins@phila.gov</a></td>
</tr>
<tr>
<td>Catherine Santos</td>
<td><a href="mailto:Catherine.Santos@phila.gov">Catherine.Santos@phila.gov</a></td>
</tr>
</tbody>
</table>

Users to Be Deleted

<table>
<thead>
<tr>
<th>User</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zachary Harris</td>
<td><a href="mailto:Zachary.Harris@phila.gov">Zachary.Harris@phila.gov</a></td>
</tr>
<tr>
<td>Alice Herbert</td>
<td><a href="mailto:Alice.Herbert@phila.gov">Alice.Herbert@phila.gov</a></td>
</tr>
</tbody>
</table>

Total users: 21

☐ Please explain any underutilization of Accurint services in the prior year, i.e. explain why it was not used in locating kin, tracking NYTD youth, or other search efforts.

According to data received from SERO between September 2016 and January 2017 we averaged just over 800 searches a month among the 12 current users. We are removing access for two staff that have not accessed Accurint in the last 12 months.

☐ Will Accurint be used in any program improvement strategies during this fiscal year? If yes, explain how.

Philadelphia DHS intends to expand our use of Accurint to support several program improvement strategies efforts toward meeting IOC goals. CWO intends to issue a policy requiring the use of Accurint for all youth with the goal of APPLA as well as any youth in foster care for whom there is no permanency resource and who are not placed with kin.

Based on current program improvement strategy efforts, DHS has already added 11 additional users based on the state’s allocation approval. Ten of the users are DHS Senior Learning Specialists, supervisor-level staff assigned to individual CUAs to provide technical assistance. The final additional user is an Administrative Assistant in the NYTD Unit to facilitate advanced searches.

We are approved for 20 users and ask at a minimum 21, the last being for the NYTD Unit. Ideally, we would request an additional ten licenses in order to add additional users to each of the floors of the main DHS office, as well two users for the Law Department. Currently, two unit Supervisors have access on each floor and are responsible for completing searches requested by any staff on those floors. This limits the extent and timeliness of the searches given that these Supervisors must also handle investigations assigned to their units. An additional user for each floor where child welfare services are provided and one for the Law Department would enhance capacity considerably. This would require an additional seven licenses for a total of 28. Through our Administrator, we will be requesting training for the staff being added.
Section 5: Required & Additional Language

5-1a. Assurances
The following pages include assurance forms to be completed by counties. These forms are included:

- Assurance of Compliance/Participation
- Documentation of Participation by the Judiciary
- Assurance of Financial Commitment and Participation

The following forms must be signed and submitted in hard copy to:

Office of Children, Youth and Families
Division of County Support
Health and Welfare Building, Room 131
625 Forster Street
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

And

Mr. Richard Steele
Juvenile Court Judges' Commission
Pennsylvania Judicial Center
601 Commonwealth Avenue | Suite 9100
Harrisburg, Pennsylvania 17102-0018
ASSURANCE OF COMPLIANCE/PARTICIPATION FORM
DOCUMENTATION OF PARTICIPATION BY THE JUVENILE COURT

The Assurance of Compliance/Review Form provided in this bulletin must be signed by the County Executive or a majority of the County Commissioners, the Juvenile Court Judge(s) or his/her designee, the County Human Services Director, the County Children and Youth Administrator, and the County Chief Juvenile Probation Officer, and submitted with the FY 2018-19 Needs-Based Plan and Budget submission.

The Assurance of Compliance/Review Form has two signatory pages. The first page is for the County Human Services Director, the County Children and Youth Administrator, the County Chief Juvenile Probation Officer, and the Juvenile Court Judge(s) or his/her designee. This page must be submitted at the time of the county’s implementation plan and needs based plan submissions. The second page is for the signatures of the County Executive or a majority of the County Commissioners. It must be submitted at the time of the county’s financial budget submission and must contain the financial commitment of the county.

COUNTY: Philadelphia

These assurances are applicable as indicated below.

___ X ___ Fiscal Year 2018-19 Children and Youth Needs-Based Plan and Budget Estimate; and

___ X ___ Fiscal Year 2017-18 Children and Youth Implementation Plan

Note: A separate, signed Assurance of Compliance/Participation form must accompany the Children and Youth Implementation Plan and the Needs-Based Plan and Budget when they are submitted separately. This Assurance of Compliance/Participation form cannot be modified or altered in any manner or the Children and Youth Implementation Plan and the Needs-Based Plan and Budget will not be accepted.

COMMON ASSURANCES

I/We hereby expressly, and as a condition precedent to the receipt of state and federal funds, assure that in compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Federal Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990, the Pennsylvania Human Relations Act of 1955 as amended, and 16 PA Code, Chapter 49 (Contract Compliance Regulations):

1. I/We do not and will not discriminate against any person because of race, color, religious creed, ancestry, national origin, age, sex, sexual orientation, or disability:
   a. In providing services or employment, or in our relationship with other providers;
   b. In providing access to services and employment for handicapped individuals.

2. I/We will comply with all regulations promulgated to enforce the statutory provisions against discrimination.

I/We assure that these documents shall constitute the agreement required by Title IV-E of the Social Security Act 42 U.S.C. § 672 (a)(2) for foster care maintenance, adoption assistance, and subsidized permanent legal custodianship payments.
Philadelphia

I/We assure:

- The County Children and Youth Agency and Juvenile Probation Office have the responsibility for placement and care of the children for whom Title IV-E foster care maintenance, adoption assistance, and subsidized permanent legal custodianship payments are claimed;
- The County Children and Youth Agency/Juvenile Probation Office will provide each child all of the statutory and regulatory protections required under the Title IV-E agency, including permanency hearings, case plans etc.;
- The agreement between the Office of Children, Youth and Families and the County Children and Youth Agency/Juvenile Probation Office shall be binding on both parties; and
- The state Title IV-E agency shall have access to case records, reports, or other informational materials that may be needed to monitor Title IV-E compliance.

I/We understand that any Administration for Children and Families disallowance incurred as a result of county noncompliance with Title IV-E foster care maintenance, adoption assistance, subsidized permanent legal custodianship, or Title IV-E administrative claim requirements will be the responsibility of the county.

I/We assure that all information herein is true to the best of my/our knowledge and belief based on my/our thorough review of the information submitted.

EXECUTIVE ASSURANCES

In addition to the Common Assurances,

I/We assure that I/we have participated in the development of the Plan, are in agreement with the Plan as submitted and that all mandated services if funded by the Plan will be delivered.

I/We assure that these Plans comply with the “Planning and Financial Reimbursement Requirements for County Children and Youth Social Services Programs” as found in 55 PA Code Chapter 3140.

I/We assure that, when approved by the Department of Human Services, the attached Children and Youth Implementation Plan and Needs-Based Plan and Budget, including any new initiatives, additional staff and/or increased services and special grants that are approved, shall be the basis for administration of public child welfare services for all children in need under Article VII of the Public Welfare Code, 62 P.S. § 701 et seq., as amended.

I/We assure that, where possible, the county will cooperate with state efforts to maximize the use of federal funds for the services in this Plan.

I/We assure that all contracts for the provision of services addressed herein will require the providers to comply with Chapter 49 provisions (contract compliance regulations).

I/We assure that expenditure of funds shall be in accordance with these Plans and estimates, and Department of Human Service regulations.

I/We assure that services required by 55 PA Code 3130.34 through 3130.38 will be made available as required by 55 PA Code 3140.17 (b)(2).

I/We assure that the capacity of both the county and the providers has been assessed and it is my/our judgment that it will be adequate to implement the Plan as presented.
I/We assure all Title IV-E foster care maintenance, adoption assistance, and subsidized permanent legal custodianship payment eligibility requirements are met for the specified children, not merely addressed by the agreement.

I/We assure that the County Children and Youth Advisory Committee has participated in the development of this Plan and has reviewed the Plan as submitted.

I/We assure that representatives of the community, providers, and consumers have been given the opportunity to participate in the development of this Plan.

I/We assure that the county programs that affect children (e.g. Mental Health, Intellectual Disabilities, and Drug and Alcohol) have participated in the development and review of this Plan.

I/We understand that the accompanying budget projections are based on estimates and that the amounts may change when the state budget is adopted and final allocations are made.

I/We understand that substantial changes to the Plans subsequent to Departmental approval must be submitted to the Regional Office of Children, Youth and Families for approval.

I/We assure that all new Guardians Ad Litem (GAL) have/will complete the pre-service training prior to being appointed to represent a child. If the GAL has not completed the pre-service training, costs incurred for representation of children by this GAL will not be claimed.

I/We assure that the County Children and Youth Agency is in compliance with all credit reporting agency requirements regarding the secure transmission and use of confidential credit information of children in foster care through electronic access for operation by counties where no agreement exists between the county and credit history agency. This also includes limiting online access to users approved by the Office of Children, Youth and Families for the explicit use of obtaining credit history reports for children in agency foster care.

COUNTY ASSURANCE OF COMPLIANCE AND PARTICIPATION DOCUMENTATION OF PARTICIPATION BY THE JUVENILE COURT

THE SIGNATURES OF THESE COUNTY OFFICIALS REPRESENT AN ACKNOWLEDGEMENT OF COUNTY COMMITMENT TO ADHERE TO THE COMMON AND EXECUTIVE ASSURANCES CONTAINED IN THE PRECEEDING PARAGRAPHS

County Human Services Director

_________________________  _________________________  ________
Name                      Signature                             Date

County Children and Youth Administrator

Cynthia F. Figueroa

_________________________  _________________________  ________
Name                      Signature                             Date

County Chief Juvenile Probation Officer

Faustino Castro-Jimenez

_________________________  _________________________  ________
Name                      Signature                             Date
DOCUMENTATION OF PARTICIPATION BY THE JUDICIARY

In addition to the Common Assurances:

I/We assure that I/we had the opportunity to review, comment, and/or participate to the level desired in the development of the Children, Youth and Families’ Needs-Based Plan and Budget.

I/We assure that the plan accurately reflects the needs of children and youth served by the juvenile court.

I/We assure that the Juvenile Probation Office has actively participated in the development of the Children, Youth and Families’ Needs-Based Plan and Budget.

Judicial Comments:

________________________________________________________________
________________________________________________________________
________________________________________________________________

Juvenile Court Judge(s)/ Designee

Judge Margaret T. Murphy  Name    Signature    Date

Name    Signature    Date


Philadelphia

COUNTY ASSURANCE OF FINANCIAL COMMITMENT AND PARTICIPATION

THE SIGNATURES OF THESE COUNTY OFFICIALS REPRESENTS AN ACKNOWLEDGEMENT OF COUNTY COMMITMENT TO ADHERE TO THE COMMON AND EXECUTIVE ASSURANCES CONTAINED IN THE PRECEDEING PARAGRAPHS AS WELL AS COUNTY COMMITMENT TO PROVIDE THE LOCAL FUNDS SPECIFIED IN THE PLAN AS NECESSARY TO OBTAIN THE MATCHING STATE AND FEDERAL FUNDS BASED ON THE COUNTY’S PROPOSAL. THE LOCAL FUND COMMITMENT AS PROVIDED IN THE COUNTY’S PROPOSAL TOTAL $__________________________.

Signature(s)

County Executive/Mayor

Eva Gladstein
Name ___________________________ Signature ___________________________ Date __________________

County Commissioners

Name ___________________________ Signature ___________________________ Date __________________

Name ___________________________ Signature ___________________________ Date __________________

Name ___________________________ Signature ___________________________ Date __________________
5-1b. CWIS Sharing Agreement

CWIS Data Sharing Agreement
October 1, 2017 – September 30, 2018

1.0 Statutory Basis

This Agreement establishes the terms and conditions in which CWIS will disclose and exchange certain information to the County Children and Youth Agencies (CCYA) via one (1) of the seven (7) approved case management systems utilized by the 67 CCYAs in accordance with the Child Welfare Act of 1980, the Child Abuse Prevention and Treatment Act (CAPTA - Public Law 93-247), and the Child Protective Services Law (CPSL) (23 Pa. C.S., Chapter 63).

These requirements were expanded with the passage of Act 29 of 2014 which amended the CPSL at 23 Pa. C.S. § 6336 (relating to information in the statewide database). Act 29 of 2014 allows DHS to establish a Statewide Database of Protective Services and to collect reports of child abuse and children in need of general protective services from the CCYAs via an electronic database. The reports shall include information relating to the subject of the report, the nature of the occurrence, information on the family, services provided, legal actions initiated, and other details required by DHS to track the safety and welfare of Pennsylvania’s children. Act 29 of 2014 also provides for the establishment of a pending complaint file and dispositions of complaints received. Access to information in CWIS is limited to persons authorized as defined under 23 Pa. C. S. § 6335 (related to access to information in the statewide database).

Both the CCYAs and County IT System Owners will use the data in order to fulfill their roles and responsibilities in delivering services required by the CPSL, the Juvenile Act, CAPTA program requirements, and, in later CWIS phases, for making eligibility determinations for the federal Title IV-E programs and supporting case planning and other requirements of Title IV-B programs.

This Data Sharing Agreement helps ensure that all users access and maintain CWIS data in accordance with applicable Commonwealth of Pennsylvania Information Technology policies and procedures as set forth in the Commonwealth Business Partner Account Registration Policy. All individuals registering for a Commonwealth Business Partner Account must read and acknowledge Management Directive 205.34 – Commonwealth of Pennsylvania Information Technology Acceptable Use Policy. In addition, this Data Sharing Agreement ensures that all CCYA Case Management Information Systems are accessed and maintained in accordance with the applicable Commonwealth and DHS Security Policies.
2.0 Definitions

**Authorized User** – Commonwealth of Pennsylvania employees, contractors, consultants, volunteers or any other user who utilizes or has access to IT resources. This includes all users with business partner accounts.

**Business Partner** - Generally, a user belonging to a non-Commonwealth entity whose access to Commonwealth systems is required as part of a contract with or legal requirement placed on that entity.

**IT Resources** – Any commonwealth computer system, Electronic Communication System, or electronic resource used for electronic storage and/or communications including but not limited to: servers; laptops; desktop computers; copiers; printers; wired or wireless telephones; cellular phones or smartphones; tablets; wearables; pagers; and all other mobile devices.

**Information Technology Systems or Systems** - Information Technology Systems or Systems include computer applications, servers, laptops, databases, routers, switches, wireless devices, mobile devices and other computer related hardware and software.

3.0 CWIS Data Sharing Agreement

This CWIS Data Sharing Agreement is entered by and between the Commonwealth of Pennsylvania (Commonwealth) and the respective CCYA as noted by the signature lines in Section 5 of this Agreement and is effective for the time period October 1, 2017 through September 30, 2018. The following information is included as appendices:

- Appendix A – CWIS Overview
- Appendix B – State and Federal Laws Regarding Confidential Records
- Appendix C – Referenced Commonwealth and Department of Human Services (DHS) IT Policies
- Appendix D – General Password Policies and Recommendations

As a user of the CWIS data, CCYAs must meet the following terms and conditions:

3.1 **CWIS Use Policy & Related OA Policies**

1. Understand that CWIS resources are intended for business use and should be used only for that purpose.
2. Ensure that use of CWIS data is compliant with the provisions of *Management Directive 205.34 – Commonwealth of Pennsylvania Information Technology Acceptable Use Policy*.
3. Retain a signed copy of this agreement which may be stored in an electronic format.

**CWIS Data Sharing Agreement**

**October 1, 2017 – September 30, 2018**
CWIS Data Sharing Agreement

4. Understand and comply with the provisions of DHS’s Incident Reporting and Response Policy. (DHS POL-SEC004)
5. Understand the permissible and non-permissible uses of CWIS data as defined by the CPSL as amended in 2014 and other state and federal laws that provide for the confidentiality of information including health related and other personal identifying information.
6. Only access information in the Statewide Database for purposes authorized under the CPSL.
7. Complete any CWIS specific training if requested by DHS’s Office of Children, Youth, and Families.

3.2 Security Requirements - Management & Operational Requirements
1. Comply with the Commonwealth and DHS policies and procedures on IT security as outlined in this section.
2. Establish and maintain a strong password and logon consistent with DHS policy. (DHS POL-SEC012)
3. Do not disclose a password used to access any system that maintains or stores CWIS data. (COPA MD 205.34)
4. Make every effort to ensure that privileged user access to any system containing CWIS data will be restricted to only staff that require access to perform operational work.
5. Secure all electronic CWIS communications (e.g. encrypted email or similar security measures) when exchanging system-derived confidential or restricted data. (COPA ITP-SEC008)
6. Retain a list of authorized county users who have access to any system that maintains or stores CWIS data and the contact information for the County IT Security Officer. Provide this list to DHS upon request.
7. Ensure that county users participate in annual security awareness training and sign a data privacy, confidentiality, and usage agreement which shall be maintained onsite for review and inspection by DHS officials upon request. (DHS POL-SEC010) An example of security awareness training used by the commonwealth is provided and may be adapted for use by counties. Successful completion of annual training includes user’s annual acknowledgment of Management Directive 205.34 – Commonwealth of Pennsylvania Information Technology Acceptable Use Policy.

3.3 Security Requirements - Technical Security Controls
1. Ensure that system connectivity to CWIS and all end users sessions are secure and can be electronically audited at all times. (COPA MD 205.34)
2. Ensure that county system owner(s) notify DHS CISO (ra-itsecurity@pa.gov) within one hour of determining a security/privacy incident related to their county case management systems and submit a follow-up investigative report within 24 hours. A security incident includes any unauthorized user accessing or obtaining CWIS data (DHS POL-SEC004)
3. Maintain required firewall settings as well as virus and intrusion protection at all times as defined in the commonwealth and DHS security policies. (DHS POL-SEC007)

4. Notify DHS CISO at ra-itssecurity@pa.gov in the event of disaster or other contingency that disrupts normal operation of the county networks.

5. Monitor county compliance with commonwealth and DHS security policies and procedures referenced in this agreement and keep records in a format that is conducive to periodic audits.

3.3 Records Access/Data Sharing

1. Comply with CWIS records access and data sharing policies, procedures, and standards as defined in Commonwealth Management Directive 205.34.

2. Understand that there is no expectation of CWIS user privacy when using any system that maintains or stores CWIS data.

3. Subject CWIS data to monitoring or other access by authorized commonwealth personnel.

4. Safeguard all CWIS data including CWIS data which could be cached, stored, and/or printed.

5. Limit data usage to "official purposes" and not for personal use under any circumstances.

6. For any system that maintains or stores CWIS data, users shall not have unauthorized data and should take measures to protect the security of their data.

7. Ensure that contractors do not disclose, duplicate, disseminate, or otherwise release CWIS data without obtaining prior written approval from DHS.

8. Ensure that CWIS data is maintained and provided consistent to the requirements of 23 Pa. C.S. § 6301 et seq.

9. Be mindful of penalties associated with the inappropriate release of data, including those set forth under 23 Pa. C.S. § 6349.

10. Disseminate information only for legitimate and official purposes consistent with all federal, state, and local laws.

11. Do not distribute CWIS derived data to the public or to unauthorized recipients unless otherwise specified in CWIS policy and procedures.

12. Maintain documentation as required by agency or CWIS (e.g. dissemination logs) to track who has had access to any system that maintains or stores CWIS data over the prior three-year period. Documentation must be available upon request.

13. Coordinate any planned system disconnection 60 working days prior to the actual disconnection with DHS, the CCYA, and the County Information System Owner.
4.0 Applicable Dates

A. **Effective Date.** The effective date of this agreement is October 1, 2017.

B. **Term.** The term of this agreement shall be for the period through September 30, 2018.

C. **Renewal.** This agreement shall be renewed annually as part of the annual Needs-Based Plan and Budget Process.

D. **Modification.** The Parties may not modify this Agreement at any time either by verbal or by written modification.

E. **Termination.** The confidential and privacy requirements shall survive any decision to terminate this agreement.

5.0 Signatory Approvals

This Agreement constitutes the entire CWIS Data Sharing Agreement and supersedes all other data exchange agreements between the DHS Office of Children, Youth and Families Parties that pertains to the disclosure of data between CWIS, CCYAs, and the County IT System Owners for the purposes described in this Agreement. Neither Party has made representations, warranties, or promises outside of this Agreement. This Agreement takes precedence over any other documents that may be in conflict with it. The terms and conditions of this CWIS Data Sharing Agreement will be carried out by authorized officers, employees, and contractors of CWIS, CCYAs, and County IT System Owners. For each agency signatory to this agreement, CWIS and the relevant entities are each considered to be a “Party” and collectively they are known as “the Parties”. By entering into this Agreement, the Parties agree to comply with the terms and conditions set forth herein and any other unstated applicable laws.

**Access to CWIS Data may be suspended or revoked for:**

1. Violating this agreement.
2. Violating agency, commonwealth, or federal laws, regulations, policies, and/or procedures.
3. Failing to cooperate with investigators during a misuse investigation.
The undersigned hereby represent that they are authorized to execute this agreement and bind the parties, their representatives, and their agents here below:

**Signatories**

<table>
<thead>
<tr>
<th>Position</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHS Deputy Secretary</td>
<td></td>
</tr>
<tr>
<td>County Executive/Solicitor</td>
<td></td>
</tr>
<tr>
<td>County Commissioner (if applicable)</td>
<td></td>
</tr>
<tr>
<td>County Children and Youth Agency Director</td>
<td></td>
</tr>
</tbody>
</table>
The Pennsylvania DHS CWIS is an electronic data exchange with 67 CCYAs using seven diverse county systems. DHS uses data collected from the county systems for state level data sharing and program coordination for child welfare services.

Current CWIS functionality is divided into seven modules listed below. Additional functionality will be added over the next few years.

- The Referral Intake module supports the recording of referrals that come in to the 24x7 ChildLine Hotline and need disseminated to the counties for follow-up.

- The Investigation and Assessment module supports the receipt of outcomes for Child Protective Services and General Protective Services referrals from counties and regions.

- The Investigation Review module provides system validations and worker review of the investigation summaries received from the counties or regions. It supports a mandated expungement process.

- The Appeals module supports the management of perpetrator appeals of the status determination of an investigation.

- The Clearance module supports the Child Abuse History Certification process for the general public who are required to acquire a clearance in order to work with children.

- The Self-Service module supports the electronic transmission of reports of suspected child abuse by mandated reporters and the submission of child abuse history clearance application.

- The Reports and Dashboards module provides operational reports for DHS and county users to monitor the status of referrals.
## State and Federal Laws Regarding Confidential Records

Below is a list of state and federal laws that may impact CWIS data. This list is not exhaustive and does not include any laws which may go into effect during the term of the Data Sharing Agreement.

