

Report on Progress from the City of Philadelphia Community Oversight Board for the Department of Human Services

February 2011

Presented to
Mayor Michael Nutter
and the Philadelphia Community

Submitted by The Philadelphia Community Oversight Board:

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FROM THE
CITY OF PHILADELPHIA
COMMUNITY OVERSIGHT BOARD
FOR THE
DEPARTMENT OF HUMAN SERVICES**

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The City of Philadelphia Community Oversight Board (COB) is deeply indebted to many groups and individuals who have provided insight, support, and guidance to us during 2010. Without this assistance, neither this report nor the COB's ongoing work would be possible.

The COB wishes to thank Mayor Michael Nutter for his significant support for the safety and well-being of Philadelphia's children. His ongoing commitment to the implementation of the Child Welfare Review Panel's (CWRP) recommendations of 2007 and significant reform efforts has continued to ensure that the Department of Human Services (DHS) will continue to strive for excellence in caring for Philadelphia's children. We also wish to thank the Mayor Nutter's staff for their ongoing support.

The COB wishes to thank the many staff members within DHS who have provided us with invaluable assistance in understanding the nature, scope, status, and time frames of the many reform efforts and activities currently underway. DHS has continued to provide us with insightful data and reports and has responded promptly to our questions. In particular, the COB wishes to thank DHS Commissioner Anne Marie Ambrose for her leadership, her assistance to the COB, and her steadfast commitment to implementing the recommendations of the CWRP and ensuring the safety and well-being of Philadelphia's children.

We wish to extend our sincere gratitude to the Pew Charitable Trusts, the William Penn Foundation, and the Annie E. Casey Foundation, all of whom have provided vital professional experts and ongoing financial support for the COB's activities. We are grateful to Casey Family Programs for being a valuable partner in providing technical assistance and guidance in implementing some of the DHS reform efforts.

We would like to acknowledge the input received during the focus groups from DHS staff, members of the medical and legal communities, social services agencies, and providers under contract to DHS. These focus group participants provided important feedback about DHS reform efforts. We wish to thank the attendees for taking the time to share their insights.

The COB is very grateful to the many stakeholders who have taken time out of their busy schedules to attend meetings, provide input, and offer suggestions for moving forward. These stakeholders, who represent a broad cross-section of Philadelphia, have provided an important perspective on the issues that the COB and DHS are addressing, and have helped us understand how the reform efforts are recognized and viewed by the community.

Finally, we appreciate the assistance of our consultants, Walter R. McDonald & Associates, Inc. (WRMA), and MFR Consultants, Inc. The consultants provided assistance with logistical support for the COB meetings, focus groups coordination, and report preparation.

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EXECUTIVE SUMMARY

STATUS OF CWRP RECOMMENDATIONS

The Department of Human Services (DHS) continues to make steady and significant progress toward implementing the Child Welfare Review Panel's (CWRP) 37 original recommendations. According to the most recent update from DHS, 19 of the recommendations were completed. Another 7 recommendations were fully implemented and DHS is continuing to monitor the implementation. DHS stated that all remaining recommendations have progressed from the *in planning* stage to the *in progress* stage, indicating consistent, ongoing improvement.

The City of Philadelphia Community Oversight Board (COB) has continued to focus its attention on specific reform areas in which recommendations have not been fully implemented. There are eight such areas that collectively encompass 13 CWRP recommendations. These recommendations are of special significance to child safety and require enhanced oversight and monitoring. Highlights of DHS progress in areas of focus are provided below. Progress made on the realignment of Community Based Prevention Services (CBPS) is also discussed.

Child Visitation

One objective of the CWRP recommendations was to enhance child safety through increased visitation for children younger than five who are receiving services from DHS' Children and Youth Division (CYD). Since the CWRP's recommendations were issued, DHS has made significant progress toward enhanced child visitation. DHS implemented a policy to conduct monthly visits to all children with an active CYD case, meaning the family was accepted for services due to safety threats or dependency issues.