<table>
<thead>
<tr>
<th>State or Federal Law</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>28 Pa. Code § 28.5 Screening and Follow-up for Diseases of the Newborn</td>
<td>A health care provider, testing laboratory, DHS, or any other entity involved in the newborn screening program may not release any identifying information relating to any newborn child screened in the newborn screening program to anyone other than a parent or guardian of the newborn child or the health care provider for the newborn child designated by a parent or the guardian except in delineated circumstances.</td>
</tr>
<tr>
<td>35 P.S. § 7607 Confidentiality of HIV-Related Information Act</td>
<td>No person or employee, or agent of such person, who obtains confidential HIV-related information in the course of providing any health or social service or pursuant to a release of confidential HIV-related information under Subsection (c) may disclose or be compelled to disclose the information, except to specific people or entities.</td>
</tr>
<tr>
<td>71 P.S. § 1690.108 PA Drug and Alcohol Abuse Control Act</td>
<td>All patient records and all information contained therein relating to drug or alcohol abuse or drug or alcohol dependence prepared or obtained by a private practitioner, hospital, clinic, drug rehabilitation, or drug treatment center shall remain confidential and may be disclosed only with the patient's consent and only (i) to medical personnel exclusively for purposes of diagnosis and treatment of the patient; or (ii) to government or other officials exclusively for the purpose of obtaining benefits due the patient as a result of his drug or alcohol abuse or drug or alcohol dependence except that in emergency medical situations where the patient's life is in immediate jeopardy, patient records may be released without the patient's consent to proper medical authorities solely for the purpose of providing medical treatment to the patient.</td>
</tr>
<tr>
<td>50 P.S. § 7111 Mental Health Procedures Act</td>
<td>All documents concerning persons in treatment shall be kept confidential and, without the person's written consent, may not be released or their contents disclosed to anyone except to specifically listed individuals or entities.</td>
</tr>
</tbody>
</table>
| 71 P.S. § 1690.112 Consent of Minor Under the PA Drug | Any physician or any agency or organization operating a drug abuse program who provides counseling to a minor who uses any controlled or harmful substance shall not be obligated to inform the parents or legal
<table>
<thead>
<tr>
<th>State or Federal Law</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>and Alcohol Abuse Control Act</td>
<td>guardian of any such minor as to the treatment given or needed.</td>
</tr>
<tr>
<td>23 Pa.C.S.A. § 6703 Address Confidentiality Program through the Office of Victim</td>
<td>Through the Office of Victim Advocate, eligible people shall receive a confidential substitute address. All records relating to applicants and program participants are the property of the Office of Victim Advocate. These records, including program applications, participants' actual addresses, and waiver proceedings, shall be kept confidential.</td>
</tr>
<tr>
<td>Advocate</td>
<td></td>
</tr>
<tr>
<td>35 P.S. § 10231.302 Confidentiality in the Medical Marijuana Act</td>
<td>All information obtained by the department relating to patients, caregivers, and other applicants shall be confidential and not subject to public disclosure, including:</td>
</tr>
<tr>
<td></td>
<td>(1) Individual identifying information about patients and caregivers.</td>
</tr>
<tr>
<td></td>
<td>(2) Certifications issued by practitioners.</td>
</tr>
<tr>
<td></td>
<td>(3) Information on identification cards.</td>
</tr>
<tr>
<td></td>
<td>(4) Information provided by the Pennsylvania State Police under Section 502(b).2</td>
</tr>
<tr>
<td></td>
<td>(5) Information relating to the patient's serious medical condition.</td>
</tr>
<tr>
<td>11 P.S. § 876-7 Confidentiality of Records in the Infant Hearing, Education,</td>
<td>Data obtained directly from the medical records of a patient shall be considered confidential and shall be for the confidential use of DHS in maintaining the tracking system and in providing appropriate services. The information shall be privileged and may not be divulged or made public in any manner that discloses the identity of the patient.</td>
</tr>
<tr>
<td>Assessment, Reporting and Referral Act</td>
<td></td>
</tr>
<tr>
<td>Pa.R.J.C.P. No. 173 Retention of Specific Information from Juvenile Records</td>
<td>All information retained according to this rule shall be confidential. This information is not eligible for inspection pursuant to Rule 160.</td>
</tr>
<tr>
<td>23 Pa. C.S. § 6344(n) Employees Having Contact with Children; Adoptive and Foster</td>
<td>The information provided and compiled under this section, including, but not limited to, the names, addresses, and telephone numbers of applicants and foster and adoptive parents, shall be confidential and shall not be subject to the Act of February 14, 2008 (P.L. 6, No. 3) known as the Right-to-Know Law. This information shall not be released except as permitted by DHS through regulation.</td>
</tr>
<tr>
<td>Parents</td>
<td></td>
</tr>
<tr>
<td>23 Pa. C.S. § 6344.2 Volunteers Having Contact with Children</td>
<td>Information provided and compiled under this section by DHS shall be confidential and shall not be subject to the Act of February 14, 2008 (P.L. 6, No. 3), known as the Right-to-Know Law. This information shall not be released except as permitted by DHS through regulation.</td>
</tr>
<tr>
<td>55 Pa. Code § 105.1 Policy; Safeguarding Information Relating to Individual</td>
<td>Information to be safeguarded. DHS will safeguard the following information:</td>
</tr>
<tr>
<td>Applicants and Recipients of Public Assistance</td>
<td>(1) The names of applicants and recipients.</td>
</tr>
<tr>
<td></td>
<td>(2) The address of any applicant or recipient and the amount of assistance any recipient is receiving except as provided in § 105.4.</td>
</tr>
<tr>
<td></td>
<td>(3) Information in applications, reports of investigations, financial and medical records, correspondence, and other recorded or unrecorded</td>
</tr>
<tr>
<td>State or Federal Law</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------</td>
</tr>
<tr>
<td><strong>55 Pa. Code § 5100.31 Confidentiality of Mental Health Records</strong></td>
<td>Persons seeking or receiving services from a mental health facility are entitled to do so with the expectation that information about them will be treated with respect and confidentiality by those providing services.</td>
</tr>
<tr>
<td><strong>55 Pa. Code § 5100.37 Records Relating to Drug and Alcohol Abuse or Dependence Under the Confidentiality of Mental Health Records</strong></td>
<td>Whenever information in a patient's records relates to drug or alcohol abuse or dependency as defined in 71 P. S. § 1690.102, those specific portions of the patient's records are subject to the confidentiality provisions of Section 8(c) of the Pennsylvania Drug and Alcohol Abuse Control Act (71 P. S. § 1690.108(c)), and the regulations promulgated thereunder, 4 Pa. Code § 255.5 (relating to projects and coordinating bodies: disclosure of client-oriented information).</td>
</tr>
<tr>
<td><strong>55 Pa. Code § 3680.34 Confidentiality of Client Records in Administration and Operations of a Children and Youth Social Service Agency</strong></td>
<td>(a) Information that may identify a child or the family, as well as other information contained in the client record, is confidential. (b) The legal entity shall ensure that no staff person discloses or makes use of information, directly or indirectly, concerning a child or the family, or both, other than in the course of the performance of his duties.</td>
</tr>
<tr>
<td><strong>55 Pa. Code § 3130.44 Confidentiality of Family Case Records in Administration and Operations of County Children and Youth Social Service Programs</strong></td>
<td>(a) Information that may be used to identify the child or the parents by name or address, and information contained in the case record, is confidential. A staff person may not disclose or make use of information concerning the child or the parents other than in the course of the performance of his duties.</td>
</tr>
<tr>
<td><strong>55 Pa. Code § 3490.242 Confidentiality of General Protective Services records</strong></td>
<td>Information obtained by the county agency or DHS in connection with general protective services may only be released as follows: (1) Under § 3130.44 (relating to confidentiality of family case records). (2) To another county agency. (3) To an official of an agency of another state that performs general protective services analogous to those services performed by county agencies or DHS in the course of the official's duties.</td>
</tr>
<tr>
<td><strong>55 Pa. Code §</strong></td>
<td>(a) A child's record is confidential.</td>
</tr>
<tr>
<td>State or Federal Law</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>3290.183 Confidentiality of Records of Family Child Day Care Homes</td>
<td>(b) A facility person may not disclose information concerning a child or family, except in the course of inspections and investigations by agents of DHS.</td>
</tr>
<tr>
<td>55 Pa. Code § 601.121 Confidentiality for Federal Low Income Home Energy Assistance Program</td>
<td>Information about a LIHEAP applicant or recipient is confidential</td>
</tr>
<tr>
<td>55 Pa. Code § 3490.91 Persons to Whom Child Abuse Information Shall be Made Available</td>
<td>Reports, report summaries, and other accompanying information obtained under the CPSL and this chapter in the possession of DHS and a county agency are confidential. Except for the subject of a report, persons who receive information under this section shall be advised that they are subject to the confidentiality provisions of the CPSL and this chapter, that they are required to insure the confidentiality and security of the information, and that they are liable for civil and criminal penalties for releasing information to persons who are not permitted access to this information.</td>
</tr>
</tbody>
</table>
| 55 Pa. Code § 3490.94 Release of the Identity of a Person Who Made a Report of Child Abuse or Cooperated in a Subsequent Investigation | (a) Except for the release of the identity of the persons who made a report of suspected child abuse or cooperated in the investigation under § 3490.91(a)(9) and (10) and 3490.92(a)(3) (relating to persons to whom child abuse information shall be made available; and requests by and referrals to law enforcement officials), the release of data that would identify the person who made a report of suspected child abuse or person who cooperated in a subsequent investigation is prohibited, unless the Secretary for DHS finds that the release will not be detrimental to the safety of the person.  
(b) Prior to releasing information under Subsection (a) to anyone other than a law enforcement official under Subsection (a), the Secretary will notify the person whose identity would be released that the person has 30 calendar days to advise the Secretary why this anticipated release would be detrimental to the person's safety. |
<p>| 55 Pa. Code § 5310.142 Confidentiality of Client Records for Children’s’ Services in Community Residential Services for the Mentally Ill | All client records and information are confidential and may not be disclosed directly or indirectly without the written consent of the child’s parent or the agency having custody of the child, if applicable, and if the child is 14 years of age or older. |
| HIPAA Privacy Rule, 45 CFR Part 160 and Subparts A and E of                           | The Rule assures certain individual rights in health information, imposes restrictions on uses and disclosures of protected health information, and provides for civil and criminal penalties for violations. |</p>
<table>
<thead>
<tr>
<th>State or Federal Law</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part 164</strong></td>
<td></td>
</tr>
<tr>
<td>42 U.S.C. § 290dd-2, 42 C.F.R. Part 2 Substance Abuse And Mental Health Services Administration</td>
<td>Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in this section, be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under this section. (Only applies to federally-assisted programs.)</td>
</tr>
<tr>
<td>18 U.S.C. § 2701, et seq. Stored Communications Act</td>
<td>Prohibits unauthorized access of electronic communications and provides civil and criminal remedies for violations, including a private right of action for aggrieved individuals. Also requires notice in the event of unauthorized access to a consumer's electronic records.</td>
</tr>
</tbody>
</table>
Appendix C

Referenced Commonwealth and DHS IT Policies

Commonwealth and DHS IT policies referenced in this agreement are listed below and included as attachments.

**Incident Reporting**

1. Incident Reporting & Response Policy - POL-SEC004
2. IT Security Incident Reporting Form – to be used by county to report an IT security incident

**Security/Privacy/Access**

1. Commonwealth of Pennsylvania Information Technology Acceptable Use Policy 205.34
2. Network Security Policy - POL-SEC007
3. IT Policy – Enterprise Email Encryption ITP008
4. Security Awareness Training Policy - POL-SEC010
5. User Identity and Access Management - POL-SEC012
General Password Policies and Recommendations

General Password Policies

1. Maintain a historical record of all issued account IDs. This record is to identify the person associated with the user ID and the timeframe during which the account ID is/was valid.

2. Multi-user systems are to employ unique user IDs and passwords, as well as user privilege restriction mechanisms. Network-connected, single-user systems are to employ hardware or software mechanisms that control system booting and include a no-activity screen blanker.

3. Computer and communication system access control is to be achieved via a minimum of user ID/password combinations that are unique to each individual user. Shared accounts or passwords are prohibited when the intent is to access files, applications, databases, computers, networks, and other system resources. Anonymous system login is not permitted.

4. Systems software is to be used to mask, suppress, or otherwise obscure all password fields to prevent the display, capture, and printing of passwords. Additional precautions may be necessary to prevent unauthorized parties from observing and/or recovering passwords. All passwords are to be encrypted or hashed both in storage and during transmission.

5. Policy does not prevent the use of default passwords -- typically used for new user ID assignment or password reset situations -- which are then immediately changed when the user next logs into the system.

6. Systems software is to limit validity of initial password(s) to the new user's first session log-on. At first log-on of a new account or after the password has been reset by an administrator or help desk, the user is to be required to choose a new password.

7. All vendor-supplied default passwords are to be changed before any computer or communications system is connected to a commonwealth network or used for commonwealth business. This policy applies to passwords associated with end-user IDs, as well as passwords associated with system administrator and other privileged users.

8. Incorrect password attempts are to be strictly limited to prevent password-guessing attacks. Upon five consecutive, unsuccessful attempts to enter a password, the involved account is to be suspended until reset by a system administrator. Reset process may be
9. delegated to the help desk or similar function approved by the Systems Administrator. When dial-up or other external network connections are involved, the session is to be disconnected. System administrators are to monitor access reports, logs, and other system activity for login attempts and report discrepancies.

10. Data encryption is required for all electronic password repositories.

11. Whenever there is a convincing reason to believe that system security has been compromised, the involved system administrator is to immediately (a) reassign all relevant passwords and (b) require all passwords on the involved system to be changed at the time of the next login. If systems software does not provide the latter capability, a broadcast message is to be sent to all users instructing them to change their passwords.

12. Least privileged. By default, all accounts should be assigned the lowest level of permissions. If elevated permissions are required, a change request should be submitted and approved before elevated permissions are granted to any account.

General Password Recommendations

Passwords are an essential component of PC security. The more complicated the password, the more difficult it is for unauthorized users to gain access to an authorized user’s system.

Users are to choose passwords that are difficult to guess. Passwords are NOT to be related to a user’s job function or personal life. Users are not to incorporate a car license plate number, a spouse's name, or fragments of an address into their passwords. A password is to neither contain any word found in the dictionary, nor any proper names, places, technical terms, or slang. When available, systems software is to block and prevent usage of easily guessed passwords.

Users are to apply the following techniques to prevent unauthorized parties from guessing passwords. When choosing passwords:

- String several words together (the resulting passwords are also known as "pass-phrases").
- Shift a word up, down, left, or right one row on the keyboard.
- Bump characters in a word a certain number of letters up or down the alphabet.
- Transform a regular word according to a specific method, such as making every other letter a number reflecting its position in the word.
- Combine punctuation or numbers with a regular word.
- Create acronyms from words in a song, a poem, or another known sequence of words.
- Deliberately misspell a word (but not a common misspelling).
Users are not to construct passwords that are identical (or substantially similar) to previously employed passwords. When available, systems software is to block and prevent password reuse.

Users are not to construct passwords using a basic sequence of characters that is then partially changed based on the date or some other predictable factor. For example, users are NOT to employ passwords like "X34JAN" in January, "X34FEB" in February, etc.

Readable-form passwords are not to be stored in batch files, automatic login scripts, software macros, terminal function keys, computers without access control, or in other locations where unauthorized persons might discover them. Passwords are to be assigned to specific, authorized users and are not to be accessible by anyone other than the authorized user. Non-repudiation depends upon the unavailability of a password to anyone other than the authorized user. Administrator passwords can be archived in a secured location with access limited only to authorized users.

Passwords are not to be written down and left in a place where unauthorized persons might discover them, except for initial password assignment and password-reset situations. If there is reason to believe a password has been disclosed to someone other than the authorized user, the password is to be immediately changed.

Passwords are never to be shared or revealed to anyone but the authorized user regardless of the circumstances. Revealing a password exposes the authorized user to the responsibility for actions that another party takes with the disclosed password.
ATTACHMENTS
Philadelphia

ATTACHMENT A
Attachment A

Commonwealth of Pennsylvania
Department of Public Welfare
PHILAELPHIA COUNTY
Child Welfare Title IV-E Waiver Demonstration Project
Initial Design and Implementation Report:
Component 3 – Evidence-Based Practice and/or System Changes

March 31, 2014
## Contents

I. Overview ................................................................. 127  
II. Clearly Defined Target Population(s) ......................... 135  
III. Clearly Defined Demonstration Components and Associated Interventions 137  
IV. Assessing Readiness to Implement the Demonstration .......... 147  
V. Work Plan ............................................................. 159  
VI. Training and Technical Assistance Assessment ................... 160  
VII. Anticipated Major Barriers and Risk Management Strategies ....... 163  
APPENDIX A ................................................................. 164  
APPENDIX B ................................................................. 169  
APPENDIX C ................................................................. 171  
APPENDIX D ................................................................. 173  
APPENDIX E ................................................................. 174  
APPENDIX F ................................................................. 179
I. Overview

Write a short introduction to your Evidence Based Practice(s) (EBP) and/or System Change(s) that make up the county’s third component of the Child Welfare Demonstration Project. Provide details as to how your engagement/assessment activities, as well as any other specific county activities defined the problem your county is attempting to address, the target population(s), and your specific interventions (EBPs and/or system changes).

In your previous IDIR you included a theory of change that provided the “big picture” of how the CWDP intended to use Family Engagement and Assessment to select appropriate county-specific interventions. At this point in the project, each county needs to develop a county-specific theory of change for your project interventions, including the expected short-term and long-term outcomes of the project as a whole and how and why the demonstration components and county-specific interventions are expected to address the identified needs of the target population(s). The theory of change should to tell a concise story of how the county is defining the problem(s) it hopes to address and to outline the intended outcomes. More importantly, the theory of change should demonstrate the series of connections that link the problems and needs being addressed with the actions the county will take to achieve desired outcomes. This overview might include a series of “if-then” statements that address the logical result of an action and should provide the county’s conceptual link between the identified problem and potential solutions.

RESPONSE:

In December 2013, the Department of Human Services (DHS) entered Year Two of the implementation of Improving Outcomes for Children (IOC) initiative. This new approach to service delivery focuses on the neighborhoods where children, youth, and families live and is critical to the design of the Child Welfare Demonstration Project (CWDP or Demonstration Project). Within IOC, case management services for children and youth involved with the child welfare system are delivered by community-based providers known as Community Umbrella Agencies (CUAs), while DHS
maintains responsibility for the hotline and investigations functions, monitoring and, oversight, and quality assurance. Given the magnitude of this system change (which is ongoing and not specifically related to the CWDP), we will align the implementation of Evidence-Based Practices, in itself another significant system change, with IOC goals and objectives. Consequently, EBPs will be developed and delivered through the CUAs and through the provider network contracted by Philadelphia’s Community Behavioral Health Department (CBH) to deliver behavioral health services and ensure comprehensive coverage for the DHS population. We will be assisted in this process by consultants at Annie E. Casey (AEC).

In Year 1 of the Demonstration Project, as part of our ongoing IOC system change, DHS and the CUAs engaged child welfare clients, particularly those involved in congregate care, in a series of Family Group Decision Making (FGDM) and Family Team Conferencing (FTC) meetings (n=809) to support safety, permanency, and well-being. At the same time, DHS worked toward the implementation of the FAST and CANS tools as a means to assess the needs of our client population and point the way to evidence-based practices that can serve those needs. Development of these tools in our Electronic Case Management System (ECMS) and training CUA staff to conduct these assessments was completed in the fall of 2013; to date, 1029 FAST and 546 CANS assessments have been completed, although these are not necessarily representative of our total population. This number is not quite large enough to gauge whether the findings support one evidence-based practice over another; however, preliminary analyses reveal that at least 32% of our youth are in need of higher level services that are currently available. Furthermore, we can see from our other assessment strategies (Quality Service Reviews (QSR), ChildStat, and routine case file reviews) that trauma-informed services are a necessity for the many children, youth, and families in our population, particularly with regard to parent-child relationships and family functioning as they support youth functioning. Consequently, we have been able to work with the CUAs to select three interventions that fit the age range and diverse needs of our general population.

**Selected Evidence-Based Practices**

*Parent-Child Interaction Therapy (PCIT)* is an evidence-based behavioral health intervention that focuses on improving the caregiver-child relationship, increasing positive parenting strategies, and increasing children’s positive behaviors while simultaneously decreasing negative child behaviors. PCIT is typically completed in 12 to 20 sessions focused on two distinct phases: Child Directed Interaction (CDI) and Parent Directed Interaction (PDI). PCIT is for children ages 2 to 8 who have experienced
stress or trauma. PCIT is an evidenced-based treatment model with highly specified, step-by-step, live coached sessions with both the parent/caregiver and the child. Parents learn skills through PCIT didactic sessions. Using a transmitter and receiver system, the parent/caregiver is coached in specific skills as he or she interacts in specific play with the child. Generally, the therapist provides the coaching from behind a one-way mirror. The emphasis is on changing negative parent/caregiver child patterns. In Philadelphia, Child-Adult Relationship Enhancement (CARE) is being offered in conjunction with PCIT as part of a separate project conducted by the Children’s Hospital of Philadelphia (CHOP). CARE is a field-initiated group training program for adults interacting with children in a variety of settings. This group model was informed by the principles of PCIT and other evidence-based frameworks for adult education. Although based on evidence-based models, this training program has not yet gone through rigorous evaluation of efficacy. However, research conducted by the PolicyLab at CHOP shows promising results. Although we may potentially expand this program based on the research, we are not including it in this Demonstration Project.

*Positive Parenting Program (Triple P)* is a parenting and family support system designed to prevent and treat behavioral and emotional problems in children and teenagers. It aims to prevent problems in the family, school, and community before they arise to keep kids safely in their communities (IOC Goal 1). Triple P uses social learning, cognitive behavioral, and developmental theory to structure the intervention combined with research focused on risk factors associated with development of behavioral and social problems in children to better support parents and provide the skills needed to be self-sufficient and manage family issues. Parents are encouraged to set their own goals and choose the types of strategies that will work for their families. In this way, parents become independent problem solvers who gain the confidence to deal with issues as they arise in the future. Because it is not a one-size-fits-all model, it can be cost efficient and effective as families only receive the services they need for a time period suitable for them.

*Functional Family Therapy (FFT)* is an intensive, short-term family therapy model targeting at-risk youth ages 10-18 with externalizing behaviors ranging from oppositional, defiant, and disruptive behaviors to serious, chronic criminal offenses. FFT has been applied to a wide range of youth and their families in various multi-ethnic and multicultural contexts. Therapy can be conducted in the family’s home by a trained therapist or in a clinical setting. Sessions occur as frequently as necessary to meet the family’s needs and are provided over a period of about three months. The FFT model is organized around phases of treatment that emphasize engaging and enhancing the motivation of the youth and family, facilitating change within the family, and generalization of changes.
We feel that these three interventions align best with all of our IOC outcomes, provide the most comprehensive coverage for all eventualities, and complement an already robust set of services available in the city of Philadelphia. As you will see in the detailed descriptions of these interventions on pages 9-18, these programs have very specific criteria for inclusion and can be considered specialized interventions in the sense that they are neither necessary nor appropriate for every child and family open for service with DHS and the CUAs. Because of our long and productive collaboration with Philadelphia’s Community Behavioral Health Department (CBH), we will continue to offer a well-tested and effective array of services for our clients who do not fit the criteria for PCIT, Triple P, or FFT.

In September 2013, Annie E. Casey sponsored a collaborative retreat for DHS and CBH that focused on our congregate care reduction initiative. As a result, they developed a service grid (Appendix A) listing the existing resources that have always functioned as our primary interventions. These interventions are still appropriate for many of our clients, but we will now add to these the specialized interventions that form the core of our demonstration project.

As we continue our engagement processes with regard to FTC and are able to analyze our assessment data, we will be in a good position to determine what percentage of our population is best served by our existing service array and what percentage would benefit from specialized services.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Outcomes</th>
<th>Timely Reunification</th>
<th>Congregate Care Reduction</th>
<th>Improved Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Maintained Safely in the Home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCIT</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Triple P</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>FFT</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

**Theory of Change:**
The impetus for IOC was the realization on the part of DHS and the provider community that there were too many children being removed from their homes; that once removed they were staying in care for too long a period of time; that the longer they stayed in care the more likely they were to be eventually placed in congregate care; and that the cumulative impact of initial removal, lengthy stays, and the congregate care experience often resulted in an inability to function properly within given societal
expectations. Our initial IDIR provided the following theory of change regard to components 1 (engagement) and 2 (assessment):

- *If* families are engaged as part of a team, and
- *If* children and families receive comprehensive screening and assessment to identify underlying causes and needs and assessment information is used to develop a service plan, and
- *If* that plan identifies roles for extended family members and various supports, including appropriate placement decisions and connects them to evidence-based services to address their specific needs and/or appropriate system changes;
- *Then*, children, youth and families are more likely to remain engaged in and benefit from treatment, so that they can remain safely in their homes, experience fewer placement changes, experience less trauma, and experience improved functioning.

Here we present an expanded theory of change regarding the implementation of the evidence-based practices described above.

- *If* engagement and assessment are successful in determining appropriate interventions, children and families will receive services to address their specific needs, and
- *If* the interventions are implemented with fidelity to the original model, the outcomes for children and families will experience improvement and
- *If* the interventions are monitored for efficiency and effectiveness, the results will be measurable, and
- *If* system changes necessary to accommodate EBPs keep pace with client needs;
- *Then* children and youth can remain safely in their homes, experience fewer placement changes, experience less trauma, and experience improved functioning, and
- *Then* we will meet IOC short and long term outcomes as detailed below.

DHS’ short and long-term outcomes connected the practice of family engagement and assessment strategies and the delivery of evidence-based interventions with the improved IOC safety, permanency, and well-being outcomes listed below:

1. Short-Term: More children and youth maintained safely in their own homes and communities
   a. Fewer children and youth experiencing repeat maltreatment in 1 year
Philadelphia

b. Fewer children and youth entering out of home care inappropriately
   c. Fewer reentries within 1 year following exit to permanency

2. Long-Term: More children and youth achieving timely reunification or other permanence
   a. More children and youth achieving permanency (reunification) within 1 year
   b. More children and youth achieving permanency (adoption, PLC) within 2 years
   c. Reduction in non-permanency outcomes for youth
   d. Reduction in length of stay

3. Long-Term: A reduction in the use of congregate care

4. Both: Improved child, youth, and family functioning
   a. Long-Term: Increase placement stability
   b. Short-Term: More children and youth placed in their own community
   c. Short-Term: More siblings kept together while in placement
   d. Long-Term: Increased child and family functioning (as measured by FAST and CANS tools)

Further,

- *If* IOC outcomes are realized
- *Then* there will be fewer children and youth in long-term foster or congregate care, and
- *If* there is a reduction in long term foster care or congregate care, *then* reinvestment can be made in community-based services, and
- *If* the prevention services are successful,
- *Then* a feedback loop will result in less need for long-term foster or congregate care.
Selection of the following **Assessment Options** will help set the context for the work outlined in the county’s implementation plan. Below, select the option that best fits your assessment of the degree to which program development work will be required to adopt tailor, or create the intervention to meet the needs of the target population. Provide a brief explanation of your choice or variation on the choice offered (assuming the details of your implementation plan will be expanded in the remaining sections of your submission) and provide the estimated date when you believe the intervention will begin to be delivered to benefit the identified target population.

**Parent-Child Interaction Therapy (PCIT)**

- **Little to no program development work.** This intervention is a direct or nearly direct replication of an existing evidence-based or evidence-informed practice or program with an experienced “purveyor” who is willing and available to work with us (e.g., a program expert who has effectively assisted other agencies, counties, States).

**Brief Explanation:** The Children’s Hospital of Philadelphia (CHOP) adopted this model as part of their Child Stability and Wellbeing project (CSAW) Philadelphia. The implemented the intervention at two foster care agencies as part of a collaborative project with DHS and CBH.

**Estimated Date of Service Initiation:** Pilot complete; scaled for first two CUAs Fall 2013; will roll out as the CUAS roll out (see Timeline, Appendix C)
Positive Parenting Program (Triple P)

- Modest adaptation of an existing evidence-based or evidence-informed intervention. We can work with a purveyor and other experts to maintain most of the core elements of the intervention that are required/recommended by the developer/expert. The developer/expert is willing and able to work with us.

  *Brief Explanation:* This intervention includes five levels, which will be phased in over the next three years. We are connected to the trainer for the Philadelphia area.
  *Estimated Date of Service Initiation:* Levels 1-3 will initiate Jan – March 2015; Levels 4-5 will initiate July – September 2015.

Family Functional Therapy

- Modest adaptation of an existing evidence-based or evidence-informed intervention. We can work with a purveyor and other experts to maintain most of the core elements of the intervention that are required/recommended by the developer/expert. The developer/expert is willing and able to work with us.

  *Brief Explanation:* This intervention is already being delivered by CBH for delinquency clients but will need to be adapted for the dependency population.
  *Estimated Date of Service Initiation:* Adaptation and capacity building will commence July 2014, training in July 2015, and service in October 2015 – March 2016.
II. Clearly Defined Target Population(s)

Describe the target population(s) for each of the Evidence Based Practice(s) and/or System Change(s), noting exclusions, geography/locations, or eligibility criteria as appropriate. In this section, the plan should:

- Describe the **characteristics and needs** of the identified target population(s).

**RESPONSE:**

**PCIT Characteristics:** PCIT was initially targeted for families with children ages 2-7 with oppositional, defiant, and other externalizing behavior problems. It has been adapted successfully to serve physically abusive parents with children ages 4-12. PCIT may be conducted with parents, foster parents, or others in a parental/caretaker role. Caregiver and child must have regular, ongoing contact to allow for daily homework assignments to be completed. We have been and will continue to serve children 2 through 8.

**PCIT Needs:** The emphasis with PCIT is on changing negative parent/caregiver child patterns by addressing the child’s externalizing behaviors that reflect their history of stress or trauma, such as: Refuse or won’t follow directions, engage in power struggles, lose temper easily/tantrum, annoy others on purpose, always want attention, steal things, destroy things, start fights/hurt others, have difficulty staying seated, have difficulty playing quietly, have difficulty taking turns, etc. PCIT benefits parents who evidence harsh or overly punitive parenting by teaching them more appropriate management skills with young children.

**Triple P Characteristics:** Two age groups are intended for the intervention, 0-5 and 6-12; but the childhood program of 6-12 can be extended to families with teenagers 13 to 16.

**Triple P Needs:** Triple P has five intervention levels of increasing intensity to meet each family’s specific needs. The intervention should be used on families with children who have disruptive behaviors and/or childhood developmental issues. Level 5 Triple P focuses on families where there are stressors on the parents such as relationship conflicts, parental depression, stress from external factors (work, poverty, etc.)

**FFT Characteristics:** FFT is an intensive, short-term family therapy model targeting at-risk youth ages 10-18.

**FFT Needs:** FFT serves youth with externalizing behaviors ranging from oppositional, defiant, and disruptive behaviors to serious, chronic criminal offenses.
RESPONSE:

We were able to complete a preliminary analysis of our FAST/CANS data, which indicated that while all our youth in care will benefit from Triple P Levels 1 and 2, approximately 30% of them may qualify for one of the three specialized interventions. The table below illustrates an estimate of how many potential referrals there will be for each of the EBPs. Of course, these referrals will be phased in over the next four years as we build capacity to implement all of the EBPs (see Timeline, Appendix E). These numbers will be finalized prior to implementation as we are able to conduct FAST/CANS analyses more thoroughly and specifically. As we move through implementation, it is possible the percentage of youth receiving a particular EBP will either increase or decrease depending on our ongoing monitoring and evaluation.

<table>
<thead>
<tr>
<th></th>
<th>Estimated # Youth Meeting Age Criteria for Each EBP</th>
<th>Estimated # Youth Receiving Each EBP (30%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCIT</td>
<td>803</td>
<td>241</td>
</tr>
<tr>
<td>PPP (Levels 1-2)</td>
<td>2153</td>
<td>2153</td>
</tr>
<tr>
<td>PPP (Levels 3-5)</td>
<td>2153</td>
<td>646</td>
</tr>
<tr>
<td>FFT</td>
<td>1297</td>
<td>389</td>
</tr>
<tr>
<td>Total</td>
<td>6407</td>
<td>3429</td>
</tr>
</tbody>
</table>
III. Clearly Defined Demonstration Components and Associated Interventions

Describe the EBPs and/or System Change(s) for each of the identified target populations. Each EBP and/or System Change must be described separately.

RESPONSE:

**Parent-Child Interaction Therapy**

Parent-Child Interaction Therapy (PCIT) is an evidence-based behavioral health intervention that focuses on improving the caregiver-child relationship, increasing positive parenting strategies, and increasing children’s positive behaviors while simultaneously decreasing negative child behaviors. PCIT is typically completed in 12 to 20 sessions focused on two distinct phases: Child Directed Interaction (CDI) and Parent Directed Interaction (PDI). PCIT is for children ages 2 to 8 who have experienced stress or trauma. PCIT is an evidenced-based treatment model with highly specified, step-by-step, live coached sessions with both the parent/caregiver and the child. Parents learn skills through PCIT didactic sessions. Using a transmitter and receiver system, the parent/caregiver is coached in specific skills as he or she interacts in specific play with the child. Generally, the therapist provides the coaching from behind a one-way mirror. The emphasis is on changing negative parent/caregiver child patterns.

- Trauma Type: Interpersonal complex trauma (i.e., physical, sexual and emotional abuse and neglect)
- Average Length of Service / Number of Sessions: 12-20 sessions, 6-9 months
- Service Delivered Where: Therapy space at community-based site
- Project Goals / Activities: Increase the positive attachment relationship between caregiver and child. Increase child compliance to adult directives and decrease reported behavioral concerns

Parent-Child Interaction Therapy focuses on two basic interactions:

- Child Directed Interaction (CDI): Caregivers learn to use the PRIDE skills: Praise, Reflect, Imitate, Describe, Enthusiasm, as they follow the child’s lead during play. They ignore annoying or obnoxious behavior and control dangerous behaviors.
- Parent Directed Interaction (PDI): Caregivers learn to use effective commands and specific behavior management techniques as they play with their child. Caregivers are taught effective time out procedures and how to manage children’s behaviors in real-world settings.
Outcomes
PCIT concludes with a post-treatment evaluation. In most cases, the pretreatment assessment procedures are repeated, including parent reports, teacher report, child report, and direct observation measures. The Dyadic Parent-Child Interaction Coding System-II observations are repeated at the end of the last discipline coaching session. Parents also complete a parent-report measure of consumer satisfaction called the Therapy Attitude Inventory. Parents and child return for post-treatment feedback sessions where pre- and post-treatment videotapes and accomplishments are reviewed. Brief parent report measures (Eyberg Child Behavior Inventory, Parenting Stress Index) can be completed at booster sessions to assist in tracking maintenance of behavioral improvements or for long-term follow-up of treatment. PCIT is an evidenced-based treatment model with highly specified, step-by-step, live-coached sessions with both the parent/caregiver and the child. Parents learn skills through PCIT didactic sessions, and using a transmitter and receiver system, the parent/caregiver is coached in specific skills as he or she interacts in specific play with the child. Generally, the therapist provides the coaching from behind a one-way mirror. The emphasis is on changing negative parent/caregiver child patterns. The goals of treatment are:
- an improvement in the quality of the parent-child relationship,
- a decrease in child behavior problems with an increase in prosocial behaviors, and
- an increase in parenting skills.

Evidence Base
PCIT draws on the following theories: Baumrind’s parenting styles, attachment theory (Bowlby), social learning theory (Bandura), Patterson’s coercion theory, and behavior modification (Skinner). PCIT is empirically supported and has been evaluated in dozens of controlled studies, with findings of: strong skill acquisition, more positive attitudes towards child, parent report of behavior problems to within normal limits, high parent satisfaction, improvements in self-reports of maternal depression and parental stress, maintenance of treatment gains up to 6 years after treatment, generalization to untreated siblings, and generalization to the home and school.

Studies that have highlighted PCIT’s effectiveness with physical abuse:
- Ware, Fortson, & McNeil (2003)
- Borrego, Urquiza, Rasmussen, & Zebell (1999)
- Fillcheck, McNeil, Herschell (2005)
Studies that have highlighted PCIT’s effectiveness with foster parents:
- Borrego & Burrell (2010)
- Urquiza, Timmer, Herschell, McGrath, Zebell, & Porter (2005)

PCIT is empirically based and recognized by the following:
- Society of Clinical Child and Adolescent Psychology, APA Division 53 (www.effectivechildtherapy.com)
- The National Child Traumatic Stress Network (SAMHSA, 2005; http://www.nctsn.org)
- Chadwick Center for Children and Families (http://www.chadwickcenter.org)
  - National Crime Victims Research and Treatment Center (U.S. Department of Justice; http://musc.edu/ncvc)

PCIT Expansion in Pennsylvania
In 2010, the Department of Public Welfare received a two-year grant from The Heinz Endowments to assist with the goal of implementing Parent-Child Interaction Therapy in Pennsylvania and issued a Request for Applications to all licensed mental health agencies in the commonwealth. Eight providers from across the state received grant assistance to receive training in PCIT.

In 2012, the University of Pittsburgh received a five-year grant for $3.3 million from the National Institute of Mental Health called "A Statewide Trial to Compare Three Training Models for Implementing an Evidence-Based Treatment (EBT)." The EBT that will be used in the statewide trial is Parent-Child Interaction Therapy (PCIT), comparing three training models for that treatment modality. The grant will help us understand what training methods are most effective for implementing an evidence-based treatment like PCIT. It will also help to build workforce capacity and significantly
Philadelphia

expand access to PCIT services in Pennsylvania for children ages 2½-7 beyond the 23 counties and 45 agencies currently offering PCIT. Seventy-two additional licensed outpatient mental health providers will be chosen to participate in the grant project. The grant will cover the cost of training four clinicians from each agency and some site preparation costs. Agencies will be recruited soon, and training is expected to begin in Spring 2014.

Discussion at Steering Committee meetings included methods for recruiting and selecting the agencies to participate in the grant and how to ensure that PCIT will be sustainable and cost-effective after the grant has ended. In addition to expanding PCIT across Pennsylvania, the grant provides an opportunity for the state to help inform PCIT International about the efficacy of various training models since currently the answer is not known to the question of which training method is most effective. For more information about the grant, contact Dr. Amy Herschell, principal investigator, University of Pittsburgh School of Medicine.

Positive Parenting Program (Triple P)

Positive Parenting Program (Triple P) is a parenting and family support system designed to prevent and treat behavioral and emotional problems in children and teenagers. It aims to prevent problems in the family, school, and community before they arise to keep kids safely in their communities (IOC Goal 1). Triple P uses social learning, cognitive behavioral, and developmental theory to structure the intervention combined with research focused on risk factors associated with development of behavioral and social problems in children to better support parents and provide the skills needed to be self-sufficient and manage family issues. Parents are encouraged to set their own goals and choose the types of strategies that will work for their families. In this way, parents become independent problem solvers who gain the confidence to deal with issues as they arise in the future. Because it is not a one-size-fits-all model, it can be cost efficient and effective as families only receive the services they need for a time period suitable for them.

Types of Approaches

- **Population Approach**: This approach of Triple P means that the program will be implemented across an entire community, such as a CUA, where all levels of Triple P service are rolled out in different manners to get the community involved, including one-on-one meetings, seminars, and group events.

- **Tailored Approach**: Tailored approaches mean one or several Triple P courses are selected that fit the needs of families being served and the intervention is given to a particular age range or risk level group through a specific delivery model.
Outcomes
Outcomes of Triple P focus on decreasing negative and disruptive child behaviors, decreasing negative parenting practices as a risk factor for later child behavior problems, and increasing positive parenting practices to increase protective factors for last child behavior problems and positive parenting reactions.

Logic Model
Triple P Logic Model:
http://www.blueprintsprograms.com/resources/logic_model/TripleP.pdf

Intervention Levels
Triple P is delivered in an outpatient or community setting for families. Triple P has five intervention levels of increasing intensity to meet each family’s specific needs. Each level includes and builds upon strategies at the previous level.

1. Level 1 (Universal Triple P): Media-based information strategy designed to increase community awareness of parenting resources, encourages parents to participate in programs, and communicates solutions to common behavioral and developmental concerns.

2. Level 2 (Selected Triple P): Specific advice on how to solve common child developmental issues and minor child behavioral problems. Parenting tip sheets and videotapes are used that demonstrate specific parenting strategies delivered through one or two brief face-to-face 20-minute consultations.

3. Level 3 (Primary Care Triple P): Children with mild to moderate behavior difficulties and includes active skills training that combines advice with rehearsal and self-evaluation to teach parents how to manage these behaviors. Level 3 is delivered through brief and flexible consultation, in the form of four 20-minute sessions.

4. Level 4 (Standard Triple P and Group Triple P): An intensive strategy for parents and children with more severe behavioral difficulties, designed to teach positive parenting skills and their application to a range of target behaviors. Level 4 is delivered in 10 individual or 8 group sessions totaling about 10 hours of intervention.

5. Level 5 (Enhanced Triple P): An enhanced family strategy in which parenting difficulties are complicated by other sources of family distress (ex. relationship conflict, depression, high stress). Program modules include practice sessions to enhance parenting skills, mood management strategies, stress coping skills, and partner support skills. This level adds three to five sessions tailored to meet the specific needs of the family to the level 4 intervention. There are other variations for parents with children with developmental disabilities (Stepping Stones Triple P) and for parents who have abused their
children in the past (Pathways Triple P). Pathways Triple P covers anger management and other behavioral health strategies to improve a parent’s ability to cope with raising children.

Triple P prides itself on its flexible delivery that ensures that it can be used on the maximum number of families and be used on different cultures of people within a community. There are different iterations of the program that will appeal to different family needs. This also allows for easy rollout of the system to meet the specific needs of some clients first and then rollout to other areas of the community with different needs. The multi-level system offers a suite of programs that can cater to a different level of need or dysfunction for a family so the family can receive exactly what they need in an efficient and effective manner.

Evidence Base
Triple P is ranked as number one on the United Nations’ ranking of parenting programs based on the extent of its evidence base, including studies from around the world for different cultures. Over the last 30 years, there have been hundreds of studies around the world that included Triple P. In the United States, there have been several studies outlining effectiveness in achieving the outcomes and being a cost effective way of providing needed services:

Studies that have highlighted Triple P’s effectiveness with behavioral and emotional problems:

Studies that have highlighted the cost effectiveness of Triple P:

Triple P is empirically based and recognized by the following:
- Department of Justice, Office of Juvenile Justice and Delinquency Prevention
- United Nations
- The National Child Traumatic Stress Network

**Functional Family Therapy**
Functional Family Therapy (FFT) is an intensive, short-term family therapy model targeting at-risk youth ages 10-18 with externalizing behaviors ranging from oppositional, defiant, and disruptive behaviors to serious, chronic criminal offenses. FFT has been applied to a wide range of youth and their families in various multi-ethnic, multicultural contexts. Therapy can be conducted in the family’s home by a trained therapist or in a clinical setting. Sessions occur as frequently as necessary to meet the family’s needs and are provided over a period of about three months. The FFT model is organized around phases of treatment that emphasize engaging and enhancing the motivation of the youth and family, facilitating change within the family, and generalization of changes.

**Outcomes**
- FFT has more than 40 years of research behind it and is widely recognized as a state-of-the-art evidence-based treatment program. Outcome assessment in FFT focuses on change within the family, such as improved parenting skills, improved communication, and reduced conflict, as well as whether the youth has refrained from substance use and criminal activity, stayed in school, and improved his or her behavior.
- Research shows that FFT achieves the following short-term outcomes: greater likelihood the youth remains at home (reduction of congregate care), improved family functioning, reduced substance use, and fewer youth mental health symptoms and/or behavior problems.
- In the long-term, FFT has been shown to reduce criminal recidivism and arrest rates, decrease substance use, and decrease behavioral health problems. Research has also shown that the younger siblings of youth who participate in FFT are less likely to have contact with juvenile court 2 ½ - 3 ½ years later.

**Theoretical Rationale**
- The FFT model draws from family systems theory and integrates behavioral approaches. FFT is based on the theory that youth’s
problem behaviors serve a function within the family. FFT is a sophisticated clinical model that increases a family’s motivation to change and tailors interventions to each family’s unique risk and protective factors.

- Family members develop ways of interacting that help them to get their relational needs for closeness or distance met, but these patterns of interacting may also create or maintain behavior problems. When changes are made in how the family interacts (e.g., improving communication, problem-solving, and parenting skills), behavior problems will be resolved. Interventions must take into account the needs of each family member and be tailored to the family’s unique risk and protective factors.

How it works: Core Intervention Components
FFT works with the entire family, so the youth and his/her caregivers are present at the sessions. Consequently, sessions are often held afterschool and on evenings and weekends. The FFT therapist will meet with the family as often as necessary. Sessions occur at least once per week, but the therapist can meet with a family multiple times per week at the beginning of treatment and during times of crisis or high need.

FFT proceeds through five phases of treatment, each designed to reduce specific risk factors and enhance protective factors.

- Early in treatment, the emphasis is on engaging the family and motivating them to participate in therapy.
- The therapist then conducts an assessment of the family, which is used to guide interventions for behavior change. Interventions often include psychoeducation/parent training and communication skills training, with a focus on changing patterns of family interaction that are maintaining the problem behavior.
- Once change has occurred within the family with respect to the presenting problems, the therapist helps the family generalize their new skills to other problems within the family as well as to situations outside of the home, such as problems that may be occurring at school. The therapist also helps the family develop supports and resources to support lasting change.

Link to Logic Model:
http://www.blueprintsprograms.com/resources/logic_model/FFT.pdf

Evidence Base
FFT is supported by 40 years of investigation that has demonstrated improvements with difficult to treat youths and their families in a range of
settings and delivery sites. FFT has been evaluated in multiple studies in samples across the United States, and in Sweden.

There have been a few studies charting the effects of FFT in Pennsylvania specifically:

- According to the 2010 Outcomes Summary from the Evidence-Based Prevention & Intervention Support Center (EpisCenter), from data collected from 12 FFT providers across Pennsylvania:
  - Of the 1,175 youth discharged from FFT across 2010:
    - 95% had no new criminal charges during treatment.
    - 73% remained drug-free (as evidenced by negative drug screen[s] during their last three months in FFT)*.
    - 60% improved on school attendance* and 60% improved on school performance*.
  - *Only reported for youth who were identified with this problem at enrollment
  - Of the 1245 parents/caregivers discharged from FFT across 2010:
    - 80% exhibited desired change.
    - 71% showed improvement in their parenting skills

- From the Pennsylvania FFT Data Highlights Report ran on 1/24/14:
  - Based on 761 youth clinically discharged in Pennsylvania during the fiscal year 2012-2013: 76.4% had improved family functioning, 66.7% improved school attendance, 68.5% improved academic performance, and 90% of the youths were living in a community.
  - At 6 months post-discharge outcomes for these youth were measured again: 90% were not in out-of-home placements, 90% maintained their behavior change, 81% had no new substance abuse, and 96% were in school, graduated, or obtained their GED.

Although FFT has been traditionally used for youth in the juvenile justice system, it is increasingly being used for the child welfare dependency population as well.

Studies that have analyzed FFT’s implementation:
- “Functional Family Therapy Program Costs.” Accessed at: [http://www.blueprintsprograms.com/programCosts.php?pid=0a57cb53ba59c46fc4b692527a38a87c78d84028](http://www.blueprintsprograms.com/programCosts.php?pid=0a57cb53ba59c46fc4b692527a38a87c78d84028)
- “Phases of FFT implementation/certification.” Accessed at
Studies that have highlighted FFT’s effectiveness with behavioral problems and delinquent recidivism:

- EpisCenter (2011). “Outcomes Summary from the Evidence-Based Prevention & Intervention Support Center.”
IV. Assessing Readiness to Implement the Demonstration

Include an analysis and overview of the requirements for the system, organizations, and community partners in implementing each EBP and/or System Change as intended, as well as specific activities to be completed prior to implementation. This includes:

- Assess the fit of each EBP and/or System Change with community values, culture, and context.

RESPONSE:

We selected PCIT, Triple P, and FFT for this demonstration project because they are an excellent fit with our ongoing initiatives: IOC, Congregate Care Realignment, and Strengthening Families. IOC is designed to accommodate community values, culture, and context because we now assign cases geographically and chose our CUAs based on their ability to deliver services in the community where the families and youth reside. The demonstration project will allow us to enhance our service delivery under the IOC model, while attempting to decrease the number of youth in congregate care and the number of youth in foster care overall so that funds can be used in the community to deliver a comprehensive array of prevention services. As our preliminary analysis of FAST/CANS data suggests and as anecdotal evidence from DHS/CUAs confirms, the selected EBPs will fill a service gap in terms of the range of ages served, the accessibility of these services, and the nature of these services. Interventions that address the specific trauma issues for children, youth and families are sorely needed. Integrating trauma-informed interventions that also provide parental guidance and behavior modification in a community setting is a more holistic approach than we have previously managed to provide. We anticipate that further analyses of FAST/CANS as those assessments grow to scale will further confirm our choice of these three EBPs.

- Assess the leadership support for the CWDP in general and the county’s selection of interventions.

RESPONSE:

Given the ongoing collaborative work we have been doing with the CUAs on IOC implementation and with CBH on integrated service delivery, DHS is now in a position to maximize those efforts through the selection of PCIT, Triple P, and FFT as our EBPs of choice. All agencies are supportive of these interventions and are committed to developing capacity, organizing training, and implementing in a thoughtful rollout that complements the rollout of
IOC. We are cognizant of the fact that, according to Implementation Science, implementation takes time and the literature suggests that comprehensive projects such as these take 4-5 years. We have assured our partners in this project that we will phase in the EBPs over time so that initial implementation can be monitored and evaluated; adaptations to service delivery, particularly in the area of recruitment and retention, can be made if necessary; and system changes can be made when required.

As PCIT and FFT are already in limited use in Philadelphia, our stakeholders are familiar with them and have already begun to accommodate them. Triple P will be new for all of us, but everyone is enthusiastic about its implementation.

Example of CUA Reactions to Triple P

“We intend to use various aspects of the Triple P model, Levels 1-4. We like the model because of its flexibility and ability to be used in different contexts by persons of varying educational background. We envision using the model as our basic parent education model (i.e. facility based group parent ed classes), as well as being used directly with families receiving services through our case management team. In addition to prevention staff being trained to deliver parent ed classes, we would like to have several other CUA staff trained, including case managers, case aides, parent mentors, and visitation coaches. This will allow for a multitude of Triple P interventions to be used throughout our continuum of services.”

“This program can be offered in clinical and non-clinical settings which makes it versatile by design and offers clinical supports to parents. Parents model behavior to the child and the family surrounding the child. Triple P offers self-sustaining characteristics that support the IOC goal to maintain children in their homes and communities. Social competence has not been a focus of other interventions; children need to know how to be socially appropriate, socially competent and successful in developing and maintaining social systems.”

“Positive Parenting Program (Triple P) is a multi-tiered system of education and support for parents and caregivers of both children and adolescents. Levels are determined by increasing need and range from brief preventive programs (public awareness campaigns, informational brochures, etc.) to interventions for children and adolescents with moderate to severe behavioral problems (individual and group programs for youth and families). Triple P interventions are offered in a variety of formats. Frequency and nature of contact varies according to program level. 2-3 months in duration and the program is also available in Spanish.”
RESPONSE:

We do not have incompatibility or misalignment because the active efforts and system structure CBH has put into place to collaborate with CUAs and to facilitate referrals to appropriate behavioral health services have resolved a lot of those issues. However, we do have ongoing work that is needed to adjust to our changing environment and to accommodate the successful delivery of EBPs leading to desirable outcomes.

**IOC Implementation:** As IOC is still a relatively new system change, and the final CUA selection has just been made, there are ongoing adjustments to the new processes that guide implementation. We are confident that these adjustments can and will be made as necessary because we are all committed to the success of IOC. Given the number of collaborative meetings with the CUAs (case teaming, implementation team meetings, expedited permanency meetings (EPMs)), we feel that the partnerships are growing stronger on a daily basis.

**Congregate Care Rightsizing:** This initiative requires ongoing monitoring and adjustment as we try to reduce our congregate care population. While we have been successful so far, we think we can do better over time. We will be helped in this process by a grant we received from the Children’s Bureau last fall that is designed to prevent homelessness for youth aging out of foster care. We hope to be able to provide services to older youth and their families that will prevent them from moving into congregate care and therefore avoid homelessness as they reach adulthood. We are currently reviewing the service array for older youth, including them in our planning group activities for the grant, and reviewing how the higher levels of Triple P and FFT might work toward the goals of reducing the congregate care population and preventing homelessness at the same time.

**Data Systems and Data Integration:** Building an electronic case management system is an ongoing process and one that continually adapts to the needs of DHS and the CUAs. We continue to work on improving the robustness of our data system and the reliability of our data, particularly as we integrate the CUA data into our system. At the same time, we continue to work with CBH on possibilities for data sharing that will enhance our ability to assess youth appropriately for the EBPs, maintain fidelity in
implementation, and develop rigorous tracking, monitoring, and evaluating mechanisms that allow us to be confident in the efficiency and effectiveness of the EBPs for our population.

In addition, there has been major progress made regarding data sharing at the aggregate level (see Appendix B). We received approval for data sharing between DHS and CBH which will allow us to share information more freely.

- Ensuring Staff Competence at the Practice Level

For each front-line person (e.g. caseworker, foster parent, therapist, etc.) involved in direct service with children or family members, please describe what is currently planned in relation to:

- Using criteria relevant to the intervention for recruiting and/or selecting the direct service provider (e.g. number of staff, qualifications, pre-requisites, experience, attitude, ability);
- The training needed, timing and length of training required, qualification of trainers, availability and access to qualified trainers;
- The supervision and coaching model, including the qualifications needed for the supervisor and/or coach.

RESPONSE:

Our CUAs are our direct service providers, along with CBH for Medicaid reimbursable services. The staff responsible for implementation differs by EBP, but the process of training and supervision will be subcontracted out to an expert on each EBP. All CUA subcontracts are subject to DHS approval, including EBP provider organizations. Decisions on which providers will implement each EBP will be decided in collaboration with the CUAs, but with the exception of PCIT which is rolling out statewide and through the PolicyLab’s project, we anticipate sole providers. DHS is already meeting weekly with CUA staff to ensure that the IOC rolls out effectively. The project manager for CWDP will also meet weekly with CUA front line staff and EBP provider staff to ensure that the EBPs also roll out effectively.

Parent-Child Interaction Therapy (PCIT)

Qualifications: The training is for mental health professionals, employed by CBH and Medicaid reimbursable, with a minimum of a master’s degree in psychology or a related field. It involves 40 hours of direct training with ongoing supervision and consultation for approximately the next four to six months. The latter can be accomplished through conference calls, videotapes, and distance-learning technology. Competency criteria will be
assessed at the completion of the 40-hour training with fidelity checks throughout the supervision and consultation period. Assessment instruments and scoring forms as well as the step-by-step clinician guide are needed for training (Hembree-Kigin, T, & McNeil, C.B., Parent-Child Interaction Therapy. New York: Plenum, 1995). Manuals for detailed implementation of the treatment program, coding of sessions, and handouts for use in treatment will complement the guide.

**Clinician Training in PCIT**

- PCIT International’s Training Guidelines (2009)
- **Training Requirements for Clinicians**
  - Master’s degree or higher in the mental health field
  - Actively working with children and families
  - Licensed in his or her field or receive supervision from a licensed individual trained in PCIT
- **Training Program**
  - 40-hours of face-to-face contact with a PCIT trainer
  - 4-6 months later a 2-day advanced live training
  - Case Experience (at least 2 families, preferably 5)
  - Regular (bi-weekly) consultation/Supervision over 1 year
  - Skill review

**Costs**

- **Estimated Training** - $35,000 for a group of 10-12 clinicians
  - 7 face-to-face workshop days
  - Weekly to monthly consultation calls
  - Video review and feedback
- **Site Set-up** - ~$2,000 per site
  - Equipment – Bug-in-the ear, sound system, one-way mirror, toys, table & chairs, assessment measures
  - Construction Costs – observation room, time-out space
- **Clinicians in training**
  - Initial lost productivity time as they are learning a new treatment

**Update on PCIT Rollout in Philadelphia (2/25/14)**

Philadelphia selected a behavioral health service provider in 2009 to deliver PCIT at two foster care agencies in Philadelphia; Bethanna and Jewish Family and Children’s Services. The provider, Children’s Crisis Treatment Center (CCTC), was selected via a competitive process, jointly sponsored by DHS, Children’s Hospital of Philadelphia’s PolicyLab and DBHIDS. In July 2013, CCTC’s contract was expanded, with the addition of two additional child welfare agencies (Community Umbrella Agencies or CUAs), NET and APM, who began offering PCIT in July 2013. CCTC, with clinical support from
Philadelphia

PolicyLab, is responsible for adhering to national PCIT standards for training, coaching and supervision. The lead clinician at CCTC (Jessica Shore) and the clinical partner at PolicyLab (Susan Dougherty) are certified by PCIT International.