In addition to implementing the CWRP's original recommendation, DHS expanded the visitation requirements to children of all ages receiving CYD services. Even though the visitation requirement was expanded and many more children require monthly visits, compliance has been maintained at more than 90 percent.

DHS developed a mechanism for overseeing visits performed by contracted agencies and monitors the quality of face-to-face visits. DHS implemented the Provider Visitation Tracking System (PVTS)—a web-based tool used by contracted agencies to report on their face-to-face visits—on July 1, 2010. Although it is operational, not all agencies have begun entering data into the PVTS. DHS also is implementing a monitoring program to ensure that the visit reports are reliable, submitted in a timely fashion, and are of sufficient quality to document the services provided during these visits. During the first six months of PVTS reporting, provider compliance with mandated visits averaged at slightly above 70 percent. While compliance is lower than desired, it represented reported compliance and not necessarily actual compliance. DHS believes that some providers are not entering visitation data in a timely fashion and, therefore, actual compliance may be significantly greater than 70 percent. DHS must work closely with the provider community in the coming months to ensure that visitation data are entered according to policy, which will enable DHS to accurately measure provider agency compliance with visitation requirements.

DHS also began conducting Quality Visitation Reviews (QVR) at the end of November 2010. The QVRs are conducted by an independent agency under contract to DHS to assess the quality of the visits made by provider agencies. Information gathered from the QVRs will be used to target any needed improvement efforts. The QVR is fully operational as of February 2011.

Safety Assessment Tool

As required by the CWRP, DHS implemented a safety assessment tool for children receiving in-home services and for children for whom there is a current investigation of abuse and neglect. DHS initiated a quality assurance review process during April 2008 to monitor the quality and completeness of the in-home safety assessments. Approximately 100–150 safety assessments are reviewed each month.

The implementation of a new out-of-home safety assessment has been delayed because DHS will use a statewide tool being developed by the Pennsylvania Department of Public Welfare (DPW). DPW was originally scheduled to roll out the new out-of-home safety assessment tool in July 2010. However, finalization was delayed and implementation is now scheduled for July 2011.

Clarification of Roles and Responsibilities

DHS has undertaken a number of steps to improve the clarification of its roles and responsibilities and those of contracted agency staff. For example, DHS streamlined the performance standards and aligned them with the targeted outcomes of safety, permanency, and well-being. The streamlined evaluation tool, which is used by the Provider Relations and Evaluation of Programs (PREP) Division, delineates the performance standards for provider agencies under contract with DHS. This helps to focus providers on their responsibilities and their role in service delivery.

Recently, DHS—with support from Casey Family Programs—began a three-year initiative to create a case management model with distinct and well-defined roles for contracted provider agency and DHS staffs. The initiative is called *Improving Outcomes for Children: A Community Partnership Approach to Child Welfare* (Improving Outcomes for Children Initiative). The core components include strengthening partnerships for service delivery at the neighborhood level; modifying current case management practices and accountability systems; clearly defining DHS staff and contracted provider staffs' roles in case management services to children and families; and creating stronger quality assurance functions within DHS.

While the COB supports the long-term plans for this initiative, the COB believes that DHS must continue to identify and implement interim steps to ensure that the respective roles and responsibilities of DHS and contracted agency staffs are clear. It is important to ensure that all workers assigned to the same case know how to coordinate their planning, service delivery, and decision-making activities for the family.

Local Office Presence

The CWRP recommended that DHS establish a local office presence in at least one geographic location deemed highly at-risk. DHS identified such a location but, due to construction and renovation costs, it is assessing several other properties in at-risk areas of Philadelphia.

Through the Improving Outcomes for Children Initiative, DHS will achieve a critical presence in the community as it engages neighborhood stakeholders to identify community needs; establishes priorities for service delivery; determines community outcome goals to supplement state-required outcomes; and plans for resource utilization. However, the COB remains concerned that DHS has yet to complete the implementation of a local office in an at-risk area of Philadelphia. The COB recommends that DHS continue with its planning to implement a local office and consider how the presence and operations of a local office should account for the new Improving Outcomes for Children Initiative.