Bethanna, which recently became a CUA, also built internal capacity to deliver PCIT with the addition of two trained Bethanna clinicians, who started training in February 2013, with certification pending in March 2014.

Four CUAs (NET, APM, Turning Points for Children (TPFC), and Tabor Northern Community Partners (TNCP)) are building internal capacity by potentially participating in the PCIT Across PA grant funded by NIMH. NET, APM, and TNCP have identified outpatient staff who will participate in the training. TPFC will train staff at Juvenile Justice Center (JJC), who will merge with TPFC in 2014. For the four CUAs who are expected to participate in the NIMH grant, training, coaching, and supervision will be provided by the grant staff in adherence to national PCIT standards.

Finally, two CUAs, Catholic Community Services (CCS) and Wordsworth (WW), are exploring collaboration with an external partner to deliver PCIT services. DHS and CBH are in discussions with these two CUAs regarding the provider selection process and how/when services will be delivered. Potential partners for delivery of services include Children’s Crisis Treatment Center and Presbyterian Children’s Village (PCV). PCV has been providing PCIT via their outpatient clinic since 2011 and has collaborated directly with the purveyor of PCIT (PCIT International) for training, coaching, and supervision.

Positive Parenting Program (Triple P)

**Qualifications**: Practitioners represent a wide range of professions because of the ease of delivery and the different levels available. Family support workers (social workers), doctors, nurses, psychologists, counselors, teachers, police officers, child safety officers, and others can be trained to provide Triple P to families.

**Training**: Triple P trainers conduct training courses with 20 participants over a 1-4 day period depending on the level selected. Triple P uses a skills-based training approached to introduce the practitioners to the range of consultation skills necessary for the effective delivery of the program. Various methods are used to do the training such as presentations, video demonstrations, clinical problem solving, rehearsals of skills, and peer tutoring. Practitioners must attend 80% of the training in order to be able to be an accredited Triple P provider, with full accreditation completed six to eight weeks after the training is completed in order to demonstrate their proficiency. Practitioners, managers, and coordinators can access periodic
follow-up support via telephone with Triple P staff. Often a formal model of telephone support is used at the start of implementation and is phased out over time. Half-day professional development opportunities are offered around assessment, program fidelity vs. flexibility, cultural diversity, engagement of hard to reach families, and other workshops that staff can select based on personal needs.

**Costs:**

<table>
<thead>
<tr>
<th>Item Description</th>
<th>Cost</th>
<th>Required Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent Workbooks</td>
<td>$20-32 per participant</td>
<td>Yes</td>
</tr>
<tr>
<td>Positive Parenting Booklets</td>
<td>$6.50 per participant</td>
<td>Yes</td>
</tr>
<tr>
<td>Parenting Tip Sheets</td>
<td>$8-11 for a set of 10</td>
<td>Yes</td>
</tr>
<tr>
<td>2- to 3-day, on-site training and half-day follow-up training</td>
<td>$21,415-$26,195 per site for up to 20 practitioners, depending on level of training</td>
<td>Yes</td>
</tr>
<tr>
<td>Telephone Consultation</td>
<td>$200 per hour</td>
<td>No</td>
</tr>
<tr>
<td>Clinical Support</td>
<td>$3,035 per day</td>
<td>No</td>
</tr>
<tr>
<td>Pre- and post-accreditation quality assurance support</td>
<td>$3,035 per day</td>
<td>No</td>
</tr>
</tbody>
</table>

**Functional Family Therapy (FFT)**

*Qualifications:* Therapists should have a master’s degree in psychology, social work or a related field. Supervisors must be licensed therapists.

*Ratios:* Trained supervisors can support up to eight clinicians. Full-time clinicians work with caseloads normally averaging 12-16 “active” cases at any given time.

*Time to Deliver Intervention:* Requires an average of 12 sessions over a three to four month period. Clinicians spend an average of 2.5 – 3 hours per family per week for face-to-face contact, collateral services, travel, case planning and documentation.

**Implementation**

The Three Phase Process of Functional Family Therapy Site Certification
- Phase I—Clinical Training: The initial goal of the first phase of FFT implementation is to impact the service delivery context so that the local FFT program builds a lasting infrastructure that supports clinicians to take maximum advantage of FFT training/consultation. By the end of Phase I, FFT LLC.’s objective is for local clinicians to demonstrate strong adherence and high competence in the FFT model.
Assessment of adherence and competence is based on data gathered through the FFT Clinical Service System, through FFT weekly consultations, and during phase one FFT training activities. It is expected that Phase I be completed in one year, and not last longer than 18 months. Periodically during Phase I, FFT LLC personnel provide the site feedback to identify progress toward Phase I implementation goals. By the eighth month of implementation, FFT LLC will begin discussions to identify steps toward starting Phase II of the Site Certification process.

- Phase II—Supervision Training: The goal of the second phase of FFT implementation is to assist the site in creating greater self-sufficiency in FFT, while also maintaining and enhancing site adherence/competence in the FFT model. Primary in this phase is developing competent on-site FFT supervision. During Phase II, FFT LLC trains a site’s extern to become the on-site supervisor. This person attends two 2-day supervisor trainings, and then is supported by FFT LLC through monthly phone consultation. FFT LLC provides one 1-day on-site training or regional training during Phase II. In addition, FFT LLC provides any on-going consultation as necessary and reviews the site’s FFT CSS database to measure site/therapist adherence, service delivery trends, and outcomes. Phase II is a yearlong process.

- Phase III—Maintenance Phase: The goal of the third phase of FFT implementation is to move into a partnering relationship to assure ongoing model fidelity, as well as impacting issues of staff development, interagency linking, and program expansion. FFT LLC reviews the CSS database for site/therapist adherence, service delivery trends, and client outcomes and provides a one-day on-site training for continuing education in FFT. Phase III is renewed on an annual basis.


Link to implementation costs:
http://www.blueprintsprograms.com/programCosts.php?pid=0a57cb53ba59c46fc4b692527a38a87c78d84028

Start Up Costs:
Initial Training and Technical Assistance
- FFT brings a program to full functionality over three phases that generally last one year each. Start-up costs are incorporated in phase one of program development. Training is team based with an optimal team size of 5-6 therapists. The cost of phase one training and technical assistance is $36,000, plus an estimated $16,000 for travel
for a total of $52,000. Some of these costs will be incurred after the program staff are trained and treating clients.

**Curriculum and Materials:**
- All costs included in training and technical assistance costs above.

**Licensing**
- All costs included in training and technical assistance costs above.

**Other Start-Up Costs:**
- Staff salaries during the training period and the cost of developing office space (more space will be needed if implementation is to be office-based).

**Intervention Implementation Costs:**
- **Ongoing Curriculum and Material** - None.
- Administrative overhead can be projected at 10-30%, again depending on program size and on where the intervention will occur (home vs. office).

**Implementation Support and Fidelity Monitoring Costs**
- **Ongoing Training and Technical Assistance**
  - All costs to support an FFT team are included in the annual fees charged by the purveyor. In addition to the first year cost of $36,000 (plus $16,000 for travel) discussed under Start-Up Costs, year 2 cost is $18,000 (plus $3,500 for travel), and the cost for year 3 and beyond is $7,000 (plus $1,000 for travel) per year.
- **Fidelity Monitoring and Evaluation**
  - The annual fee includes support for the Clinical Services System (CSS), a web-based application for tracking progress notes, completing assessments, and reporting outcomes in accordance with the model design.
- **Ongoing License Fees** - See above
- **Other Implementation Support and Fidelity Monitoring Costs** - None

**Other Cost Considerations:**
- The scale of an FFT program can affect costs, with multiple teams being able to take advantage of combined trainings and other required events for implementation. Some states have developed a statewide training process that can also reduce costs. With therapist caseloads of 12 and supervisors seeing 5 youth/families and an average service length of 12 weeks, the program could serve approximately 600 youth/families. Average youth/family cost in this example would be $2,800.
For clarification on how the implementation of the EBPs intersects with the CUA rollout, see Timeline in Appendix C.

- Organizational Supports Needed

Please describe whether or not host agencies have been identified at this time. If such agencies have not yet been identified, describe the agency recruitment and “buy-in” process you are planning to use.

RESPONSE:

As mentioned previously, the CUAs are our host agencies and have been collaborating with us on this project for the last year. The CUAs will be primary drivers of EBP implementation; however, the DHS Project Manager will ensure that the interventions are implemented with fidelity to the model, consistency across the CUAs, and compliance with data reporting requirements.

Describe how host agencies that will employ front-line staff (e.g. public child welfare, private providers) will need to change in order to support new ways of work or services that were not previously supported by their organization. What new policies, procedures, or resources likely will be needed at the agency level?

RESPONSE:

DHS, CUAs and CBH will have to adjust to accommodate the provision of the selected EBPs. We believe will have to:

1. Hire a DHS Project Manager to oversee the day-to-day implementation factors and coordinate with a counterpart at CBH and each of the CUA agencies.

2. Allocate resources, most likely staff-related, either in allocating time from current staff or hiring new staff, aside from the mental health professionals needed for PCIT and higher level Triple P. Even on the lower levels of Triple P, which do not require a mental professional, there will have to be dedicated staff at the CUAs to be trained and to implement the program. With regard to FFT, there will be a liaison with CBH to work on referrals as we expand the program to include dependency youth.
3. Collaborate with CBH and the CUAs to develop recruitment procedures for hiring staff, refine assessments, and finalize inclusion criteria.

4. DHS will work with CBH and the CUAs to develop policies and procedures to guide the project to full implementation. We will consult with Annie E. Casey (AEC) as they have guided us so well in the past.

- System Supports – Describe the systemic supports that will facilitate the implementation of these interventions/system changes, including:
  
  Anticipated changes in funding mechanisms and streams during the demonstration period

RESPONSE:

The collaboration between DHS and CBH to consider blended funding opportunities, such that MA billable services would be covered by CBH and non-billable services by DHS. This type of blended approach will ensure the sustainability of the services over time. From the DHS perspective, all three evidence-based programs will be funded via Special Grant. Absent the Child Welfare Demonstration Project, these programs would be funded using prevention/preventative funds in the Needs Based Budget.

- The financial resources that might/will be able to sustain this intervention after the demonstration project ends;

RESPONSE:

Absent the child Welfare Demonstration Project, additional State and Local funds will be required to offset the loss of Federal funds. These additional funds are not currently budgeted.

- Any significant changes in policies, procedures, or contracting relationships that will be needed at any level (e.g. State, county, agency);

RESPONSE:

In collaboration with our project partners, we will develop and distribute the protocols for each intervention and, if necessary, translate those protocols into policy. There should be no change to our contracting relationships.
- Systems partners who have agreed to collaborate (e.g. mental health, education, courts, substance abuse providers, other providers);

RESPONSE:

The CUAs and CBH has already agreed to collaborate.

- Systems partners who will need to partner or collaborate differently but are not yet on board (e.g. mental health, education, courts, substance abuse providers, other providers).

RESPONSE:

We would like to enlist the support of the School District of Philadelphia and Family Court.

- The fidelity data system, including whether or not a data system and associated infrastructure (e.g. Web-based data entry) are available or you will be developing the data system to track fidelity;

RESPONSE:

As discussed previously, we will work to integrate date related to this project into our Electronic Case Management System (ECMS) along with the CUA data that will be necessary to track outcomes.

- The outcome measures, monitoring, and data systems that are required or optional and that will be developed and sustained over time.

RESPONSE:

The outcome measures will relate to the IOC outcomes of interest described previously. We will most likely develop additional measures that indicate improvement related to the present problems of participants in the EBPs. The Division of Performance Management will work with IT to develop compliance and outcome reports as each intervention is implemented.
V. Work Plan

Provide a plan and estimated timeline for activities associated with the implementation of each EBP and/or System Change. This should be completed as an addendum to your currently approved Work Plan. If there are any changes necessary to your current work plan, this should also be submitted for ACF consideration. To the extent possible, this section should include a description of the key tasks, responsible parties, timeframes for beginning and completing activities, and products or benchmarks of progress that will serve as evidence of completing the activities, noting the phasing or staging of providers, services, or other activities if there are multiple implementation locations.

See Timeline, Appendix C

See Workplan, Separate Attachment
VI. Training and Technical Assistance Assessment

Include a description of the State and/or Federal training and technical assistance (T/TA) resources the county anticipates it will need in order to implement the demonstration, making note of any strengths and gaps in those resources.

RESPONSE:

If it proves to be necessary, we will call on the state’s Child Welfare Training Institute for assistance.

The following responses are in regard to other outside experts needed to implement any aspect of the interventions selected by the county:

- Identify the experts available to you to assist in the use of this intervention.

RESPONSE:

As we are already collaborating with CBH, we will use their expertise in helping us finalize our implementation plan, particularly around capacity building, timing and adaptation of FFT for the dependent population.

We will continue to work with Annie E. Casey (AEC) on those same issues as they have been invaluable to us the past and with the present project. They will also be able to help us identify other jurisdictions with experience in delivering these EBPs so that we can learn from them in terms of successes achieved, problems encountered, and barriers likely to arise.

We will use the expertise of the PolicyLab at the Children’s Hospital of Philadelphia (CHOP) who have been instrumental in piloting PCIT in Philadelphia and who are also involved with the expansion of PCIT in Pennsylvania. We will learn from the trainers and coaches involved with start-up on Triple P, all levels.
RESPONSE:

We have worked with our partners for a very long time and our confidence in them has only grown stronger the longer we work together. CBH and the PolicyLab are particularly knowledgeable about the interventions themselves. AEC is very knowledgeable about dissemination of these interventions.

RESPONSE:

Although we did not specifically assess for this particular project, the partners reference above have been involved from the beginning in our IOC efforts, Congregate Care Reduction, etc. as well as this current project. In terms of the outside vendors who will train, coach and supervise on the expansion of Triple P, we have come to understand that they are the most respected providers of these services.

RESPONSE:

Some purveyors or experts have waiting lists or lack the capacity to engage in larger-scale efforts. Are these purveyors or experts available in a timely manner? Do they have the capacity needed to assist you?

RESPONSE:
We have been in contact with Triple P America to assure ourselves that they are willing and have to capacity to respond when we are ready for that intervention. CBH is most familiar with FFT implementation and, given enough time, will be able to work with us on its extension to dependency cases. PCIT trainers are already on board (see Timeline in Appendix C).

- Are they willing and able to help you build your own capacity (State or county level) to provide ongoing selection, training, coaching, data systems, etc.? Or will there be an ongoing relationship with the purveyor/experts and costs associated with maintaining this implementation infrastructure?

RESPONSE:

Most of our partners are internal so they will automatically be involved in ongoing selection. Training and coaching will be an ongoing expense until we reach full implementation and possibly beyond to account for staff turnover. Our data systems are our own, although we will be working with a yet to be decided provider of technical products and services as we begin to explore predictive analytics to use for this project and others.

For a snapshot of the selected EBPs, populations to be served, service providers, and ongoing system issues involved in implementing the program models, please see Appendix D. For a description of our partner agencies, see Appendix E. For an updated Distribution Map of CUAs under IOC, see Appendix F.

- Describe your budget for initial and ongoing involvement. Is it adequate?

RESPONSE:

We will be developing a model of braided resource utilization. CBH will cover Medicaid billable services (Levels 4-5 Triple P and expansion of FFT) and DHS will provide for non-clinical components, as well as some of the financial and data costs related to child welfare services. We anticipate training costs for PCIT to be covered through the previously mentioned NIMH grant and we have additional staff costs covered in our Needs Based Budget. Levels 1-3 of Triple P are relatively inexpensive and can be covered through the use of discretionary funds.
VII. Anticipated Major Barriers and Risk Management Strategies

Identify any anticipated major barriers to executing the implementation of each EBP and/or System Change and any planned strategies to address them.

RESPONSE:

It is important to note that DHS is running a dual system while we continue to implement IOC over the next several years. Although all 10 CUAs have been selected, and full implementation of the IOC initiative is expected to be complete in the fall of 2015, the accelerated rollout of IOC and the anticipated rollout of EBPs may present some logistical problems for the CUAs. Accordingly, DHS plans to hire a project manager with experience in resource development to ensure that the EBPs are developed appropriately, implemented with fidelity to the model, and integrated into IOC case management practice without jeopardizing case transfers as mandated by IOC or interrupting delivery of the current array of child welfare services being offered.
**APPENDIX A**

## CBH & DHS Services Currently Available

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CBH</strong></td>
<td><strong>CBH</strong></td>
</tr>
<tr>
<td>Family Focused -- Behavioral Health (Entire family)</td>
<td>(FFBH) – Implemented by NET designed to serve families with multiple siblings who are receiving or being referred to BHRS. Typically one or more of the children has been exhibiting chronic behavioral issues.</td>
</tr>
<tr>
<td>Family and Community Treatment (step down)</td>
<td>(FACT) – A one year in home family therapy service provided by one Masters’ level clinician in the role of family therapist but also able to provide individual therapy to family members.</td>
</tr>
<tr>
<td>Behavioral Health Rehabilitative Services</td>
<td>(BHRS) - Short term interventions to prevent placement into 24/7 psychiatric level of care and to promote youth being able to function in all domains, can be delivered in home, school or community. Components include TSS, Mobile Therapy, and Behavioral Specialist Consultant.</td>
</tr>
<tr>
<td>TSS – Therapeutic staff support</td>
<td>Therapeutic staff (BA level) support may be provided in the home, school, or other community settings. The role of the TSS is to implement the clinical interventions that described in the child's treatment plan to help make positive changes in behavior. The TSS should also provide encouragement to the child as well as feedback about how the child's behavior affects others.</td>
</tr>
<tr>
<td>Mobile Therapy</td>
<td>A mobile therapist provides therapy to children to support children and families in coping with issues such as loss, developmental delays or disabilities, anger management, parenting, and behavior modification.</td>
</tr>
<tr>
<td>BSC</td>
<td>A behavior specialist is a Masters’ level professional who works with the child, the family, and the school to develop a plan for re-shaping the child's behavior. The behavior specialist observes the child's behavior in the child's own setting. The behavior specialist</td>
</tr>
</tbody>
</table>
identifies the child's strengths and develops a
treatment plan with to addresses the child's
behavioral needs, while building on the child's
strengths.

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Transition and Stabilization Services (CTSS)</td>
<td>Short-term –max 90 days- that addresses MH and stabilization needs of children aged 4 to 21 years in foster care. In home individual and family therapy, crisis intervention and 1:1 support and modeling in home, school and community.</td>
</tr>
<tr>
<td>Family Based Mental Health Services</td>
<td>(FBMS) – Goal is to reduce out of home placement and to strengthen and maintain families through therapeutic interventions. Provided 24/7 by specific teams – 32 week program and provides transition to other community based services.</td>
</tr>
<tr>
<td>Functional Family Therapy (FFT)</td>
<td>JJ involved – Evidenced based treatment that addresses the youth with delinquency issues and designed to prevent or decrease delinquency, violence, disruptive behaviors and substance abuse. Duration 14 weeks.</td>
</tr>
<tr>
<td>Multi-Systemic Therapy for Problem Sexual Behavior (MST-PSB)</td>
<td>High level of intensity and frequency, delivered in home, school, or community; incorporates treatment interventions place a high premium on approaching each client/family as unique.</td>
</tr>
<tr>
<td>Multidimensional Treatment Foster Care</td>
<td>MTFC is an alternative to regular foster care, group or residential treatment, and incarceration for youth (ages 13-18) who have problems with chronic disruptive behavior. The goal of the MTFC program is to decrease problem behavior and to increase developmentally appropriate normative and prosocial behavior in children and adolescents who are in need of out-of-home placement. Youth come to MTFC via referrals from the juvenile justice, foster care, and mental health systems.</td>
</tr>
<tr>
<td>Parent-Child Interaction Therapy (PCIT)</td>
<td>An evidence-based practice that is a family focused approach for children 2-8 who present with moderate to severe BH challenges. Live coaching and treatment of both child and caregiver together.</td>
</tr>
</tbody>
</table>

Expansion into CUAs currently.
| **Outpatient** | **Individual**  
|               | **Family**  
|               | **Group**  
|               | **Enhanced (Evidence-based)**  
|               | **ECSFT (Future)**  |
| **High Fidelity Wraparound** | **High Fidelity Wraparound** is a process to improve the lives of children with complex needs and their families. It is not a program or a type of service. The process is used by communities to support children with complex needs and their families by developing individualized plans of care. The key characteristics of the process are that the plan is developed by a family centered team, is individualized based on the strengths and culture of the child and their family, and is needs rather than services driven. |
| **School based Services** | **STS – School Therapeutic Services** is a MH treatment developed as an alternative to BHRS in a school setting. Full range of therapeutic services, tailored to be age appropriate BH interventions. |
| **Acute Partial Hospital Program (PHP)** | Combines elements of inpatient and outpatient in a structured therapeutically intensive program. Is an alternative to hospitalization for individuals who pose a threat to self or others. Used for individ d/c from inpatient. |
| **Enhanced CM (Catch)** | |
| **Drug and Alcohol** | **Outpatient**  
| | **IOP**  
<p>| | <strong>Residential (ST and LT)</strong>  |
| <strong>Family Empowerment Services (FES)</strong> | The Family Empowerment Services (FES) program is a prevention service designed to enhance the ability of families to provide for their children’s well-being in a minimally intrusive, time-limited manner during the reunification process. Primary service includes case management, assessment of strengths and needs, interventions, arrangement/coordination of services to meet the family’s specific needs. Service is provided for 90 days. |</p>
<table>
<thead>
<tr>
<th>Service Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieving Reunification Center (ARC)</td>
<td>Is a “One Stop Center designed to assist parents with children in out of home placement overcome barriers toward family reunification. ARC offers a comprehensive range of services focused on ensuring child safety while strengthening the family’s stability and self-sufficiency by bringing systems together for positive family outcomes. All services offered are in one location including counseling; parent education, housing/financial counseling, workforce development, outpatient mental health, child care and supervised visits.</td>
</tr>
<tr>
<td>Intensive Prevention Services (IPS)</td>
<td>IPS is an intensive intervention program designed to engage youth between the ages of 10-17 years old, who have been identified as exhibiting high and/or at risk behaviors. Service is provided for 4 months, 15 hours per week.</td>
</tr>
<tr>
<td>Family Reunification (FR)/Time Limited Family Reunification (TLFR)</td>
<td>Program provides 12 weeks of intensive services designed to assist families with the reunification process whose children are returning from out of home placements such as Congregate Care facilities, Treatment Foster Homes, Medical Foster Homes, and Foster care.</td>
</tr>
<tr>
<td>Family School</td>
<td>Family School provides services to families with children from birth to 5 years old residing with the parent or in an out of home placement such as foster care. Services include early intervention, parenting education, education around abuse and neglect prevention, child health, and school based child care.</td>
</tr>
<tr>
<td>Achieving Independence Center (AIC)</td>
<td>The AIC is a “One Stop Center” designed to help youth achieve their future goals of self-sufficiency. Come of the services offered by the AIC include: life skills training, education, job training, employment, technology and mentoring. Youth must be between the ages of 14-21 years of age and be in or have been in out of home dependent placement.</td>
</tr>
</tbody>
</table>
| Rapid Service Response Initiative (RSRI)        | The Rapid Service Response Initiative is designed to offer services to families that have

Page 167
been reported to the Department of Human Services for child abuse and/or neglect as well as situations where the initial risk to the child is deemed moderate to high and services are needed by the families. These supportive services assure that families can effectively utilize their own strengths and community resources to maintain the safety of their children without long term intervention by DHS. RSRI services are limited to sixty calendar days from the date that the DHS referral is given to the RSRI provider. The RSRI provider makes weekly in person contact with the family.

| In Home Protective Services (IHPS) | IHPS is a safety and family in-home service delivery model that is designed to reduce safety threats and increase the protective capacities of the family while maintaining children in their own homes with a safety plan. IHPS agencies work collaboratively with DHS and utilize a Safety Plan and a Family Service Plan to guide service delivery. IHPS specialties include: Sex Abuse, Cognitively Impaired Caregiver and Medically Fragile Children. Services must include minimally home visits twice per week for children 5 and under and once per week for children over 5 years old. The service duration for General IHPS typically is 6 months and for Specialty IHPS, 12 months. |
| Family Stabilization Services (FSS) | FSS agencies offer in home services support to court involved families for stabilization purposes due to a youth in the home with identified concerns such as truancy and incorrigibility. Families who receive this service do not meet the safety threat guidelines. The FSS provider engages the youth and the family to implement the Family Service Plan goals and objectives. |
APPENDIX B

June 19, 2013

Ms. Anne Marie Ambrose, Commissioner
Philadelphia Department of Human Services
1515 Arch Street, Eighth Floor
Philadelphia, Pennsylvania 19102

Dear Commissioner Ambrose:

Thank you for your letter requesting the Department of Public Welfare’s (DPW) permission for the Philadelphia Department of Human Services (DHS) to share information with Community Behavioral Health (CBH) in a cross-system collaboration between DHS and CBH. This study is to better understand the populations of children served by DHS, Philadelphia’s Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) and Community Behavioral Health (CBH). Pursuant to 23 Pa. C.S., Section 6342 (relating to studies of data in records), 55 Pa. Code, Section 3130.44 (relating to confidentiality of family case records) and 55 Pa. Code 3490.38 (relating to authorized studies of child abuse data), your request is approved for the research study as described in your letter provided to DPW dated May 16, 2013.

We appreciate receiving the information that has been outlined in regard to the proposed research. We are including a copy of the Nondisclosure Agreement that all individuals with access to this information must sign. These documents must be signed and a copy emailed to DPW, attention Sharon Mathna smathna@pa.gov. Please note the following requirements for approval to conduct studies. The person requesting the research data must provide DPW, through the Office of Children, Youth and Families, with the following:

1) An advance copy of the report at least three weeks prior to release of the report to the public;

2) An opportunity for comment and the inclusion of the comments in the report released to the public or otherwise;

3) A briefing on the finding of the study along with a list of the intended recipients; and

4) The opportunity to review confidentiality agreements executed by each employee with respect to release of/use of confidential information in any manner whatsoever.

OFFICE OF CHILDREN, YOUTH & FAMILIES
PO BOX 2675 | HARRISBURG, PA 17105-2675 | 717.787.4756 | Fax 717.787.014 | www.dpw.state.pa.us
Ms. Anne Marie Ambrose

If you have any questions, please feel free to contact Ms. Mathna of my staff at (717) 214-5982.

Sincerely,

Cathy A. Utz
Acting, Deputy Secretary

Enclosure

c: Dr. Arthur C. Evans, Commissioner, Department of Behavioral Health
   Ms. Cynthia Schneider, Deputy City Solicitor
   City of Philadelphia, Law Department
   Mr. Brian Ciaplier, DHS Deputy Commissioner of
   Performance Management & Accountability
   Ms. Sharon Mathna, Office of Children, Youth & Families
# APPENDIX C

## TIMELINE

### EBP Implementation Aligned with CUA Implementation

<table>
<thead>
<tr>
<th>DATE</th>
<th>PCIT</th>
<th>Triple P Level 3</th>
<th>Triple P Level 4</th>
<th>FFT</th>
<th>CUA STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>YEAR 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>April13 – March14</td>
<td>Pilot complete;</td>
<td></td>
<td></td>
<td></td>
<td>CUA 1 (NET) and CUA 2 (APM)</td>
</tr>
<tr>
<td></td>
<td>implementation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>initiated CUA 1-2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>March14 - June14</td>
<td>CUA 8 certified</td>
<td></td>
<td></td>
<td></td>
<td>CUA 3 (TPFC) and CUA 4 (CCS)</td>
</tr>
<tr>
<td></td>
<td>clinicians (2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>YEAR 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>July14 – Dec14</td>
<td>Training and implementation CUA 4</td>
<td></td>
<td></td>
<td></td>
<td>CUA 5 (Wordsworth), CUA 6 (TNCP) and CUA 7 (NET)</td>
</tr>
<tr>
<td>Jan15 - March15</td>
<td>NIMH training CUA 1, 2, 3, 6, 7, 9; alternate training CUA 5, 10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Begin discussions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>with DHS,CUAs 1-5 and PPP regarding content and schedule for delivery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Training and</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Implementation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>initiated CUA 1-5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>April15 – June15</td>
<td>Implementation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>remaining CUAs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Begin discussions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>with DHS,CUAs 6-10 and PPP regarding content and schedule for delivery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Complete discussions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>with DHS,CUAs 1-5 and PPP regarding content and schedule for delivery and finalize protocols</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Complete discussions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>with DHS, CBH, AEC regarding adaptation for dependency cases and capacity building</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>with DHS, CBH,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>AEC regarding</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>adaptation for</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>dependency cases and</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>capacity building</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CUA 8 (Bethanna), CUA 9 (TPFC) and CUA 10 (Wordsworth)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>YEAR 3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>July15 – Sept15</td>
<td>ONGOING IMPLEMENTATION</td>
<td></td>
<td></td>
<td></td>
<td>ONGOING IMPLEMENTATION</td>
</tr>
<tr>
<td>Oct15 – Dec15</td>
<td>ONGOING IMPLEMENTATION</td>
<td></td>
<td></td>
<td></td>
<td>ONGOING IMPLEMENTATION</td>
</tr>
<tr>
<td></td>
<td>ONGOING IMPLEMENTATION</td>
<td></td>
<td></td>
<td></td>
<td>ONGOING IMPLEMENTATION</td>
</tr>
<tr>
<td>Date Range</td>
<td>Activity 1</td>
<td>Activity 2</td>
<td>Activity 3</td>
<td>Activity 4</td>
<td>Notes</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------</td>
<td>---------------------</td>
<td>---------------------</td>
<td>---------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Jan16 – March16</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>April16 – June16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>YEAR 4</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>July16 – Sept16</td>
<td>ONGOING IMPLEMENTATION</td>
<td>ONGOING IMPLEMENTATION</td>
<td>ONGOING IMPLEMENTATION</td>
<td>ONGOING IMPLEMENTATION</td>
<td>Tracking and Monitoring</td>
</tr>
<tr>
<td>Oct16 – Jun17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>YEAR 5</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>July17 – June18</td>
<td>ONGOING IMPLEMENTATION</td>
<td></td>
<td></td>
<td></td>
<td>FINAL REPORT</td>
</tr>
</tbody>
</table>
# APPENDIX D

## DHS SELECTED EVIDENCE BASED PRACTICES FOR CHILD WELFARE DEMONSTRATION PROJECT

<table>
<thead>
<tr>
<th>EBP Models</th>
<th>Ages Served</th>
<th>DHS CW Populations Targeted</th>
<th>Who Provides</th>
<th>System Issues for Models</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Programmatic</td>
</tr>
</tbody>
</table>
| PCIT       | 2-8         | - Children at-risk of removal  
- Children in out-of-home family settings | Training by experts; service by CBH | - Test in outpatient setting  
- Expand the population served  
- Utilizing a reliable screening assessment to determine clinical eligibility for service. | - Methodology for projecting capacity needed  
- Maintaining sufficient referrals to reduce financial risk  
- PCIT provider relationship & accountability to CUA (how does CBH track) | - Funding for non-Medicaid covered costs  
- Financial viability if referrals are inadequate |
| FFT        | 12-18       | - Youth at risk of removal  
- Youth placed in a family setting  
- Truant Youth  
- Youth stepping down from a CC settings | A CBH Service currently for JJ youth; will expand as part of CWDP to include dependent youth | - Engagement rate of families  
- Expand and tailoring service, as appropriate, to meet needs of CW youth  
- Utilizing a reliable screening assessment to determine clinical eligibility for service. | - Methodology for projecting capacity needed  
- Maintaining sufficient referrals to reduce financial risk  
- Establishing a formal referral process to CUA from CBH FFT providers  
- FFT provider relationship & accountability to CUA (how does CBH track) | - Financial viability if referrals are inadequate  
- Funding for non-Medicaid covered costs |
| PPP        | 0-16        | Children & Youth who are:  
- At-risk of removal  
- In an out-of-home family (foster and kin) settings  
- Stepping down from a CC settings | New service proposed for Demonstration Project | Determine how service will be delivered. | - Is PPP a fiscally sustainable and culturally appropriate model for an urban child welfare context? | - Funding via private grants at CUAs 3, 9, and 10 |
APM employs over 120 bilingual/bicultural professionals in several sites and serves over nine thousand persons a year with an annual budget of over $11 million. APM’s historic founding was a response to exclusion of Latinos, especially those for whom English was a barrier, from access to services and public resources. Over the years, APM has gained a positive reputation for its cultural sensitivity not just to the Latino community, but also to African American and other ethnicities within the community. APM’s staff is diversified in that there are eighteen different ethnicities represented. In addition, APM provides bilingual and culturally appropriate services through its staff, especially its health and human services staff. APM assist families in achieving their greatest potential and envisions a healthy community, where all families are self reliant, where children are protected and nurtured to become APM is a non-profit agency that was formed in 1970 for the purpose of promoting the welfare of Puerto Rican/Latino residents in Philadelphia. APM works directly with the community to convene and directly consult with community residents and provider networks, stakeholders, business owners and investors to create a long term strategy for neighborhood change and improvement. APM is committed to and experienced in engaging a broad spectrum of community stakeholders to inform and enhance our services.

Founded in 1970, NET is one of the oldest and largest non-profit organizations in the region. They offer a wide range of behavioral health and social services to adults, adolescents, children and families in Philadelphia, the Lehigh Valley, and the state of Delaware. NET’s mission is to provide a comprehensive recovery and resiliency-oriented system of behavioral health and social services utilizing a quality-driven, cost-effective provider network. NET has over 20 years’ experience offering child welfare services including in-home, all levels of resource home care, adoption, and residential. In the past fiscal year, they served over 400 children and youth and their families in various child welfare programs. They are committed to keeping children and youth in community settings, preferably their own community, and have only pursued program development opportunities consistent with this vision. NET’s full-time staff are 68% female and 32% male. In terms of race/ethnicity, our staff are 44% Caucasian, 46% African American, 8.5% Latino, and 1.5% Asian. NET utilizes a number of independent contractors for clinical and school-based services, among other roles. Our current pool of contractors is 65% female and 35% male, with 24.5% Caucasian, 73% African American, 1.2% Latino, and 1.2% Asian.
Philadelphia

**Wordsworth**’s mission is to provide education, behavioral health and child welfare services to children and youth who are experiencing emotional, behavioral and academic challenges so that they are empowered to reach their potential and lead productive, fulfilling lives. The agency was founded in 1952 as a school to meet the needs of children with reading disabilities. During its sixty year history, the agency has continuously developed its array of services and approach to treatment in response to the changing needs of its clients and an ever-evolving body of research and best practices. With a full continuum of child welfare, behavioral health and specialized education services, the agency is able to use an integrated understanding of each child/youth that views them within the context of their family and larger environment. The agency has prioritized the development and expansion of community-based programs that engage children, youth and families in their own homes, and is committed to the belief that services are most effective, in both the short and long term, when they actively engage and collaborate with all systems that impact the child and family. Wordsworth is a multi-site organization, with multi-system programming and an organizational budget of $38.5 million annually. For more than ten years, Wordsworth has maintained full accreditation through the Joint Commission (including full certification of its Foster Care program) which reflects the quality of the organization’s administrative and program leadership. For over 60 years, Wordsworth has responded to the needs of children and families and has always demonstrated the flexibility to develop new programs and refine others when necessary.

Over the last 20 years, **Catholic Social Services** has created numerous programs responding to the requests and needs of the City of Philadelphia, DHS and Family Court. Some of the more notable examples include: Del La Salle Aftercare (now known as Reintegration Services), The Mitchell Hall Program (farm-based residential program), Brother Rousseau Academy (day treatment for pre-adolescents), and DelStar (outpatient sex offense specific treatment program). In addition, the Out of School Time Programs run by CSS consist of 12 Programs at 10 locations: 9 elementary, 2 middle schools and 1 high school program, serving 2,000 unduplicated children this past year, and which required the hiring of close to 100 full time staff. All of these programs required a start-up from scratch, and involved the recruitment and retention of over 100 staff. CSS is a long-standing member of Catholic Charities USA, Pennsylvania Council for Children Youth and Families (PCCYFS), and the Philadelphia Alliance, all of which keep staff regularly posted on federal state and local policy requirements. Employees of CSS, CORA, JFCS and NFI are well trained in the state regulations which govern their respective programs. Yearly license reviews for DPW licensed programs ensure that regulations and policies are being maintained; internal quality assurance mechanisms also exist within each agency of the CSS.
Philadelphia Partnership (see above). CSS has over 40 years experience providing outpatient mental health services utilizing therapists and psychiatrists as subcontractors. Quality service provision is ensured via CSS’s continuous quality improvement (CQI) process, which monitors both quantitative and qualitative measures throughout the case lifecycle. All subcontractors are subject to rigorous qualifications, including a written contracting process.

**Turning Points for Children (TPFC) and Public Health Management Corporation (PHMC),** have joined forces to create a transformative new approach to improving outcomes for children involved in Philadelphia’s child welfare system. TFPC has long supported families in raising safe, healthy, educated, and strong children by partnering with caregivers to develop and strengthen protective qualities and by offering them the tools, skills, and resources they need to ensure their children’s optimal development. PHMC, meanwhile, has been working to improve outcomes for children by incorporating children and family services into their array of integrated programs spanning behavioral health/recovery, nurse-managed primary care and homeless health services, nurse home visiting, chronic disease management and prevention, tobacco control, early intervention, HIV/AIDS, violence intervention, parenting supports for families, and much more, plus research and evaluation that allow PHMC to assess and address issues effectively.

On February 1, 2013, TPFC became an affiliate of PHMC, combining the expertise of leadership and rich programming in child welfare, managed care in health and behavioral health, strategies for prevention, management services, and a range of programs essential for strengthening families, along with combining the mission-driven perspective of a non-profit with the fiscal control and management capabilities of a rigorous corporate structure. The Community Umbrella Agency in the 15th Police District will be led by TPFC, with shared staff in key leadership and administrative supports areas from PHMC, including information systems management, contracts management and quality assurance. The affiliation with PHMC will also provide TPFC with access to a well-established and supported technology infrastructure, including network and telephone support that PHMC already provides to 2000 users, data management systems which will be used to support the CUA. PHMC will provide services to TPFC via a management contract that will be reviewed and renewed on an annual basis.

**Bethanna** is a Christian organization that provides the highest quality system of care for children and families in order to ensure safety, restore emotional wellness, and build family stability. Core to Bethanna’s mission is providing services with excellence. Embodied in this pursuit of excellence is ensuring that the worth and dignity of each child and family member served
is respected and valued. This is reflected in Bethanna's absolute commitment to implement strengths based approaches in all aspects of service delivery. Bethanna offers two primary levels of service and family-based support services that address the challenges most children and families encounter.

**Permanency Services:** Pathways to Permanency - Adoption and Foster Care. Permanency is our agency’s highest priority. Adoption and Foster Care are Bethanna’s largest service division. Many children entering into our care are eligible for multiple services depending on their needs. Bethanna's professional staff and foster and adoptive parents are well trained and challenged daily to provide the best for the infants, children and teenagers.

**Community Treatment Services:** Supporting children along their journey Finding the appropriate treatment option is the first step on the path to emotional recovery. Intensive mental health support is provided for youth and foster and adoptive parents.

In an unprecedented partnership initiative, Tabor Children’s Services and Northern Children’s Services have collaborated to create **Tabor Community Partners (TCP)**, a Pennsylvania nonprofit corporation designed to provide high impact community-based services. Both Northern and Tabor have a long and demonstrated history of providing high quality services and collaborating with other stakeholders in the Philadelphia area. The shared missions of both organizations, combined with their expertise in serving children and families, resulted in the creation of this entity. As the parent agencies, together Tabor and Northern bring TNCP extensive experience providing prevention services, in-home, placement, adolescent, behavioral health, child protective and community-based services.

TCP is family-centered, community-based, trauma-informed, and culturally competent. Tabor and Northern have worked 105 and 160 years respectively to support individuals and families in their homes and communities through a continuum of care that is integrated and timely. Both agencies have demonstrated the ability to adapt to meet the changing needs of DHS, communities, and most importantly, the needs of individuals and families. TCP is an example of building a strong community network that utilizes local solutions to meet the needs of individuals and families.

**Community Behavioral Health (CBH)** is a not-for-profit 501c (3) corporation contracted by the City of Philadelphia to provide mental health and substance abuse services for Philadelphia County Medicaid recipients. Supported through state funding, CBH works in partnership with the City of Philadelphia.
Philadelphia

Philadelphia and the Commonwealth of Pennsylvania to provide vital behavioral health services. Today, CBH is responsible for providing behavioral health coverage for the City’s 420,000 Medicaid recipients. Its primary activities include:

- Authorizing payment for behavioral health services
- Requiring provider agencies to deliver effective and medically necessary services
- Achieving management and operational efficiencies to lower healthcare costs
ATTACHMENT B
I. **Overview**

Provide a brief summary of major demonstration activities completed to date, as well as any significant evaluation findings (please note that the University of Pittsburgh will be providing a section on evaluation activities and preliminary findings; if counties have engaged in any internal evaluation strategies, an overview of these findings can be included here). Summarize any major changes to the design of the demonstration or to the evaluation since the previous semi-annual report (NOTE: Any significant changes to the design of the proposed demonstration or evaluation must be approved by the Children’s Bureau before they are implemented).

Examples of major accomplishments given by ACF include training, implementation milestones, and any other noteworthy accomplishments (please cross-reference with your county implementation plan) – the final compiled submission to ACF will include county specific items AND items that pertain to the project as a whole (statewide).

RESPONSE:

In 2013, the same year that Pennsylvania entered into the Child Welfare Demonstration Project, Philadelphia’s Department of Human Services (DHS) began rolling out Improving Outcomes for Children (IOC), a system-wide transformation. Prior to IOC, DHS operated a dual case-management system in which families had a caseworker from DHS and additional caseworker(s) from private provider agencies. In order to implement a single case-management system (i.e., “one family, one worker”), DHS transferred primary case management responsibilities to ten newly created community-based agencies called Community Umbrella Agencies (CUAs). Building the infrastructure to support IOC was a major undertaking, and Philadelphia’s child welfare system has only recently begun to stabilize as the implementation of IOC is now complete.

Since 2013, a number of major demonstration activities have been completed as outlined in Philadelphia’s CWDP Work Plan. Specifically, all ten of the CUAs were selected and are now running at capacity. CUA staff were hired and trained to reflect caseload ratios of 1 CM:10 families. All CUA case-carrying staff completed CANS and FAST training. Additionally, Practice Specialists, Teaming Coordinators, and Social Work Administrators were hired to support the Family Team Conferencing process. Senior Learning Specialists and Practice Coaches were also hired to provide technical assistance and to promote continuous quality improvement among the CUAs. In accordance with the CWDP’s Theory of Change, CUA practice guidelines include policies for engaging families through Family Team Conferences (FTC), assessing families using CANS, FAST, and ASQ tools, and utilizing consults to connect families with informal services including evidence-based practices (e.g., PCIT, FFT, Triple P). DHS Division of Performance Management and Technology (PMT) also developed databases to track the aforementioned demonstration activities, and quarterly compliance reports are produced.

The completed implementation of IOC represents a major accomplishment for the City of Philadelphia, and present data indicate that outcomes are improving for children and families receiving CUA services. For example, 46% of children in out-of-home care in Philadelphia are now living with kin as compared to only 32% pre-IOC. The percent of children living within 5 miles of their home increased from 46% to 56% since IOC began, and permanencies continue to increase each year. The percent of children and youth living in congregate care decreased from 22% in 2013 to 13% in 2017. These outcomes suggest that IOC may be a promising practice for children and families in Philadelphia.

Under the leadership of a newly hired Commissioner and Executive Team, DHS is now focusing attention on refining and improving the quality of services provided within IOC. In February 2017, DHS hired IOC’s first ever Operations Director, replacing the Chief Implementation Officer for IOC and representing a shift in the system from implementation to operation. Although there are positive outcomes associated with the implementation of IOC, there are also elements of the system that require continued attention and work. The newly hired Operations Director is a former CUA Director and is knowledgeable about Philadelphia’s child welfare system. As part of her new role, the
Operations Director is assessing the strengths and challenges associated with IOC and will be making changes and adjustments to system processes to continually improve services for children and families active with the CUA. Such changes will be consistent with the Demonstration Project and will include modifications to the teaming and assessment processes as well as an increased focus on connecting children, youth, and families to informal, community-based behavioral health and prevention services. In January 2017, DHS implemented monthly cross-systems collaborative meetings between DHS and CUA leadership in order to improve collaboration, communication, and the successful refinement of IOC. There are now monthly leadership meetings for DHS and CUA Directors, DHS Administrators and CUA Case Manager Directors, DHS and CUA Intervention Directors, and DHS and CUA Supervisors. These meetings serve as a mechanism for all levels of leadership to receive consistent communication from DHS’ Executive Team regarding system updates, including information pertaining to the CWDP.

In March 2017, DHS hired the Intervention Development Director to continue the implementation and monitoring of the CWDP under the leadership of the IOC Operations Director. Prior to this hire, DHS did not have a project manager for the CWDP for approximately eight months. The newly hired Intervention Development Director formerly worked for Philadelphia’s DHS and is well versed in the city’s child welfare system and Demonstration Project. During her first few months of hire, the Intervention Development Director met with a variety of system stakeholders to determine the status of the CWDP implementation and to identify strengths and barriers to engagement, assessment, and service connection. The Intervention Development Director is charged with providing leadership to the CUA Intervention Directors, who all serve on the CWDP Implementation Team. In April 2017, the Intervention Development Director began monthly group and individual meetings with the CUA Intervention Directors to provide leadership and oversight for the CWDP-related activities. The Intervention Development Director is working in close collaboration with Community Behavioral Health’s (CBH) Behavioral Health Implementation Advisor to improve the informal service connection for children and families, with a focus on Evidence Based Practices.

II. Demonstration Status, Activities, and Accomplishments

Provide a detailed overview of the status of the demonstration in the following areas:

A. Numbers and types of services provided to date. Note in particular the implementation status of designated EBPs. We can send you the numbers from the last Progress Report – please review for accuracy and then we can add the last six months (June – December/2016). The Program Monitoring format should be helpful in gathering data for CANS/FAST/ASQ. In addition, provide detailed information about EBP services provided to date. These numbers will be provided to ACF by county and in aggregate where applicable. Report this information using the tables below. Global number and across counties. Numbers and types – CANS/FAST; Family Engagement meetings; EBP by county – tables in document – not excel spreadsheet

Please note, that all data is to be included for the reporting period. If information is unavailable, please provide a narrative including information as to:

a) why it is not available
b) the steps to be taken to collect the data
c) anticipated timeframe information will be available.

RESPONSE:
### Family Engagement

<table>
<thead>
<tr>
<th>County</th>
<th># of cases that are eligible for a family engagement meeting</th>
<th># of cases where a family engagement meeting occurred</th>
<th>% of those that received services out of those eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philadelphia*</td>
<td><strong>Total eligible cases</strong> = 5,342</td>
<td><strong>Total FTCs</strong> = 4,898</td>
<td>Overall % received FTC = 92%</td>
</tr>
<tr>
<td></td>
<td>Eligible new cases = 1,431</td>
<td>FTCs for new cases = 1,144</td>
<td>% of new cases received FTC = 80%</td>
</tr>
<tr>
<td></td>
<td>Eligible ongoing cases = 3,911</td>
<td>FTCs for ongoing cases = 3,754</td>
<td>% of ongoing cases received FTC = 96%</td>
</tr>
</tbody>
</table>

*Report Period includes all eligible new and ongoing cases at the family level from January 1, 2017 – June 30, 2017. The overall cases are broken out in italics by new and ongoing cases. Data for initial meetings goes through 06/09/17 to allow for the meetings to occur within the initial 20 day timeframe.

### Child and Adolescent Needs and Strengths (CANS)

<table>
<thead>
<tr>
<th>County</th>
<th># of cases that are eligible for a CANS</th>
<th># of cases that received a CANS</th>
<th>% of those that received services out of those eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philadelphia*</td>
<td><strong>Total eligible cases</strong> = 4,568</td>
<td>Total CANS = 844</td>
<td>Overall % received CANS = 18%</td>
</tr>
<tr>
<td></td>
<td>Eligible new cases = 906</td>
<td>CANS for new cases = 141</td>
<td>% of new cases received a CANS = 16%</td>
</tr>
<tr>
<td></td>
<td>Eligible ongoing cases = 3,662</td>
<td>CANS for ongoing cases = 703</td>
<td>% of ongoing cases received a CANS = 19%</td>
</tr>
</tbody>
</table>

*Report Period includes all eligible new and ongoing cases at the child level from January 1, 2017 – June 30, 2017. The overall cases are broken out in italics by new and ongoing cases.

### Family Advocacy and Support Tool (FAST)
**County** | # of cases that are eligible for a FAST | # of cases that received a FAST | % of those that received services out of those eligible
--- | --- | --- | ---
Philadelphia* | **Total eligible cases** = 2,671 | **Total FAST** = 695 | Overall % received FAST = 26%
| Eligible new cases = 370 | FAST for new cases = 86 | % of new cases received FAST = 23%
| Eligible ongoing cases = 2,301 | FAST for ongoing cases = 609 | % of ongoing cases received FAST = 27%

*Report Period includes all eligible new and ongoing cases from January 1, 2017 – June 30, 2017. The overall cases are broken out in italics by new and ongoing cases.

| Ages and Stages Questionnaires (ASQ) | County | # of cases that are eligible for an ASQ | # of cases that received an ASQ | % of those that received services out of those eligible
--- | --- | --- | --- | ---
| Philadelphia* | **Total eligible cases** = 5,724 | **Total ASQ** = 583 | Overall % received ASQ = 10%
| Eligible new cases = 1,328 | ASQ for new cases = 50 | % of new cases received ASQ = 4%
| Eligible ongoing cases = 4,396 | ASQ for ongoing cases = 533 | % of ongoing cases received ASQ = 12%

*Report Period includes all eligible new and ongoing cases from January 1, 2017 – June 30, 2017. The overall cases are broken out in italics by new and ongoing cases.*
### Evidence-Based Practices (EBPs):

<table>
<thead>
<tr>
<th>County</th>
<th># of children/youth were referred for an EBP</th>
<th># of children/youth that received an EBP</th>
<th>% of those that received services out of those eligible**</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Philadelphia</strong>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCIT</td>
<td>13</td>
<td>2</td>
<td>15%</td>
</tr>
<tr>
<td>FFT</td>
<td>81</td>
<td>37</td>
<td>46%</td>
</tr>
<tr>
<td>Triple P</td>
<td>56</td>
<td>15</td>
<td>27%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>150</strong></td>
<td><strong>54</strong></td>
<td><strong>36%</strong></td>
</tr>
</tbody>
</table>

*Report Period includes number of children who were referred to an EBP and the number of those referred who are receiving an EBP during the period December 15, 2016 – June 15, 2017. This reporting period is used, because 6/15/17 is the date of the CUA’s last EBP data submission.

**Note: The percent of children/youth who received services out of those eligible was calculated by dividing the number of children/youth who received an EBP by the number of children/youth who were referred for an EBP.

### B. Other demonstration activities begun, completed, or that remain ongoing (e.g., introduction of new policies and procedures, staff training). This section will be county specific in reporting to ACF; the emphasis is on “major” activities.

Please provide detailed information to include:

- the current status
- why is this effort needed
- on-going effort?
- if effort experienced difficulty provide additional information explaining why do you believe effort was challenged? What are the outcomes and future status.