Child Fatality/Near Fatality Review and Implementation of Recommendations

DHS successfully met the CWRP requirements for improving the child fatality review process and establishing a mechanism for implementing the recommendations from the review. DHS reports that the Act 33 Review Team is completing the reviews of child fatalities and near fatalities in a timely manner and consistent with the legal requirements set out by the Act. Since the establishment of the Act 33 Review Team in January 2009, 43 meetings have been held. There have been 43 recommendations from the near fatality reviews and 19 recommendations from the child fatality reviews, for a total of 62 recommendations. DHS reports that 25 of the 62 recommendations have been assigned, implemented, and completed. The remaining recommendations are in progress and assigned for implementation.

Evidence-Based Model of Practice

DHS employed case reviews and ongoing data analyses to support implementing the evidence-based model of practice. The information from the case reviews and data analysis is being used to inform decision making, improve practice, and monitor outcomes. In addition to conducting fatality/near fatality reviews, DHS is conducting ChildStat reviews and Quality Service Reviews.

During a ChildStat review, DHS staff examine a case or cases in a particular area of service (e.g., Hotline, Ongoing Services, and In-Home Protective Services). Following a case presentation, attendees discuss the strengths and weaknesses of the service intervention, acknowledge exemplary services, identify potential areas for improvement, and develop recommendations to improve ongoing case practices. ChildStat meetings are held monthly.

Quality Service Reviews occur six times annually. Their purpose is to assess DHS performance in specific service areas and to identify necessary systemic improvements for DHS and its partner agencies. Quality Service Reviews are conducted by a team composed of DHS and contracted agency staff members. The team conducts a three-day review of 12 sample cases. Interviews with social workers, supervisors, and family members also are conducted. The reviews use a structured process and a scoring tool to evaluate cases. Ratings from the review for each indicator suggest where DHS practices appear to be effective and identify practices that need further improvement.

DHS developed a standard data report that provides information related to referrals received by DHS; outcomes of abuse and neglect investigations; changes in caseload size; the population of children in placement; and DHS' compliance with child visitation policies. Finally, DHS has an external monitoring program to validate and evaluate child visitation contacts.

Expanded Use of Family Case Conferences

DHS implemented Family Group Decision Making agency-wide during March 2009. While this initiative offers tremendous value for families receiving services, both COB and DHS have concerns about the relatively small number of referrals to Family Group Decision Making, and the even smaller number of referrals that result in completed family conferences.

Criminal Background Checks

DHS is still in the planning phase of establishing a process for conducting background checks on each member in a child's household. A pilot for conducting criminal background checks for reunification cases was scheduled for implementation in 2010. However, the draft *Policy and Procedure Guide, Criminal History Clearances for Investigations and Reunifications* has not been finalized; forms for requesting and responding to criminal history searches have not been developed; and training for DHS social work staff about how to use information from criminal background checks for reunification, including a special curriculum on confidentiality issues, has not been conducted.

The COB recommends that DHS implement the pilot for conducting criminal background checks in reunifications, as planned. The COB will work closely with DHS in the coming months to facilitate the planning, completion, and evaluation of the pilot, and determine the next steps for conducting criminal background checks in other DHS cases.

Co-Location

DHS identified a site for the co-location of DHS, police, and medical and forensic interview personnel to facilitate collaborative decision making in the investigative phase of casework. The title to the property is expected to be secured during July 2011. DHS allocated funding in its fiscal year 2010 and 2011 budgets for the initiative.

Realignment of Community-Based Prevention Services

DHS reorganized Community-Based Prevention Services to effectively target and serve the most at-risk children and families possible, particularly those receiving or transitioning from DHS mandated or protective services. Significant accomplishments of the community-based prevention services include the implementation of a new domestic violence program, creation of the DHS Education Support Center, and implementation of the Alternative Response System. The domestic violence program includes the provision of domestic violence education, counseling, and aftercare support services. The Education Support Center's goals include improving educational outcomes for children in DHS' care and improving educational opportunities for children in target areas of the city that have high rates of abuse, neglect, and delinquency.

The Alternative Response System engages and supports families with enhancing their abilities to meet the needs of their children in the least intrusive, time-limited manner through the use of community resources. DHS Family Assessment staff complete a comprehensive safety assessment and if they determine that safety threats do not exist, but there is still a need for services, the family is referred to one of the contracted Alternative Response System service providers for in-home case management support services. Within 72 hours of receiving the referral, the service providers and DHS staff conduct a joint visit in the family's home. This visit serves as DHS' closing visit. By referring the family to the Alternative Response System provider, DHS is deciding not to accept the family for CYD services and the case is closed.

While there have been many successes related to the realignment of Community-Based Prevention Services, DHS is still refining the array of services provided as well as how the services are delivered. The COB will work with DHS to ensure that there are mechanisms in place to monitor the ongoing delivery of services and the safety and well-being outcomes for children and families served.

KEY OUTCOME MEASURES

DHS has continued to report on and refine the four key outcome measures identified by the COB as indicators of DHS performance related to child safety and well-being. These measures are

- occurrence of repeat maltreatment and length of time between incidents of child maltreatment;
- severity of repeat maltreatment;
- incidence of child maltreatment in placement; and
- reentry into foster care and other placement types.

The outcome measures will become a means of assessing progress made by DHS relative to the specific child outcomes listed above. However, the reporting of these measures continues to evolve and many of the measured data are not comparable from one *Report on Progress* to another. The COB believes that drawing conclusions from the outcome data provided to date would be premature. The DHS Performance Management and Accountability Division is stabilizing the definitions, reporting methods, and data sources for these measures. Once this process is completed, the COB will be able to draw conclusions by comparing the findings from these reports over time.

Section 3 of this report presents the preliminary outcome measures findings and discusses the progress that DHS has made in pursuing outcome measure reporting. The COB will continue to monitor DHS progress in reporting the measures, as well as the trends and findings from these reports. The COB recognizes that DHS' overall reporting capability, including the reporting related to the outcome measures, is highly reliant on the progress made in implementing enhancements to the Agency's case management information system. The COB hopes that addressing DHS' technology needs will be a high priority in the coming year.

FOCUS GROUP FINDINGS

In June 2010, the COB held a number of focus groups to solicit input from professionals in the community who are involved in cases of child maltreatment and from DHS social work services managers, supervisors, and managers. DHS embarked on a major reform effort and worked diligently to address the recommendations developed by the CWRP. By its very nature, a major reform effort creates both positive and negative reactions and leads to some upheaval as major changes are implemented. To some extent, the focus groups reflected common reactions to a system in the midst of major change.

Overall, both DHS staff and community members who participated in the focus groups were positive about DHS reforms, although room for improvement exists in many areas. Most felt that DHS had taken great strides to make child safety its primary goal and were supportive of the practice-related reforms DHS had implemented. However, the changes brought about by the reform efforts have not been without challenges for both social work services managers and professionals from community agencies that work directly with children and families involved with DHS. While participants identified many improvements, they also stated that additional work was needed to fully realize the benefits of the reforms. Some of the key opportunities for further improvement identified during the focus groups included clarifying the roles and responsibilities of DHS and contracted agency social workers, ensuring consistency in the implementation of the new practices across DHS, improving communication about reforms and DHS procedures and practices, reducing the burden of case documentation, and identifying ways to improve the organizational culture and morale of DHS staff.

NEXT STEPS

DHS is making steady progress on all of the CWRP recommendations, but not all recommendations have been fully implemented. In particular, DHS has made great progress in completing the practice-related reforms, and this has helped to improve the overall safety of Philadelphia's children. The COB is committed to working with DHS to implement the remaining recommendations and provide oversight as the Department continues to engage in its reform efforts.