RESPONSE:

As evident in the tables above, Philadelphia DHS is most successful in implementing family engagement strategies as compared to the other two components of the CWDP (i.e., assessment and services). During this reporting period, 5,342 new and ongoing cases were eligible to receive a Family Team Conference (FTC) and 4,898 new and ongoing cases received a conference, indicating that approximately 92% of all CUA-involved families received a FTC in accordance with DHS policy.
Because the use of FTCs has become a standardized practice, DHS has shifted its focus from implementation to refinement of the engagement process. Indeed, data from the state-led family engagement evaluation indicate that though Philadelphia has maintained a high degree of fidelity to the intended FTC model, ensuring quality participation in the FTCs from families and their informal supports remains challenging. During this reporting period, DHS took several steps toward identifying what is working well with the current model and what components might need to be improved. Specifically, members of the DHS Executive Team visited several jurisdictions that have been successful in using the teaming process to improve child welfare outcomes, and DHS is now in the process of forming a system-wide workgroup to refine Philadelphia’s local FTC process. Membership in this workgroup will include representatives from the DHS Executive Team, the CWDP Implementation Team, all ten CUAs, Policy and Planning, and DHS University (i.e., training and technical assistance).

The full implementation of the assessment component of the CWDP (e.g., CANS, FAST, and ASQs) remains challenging for Philadelphia county. In order to better understand the nuances of these challenges, DHS’ Intervention Development Director met individually with each of the CUA Intervention Directors, several of the CUA CANS/FAST on-site experts, and the lead CANS/FAST trainer at DHS University. According to these system leaders, the onboarding of an entirely new child welfare workforce in the midst of burgeoning caseloads put tremendous strain on Philadelphia’s system during the implementation of IOC. As such, the CUAs prioritized systematizing safety assessments and practice over wellbeing assessments and informal service connections, including EBPs. Although CUA case managers continue to receive CANS/FAST training, they are not yet proficient in utilizing these tools to guide case planning. With the implementation of IOC now complete and the reduction of caseloads, Philadelphia county is taking strategic steps to increase the meaningful use of wellbeing assessments to assist case managers in facilitating appropriate connections to behavioral health and prevention services for children and families, with an eye toward evidence-based practices.

To increase understanding and awareness of wellbeing assessment and services, DHS is conducting a census of behavioral health service (BHS) receipt, including EBPs such as FFT and PCIT, among all CUA-involved children and youth over five years old in Philadelphia. Due to the lack of a comprehensive data sharing agreement between Philadelphia’s DHS and Community Behavioral Health (CBH) systems, DHS does not currently know the number of children and youth with a BHS connection, nor does DHS know how service connections may vary based on geographic location, child-level demographics, or child welfare characteristics. Furthermore, DHS knows little beyond anecdotal information about the type and scope of the barriers that prevent BHS connections.
In order to complete the census, CUA case managers will complete a few basic questions about BHS receipt for each child on their caseload. This census will allow DHS to identify which children and youth have a BHS in place, which barriers impact children and youth from receiving a BHS, and which children and youth do not need a BHS. Following the census, the CUA Intervention Directors will develop and implement CUA-specific plans to review all cases with children who do not have a BHS in place. If a BHS is needed, but there are barriers in place, the CUAs will consult with DHS and CBH to address the barriers to promote service connections. If it is determined that no BHS is needed, an up-to-date CANS/FAST assessment will be required in the electronic file. Thus, DHS will use this census to begin to identify a cohort of children and youth for whom the CANS/FAST must be completed. After the census, DHS will set benchmarks for the completion of the CANS/FAST assessments until the use of these wellbeing assessments is systematized and completed per policy. Additionally, DHS will set benchmarks for the completion of the ASQ for younger children as per policy.

After the completion of the BHS census, DHS’ Intervention Development Director and CBH’s Behavioral Health Implementation Advisor will co-lead a workgroup to interpret and respond to the results of the census. Additional members of this workgroup will include the IOC Operations Director, CUA staff (i.e., Directors, Intervention Directors, Case Manager Directors, Supervisors, Case Managers), and representatives from CBH, DHS Policy and Planning, DHS University, and DHS’ Division of Performance Management and Technology and Division of Prevention. In addition to making recommendations to overcome the systemic barriers to BHS receipt as identified by the census, this workgroup will be charged with improving the utilization of the CANS/FAST tools in order to promote their use in case planning, consultation, and service referral.

Simultaneous to the upcoming BHS census, Philadelphia continues to take steps toward increasing the use of EBPs, including those identified by the CWDP (i.e., Triple P, FFT, and PCIT). Over the past year, CBH held a number of EBP trainings, including the PCIT Overview and Information Session, CBH 101 with EBPs for Child Welfare, and EBP 101 with CWDP Highlights. These trainings were provided to a number of different stakeholders, including CUA staff, advocates, and other provider communities. CBH continues to offer ongoing support to the providers of FFT and PCIT, and will soon offer an enhanced rate for both of these EBPs. These enhanced rates will allow CBH to better track referrals for FFT and PCIT for the CWDP, and this improved tracking process will more accurately reflect the numbers of referrals to PCIT and FFT among CUA-involved children and youth in Philadelphia. In addition to training and technical support, CBH and DHS continue to facilitate face-to-face meetings between CUA Intervention Directors and BHS Providers to further build the partnership between child welfare and behavioral health services in Philadelphia. Referrals to FFT and PCIT continue to increase,
and during this last reporting period, CBH received more referrals for these EBPs than any prior reporting period.

Because FFT and PCIT are behavioral health interventions, CBH funds these services and supports their implementation. However, Triple P is not a medicaid reimbursable service and is therefore not funded or directly supported by CBH. As such, DHS has been cautious about a citywide roll out of Triple P due to limited sustainable funding sources. Currently, three CUAs receive private grant funding to offer Triple P to CUA-involved children and youth in Philadelphia. These three CUA sites have allowed the county to pilot Triple P on a smaller scale prior to making a decision to RFP the model citywide.

In February 2017, Philadelphia DHS leadership participated in the CWDP Executive Committee Meeting along with the other counties from Pennsylvania’s Demonstration Project. At this meeting, counties implementing Triple P reported that the model was very costly, and they were concerned that the model would not be sustainable after the Demonstration Project ends. Following the Executive Committee Meeting, DHS discussed these concerns with the three CUAs implementing Triple P in Philadelphia. The CUAs confirmed that the model is not financially sustainable without an external funding stream. Specifically, the ongoing training and technical assistance required to implement Triple P must be purchased from the developer and are quite costly. Without funding from the Demonstration Project, these costs would be prohibitively expensive for Philadelphia. In addition to the fiscal concerns, the CUAs reported that the implementation of Triple P in Philadelphia has required a substantial amount of work to adapt the model to be more culturally appropriate for an urban, primarily non-white population of parents. According to the CUAs, many of the Triple P materials are based in a culture that is not congruent with an urban context. Because of the aforementioned fiscal and cultural concerns, Philadelphia DHS recently requested to not proceed with the full citywide implementation of Triple P as part of the CWDP. Philadelphia is proposing to focus attention on the continued implementation of FFT and PCIT rather than investing in an EBP that may require significant adaptation to be culturally appropriate and may not be financially sustainable after the Demonstration Project ends. The CUAs providing Triple P will continue to do so through the duration of their grants.

C. Challenges to implementation and the steps taken to address them. We are gathering county specific information. If there are global themes we will address them as such in the report to ACF. Please be specific as to the difficulties experiencing, belief why difficulty, and what has been done or will be done to address each challenge. What is the future actions plans?

RESPONSE:
As described more fully above, DHS has shifted from implementing to stabilizing and refining Philadelphia’s new child welfare system, IOC. This shift represents both a challenging and exciting context for furthering the work of the CWDP. During the implementation of IOC, the focus of the CUAs was primarily on compliance and safety, though there is now an expanded focus toward quality practice and wellbeing outcomes. Shifting the culture of a system is difficult work. However, as the newly implemented system stabilizes, staff turnover decreases, and caseload sizes become more manageable, the workforce has a growing capacity to improve the skills necessary for quality family engagement, wellbeing assessments, and appropriate service connections. The recently hired IOC Operations Director and Intervention Development Director have taken initial steps to improve communication among system partners and cast a vision for this new phase of IOC development. The monthly multi-level DHS and CUA leadership meetings provide a regular forum for increased communication and collaboration. DHS and CUA executive leadership are committed to regularly participating in these meetings to jointly strategize moving the system forward with regard to best practice.

This section should address both activities and accomplishments that have been completed to date as well as any that remain in progress or that have been delayed. Include an updated work plan that highlights progress in implementing the demonstration. County work plans should be updated if there are changes. In responding to ACF we will discuss our progress in global terms and how we are meeting our overall Theory of Change. County specific responses are needed to capture this information – please be as thorough as possible.

PLEASE SEE ATTACHED COMPLETED WORK PLAN FROM PHILADELPHIA.

PCG will complete the Trauma-Informed Section as in the previous report: As noted previously, the CANS without the trauma module and the FAST could be considered trauma screenings. The CANS with the trauma module could be considered a trauma assessment. In terms of interventions, the only selected intervention that is CLEARLY an EBI is Trauma-Focused CBT.

III. Recommendations and Activities Planned for Next Reporting Period

Describe major demonstration activities that will be started, continued, or discontinued during the subsequent reporting period. Highlight any recommendations for changes to the design and implementation of the demonstration based on challenges encountered during the current or prior reporting period, or based on evaluation findings to date. The county emphasis in this section should be “major” items – if they were identified in the challenges section above, develop a plan for addressing this item. Also, include any “major” upcoming implementation milestones for your county. Provide detailed
information as to reason for discontinuing an activity and what if any options are to overcome challenges.

RESPONSE:

With regard to engagement, Philadelphia will continue to conduct regular FTCs for children, youth, and families receiving CUA services. Additionally, the newly formed workgroup will draw from lessons learned locally and from other jurisdictions to suggest modifications and refinements to the current FTC process so that families are more meaningfully engaged through the teaming process.

With regard to assessment, Philadelphia will conduct a census of all behavioral health services to better understand and elevate the importance of wellbeing assessment and services among CUA-involved children, youth, and parents. Following this census, benchmarks will be established for CANS/FAST and ASQ assessments to improve the rate of completion. Additionally, DHS will include the use of wellbeing assessments in its upcoming public scorecard, which highlights each of the CUAs’ performance across a variety of domains. This scorecard will provide a public accountability mechanism to track the CUAs’ use of wellbeing assessments, including those tracked through the CWDP. Furthermore, a workgroup will be established to examine more carefully how these assessments can be better utilized to inform case planning and service connection. This workgroup will also explore barriers to completing the CANS/FAST and ASQ tools and will make recommendations to address these barriers and improve the use of these assessments.

With regard to the use of EBPs, DHS will continue to partner with Philadelphia’s managed care organization, CBH, to support the use of FFT and PCIT among children, youth, and families receiving CUA services. CBH will continue to offer trainings about these and other relevant EBPs to stakeholders across the city. DHS and CBH will continue to promote these EBPs and raise awareness of their effectiveness through joint site visits between behavioral health providers and CUA Intervention Directors. DHS will issue regular “Practice Tips” in their newsletter highlighting an EBP case example and providing referral information. These newsletters are circulated across DHS and CUA staff. This fall, DHS and CBH will also hold a forum to connect directors from CUAs and behavioral health providers, including those who provide FFT and PCIT.
<table>
<thead>
<tr>
<th>Action Step</th>
<th>Responsible Party</th>
<th>Began</th>
<th>Complete</th>
<th>Evidence of Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 Cost Estimates and Fiscal Decision Making (IOC CUAs)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.0 Selection and Contracting with Partners (IOC CUAs)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Request for Proposal and selection all CUAs</td>
<td>IOC Executive Leadership Team</td>
<td>Complete</td>
<td>Complete</td>
<td>Documentation of RFP and selected CUA</td>
</tr>
<tr>
<td>3.0 Staff Hiring and Training</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1 Staff Hiring and Training – CUAs &amp; Providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hire CUA Case Managers for all CUAs to reflect 1 CM:10 families</td>
<td>CUA</td>
<td>Complete</td>
<td>Ongoing</td>
<td>The current caseload size fluctuates around 1 CM: 10 families</td>
</tr>
<tr>
<td>Training for all CUAs: CANS training &amp; database training for CUA Case Managers, to reflect the new ratio of 1 CM:10 families</td>
<td>DHS University</td>
<td>Complete</td>
<td>Ongoing</td>
<td>Ongoing training continues. List of staff trained available</td>
</tr>
<tr>
<td>Hire CANS staff for existing in-home and foster care provider agencies</td>
<td>In-Home and Foster Care Service Providers</td>
<td>Complete</td>
<td>Complete</td>
<td>List of existing staff available</td>
</tr>
<tr>
<td>Training for existing in-home and foster care provider staff administering the CANS</td>
<td>DHS University</td>
<td>Complete</td>
<td>Complete</td>
<td>Curriculum and documentation of training participants available</td>
</tr>
<tr>
<td>3.2 Staff Hiring and Training – Teaming and Technical Assistance and Continuous Quality Improvement (DHSU)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hire and train Practice</td>
<td>Child Welfare</td>
<td>Complete</td>
<td>Complete</td>
<td>42 hired and</td>
</tr>
<tr>
<td>Action Step</td>
<td>Responsible Party</td>
<td>Began</td>
<td>Complete</td>
<td>Evidence of Completion</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>--------------------------</td>
<td>-------</td>
<td>----------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Specialists for all CUAs (Teaming)</td>
<td>Operations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hire and train Teaming Coordinators for all CUAs (Teaming)</td>
<td>Child Welfare Operations</td>
<td></td>
<td>Complete</td>
<td>Complete 42 hired and trained</td>
</tr>
<tr>
<td>Hire and train Social Work Administrators for all CUAs (Teaming)</td>
<td>Child Welfare Operations</td>
<td></td>
<td>Complete</td>
<td>Complete 5 hired and trained</td>
</tr>
<tr>
<td>Hire and train Practice Coaches for all CUAs (TA &amp; CQI)</td>
<td>Child Welfare Operations / DHSU</td>
<td></td>
<td>Complete</td>
<td>Ongoing 24 positions; 20 hired and trained.</td>
</tr>
<tr>
<td><strong>3.3 Developing Supervisory Coaching Plans</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hire and Train Senior Learning Specialists for all CUAs (TA &amp; CQ)</td>
<td>Child Welfare Operations / DHSU</td>
<td></td>
<td>Complete</td>
<td>Complete 10 positions: 10 hired and trained.</td>
</tr>
<tr>
<td><strong>4.0 Data System Initiation / Modification</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IT Systems Development: Family Team Conferencing Database</td>
<td>Administration &amp; Management</td>
<td>Complete</td>
<td>Complete</td>
<td>Database available</td>
</tr>
<tr>
<td>IT Systems Development: FAST/CANS Database</td>
<td>Administration &amp; Management</td>
<td>Complete</td>
<td>Complete</td>
<td>Database available</td>
</tr>
<tr>
<td><strong>5.0 FAST/CANS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>5.1 FAST/CANS for Community Umbrella Agencies</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CUA Practice Guidelines are amended to include FAST/CANS</td>
<td>Policy &amp; Planning</td>
<td>Complete</td>
<td>Complete</td>
<td>CUA Practice Guidelines are available</td>
</tr>
<tr>
<td>Implementation for all CUAs: FAST assessment for any family in CUA who is accepted for in-home or placement services</td>
<td>Child Welfare Operations</td>
<td>Complete</td>
<td>Ongoing</td>
<td>Report documenting how many families eligible for FASTS and how many FASTS occurred for CUAs</td>
</tr>
<tr>
<td>Action Step</td>
<td>Responsible Party</td>
<td>Began</td>
<td>Complete</td>
<td>Evidence of Completion</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>------------------------------------</td>
<td>-------------</td>
<td>----------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Implementation for all CUAs: CANS assessment for any child or youth in</td>
<td>Child Welfare Operations</td>
<td>Complete</td>
<td>Ongoing</td>
<td>Report documenting how many families eligible for CANS and how many CANS occurred for the CUAs</td>
</tr>
<tr>
<td>CUA who is experiencing a placement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.2 FAST/CANS for Existing In-Home and Foster Care Provider Agencies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Modification of FY’14 contracts for existing in-home and foster care</td>
<td>Finance</td>
<td>Complete</td>
<td>Complete</td>
<td>Contracts contain necessary funding and requirements to administer CANS</td>
</tr>
<tr>
<td>service providers to administer CANS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implementation for FAST assessment for any family receiving existing in-</td>
<td>Existing In-Home and Foster Care</td>
<td>Complete</td>
<td>Ongoing</td>
<td>Report documenting how many families eligible for FASTS and how many FASTS occurred</td>
</tr>
<tr>
<td>home or foster care services at the time of accept for service</td>
<td>Service Providers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implementation for CANS assessment for any family receiving existing in-</td>
<td>Existing In-Home and Foster Care</td>
<td>Complete</td>
<td>Ongoing</td>
<td>Report documenting how many families eligible for CANS and how many CANS occurred</td>
</tr>
<tr>
<td>home or foster care services at the time of accept for service</td>
<td>Service Providers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.0 Teaming</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.1 Plans for Initiating Service Delivery for Family Team Conferencing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action Step</td>
<td>Responsible Party</td>
<td>Began</td>
<td>Complete</td>
<td>Evidence of Completion</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>--------------------------------------</td>
<td>--------</td>
<td>----------</td>
<td>---------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>CUA Practice Guidelines</td>
<td>Policy &amp; Planning</td>
<td>Complete</td>
<td>Complete</td>
<td>CUA Practice Guidelines are available</td>
</tr>
<tr>
<td>Family Team Conferencing Protocol</td>
<td>Policy &amp; Planning</td>
<td>Complete</td>
<td>Complete</td>
<td>Teaming Protocol is available</td>
</tr>
<tr>
<td>Implementation for all CUAs:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Child Safety Conferences</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Family Support Conferences</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Permanency Conferences</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Placement Stability Conferences</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Welfare Operations</td>
<td>Complete</td>
<td></td>
<td></td>
<td>Report documenting how many conferences occurred, additional reports needed on timeliness and outcomes.</td>
</tr>
<tr>
<td>6.2 Family Group Decision Making</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protocol for FGDM Conferences</td>
<td>Policy and Planning</td>
<td>Complete</td>
<td>Complete</td>
<td>FGDM protocol is available</td>
</tr>
<tr>
<td>FGDM Conferences available for for families accepted for in-home service and for families experiencing a child or youth with an initial placement</td>
<td>Child Welfare Operations</td>
<td>Complete</td>
<td>Complete</td>
<td>FGDM is a voluntary service that is offered in Philadelphia</td>
</tr>
<tr>
<td>7.0 Infrastructure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.2 Development of Roles &amp; Responsibilities</td>
<td>Child Welfare Operations, Policy and Planning</td>
<td>Ongoing</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>7.3 Development of Quality &amp; Safety Standards</td>
<td>Child Welfare Operations, Policy and Planning</td>
<td>Ongoing</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>7.4 Development of Implementation Team</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action Step</td>
<td>Responsible Party</td>
<td>Began</td>
<td>Complete</td>
<td>Evidence of Completion</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------------</td>
<td>-------</td>
<td>----------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Internal DHS CWDP Implementation Team formed</td>
<td>Child Welfare Operations</td>
<td>Complete</td>
<td>Complete</td>
<td>List of CWDP Project Lead and Team Members Available</td>
</tr>
<tr>
<td>Partnership with CBH established</td>
<td>Child Welfare Operations</td>
<td>Complete</td>
<td>Complete</td>
<td>Regular meetings held; Behavioral Health Implementation Advisor hired and collaborating with DHS</td>
</tr>
<tr>
<td><strong>7.5 Development of Management Procedures/Positions/Functions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Team Conferencing is incorporated into the CUA Guidelines</td>
<td>Policy &amp; Planning</td>
<td>Complete</td>
<td>Complete</td>
<td>CUA Guidelines</td>
</tr>
<tr>
<td>Family Team Conferencing Policy</td>
<td>Policy &amp; Planning</td>
<td>Complete</td>
<td>Complete</td>
<td>Policy available</td>
</tr>
<tr>
<td>FAST and CANS are incorporated into the CUA Guidelines</td>
<td>Policy &amp; Planning</td>
<td>Complete</td>
<td>Complete</td>
<td>CUA Guidelines</td>
</tr>
<tr>
<td>Updated expectations surrounding FGDM are documented in DHS Policy</td>
<td>Policy &amp; Planning</td>
<td>Complete</td>
<td>Complete</td>
<td>Policy available</td>
</tr>
<tr>
<td>Updated expectations surrounding FAST &amp; CANS for existing in-home and foster care cases are documented in provider contract standards</td>
<td>Performance Management &amp; Accountability</td>
<td>Complete</td>
<td>Complete</td>
<td>Policy available</td>
</tr>
<tr>
<td><strong>8.0 Development of Monitoring Plan</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IOC Executive Leadership Team charged with monitoring the CWDP Implementation plan</td>
<td>Child Welfare Operations</td>
<td>Complete</td>
<td>Ongoing</td>
<td>CWDP included on agendas</td>
</tr>
<tr>
<td><strong>9.0 Communication Plan &amp; Strategies</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action Step</td>
<td>Responsible Party</td>
<td>Began</td>
<td>Complete</td>
<td>Evidence of Completion</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>----------------------------------------</td>
<td>--------</td>
<td>----------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Monthly DHS newsletter provides updates on progress with the CWDP...</td>
<td>Communications Office</td>
<td>Complete</td>
<td>Ongoing</td>
<td>Regular newsletters</td>
</tr>
<tr>
<td>10.0 Quality Assurance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PMT provides quarterly reports regarding quantity of Family Team...</td>
<td>Performance Management &amp; Accountability</td>
<td>Complete</td>
<td>Ongoing</td>
<td>Quarterly reports...</td>
</tr>
<tr>
<td>PMT provides quarterly reports regarding quantity of CANS</td>
<td>Performance Management &amp; Accountability</td>
<td>Complete</td>
<td>Ongoing</td>
<td>Quarterly reports...</td>
</tr>
<tr>
<td>PMT provides quarterly reports regarding quantity of FASTs</td>
<td>Performance Management &amp; Accountability</td>
<td>Complete</td>
<td>Ongoing</td>
<td>Quarterly reports...</td>
</tr>
<tr>
<td>PMT provides quarterly reports regarding quantity of ASQ and ASQ-SE</td>
<td>Performance Management &amp; Accountability</td>
<td>Complete</td>
<td>Ongoing</td>
<td>Quarterly reports...</td>
</tr>
<tr>
<td>PMT provides quarterly reports of EBP referrals made by the CUAs</td>
<td>Performance Management &amp; Accountability</td>
<td>Complete</td>
<td>Ongoing</td>
<td>Quarterly reports...</td>
</tr>
</tbody>
</table>
ATTACHMENT C
Juvenile Probation Services Grant
JJSES Implementation Plan
FY 2017-2018

County:

PART ONE: Current Status of 2016-2017 JJSES Implementation

Describe the current status of your department’s implementation of each of the approved activities included in your FY 2016-2017 JJSES Implementation Plan and any impact the activities have had on your department:

EXAMPLE:

Activity #1: Stakeholder engagement

Objective: To continually engage stakeholders to ensure JJSES knowledge is fresh and implementation efforts run smoothly.

Action Plan: To convene an annual meeting of stakeholders in a forum that allows for the presentation of JJSES, the county progress within JJSES, and question/answer session for stakeholders.

Target Date: May 23rd, 2016

Comments: This area of need was further amplified by the departure of a significant amount of institutional knowledge as a result of retirements and turnover.

Current Status/Impact: A meeting was held on May 23rd with a variety of stakeholders within the county and with service providers. The meeting was extremely beneficial and prompted the need to have this activity as an ongoing forum with additional training aspects added to enhance the knowledge and skill set of our stakeholders around JJSES. This area will again be addressed in the FY17-18 plan and include more formalized engagement with the stakeholders in the form of training through the Judges Academy and at the local level.

A. Stage One (Readiness):

Activity: Intro to EBP training for new Juvenile Probation Officers

Objectives: To educate new Juvenile Probation Officers on benefits of utilizing evidenced based practices

Action Plan:

✓ Incorporate evidence based training into the county training curriculum for new JPOs.

○ Send new JPOs to the JCIC sponsored Orientation for the New Juvenile Probation Professional

Target Date: September 2016
Comments: EBP 101 has been included in the training curriculum for JPO trainees. Since July 1, 2017, newly hired JPOS received the training. In regards to sending new JPOS to the JCJC sponsored Orientation for the New Juvenile Probation Professionals, we were informed by JCJC training staff that the program was being evaluated and reviewed for updates and changes for spring 2017. Philadelphia County provides a 4 week training orientation for all new incoming JPOs.

Current Status/Impact: Providing the knowledge of EBP 101 to JPO trainees in their orientation helps build a foundation needed to improve outcomes for youth and families.

Activity: Stakeholder Engagement

Objectives: To communicate updates on current and new JJSES initiatives to system stakeholders

Action Plan:
- ✓ To meet with representatives from Public Defender’s Office, District Attorney’s office and DHS to provide updates on status of current and new JJSES initiatives.
- ○ To conduct biannual provider meetings that would include updates on JJSES initiatives.

Target Date: Biannual meetings from July 1, 2016-June 30, 2017; Informal meetings on changes to current or new initiatives as needed

Comments:

Current Status/Impact: On 9/19/16, Judges, stakeholders, and probation representatives met to discuss philosophy of graduated response and future implementation in Philadelphia County. On 2/23/17 Probation and Reintegration staff met to discuss system updates. JJSES initiatives, and YLS criminogenic needs. On 4/13/17, Probation Administration, DHS, PDS, and DA representatives met to discuss graduated response pilot program. On 4/18/17 public defenders were trained on the proposed graduated response system. A request has been made to DHS-Juvenile Justice division to schedule a providers meeting to review updates.

B. Stage Two (Initiation):

Activity: Quality Assurance for PaDrai

Objectives: To monitor demographics and overrides

Action Plan:
- ✓ Request JCJC to create custom report in JCMS with details of PaDRAI results by date range
- ✓ JDAI coordinator will review report quarterly, analyze overrides and demographics and provide report of the data

Target Date: Quarterly from July 1, 2016 to June 30, 2017

Comments: JCJC created custom report PaDRAI Brief. In August 2016 JDAI coordinator ran the report in JCMS, reviewed data and provided initial report.
Current Status/Impact: Development of report led to additional detention assessment reports being created in JCMS and currently being field tested in Philadelphia. Reviewing the report quarterly helped identify reasons for overrides (ie parental refusal) which allowed for the work group to develop creative strategies to address those reasons.