COB oversight and DHS improvement efforts rely on accurate and comprehensive data about services provided and outcomes achieved. The COB will continue to work with DHS to identify how data and analysis can be used to evaluate performance and target further improvement. As DHS progresses with its reform efforts, the COB also hopes to work with the Department to expand outcome measurement to areas relating to child permanency and well-being. In addition, the COB will support the Agency's continuing efforts to acquire an adequate case management and reporting information system to improve case documentation practices and provide needed support to DHS staff members.

The COB plans to engage in a detailed priority-setting effort to establish objectives and areas of focus for 2011. The priority-setting effort will be informed by the input and perspectives obtained from the June 2010 focus groups, from additional staff and community input, as well as

from the knowledge the COB has obtained from its ongoing assessment and analysis of DHS programs. The priority-setting activity is an opportunity to work with DHS and the community to consolidate the many CWRP recommendations, action plans, and findings and recommendations from the various review processes into a cohesive strategy for ongoing reform and oversight by the COB.

SECTION 1. INTRODUCTION

It has been more than three years since the Child Welfare Review Panel (CWRP) issued its report, *Protecting Philadelphia's Children: The Call to Action*, which identified 37 recommendations to improve the performance of the Philadelphia Department of Human Services (DHS). The creation of the City of Philadelphia Community Oversight Board (COB) was a recommendation made by the CWRP. An executive order from the mayor's office charged the COB with monitoring DHS' implementation of the recommendations. The order also required the COB to issue twice-yearly progress reports.

Since the February 2010 *Report on Progress*, the COB has focused its attention on specific recommendations and reform efforts that have not been fully implemented. These recommendations are of special significance to child safety, and require enhanced oversight and monitoring. Currently, 13 of the CWRP's original recommendations are included within the eight areas of focus. The areas of focus include:

- Child Visitation
- Safety Assessment Tool
- Clarification of Roles and Responsibilities and Local Office Presence
- Child Fatality/Near Fatality Review and Implementation of Recommendations
- Evidence-Based Model of Practice
- Expanded Use of Family Case Conferences
- Criminal Background Checks
- Co-Location

The COB collects and analyzes quantitative and qualitative data, reviews reports and implementation plans, and oversees the implementation of tasks aimed at improving the safety of children in Philadelphia. The COB continues to work with DHS to develop and monitor key safety outcome measures to gain a better understanding of whether or not DHS is achieving its program goals and the overall objective of improving child safety.

Subsequent to the February 2010 *Report on Progress*, the COB determined that it was time to assess the reform efforts as perceived by DHS staff and by professionals in the community who provide services to children and families involved with DHS. DHS services recipients were not included in the focus groups due to limited resources and because they have other avenues for providing feedback.

The COB conducted 14 focus groups. One-half of the focus groups were held with professionals from the medical and legal communities, Family Court, DHS social service agencies, and agencies that have contracts with DHS. An additional 7 focus groups were held with DHS staff from Hotline, Intake (Investigation and Assessment), and Ongoing Service Regions. A separate meeting also was held with DHS upper management.

REPORT OVERVIEW

This report has three major sections that provide the COB's assessment of DHS progress.

Section 2. Status of the Recommendations from the Child Welfare Review Panel.

This section provides a summary of the status of the implementation of the CWRP's 37 recommendations provided by DHS to the COB. Recommendations that were given special attention by the COB during this period are addressed individually in the subsection titled Areas of Focus. This section also provides information on DHS progress in realigning the Division of Community-Based Prevention Services (CBPS).

Section 3. Key Outcome Measures. This section provides the current status of the key outcome measures identified by the COB as indicators of DHS performance related to child safety and well-being. These measures are occurrence of repeat maltreatment and length of time between incidents of child maltreatment; severity of repeat maltreatment; incidence of child maltreatment in placement; and reentry into foster care and other placement types.

Section 4. Focus Group Findings. This section discusses the major cross-cutting and overarching themes identified in the focus groups. It also provides highlights of the findings from each individual focus group—medical community, legal/advocacy community, Family Court, social services agencies, DHS contracted agencies, DHS Hotline, DHS Intake (Investigation and Assessment), DHS Ongoing Service Regions, and DHS management.