Activity: Complete a review of YLS data and current policy
Objectives: To determine best practices for YLS assessments
Action Plan:
- Conduct a review of data on total number initial YLS assessments completed monthly by the department
- Conduct a review of the number of YLS assessments from each unit and staff averages of initial YLS assessments per month
- Based on the data, develop a proposal for a YLS unit
- Based on review of data determine practicality of completing closing YLS assessments

Target Date: February 2017

Comments: In September 2016, Deputy Directors began exploring YLS data and staffing needs. Data was collected over several months to determine number of YLS assessments each month per district and per JPO. Using that data, a proposal for a YLS unit has been developed along with protocols.

Current Status/Impact: At this time next steps and staffing is being evaluated and this activity will continue on the FY2017-2018.

Activity: YLS Booster Trainings
Objectives: Ensure fidelity and quality of assessment and reassessments
Action Plan:
- Schedule each unit for YLS booster training to be conducted by new YLS master trainer with assistance from experienced YLS master trainer.
- Training department YLS master trainers to develop booster cases based on a county case and the reassessment for the case.
- Supervisors (YLS Master Trainers) to conduct the training with focus on quality of assessments, comments, scoring, and written summary.

Target Date: Fall 2016 and Spring 2017

Comments: Fall 2016 boosters were completed. Spring 2017 booster training is in process.

Current Status/Impact: Providing boosters ensure staff continue to strive for quality assessments and provide a forum to address staff questions/concerns of assessments. Fall 2016 and Spring 2017 boosters were supervisor led since supervisors received YLS master training in Spring 2016. Supervisors were supported by the department's core group of YLS MTs.
Activity: Case Plan Development

Objectives: To implement a case plan as part of the graduated response system

Action Plan:

- To develop a case plan and policy that is used with graduated response system.
- Train probation officers selected for the pilot graduated response system on effective case planning
- Train pilot staff on how to identify SMART goals.
- Send staff to the Case Plan Forum

Target Date: December 2016 for pilot program

Comments: Since July, a case plan has been developed in draft form by the graduated response workgroup and will be included in the pilot of the graduated response system. In September 2016, 4 staff members attended the case plan forum.

Current Status/Impact: 2 JPOS field tested case plan from 11/17/16 through 1/30/17. Based on feedback from staff trained for the Graduated Response field test, it was decided to delay use of case plan to allow staff time to adjust to the graduated response model and associated forms. 1 JPO in the Graduated Response pilot continues to pilot the case plan.

C. Stage Three (Behavioral Change):

Activity: Utilization of Brief Intervention Tools (BITS)

Objectives: To incorporate BITS with juveniles on supervision in conjunction with the graduated response system

Action Plan:

- BITS master trainers to provide a BITS training for probation officers selected for the graduated response system pilot program
- Upon completion of the graduated response pilot program, identify a trainer to complete BITS training for all JPO
  - Train all JPOs to use BITS with supervision cases

Target Date: January 2017 for JPOs involved with pilot program; May 2017 for all JPOs

Comments: Two staff members are master trainers on the BITS. These staff will train the probation officers selected for the graduated response system pilot.

Current Status/Impact: Due to time delays with graduated response roll out, BITS training has not yet been completed but will included in activities for 2017-2018.
Activity: Implement a Graduated Response System

Objectives: To assist JPOs with engaging youth through a behavioral management approach to supervision which incorporates a response of an incentive or intervention.

Action Plan:

- Graduated Response committee will finalize policy and procedures including drafts of grids, behavioral definition and incentive options.
- Train approximately 2-4 JPOs and supervisors on the Graduate Response System, case plan, and BITS so that a field test can be conducted for 30 days.
- Upon completion of field test, select and fully train 1 JPO and supervisor from each district to participate in pilot program.
- Based on feedback from staff and Judges on pilot program, make necessary adjustments prior to training staff and implementing department wide.
- Graduate Response workgroup to meet weekly to review progress.

Target Date: Field Test November 2016; Pilot Program-December 2016; Full implementation-February 2017

Comments: The graduate response workgroup in conjunction with consultant Dr. Naomi Goldstein continues to meet approximately 1-2 times per week to develop the final drafts of policy, intervention/incentive options, and behavioral definitions.

Current Status/Impact: Field test with 2 JPOs occurred 11/14/16 through 1/30/17. Based on feedback, necessary adjustments were made to grids and procedures. Pilot program with 1 JPO per district began April 1, 2017 and will continue through August 30, 2017. In May, Philadelphia participated in the statewide Graduated Response Forum. Staff from Philadelphia County continue to participate on the statewide Graduated Response Committee.

D. Stage Four (Refinement):

Activity: Policy Alignment

Objectives: To align policies with evidence based practice language

Action Plan:

- To continue review of all current policies and make changes to reflect evidence based language.
- Incorporating evidence based language in new policies and procedures.

Target Date: Ongoing

Comments: This is an activity that began in FY 2015-2016.

Current Status/Impact: To date 23 policies have been reviewed by the Policy Committee and submitted for final approval. All new policy/procedures include EBP language. Including evidence based language and practices in policies and procedures provides continuity and a common language for all stakeholders.
E. Building Block activities within the JJSES Framework (i.e. Diversion, Delinquency Prevention, Family Involvement, Continuous Quality Improvement):

Activity: Continuous Quality Improvement for Supervisors

Objectives: To provide supervisors with tools in leading evidence based probation districts

Action Plan:

☐ Consult with Carey Group on conducting EBP briefcase training for supervisors

Target Date: June 2017


Current Status/Impact: To provide support to supervisory staff prior to implementing the briefcases, it was determined that the Deputy Directors would model 2 of the briefcases for the supervisors. On 3/2/17 the Directors conducted Module 17: Using Incentives/Rewards to Encourage Prosocial Behavior. On 5/19/17 Directors with 1 supervisor volunteer conducted Module 18: Effective Responses to Noncompliant Behavior.
PART THREE: Youth Level of Service Data

In this section, provide YLS data for calendar year 2016 (January 1, 2016-December 31st, 2016)

Youth Level of Service Data for 2016:

1. The total number of ALL YLS assessments completed and the override percentage during 2016.
   - All YLS scored in this period: 2972
   - Override percentage: 0%

2. The number and percentage of all juveniles scoring within each risk level for initial assessments.
   - Number of YLS Initial Assessments scored during this period: 1296
   - Low: 596 (40%)
   - Moderate: 678 (52%)
   - High: 22 (2%)
   - Very High: 0 (0%)

3. The number and percentage of all juveniles scoring within each YLS domain and risk level for initial assessments.

<table>
<thead>
<tr>
<th>Prior and Current Offenses</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>80%</td>
<td>16%</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>(1031)</td>
<td>(213)</td>
<td>(52)</td>
</tr>
<tr>
<td>Family Circumstances/Parenting</td>
<td>82%</td>
<td>15%</td>
<td>3%</td>
</tr>
<tr>
<td></td>
<td>(1065)</td>
<td>(194)</td>
<td>(37)</td>
</tr>
<tr>
<td>Education/Employment</td>
<td>21%</td>
<td>62%</td>
<td>17%</td>
</tr>
<tr>
<td></td>
<td>(276)</td>
<td>(799)</td>
<td>(221)</td>
</tr>
<tr>
<td>Peer Relations</td>
<td>39%</td>
<td>46%</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>(509)</td>
<td>(592)</td>
<td>(195)</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>52%</td>
<td>35%</td>
<td>13%</td>
</tr>
<tr>
<td></td>
<td>(675)</td>
<td>(457)</td>
<td>(164)</td>
</tr>
<tr>
<td>Leisure/Recreation</td>
<td>27%</td>
<td>20%</td>
<td>53%</td>
</tr>
<tr>
<td></td>
<td>(356)</td>
<td>(253)</td>
<td>(687)</td>
</tr>
<tr>
<td>Personality/Behavior</td>
<td>31%</td>
<td>67%</td>
<td>3%</td>
</tr>
<tr>
<td></td>
<td>(398)</td>
<td>(862)</td>
<td>(36)</td>
</tr>
<tr>
<td>Attitudes/Orientation</td>
<td>68%</td>
<td>31%</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>(883)</td>
<td>(404)</td>
<td>(9)</td>
</tr>
</tbody>
</table>

Signature: ___________________________  Date: ________________

Chief Juvenile Probation Officer

Signature: ___________________________  Date: ________________

Juvenile Court Administrative Judge
ATTACHMENT D
Attachment D

Child Welfare Demonstration Project (CWDP) Implementation Team

June 2017

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Akbar, Nafeesa</td>
<td>Bethanna, CUA 8</td>
</tr>
<tr>
<td>Ali, Kimberly</td>
<td>Deputy Commissioner for Child Welfare Operations</td>
</tr>
<tr>
<td>Blake, Robert</td>
<td>Wordsworth, CUA 5</td>
</tr>
<tr>
<td>Bottalla, Paul</td>
<td>Policy and Planning Director</td>
</tr>
<tr>
<td>Boyd, Staci</td>
<td>Operations Director, IOC</td>
</tr>
<tr>
<td>Chestnut, Cynthia</td>
<td>NET Community Care, CUA 1 and 7</td>
</tr>
<tr>
<td>Farlow, Timene</td>
<td>Deputy Commissioner for Juvenile Justice Services</td>
</tr>
<tr>
<td>Figueroa, Cynthia</td>
<td>DHS Commissioner</td>
</tr>
<tr>
<td>Gaynor, John</td>
<td>Catholic Community Services, CUA 4</td>
</tr>
<tr>
<td>Houlon, Jonathan</td>
<td>Chief Deputy City Solicitor, Child Welfare Unit, Law Department</td>
</tr>
<tr>
<td>Keafer, Heather</td>
<td>Director of Communications</td>
</tr>
<tr>
<td>Kinsler, Brenda</td>
<td>DHS Teaming Director</td>
</tr>
<tr>
<td>Labree, Emily</td>
<td>Turning Points for Children, CUA 9</td>
</tr>
<tr>
<td>Maldonado, Waleska</td>
<td>Deputy Commissioner for Prevention</td>
</tr>
<tr>
<td>Morciglio, Robertoluis</td>
<td>Asociación Puertorriqueños en Marcha, CUA 2</td>
</tr>
<tr>
<td>Morris, Laura</td>
<td>Behavioral Health Implementation Advisor, Community Behavioral Health</td>
</tr>
<tr>
<td>Rodriguez, Liza</td>
<td>Deputy Commissioner for Performance Management and Technology</td>
</tr>
<tr>
<td>Santana, Nicole</td>
<td>Turning Points for Children, CUA 3</td>
</tr>
<tr>
<td>Shapiro, Jessica</td>
<td>First Deputy Commissioner</td>
</tr>
<tr>
<td>Simi, Christopher</td>
<td>Deputy Commissioner for Finance</td>
</tr>
<tr>
<td>Terrell, Luciana</td>
<td>Director of the Educational Support Center</td>
</tr>
<tr>
<td>Thompson, Allison</td>
<td>Intervention Development Director, DHS</td>
</tr>
<tr>
<td>VanDenBerghe, Cre</td>
<td>Tabor Community Partners, CUA 6</td>
</tr>
<tr>
<td>Williams, Gary</td>
<td>Chief Learning Officer, DHS University</td>
</tr>
<tr>
<td>Williams, Justin</td>
<td>Wordsworth, CUA 10</td>
</tr>
</tbody>
</table>
ATTACHMENT E
Philadelphia COB Board Members

CHAIR:
David Sanders, Ph.D.
Casey Family Programs
1300 Dexter Ave. N, Suite 300
Seattle, Washington 98109
206-270-4988
Fax: 877-418-1635
dsanders@casey.org

Marc Cherna, MSW
Director, Department of Human Services
Allegheny County
Human Services Building
One Smithfield Street
Fourth Floor
Pittsburgh, PA 15222-2225
Phone: 412-350-5701
Fax: 412-350-4004
Marc.Cherna@AlleghenyCounty.US

W.Wilson Goode, Sr., Min.D.
Senior Fellow
National Director, Amachi
2000 Market Street, Suite 550
Philadelphia, PA 19103
Phone: 215-729-0248
wgoode@amachimentoring.org

Todd Lloyd
Todd Lloyd, MSW
Senior Policy Associate, External Affairs
Jim Casey Youth Opportunities Initiative
The Annie E. Casey Foundation
503 N. Charles Street | Baltimore, MD 21201
Direct: 410.547.3650 | Mobile: 717.514.9779
TLloyd@aecf.org

Linda Mauro, DSW
2347 Wallace St.  Unit A
Philadelphia, PA 19130
Phone: 215-204-6103
lmauro@temple.edu
Kathleen G. Noonan, JD
PolicyLab at Children’s Hospital of Philadelphia
34th Street and Civic Center Boulevard
CHOP North, Room 1535
Philadelphia, PA 19104-4399
Phone: 267-426-0842
Cell: 215-221-2605
noonank@email.chop.edu

Judith Silver, Ph.D.
Children’s Hospital of Philadelphia
North, Room 1460
34th Street and Civic Center Boulevard
Philadelphia, PA 19104
Phone: 215-590-7723
SILVERJ@email.chop.edu

Phyllis Stevens
478 Moyer Road
Harleysville, PA 19438
215-256-0669
taplink@comcast.net

Ameera Sullivan
1317 N. 19th Street, Apt C,
Philadelphia, PA 19121
Phone: 267-975-6598
Tub84613@temple.edu
Carol Tracy, JD
Executive Director
Women’s Law Project
125 S. 9th Street, # 300
Philadelphia, PA 19107
Phone: 215-928-9801
Fax: 215-928-9848
ctracy@womenslawproject.org

Tracey Williams
Member
The Achieving Reunification Center
5419 Master Street
Philadelphia, PA 19131
Phone: 215-921-2010
Wtracey10@yahoo.com

Shelly Yanoff
126 W. Mt Airy Avenue,
Philadelphia, PA 19119
Phone: 215-247-5070
shellyyanoff@gmail.com
EX-OFFICIO MEMBERS:

Cindy W. Christian, MD
Chair, Child Abuse and Neglect Prevention
Children's Hospital of Philadelphia
Associate Professor of Pediatrics
University of Pennsylvania School of Medicine
34th Street and Civic Center Blvd., Room 2416
Philadelphia, PA 19104
Phone: 215-590-2058
CHOP operator at 215-590-1000
Fax: 215-590-2180
Christian@email.chop.edu

David T. Jones
Commissioner, Department of Behavioral Health and Intellectual disAbility Services (DBHIDS)
1101 Market Street, 7th Floor
Philadelphia, PA 19107
Phone: 215-685-6082
Fax: 215-685-5467
David.T.Jones@phila.gov

Cynthia F. Figueroa
Commissioner
Department of Human Services
1515 Arch Street, 8th floor
Philadelphia, PA 19102
Phone: 215-683-6001
Cynthia.Figueroa@phila.gov
ATTACHMENT F
### DHS Executive Cabinet

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ali, Kimberly</td>
<td>Deputy Commissioner, Child Welfare Operations</td>
</tr>
<tr>
<td>Bottalla, Paul</td>
<td>Director, Policy and Planning</td>
</tr>
<tr>
<td>Boyd, Staci</td>
<td>Operations Director, Child Welfare Operations</td>
</tr>
<tr>
<td>Farlow, Timene L.</td>
<td>Deputy Commissioner, JJS</td>
</tr>
<tr>
<td>Figueroa, Cynthia F.</td>
<td>Commissioner</td>
</tr>
<tr>
<td>Garrett-Harley, Vanessa</td>
<td>Chair, Social Services Law Group</td>
</tr>
<tr>
<td>Harrison 3rd, Samuel B.</td>
<td>Operations Director, Child Welfare Operations</td>
</tr>
<tr>
<td>Keafer, Heather</td>
<td>Director, Communications and External Communications</td>
</tr>
<tr>
<td>Maldonado, Waleska</td>
<td>Deputy Commissioner, Prevention Services</td>
</tr>
<tr>
<td>Mounelasy, Vongvilay</td>
<td>Deputy Commissioner, A and M</td>
</tr>
<tr>
<td>Rinehart, Christi</td>
<td>Director of Operations, Child Welfare Operations</td>
</tr>
<tr>
<td>Shapiro, Jessica S.</td>
<td>First Deputy Commissioner</td>
</tr>
<tr>
<td>Simi, Christopher</td>
<td>Deputy Commissioner, Finance</td>
</tr>
<tr>
<td>Williams, Gary D.</td>
<td>Chief Learning Officer</td>
</tr>
</tbody>
</table>
ATTACHMENT G
Prevention Program IOC Alignment | FY17

Prevention Program Review Preliminary Findings

Philadelphia DHS (DHS) is reviewing its prevention funding and programs for the purpose of identifying quality services that are align with DHS' Improving Outcomes for Children. The core objective of this review is to make recommendations and implement strategies to enhance DHS' prevention service continuum in meeting the complex needs of families served across Philadelphia. As a result of this review, the array of prevention programs will be enhanced to include additional options for case diversion for families who do not require assistance from the formal child welfare system and are better served through community based prevention.

Context for Prevention Program Review:

As of March 31, 2016, approximately 6,303 families and over 10,000 children were receiving child welfare services from the formal child welfare system of DHS. This is not inclusive of the thousands of families and children served by prevention programs funded by DHS. Of the 10,000 children receiving formal child welfare services from DHS over 6,000 are in dependent placement. In 2013, prior to DHS' IOC transformation and the significant changes in child welfare legislation across the Commonwealth, DHS' dependent placement population was approximately 4,000 youth. A comparison of FY16 and FY15 provides insight into trends and growth of Philadelphia's child welfare system:

- CYD FY16 to FY15 Year to date comparisons, July 1 through March 31:
  - Hotline calls are up 22%, 21,164 compared to 17,411
  - Reports are up 30%, 19,512 compared to 14,975
  - Investigations are up 12%, 14,213 compared to 12,739

Point-in-time: The number of families receiving in-home services increased 12%, to 2000 families on 3/31/16 from 1,784 on 3/31/15

Given DHS' growth in population served, DHS has initiated an ongoing review and analysis of its prevention programs to ensure resources are being allocated responsibly and produces outcomes that are aligned with IOC:

1. Maintaining children in their own homes and within their own communities
2. Timely reunification or other form of permanency
3. Reduction in congregate care placements
4. Improving child and family functioning

Prevention Review Goals:
Conduct an analysis on service utilization and impact of Philadelphia DHS prevention programming:

Assess community and neighborhood needs by Community Umbrella Agency region to determine optimal allocation of prevention funding and intervention;

Revise Philadelphia DHS prevention service continuum to include programs that support DHS/IOC desired outcome.

Preliminary Data Observations

The CUA regions with the highest Accept For Service (AFS) rates typically included high indicators of poverty, crime and high school drop percentages. On average these regions also included a higher rate of child abuse and neglect reporting. The information below provides a general trend of what the data revealed by CUA region.

Accept for Service rates:

The Community Umbrella Agency regions that had the highest AFS rates in 2015 are:

CUA 5 – 422 (families accepted for services by DHS)
CUA 3 – 358
CUA 9 – 348
CUA 2 – 340
CUA 10 – 312

Note: DHS accepted a total of 3022 families for service in 2015. CUA Region 6 have the fewest number of families accepted totaling 199.

Volume of reports by CUA and by report type:

CUA 5 CPS 686 and GPS 1,733
CUA 3 CPS 614 and GPS 1,446
CUA 9 CPS 534 and GPS 1,417
CUA 2 CPS 530 and GPS 1,359
CUA 4 CPS 525
CUA 10 GPS 1,238
Prevention Program IOC Alignment | FY17

Note: CUA 6 and CUA 7 have the fewest number of reports generated within a region. CUA 6 - 360 CPS reports and 891 GPS reports; CUA 7 - 381 CPS reports and 1003 GPS reports.

High School Drop Out Rates (categorized by highest and second highest CUA regions over a 6yr time period)

CUA regions with highest rate percentages:

CUA 8
CUA 2
CUA 1

CUA regions with second highest drop-out rate percentages:

CUA 10
CUA 7
CUA 3
CUA 5

Note: See attachment for specific zip codes and percentages.

Child Care Provider categorized by star level and by CUA region (as of December 2015):

CUA 2 - 77 Child Care Providers - 5 of the 77 are level 4
CUA 1 - 95 Child Care Providers - 2 of the 95 are level 4
CUA 7 - 98 Child Care Providers - 2 of the 98 are level 4
CUA 3 - 141 Child Care Providers - 9 of the 141 are level 4
CUA 6 - 207 Child Care Providers - 7 of the 207 are level 4

Note: CUA region 5 has the highest number of child care providers totaling 321. (Of the 321, 10 are level 4)

Children with elevated blood lead levels and children entering homeless shelters

Both data mappings for children with elevated blood levels and children entering shelters remarkably mirror the data mappings for families who are accepted for services and CUA regions with high rates of child abuse reporting. The top five CUA regions impacted are CUAs 5, 3, 9, 2 and 10. However, it should be noted that other CUA regions are affected by...
the same challenges and in many instances there is not a huge difference in the percentage
ratings.

Brief Summary:

The data reviewed highlight communities and neighborhoods, by CUA region, that are
significantly impacted by poverty and have high concentrated populations who are brought
to the attention of DHS. Families in these neighborhoods are apt to be accepted for child
welfare service at a disproportionate rate when compared to more resourced communities.
Additionally, high school drop-out rates are higher within these same CUA regions and
level 4 star child care facilities are woefully scarce throughout the city, particularly in the
neighborhoods with higher rates of DHS involvement. Poverty indicators (i.e. youth
homelessness, substance abuse and children impacted by high lead blood levels) are
prevalent in these same neighborhoods compounding the complexities of family dynamics
for Philadelphia’s most vulnerable children and youth.

Preliminary Recommendations:

Identify “Anchor” prevention service categories/programs that DHS will maintain to meet
specific needs of neighborhoods by CUA region (see Anchor program attachment).

- The framework of the Anchor programs attached is not an all inclusive list and
  programs will be added as needed based on further analysis. However, the
  programs listed are identified as priority programs that DHS will further develop to
  meet particular needs of communities served and provide additional options for
  service intervention outside of the formal child welfare system.

Terminate programs that are either underutilized; duplicative in nature; and/or not
aligned with IOC outcomes (see grid attached labeled FY 2017 Programs not
Recommended for Funding)

- 2.4 million dollars have been identified as a result of recommended cuts and can be
  repurposed based on the needs of communities.
- There are additional prevention type programs managed by CYD that are currently
  under review and additional recommendations are pending.

Increase (in some instances reallocate) funding for Family Empowerment Services (FES) in
high risk neighborhoods. Additionally, provide additional guidelines and develop enhanced
mechanism for monitoring and tracking the use of FES’ discretionary emergency funding
for families.

Use existing partners i.e. Philadelphia Youth Network and Parks and Recreation to increase
career awareness/readiness and Work Study and/or apprenticeship programs to serve.
Prevention Program IOC Alignment | FY17

older youth in high poverty communities and incentivize high school completion for at risk youth.

Establish program service priorities for SCOP providers that would target particular needs of neighborhoods. Note: SCOP providers consist of a conglomerate group of grass root organizations that receive grant money from DHS.

Review Standards for all prevention programs and make revision that support outcome driven service delivery. This process is ongoing and recommendations throughout the remaining FY and into the upcoming FY. (See attachment of programs with brief program description)
### Anchor Programs

<table>
<thead>
<tr>
<th>Diversion Case Management:</th>
</tr>
</thead>
<tbody>
<tr>
<td>FES</td>
</tr>
<tr>
<td>Health Federation</td>
</tr>
<tr>
<td>Truancy Prevention</td>
</tr>
<tr>
<td>RSRI</td>
</tr>
<tr>
<td>FGDM</td>
</tr>
</tbody>
</table>

Diversion Case management programs offer support and intervention to families experiencing stressors that may be manifesting in risks that could result in transitioning to mandated services. These services will be available during the investigation of allegations of abuse and neglect when there is not an immediate safety threat present. The Anchor services will aid in alleviating these stressors through assessment of current family needs and appropriate planning to include referral and linkages to services that will address identified needs and build family stability and resilience.

Increased capacity in the Diversion Case Management will allow for less families to become involved with mandated child welfare services, by decreasing truancy, supporting families with drug and mental health challenges and providing supports.

### Domestic Violence

<table>
<thead>
<tr>
<th>Congreso</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lutheran Settlement House</td>
</tr>
<tr>
<td>Menergy</td>
</tr>
<tr>
<td>Women Against Abuse</td>
</tr>
<tr>
<td>Women In Transition</td>
</tr>
<tr>
<td>Woman Organized Against Rape</td>
</tr>
</tbody>
</table>

Domestic Violence programs provide an array of services to include, individual, family, and teen counseling to victims of intimate partner abuse. The programs also provide emergency and temporary housing and aftercare support. DV provider interventions allow families to improve child and family functioning.

Increased capacity to the DV Programs will allow more families to be housed in safe settings, more victims of abuse to receive counseling and other supports as they build their resilience and are able to build and maintain a stable environment.

### Educational Support

<table>
<thead>
<tr>
<th>OST</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESC</td>
</tr>
<tr>
<td>FAST (Families and Schools Together)</td>
</tr>
<tr>
<td>Free Library</td>
</tr>
</tbody>
</table>
Pa. School for the Deaf

Education Support Services programs are designed to improve the educational stability, continuity and well-being of children and youth involved with DHS. The involvement includes out-of-home placement as well as in-home services. These supports ensure that children’s education process is not disrupted by involvement in the child welfare system and that supportive educational programs are available and viable to youth in their own communities. Education Support Programs improve child and family functioning and effectively allow children to continue to receive education and educational supports in their own communities. Increased capacity for the ECS programs align with DHS and Citywide goals for educational success for the most vulnerable youth (i.e., Universal PreK and the Readby4th initiative).

**Parenting/Housing**
- Together as Adoptive Parents
- Crisis Nurseries
- Maternity Care Coalition
- Temple GrandMa’s Kids
- Grand Central

The Parenting and Housing Programs address the immediate needs of families involved with DHS. Parenting skill building remains a vital component of effective intervention and encompasses all of the IOC goals, maintaining children in their home and communities, timely reunification, reduction of congregate care and the improvement of child and family functioning. Housing resources are concrete mechanisms to insuring safe environments for children and families. Increased capacity for housing resources will reduce and shorten DHS involvement with families whose precipitating factor of involvement with DHS is inadequate housing.