The following appendices are included in this report:

- Appendix A. DHS Status Report: Implementation of Child Welfare Review Panel Recommendations
- Appendix B. Present Danger Assessment: Out-of-Home Care Settings
- Appendix C. Out-of-Home Safety Assessment
- Appendix D. DHS Division of Performance Management and Accountability Data Report to the Community Oversight Board, October 17, 2010

SECTION 2. STATUS OF THE RECOMMENDATIONS FROM THE CHILD WELFARE REVIEW PANEL

This section provides an update of the Philadelphia Department of Human Services' (DHS) progress in implementing the original recommendations of the Child Welfare Review Panel (CWRP) that were included in the CWRP's report of May 31, 2007.

BACKGROUND

In May 2007, the CWRP made 37 recommendations that were grouped into four areas:

- Mission and Values
- Practice
- Outcomes and Accountability
- Leadership and Infrastructure

As a means of monitoring DHS progress toward planning and implementing the recommendations, the Community Oversight Board (COB) has used the following classification system:

- *Completed*—DHS fully implemented a plan to address the recommendation to the satisfaction of the COB.
- *Ongoing*—DHS fully implemented a plan to address the recommendation and activities are ongoing.
- *In progress*—DHS has partially implemented a plan to address the recommendation.
- *In planning*—DHS has not developed a plan for implementation that is acceptable to the COB.

The COB used these classifications in its January 2009, August 2009, and February 2010 *Reports on Progress* to provide an update on DHS progress. At the COB's request, DHS has continued to use these same classifications to provide ongoing progress reports.

DHS REPORT ON PROGRESS

DHS regularly updates the COB regarding the status of implementing the CWRP recommendations. Table 2.1 below provides a summary of the implementation status. In the February 2010 *Report on Progress*, 8 recommendations were determined to be completed by the COB. As of November 2010, DHS reported that 11 additional recommendations had been completed. The 7 recommendations listed as *ongoing* in table 2.1 were reported by DHS to be *completed and ongoing*. This means that the initial CWRP recommendation was fully implemented and DHS continues to monitor the ongoing operational changes that resulted from the implementation. Since the February 2010 *Report on Progress*, DHS indicated that all remaining recommendations have progressed from the *in planning* stage to the *in progress* stage.

As part of the COB's priority setting for 2011, it will carefully review all of the recommendations reported as *completed* and determine the need for ongoing oversight.

Table 2.1 DHS Implementation of CWRP Recommendations, November 2010

Recommendations	Completed	Ongoing	In Progress	In Planning	Total
Phase 1					
Mission and Values	2	0	0	0	2
Child Safety Practices	4	0	4	0	8
Outcomes/Accountability	5	1	0	0	6
Leadership/Infrastructure	1	1	0	0	2
Phase 2					
Mission and Values	2	0	0	0	2
Child Safety Practices	4	4	4	0	12
Outcomes/Accountability	1	0	1	0	2
Leadership/Infrastructure	0	1	2	0	3
Total	19	7	11	0	37

A detailed table that lists the implementation status of each recommendation and DHS' update reported to the COB is presented in appendix A.

AREAS OF FOCUS

Beginning with the August 2009 *Report on Progress*, the COB began identifying areas of focus with regard to DHS' implementation of the original CWRP recommendations. These areas include recommendations that had not been fully implemented and which the COB felt were of special significance and required enhanced oversight and monitoring. Currently, 13 of the CWRP's original recommendations are included within eight focus areas:

- Child Visitation
- Placement Safety Assessment Tool
- Clarification of Roles and Responsibilities and Local Office Presence
- Enhanced Fatality Reviews and Implementation of Recommendations
- Evidence-Based Model of Practice
- Expanded Use of Family Case Conferences
- Criminal Background Checks
- Co-Location

Child Visitation

The COB recognizes that ensuring that children are visited on a regular basis by DHS social work services managers and contracted agency staff is crucial to identifying risk issues and

assuring child safety and well-being. The importance of conducting regular face-to-face visits with children and their caregivers is evidenced in 3 of the original CWRP recommendations:

DHS staff must—on at least a monthly basis—conduct face-to-face contacts with all families receiving any service supported through the Children and Youth Division (CYD) that have a child 5 years of age or younger and physically observe the condition, safety and behavior of any such child, as well as parental capacity.
(2.b.ii, Phase 1)

DHS must validate that contracted agencies are making face-to-face contact with children, that they are performing safety assessments at each contact, and that the contacts are sufficiently frequent and adequate to determine the safety of the child.
(3. b.ii, Phase 1)

DHS must enhance the frequency of face-to face contacts with children of all ages. Since face-to face contacts are the most important actions to ensure child safety, DHS staff must conduct a minimum of one face-to-face contact per month with each child in its care. More frequent contact may be warranted depending on the specific safety and risk factors in each case.
(2. a.iii, Phase 2)

Visitation by Social Work Services Managers

DHS policy and practice related to visitation has evolved during recent years. In July 2008, DHS implemented a policy requiring all children five years of age and younger to be visited at least monthly by a DHS social work services managers. Until December of that year, the requirement included only those children in the five-county service area. In December 2008, the policy was extended to all children five years and younger, regardless of location, and also required that children of any age be visited at least monthly, with certain exceptions for children being served by specific programs (e.g., In-Home Protective Services). Various adjustments to the policy were made during 2009, specifically related to time frames for required visits for children in various programs.

DHS policy has again expanded the scope of the child visitation requirement for social work services managers and contracted agency staff. The current policy, implemented during July 2010, requires that all children with an active case with the Children and Youth Division (CYD) receiving services, regardless of age or program, be seen at least monthly. A CYD case is considered active when a family is accepted for services due to safety threats or dependency issues. The new policy substantially increased the number of children for whom monthly visits are required.

Table 2.2 presents the most recent statistics on child visitations performed by DHS social work services managers for January–December 2010. The February 2010 *Report on Progress* reported that, from January through December 2009, compliance with the visitation requirements averaged 93 percent for children who required visits according to the policy at that time. As can be seen in table 2.2, DHS has maintained, and even improved upon, the 2009 compliance for child visitation.

Table 2.2 Child Visitation Compliance by DHS Social Work Services Managers, 2010

Month	# Children Visited	# Children Requiring Visits	% Compliance
January	4,619	4,914	94%
February	3,961	4,324	92%
March	4,671	4,947	94%
April	4,487	4,811	93%
May	3,806	4,063	94%
June	4,611	4,851	95%
July*	6,972	7,507	93%
August*	7,075	7,355	96%
September*	6,769	7,178	94%
October*	6,737	6,836	93%
November*	6,178	6,621	93%
December*	6,057	6,543	93%

* Visitations required for all children receiving DHS service regardless of age or program.

As noted above, DHS visitation policy from January–June 2010 did not require visits to all children. The fact that DHS maintained more than 90 percent compliance, even after implementing the policy requiring monthly visitation for all children, is very positive. This occurred even though the number requiring monthly visits increased by more than 2,000 children. It appears that DHS staff responded well to the new visitation requirements and that a transition period was not necessary to move from the limited visitation requirement to a requirement for all children.

The visitation requirements were first implemented for all children in service who were five years of age or younger because they are considered the most at-risk population served by DHS. Table 2.3 shows the visitation compliance for the population of children age five and younger.

Table 2.3 Child Visitation Compliance by DHS Social Work Services Managers, for Children Younger than Five Years of Age, 2010

Month	# Children Visited	# Children Requiring Visits	% Compliance
January	2,183	2,331	94%
February	1,983	2,291	87%
March	2,184	2,296	95%
April	2,143	2,301	93%
May	1,879	1,999	94%
June	2,259	2,596	87%
July	2,171	2,641	82%
August	2,334	2,641	88%
September	2,175	2,280	95%
October	2,004	2,113	95%
November	2,001	2,113	95%
December	1,942	2,057	94%

As seen in table 2.3, DHS compliance with visitation requirements for children age five and younger was 82 percent when the monthly visitation requirement was expanded to all children in July 2010. In the two months following the implementation of the expanded visitation requirement, DHS significantly increased its compliance for conducting monthly visits with children younger than five years old. In September 2010, DHS attained 95 percent compliance. Since that time, DHS has continued to maintain compliance at 94 to 95 percent.