**Community Engagement**
- The Attic
- Teen Shop
- Mazzoni Center
- Boys/Girls Track
- Big Brothers/Big Sisters
- Covenant House
- SCOP

Community Engagement Programs involve youth in programs to promote their well-being and successful functioning. The programs provide mentoring, skill building, and purposeful activities that enhance self esteem and reduce delinquency. Increased capacity for Community engagement programs will allow more youth to benefit from the programs, especially targeting youth involved with DHS and youth living in poverty and high crime areas.
An Evaluation of the Family Support Center Network

November 2016
INTRODUCTION

The Allegheny County Department of Human Services (DHS) conducted an evaluation of 25 Family Support Centers (FSC) in order to answer a number of questions concerning their operation and impact. The evaluation utilized both quantitative and qualitative data collection methods and included the following domains:

- Family engagement
- Connections to social services
- Early childhood development and school readiness
- Maternal and infant health
- Child abuse and neglect

This executive summary begins with a description of the Family Support Network, followed by key findings from the evaluation. It concludes with a discussion of next steps. The evaluation components are:

<table>
<thead>
<tr>
<th>EVALUATION COMPONENT</th>
<th>EVALUATOR(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Engagement</td>
<td>Allegheny County Department of Human Services</td>
</tr>
<tr>
<td>Connections to Social Services</td>
<td>Allegheny County Department of Human Services</td>
</tr>
<tr>
<td>Early Childhood Development and School Readiness</td>
<td>Allegheny County Department of Human Services, University of Pittsburgh Office of Child Development</td>
</tr>
<tr>
<td>Maternal and Infant Health</td>
<td>Allegheny County Department of Human Services, Chelsea Wentworth, Ph.D.</td>
</tr>
<tr>
<td>Child Abuse and Neglect</td>
<td>Allegheny County Department of Human Services, Chapin Hall Center for Children</td>
</tr>
</tbody>
</table>
Evaluation findings are provided for the network as a whole, rather than for individual centers. The evaluation found that FSC communities have lower-than-expected rates of child abuse investigations and that FSC participants are developing relationships with other participants that continue outside of the FSC and its scheduled activities. However, FSCs were less successful in connecting families to social services and improving school readiness and maternal/infant health outcomes.

THE FAMILY SUPPORT CENTER NETWORK

The Allegheny County FSC network originated in the early 1990s, with initial funding from the local foundation community. In 1994, the Family Support Policy Board was created to bring parent leaders to the table with other community stakeholders such as public and private funders, elected officials and community collaborators. As an advisory body that includes parents as important contributors to the decision-making process on family support initiatives, the Policy Board soon became a national model for parent leadership and governance.

Two decades later, the Allegheny County FSC network consists of 26 FSCs, under the operational leadership of 11 lead agencies. The network serves approximately 3,600 families each year.

WHAT IS FAMILY SUPPORT?

FSCs are community-based, participant-driven hubs of programs, services and supports designed to improve outcomes for children (birth through five) and their families. FSCs strive to promote the healthy development of children by supporting the families and communities in which they live, increasing the strength and stability of families as well as parents’ confidence in their parenting abilities. FSCs are located in sites as varied as schools, apartment buildings and health centers. In general, each FSC is staffed by a site director and one or more of the following: Family Development Specialists, Child Development Specialists, Nurses, Community Aides and Service Coordinators. Each site also either employs or shares (with another site) a van driver and a data entry specialist. Four of the most active FSCs are those serving large immigrant populations.

While each FSC is unique, offering its own menu of services, all are based on the philosophy that parents are a child’s first and most important teachers. At a minimum, every FSC works with parents and children to ensure that:

- Expectant mothers are receiving prenatal care and preparing for the arrival of the child
- Families identify and secure appropriate public benefits, including health insurance

---

PRINCIPLES OF FAMILY SUPPORT

- Grown from, designed and improved by participants and community members.
- Relationship-based, fostering respectful partnerships between and among parents, peers and professionals.
- Strengths-based, building on existing individual, family, community and cultural abilities and capabilities.
- Designed by and for participants to meet their priorities, collaborative among agencies to ensure easy access and use.
- Reflects, respects and enhances the cultural values of the neighborhood through the staff it hires and the materials and activities it provides.
- Enhanced through program evaluations that reflect family support principles and that contribute to continuous program improvement.
- Based in the community, serves the entire family without eligibility requirements, and voluntary.
• Every child has up-to-date vaccinations
• Developmental screenings are conducted on every infant and child
• Referrals are made for early intervention services, when appropriate
• Appropriate and meaningful interactions are occurring between parents and children
• Parents develop goal plans for themselves and their children and are connected to supports that will help them achieve the identified goals
• Every child is ready to begin kindergarten

FSCs also provide drop-in and scheduled programming and socialization opportunities as well as offering the evidence-based Parents as Teachers home visiting curriculum. Centers may also offer or partner with agencies that provide one or more of the following activities: afterschool and summer programs for youth, career readiness training, concrete goods, counseling, child care, Head Start or Early Head Start, ESL and literacy programs, food bank, transportation and parent support groups.

WHO ARE THE LEAD AGENCIES AND THE INDIVIDUAL FAMILY SUPPORT CENTERS?
Lead agencies are an important part of the Allegheny County Family Support Network. Each agency has administrative responsibility for one or more Family Support Centers, providing fiscal and programmatic oversight. In addition, lead agencies provide expertise in a variety of areas to support participation families.

1) The Allegheny Intermediate Unit (AIU) provides specialized educational services to Allegheny County’s suburban school districts and vocational/technical schools. The AIU is the lead agency for the following FSCs:
• Clairton Family Center
• Duquesne Family Center
• East Allegheny Family Center
• Highlands Family Center
• Latino Family Center
• Lincoln Park Family Center
• McKeesport Family Center
• Steel Valley Family Center
• Sto-Rox Family Center
• Wilkinsburg Family Center
2) **Children's Hospital of Pittsburgh of UPMC** is one of the top children's hospitals in the nation, renowned for excellence in pediatric care. Children's Hospital is the lead agency for the following FSCs:
   - Braddock Family Care Connection
   - Hilltop Family Care Connection
   - Lawrenceville Family Care Connection
   - Rankin Family Care Connection
   - Turtle Creek Family Care Connection

3) **Family Resources of Pennsylvania** works to prevent and treat child abuse by providing community services and treatment to families, educating parents, and advocating for children. Family Resources is the lead agency for the Hill District Center for Nurturing Families.

4) **Focus on Renewal** is a comprehensive social service organization that provides health care, economic services, and social services to the Strip District community. Focus on Renewal is the lead agency for the Positive Parenting Program.

5) **The Homewood-Brushton YMCA** provides youth and adults with programming to improve the quality of their lives, and is the lead agency for the Homewood-Brushton FSC.

6) **Primary Care Health Services, Inc.** provides primary and preventive health care services to medically underserved and indigent populations in Allegheny County, and is the lead agency for the Wilkinsburg FSC.

7) **Providence Connections** provides inner-city children with a stimulating and engaging childcare experience, and supports the entire family with highly trained family development specialists. It is the lead agency for the Providence FSC.

8) **South Hills Interfaith Ministries** is a human services organization dedicated to providing the resources necessary for struggling families to achieve self-sufficiency. It is the lead agency for the Prospect Park Family Center.

9) **The Kingsley Association** provides social and educational services to children, youth, and their families and is active in community mobilization; it is the lead agency for the East Liberty FSC.

10) **The Urban League of Greater Pittsburgh** enables African Americans to secure economic self-sufficiency, parity and power, and civil rights, and serves as the lead agency for the following FSCs:
    - Duquesne Family Support Center
    - East Hills Family Support Center
    - Northview Heights Family Support Center

11) **The Council Of Three Rivers American Indian Center, Inc.** supports Native American families in the Pittsburgh area and is the lead agency for the Greater Hazelwood FSC.
WHERE ARE FAMILY SUPPORT CENTERS LOCATED?

Figure 1 shows the location of FSCs in Allegheny County, and Figure 2 displays the various settings in which they are located.

FIGURE 1: Location of Allegheny County Family Support Centers

- Family Support Centers
- City of Pittsburgh limits
- Allegheny County
FIGURE 2: Family Support Center Settings (n = 26)

- Commercial buildings: 9
- Community center / community-based organization: 8
- Storefront: 3
- Apartment building: 3
- School: 1
- Church: 1
- Health center: 1

WHO IS SERVED BY FAMILY SUPPORT CENTERS?
Approximately 6,000 new families were enrolled in the 25 FSCs from 2009 through 2014, representing a total of 17,000 individuals (7,000 adults and 10,000 children). Figure 3 provides a look at the typical FSC family.

FIGURE 3: What does the Typical Family Look Like?
- Headed by a 35-year-old single female parent with high school education, $15,000 yearly income
- Child in family has public housing or private health insurance
- 80% are white, 3% are African-American
- Average household income: $15,000
EVALUATION FINDINGS

The evaluation was conducted on both individual FSCs and the network as a whole. Individual results were presented to each FSC as well as to FSC leadership, but this section provides only network-wide findings. As expected, wide variations exist in the findings for individual FSCs.

In order to determine whether FSCs were operating as anticipated and improving stated outcomes, the evaluation integrated quantitative data (FSC data management application, local school districts, Pre-K Counts, child welfare case information and other human services data) and qualitative data collection methods. Qualitative data methods included a direct data collection component, in which telephone surveys were administered to 145 families, on-site visits to each FSC that included observations of activities and interviews with staff, and interviews with DHS FSC monitors. In addition to DHS staff, evaluation components were conducted by Chapin Hall, the University of Pittsburgh and Dr. Chelsea Wentworth.

Positive Findings
Positive outcomes were identified in three key areas:
1. Preventing Child Abuse and Neglect
2. Fostering Supportive Relationships
3. Engaging High-Risk Families

Preventing Child Abuse and Neglect
The analysis matched neighborhoods with an FSC to similar neighborhoods without an FSC (matched characteristics were those that indicate socioeconomic risk, such as poverty, single parent-headed households and number of adults without a high school diploma). The FSC neighborhoods showed lower-than-expected rates of child abuse and neglect investigations than the matched neighborhoods without an FSC. The non-FSC neighborhoods had a rate of 41.5 child welfare investigations per 1,000 children; those with an FSC had rates of only 30.5 investigations per 1,000 children. This is particularly significant because, in general, neighborhoods with these characteristics have higher rates of child abuse/neglect allegations. Therefore, this finding suggests that the presence of an FSC may have a cumulative protective effect on child abuse for the community and reduce the incidence of child safety events that warrant child welfare involvement.

Fostering Supportive Relationships
While providing services and connecting families to traditional supports were intended FSC goals, no formal service system can provide day-to-day and long-term support. Natural supports, such as extended family, friends and community resources can strengthen families and provide an ongoing buffer against life’s daily challenges. It is therefore significant that family members active in FSCs were found to be establishing informal support relationships and networks through their participation in the FSC. Sixty-one percent of surveyed families reported that they connect with each other outside of the FSC; they meet up at school and during play dates, talk on the phone and meet for lunch, and get together for activities with their children.
Engaging High-Risk Families

Families at higher-risk are traditionally difficult to engage and reach with services, and this is true for FSCs as well. However, the Parents as Teachers program seems to be a positive exception. Two-thirds of families participating in that program met the definition of high risk. These services are specifically designed for families with intensive needs, and this finding indicates that the program is achieving its goal by reaching and engaging the right target population. This represents a key success on the part of the staff and engagement efforts, connecting with families in their homes while they are experiencing a high level of need and risk may be a way to provide a foundation for engaging them more fully outside of the home, particularly in services designed to prevent future crises.

Other Findings

Unfortunately, FSCs did not achieve the hoped-for outcomes in the following areas:

1. Connections to Social Services
2. Child Development and School Readiness
3. Maternal and Infant Health
4. Family Engagement

Connections to Social Services

FSCs were never intended to provide a comprehensive range of services to meet all of the needs of participating families. Rather, they were designed to engage high-risk families, provide a supportive environment in which to identify their needs, and provide referrals and linkages to already-established community services. Unfortunately, the data show minimal referral, follow-up activity, and service access, even during the period of time immediately following FSC enrollment, when these activities would be most expected.

For example, staff reported that many participating families were in need of mental health support, particularly in regard to trauma and stress. However, only 28 percent of participants ever accessed a publicly funded mental health service, and only three percent did so within 12 months of initially engaging with the FSC. Given the socioeconomic characteristics of the communities in which FSCs are located, it is logical to assume that nearly all participants would be eligible for some form of public assistance. Yet only 12 percent accessed public benefits within 12 months of enrollment. These findings are particularly discouraging because 1) FSC staff develop close relationships with participants and are well-placed to learn about their unmet needs and 2) as a community-based resource, FSCs are perfectly positioned to serve as a front door to formal and informal community resources. This represents a significant missed opportunity and one which can realistically be targeted for improvement through a concerted effort on the part of the system.
Child Development and School Readiness

Early childhood development and school readiness are primary FSC goals, addressed through a variety of structured and informal activities. Researchers utilized public school and research-focused early childhood data to analyze academic and social/behavioral outcomes of children who had and had not attended an FSC in the year prior to kindergarten entry (children were matched by school district and demographic characteristics). The analysis found that FSC children in preschool and kindergarten did not exhibit better outcomes on standardized instruments, but rather were equal to the non-FSC students. Behavioral measures for the FSC students were worse than those of their non-FSC peers, which may be an indication of the risk level of the children served by the FSCs. In a positive finding, analysis suggests that children who were more active with FSC programming and activities had better preschool attendance rates than the children with only occasional FSC participation.

Looking at kindergarten enrollment, attendance and number of school moves (to other buildings/districts), no differences were found between FSC children and non-FSC children matched by school district, demographics, receipt of public benefits (poverty proxy measure) and history of other human services involvement, although more FSC children repeat their kindergarten year than their matched peers. Similar to the preschool finding, more active participation with an FSC is associated with better kindergarten attendance.

Maternal and Infant Health

FSCs were designed to provide a wide range of assistance to mothers before and after the birth of their child. FSC-involved mothers were matched with non-FSC mothers on demographics, marital status, education, health history and history of human services involvement. Based on this analysis, FSC mothers received less prenatal care than a group of matched peers, and there were no differences between the FSC and matched non-FSC groups in measures of pre-term delivery, low birthweight or APGAR scores.

Qualitative data gathered through observation and interviews with staff and caregivers revealed three main themes related to FSC's maternal and child health services:

1. The delivery of maternal and child health services often takes a back seat to the need for support in crisis situations (e.g., utility shut-off, eviction, lack of food, transportation issues, domestic violence). This support is highly valued by parents and can prevent a crisis from escalating into a complicated, long-term problem.

2. Although not intended, mothers feel that once they give birth, their health and well-being is secondary to that of their children, giving them the impression that their own health is important only because it supports their ability to parent. There is also a reported lack of clarity about how maternal health can and should be supported and achieved.
3. FSC staff often function as the primary support for families without extended family or other support systems; many families report that this is the most important service they receive. Unfortunately, staff report that inadequate resources and increasing administrative responsibilities make it difficult for them to provide this support. This leads to the perception that their work is not valued, a perception compounded by conflicting responsibilities, stagnant wages, cuts in benefits, and high turnover/recruitment delays.

Family Engagement

Engaging families — and keeping them engaged — is vital to the strength and relevance of each FSC and the network as a whole. The evaluation found wide variability among FSCs in frequency of contact with enrolled families, with a significant proportion of enrolled families having very minimal contact. Contacts with FSC staff are highest in the first three months following enrollment and then decrease continuously; after six months, nearly two-thirds of enrolled families connect with the FSC or its staff less than once a month and overall, 47 percent of participants exit due to lack of interaction. Analysis shows that in general, in a given year, approximately one-third of enrolled families have no contact with the FSC, one-quarter are casually engaged and nearly 40 percent are consistently active. In addition, evaluation findings suggest that children who are engaged in FSCs following child welfare involvement fare no better, in terms of future child welfare involvement, than a control group of children who do not engage with an FSC. With the exception of the way in which Parents as Teachers successfully engaged high-risk families, these findings suggest that FSCs are inconsistent in their methods and procedures used to engage families, and indicate that family engagement strategies can, and should, be significantly improved.

NEXT STEPS

DHS intends to implement a number of strategies to strengthen the Allegheny County Family Support Center network. These strategies, in combination with existing parent leadership and core programming, are intended to achieve improved outcomes in the following domains:

- Parent Engagement and Leadership
- Outreach and Family Engagement
- Home Visiting
- Center-Based Activities
- Connecting Families to Appropriate Services
- Co-locating Services (e.g., Parent-Child Interaction Therapy, Behavioral Health Services) Based on Community Need
1. Continued Commitment to the Protective Factors Framework
   The Protective Factors framework was developed by the Center for the Study of Social Policy, based upon research that has consistently demonstrated that the likelihood of child abuse and neglect is decreased when these protective factors are in place within a family system. DHS is committed to this framework as a guide to FSCs' approach to supporting families.

2. Continued Utilization of the Standards of Quality for Family Strengthening and Support for Assessment, Training and Monitoring
   The Standards of Quality for Family Strengthening and Support were developed by the California Network of Family Strengthening Networks and adopted by the National Network of Family Strengthening Networks in 2013. DHS remains committed to the use of these Standards as the benchmark of quality in the Allegheny County FSC network and to guide training and monitoring.

3. Create an Integrated Management Information System
   The FSC evaluation was limited by the lack of data needed to address key research questions; at the same time, the constraints of the existing management information system (MIS) limit the ability of FSCs to use data to manage their operations. To address this issue, DHS will fund the creation of an Integrated MIS for all FSCs in the network. The new MIS will provide real-time data to support management decision-making, monitoring and cross-system collaboration.

4. Use of Community Data
   DHS will compile key data about the communities served by existing FSCs and use these data to 1) drive decisions regarding FSC funding and location and 2) inform partnerships, with FSCs and parent leaders, designed to support community prevention goals.

5. Use of a Common Assessment Tool
   DHS's practice model includes the use of a common assessment across all programs. Beginning in Fiscal Year 2016/17, all FSCs will transition to the use of the Family Advocacy and Support Tool (FAST), a standardized assessment for use with families.
EVENING REPORTING CENTERS

Evening Reporting Centers (ERC's) are community based alternatives to secure confinement. ERC programs are based on a sound understanding of adolescent developmental research which urges us as practitioners to consider all the ways in which a teenager's brain is fundamentally different from an adult. These programs aim to provide youth with prosocial opportunities to develop autonomous decision-making and critical thinking skills through strength-based programming.

For the Pre-adjudicatory Evening Reporting Center, the primary two objectives are to promote court appearances and reduce the likelihood of re-arrests while allowing youth to remain at home and continue to attend their neighborhood school. Eligibility for the program is largely determined by the Pennsylvania Detention Risk Assessment Instrument which informs the intake unit and Master at the Philadelphia Juvenile Justice Services Center (PJJSC) which youth are at a low, moderate, or high risk to re-offend or fail-to-appear in the pre-adjudicatory period. This ERC has the ability to service 20 youth, male or female, and provide gender-specific programming.

For 2016 the program serviced 84 youth, had an average length of stay of 69.5 days and reported a 90.5% overall success rate.

In February 2016 the Juvenile Probation Department in conjunction with DHS launched a second Evening Reporting Center for adjudicated youth on probation who needed highly structured and well supervised group activities during high risk time periods.

There were 68 youth serviced in 2016, and thus far 7 youth successfully completed the six month pilot program earning their discharged from supervision entirely.

The Post-ERC runs five-days-per-week and alternates Saturdays with 55% of youth also receiving additional therapeutic services. See below for year to date outcome data:

<table>
<thead>
<tr>
<th>Post ERC Early Outcome Data</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth Serviced:</td>
<td>68</td>
</tr>
<tr>
<td>Average Daily Attendance</td>
<td>96.9%</td>
</tr>
<tr>
<td>Average Age:</td>
<td>16.95</td>
</tr>
<tr>
<td>Average Length of Stay:</td>
<td>109</td>
</tr>
<tr>
<td>Re-arrest:</td>
<td>3%</td>
</tr>
<tr>
<td>Failure to Appear in Court:</td>
<td>10.35%</td>
</tr>
<tr>
<td>% of Youth Still Active as of 12/31</td>
<td>45%</td>
</tr>
</tbody>
</table>
PMT Program Improvement Strategies:

Under new DHS Commissioner Cynthia Figueroa, two key DHS divisions were integrated – Performance Management and Information Technology. The new Division of Performance Management & Technology (PMT) brings together core infrastructure functions of the department: Monitoring and Evaluation of Community Umbrella Agencies (CUAs), service providers (child welfare, juvenile justice, and prevention) and DHS child welfare practice; Data Warehouse & Analytics; Information Systems; and Performance Management. Starting in October 2016, the new PMT division launched several key initiatives to improve and modernize how DHS collects and analyzes data, evaluates providers, and utilizes modern technology to facilitate quality child welfare practice. These initiatives will continue to be developed, implemented, and enhanced in FY18 and FY19. The following sections summarize the status of new and continuing initiatives.

A. Monitoring & Evaluation

1. CONTINUING: Increase staff to perform Quality Visitation in order to survey a greater percentage of families and incorporate home visits for children and youth in placement.
   - In FY17, DHS increased staff in the Quality Visitation unit, enhancing capacity to conduct in-person caregiver interviews for In-home Cases and phone interviews for Placement Cases.
   - In FY18, DHS will utilize a third party expert, supported by Casey Family, to review and enhance the Quality Visitation tools, process, and outcome reporting. DHS will also explore conducting a sample of in-person interviews for Placement Cases.
   - In FY19, DHS will explore contracting with a qualified vendor to conduct a third-party Visitation Audit. This Audit will enable DHS to validate internal Quality Visitation processes and identify additional practice areas for quality assurance.

2. NEW: Re-assign Subcontractor(Provider) monitoring from CUAs to DHS to streamline reviews; ensure frequency, consistency and quality; disseminate results across CUAs, and centralize decision making around intake closures, and other provider performance issues.
   - In FY17, PMT conducted information and planning meetings with CUA Quality Assurance directors to address questions and concerns regarding the transition of all provider monitoring back to DHS.
   - In FY18, PMT will begin monitoring and evaluating all contracted providers, increasing the monitoring frequency from once to twice a year. PMT will also assess and refine monitoring and evaluation tools to collect and report on quality and outcome indicators in addition to administrative and compliance indicators. DHS will issue its first Provider Scorecard in July 2018.
   - In FY19, PMT will overhaul all monitoring and evaluation tools for providers in order to align them with quality and outcome targets. This process will lead to the development and publication of a comprehensive Provider Scorecard.

3. CONTINUING: Develop Comprehensive Case File Review Tool to capture quality practice indicators as well as compliance.
In FY17, PMT implemented the Comprehensive Case File Review for Community Umbrella Agencies and began reviewing 240 CUA case files every five weeks. Concurrent with the launch of this new case file review process, PMT began convening quarterly “Closing the Loop” meetings with individual CUAs to discuss case file review scores and collaboratively identify key areas for practice improvements.

In FY 18, PMT will increase the number of case file reviews per CUA to 15% of each CUA’s case. This will allow for a larger and more equitable case sample of CUAs. PMT will hire additional analysts to account for the larger case samples and ensure the rigor and reliability of the reviews. PMT will also analyze alignment of Comprehensive Case File review indicators with children outcomes in order to validate and refine the tool.

In FY19, PMT will implement refinements to the Comprehensive Case File Review to streamline the tool, incorporate additional quality practice indicators, and improve data aggregation processes.

B. Performance Management

1. NEW: PMT will produce the new CUA Scorecard for the system. The CUA Scorecard includes 9 domains of performance and sub-indicators for completion, quality, and timeliness in most of the domains. Most of the indicators are drawn from the Comprehensive Case File Review tool. The domains are: Case Planning, Safety Assessments, Visitation, Court Practice, Supervision, Children and Family Assessments, Permanency, Finance, and Leadership.

   - In FY17, PMT led the planning and development of the Scorecard and engaged multiple stakeholders in providing feedback.
   - In FY18, PMT will launch the Scorecard, starting with a CUA Scorecard Baseline Report (based on FY17 performance) to be published in September, continuing with quarterly Scorecards, and culminating in an annual Scorecard Report.
   - In FY19, PMT will continue to enhance the CUA Scorecard by integrating additional, validated well-being indicators and by conducting reliability tests of the scoring methodology. DHS will also begin utilizing CUA Scorecard performance to inform decisions on CUA contracts.

2. NEW: PMT will conduct research, develop a plan, and implement Performance-Based Contracting (PBC).

   - In FY 17, PMT hired an Evaluation Associate to conduct research on performance based contracting practices in other jurisdictions, identify models that can be adapted to Philadelphia, and convene a multi-stakeholder planning group to inform the development of a new PBC model for Philadelphia DHS that considers the CUA structure.
   - In FY18, DHS will continue the PBC model development process, including re-aligning financial and information technology systems to ensure that DHS has the infrastructure to begin implementation in FY19.
   - In FY19, DHS will hire a Director of PBC and a team of analysts to begin implementing and monitoring PBC and tracking the progress of the indicators and outcomes embedded in the model.

C. Data Analytics Modernization
1. **CONTINUING:** PMT will identify data elements to be utilized for program delivery and outcome monitoring.

   - In FY17, PMT identified key data elements that were used for various outcome measurements and performance management efforts. These data elements include: Numbers of cases accepted for service and cases closed, Number of families receiving in-home services, Number of children and youth receiving placement services, Number of children and youth discharged to permanency, by permanency type, CFSR data elements, of the children and youth discharged to reunification in the reporting period year, what number re-enter out-of-home placement within 12 months of discharge. For more detail, please see the June 30th Community Oversight Report in the Attachments section.

   - In FY18, and as part of the Data Analytics modernization strategy, PMT will finalize automating key management reports for CUA and DHS practitioners. These management reports include Case Censuses with key elements, such as Safety Assessment and Visitation due dates. These management reports are designed to provide CUAs with easy-to-access case-level, child-level, and aggregate information and enable them to better monitor their performance and outcomes. Also in FY18, as part of the PMT Data & Technology improvement strategies, PMT will launch the new Data Warehouse, which will facilitate further enhancements to the data management tools available for CUAs.

   - In FY18, PMT will begin planning for a new Data Fellows/Stewards program modeled after Allegheny County’s program, which integrates research and data-informed work in the day to day practice of child welfare workers.

   - In FY19, PMT will launch the first “Early Warning System” for cases at-risk of a near fatality or fatality utilizing longitudinal analyses of DHS and public data sets and in partnership with a research institution. In FY 19, PMT will also launch a Data Fellows/Stewards program to bridge research, data, and practice.

**D. Data & Technology**

For the detailed program improvement strategies in PMT Data & Technology, please see the Information Technology section of this Needs Based Plan on page X.
ATTACHMENT L