Child Visitation Performed by Contracted Agencies

Until recently, DHS has not had the capability to report statistics on visits performed by contracted agency social workers. Assigned social workers in contracted agencies must follow the same requirements as DHS social work services managers for monthly face-to-face contact for children they serve. Because many children served by DHS are receiving their primary services from a contracted agency, the inability to analyze the overall compliance of contracted agencies with the visitation requirements has resulted in a major reporting gap. To address this gap, DHS implemented the Provider Visitation Tracking System (PVTS) on July 1, 2010. PVTS is a web-based tool used by contracted agencies to report on their face-to-face visits. The system was initially piloted with a few contracted agencies, during January–June 2010. Although the PVTS is now fully implemented, not all agencies have begun entering their data into it. Once provider agency reporting is fully implemented, DHS should be able to report visitation

compliance in the same manner as is done for visits performed by social work services managers (i.e., percentage of compliance for all children requiring a face-to-face visit). The number of visits performed by the contracted agencies that have entered data is shown in table 2.4 below. (This table does not include the visitations that were reported by a small number of agencies involved in the 6-month pilot.)

Table 2.4 Preliminary Child Visitation Reporting by Contracted Agencies (July–December 2010)

Month	Agencies Entering Visits	Children To Be Visited	Visits Completed	Not Visited	Visit Ratio (%)
July	52	4,984	3,113	1,871	62.5%
August	52	4,953	3,485	1,468	70.4%
September	57	4,854	3,456	1,398	71.2%
October	57	4,794	3,495	1,299	72.9%
November	53	4,709	3,384	1,325	71.9%
December	54	4,693	3,150	1,543	67.1%

Table 2.4 shows that provider compliance with the visitation policy was 62.5 percent during the first month of PVTs reporting (July, 2010). In the following months, the compliance increased to more than 70 percent with the exception of December. It is important to note that the compliance level represents reported compliance with DHS’ visitation requirements. DHS believes that some agencies are not reporting all of their completed visits, and some are not reporting visits within the required time frame. To the extent that this is the case, the actual number of visits performed by provider agencies may be higher than what is reported in table 2.3.

In addition, table 2.4 documents that the number of provider agencies reporting visits during this initial stage of implementation has ranged from 52 to 57. DHS indicates that, as of December 2010, 29 provider agencies have not yet begun reporting on visitation contacts through PVTs. These agencies currently serve 233 children, the majority of whom are in group homes or residential care. DHS initially considered exempting these programs from reporting on visitation. However, DHS has decided that all contracted providers, including those providing congregate care, will report on face-to-face contacts. Visitation data from these agencies will be monitored by the COB and included in future *Reports on Progress*.

Quality Visitation Review

Statistical compliance with the visitation policy only indicates whether or not children have been seen. DHS implemented a monitoring program to ensure that the visit reports are reliable and to evaluate the quality of services provided during these visits. The Quality Visitation Reviews (QVR) began at the end of November 2010 and are being conducted by an independent agency (the Kinnamon Group) under contract to DHS. The QVRs replace previous visitation monitoring

efforts that included phone call verifications performed by DHS staff and in-person visits made to families by a DHS Consumer Satisfaction Team. The reviews are being conducted through visits by a representative of the QVR agency with a focus on the quality of the assigned social workers' visitations. The process will examine social worker interaction with the family related to child safety, permanency, and child well-being. The QVR agency's findings will be reported back to DHS.

Discussion

During the period since the last *Report on Progress*, DHS has made significant progress with implementing enhanced child visitation. DHS expanded the visitation requirements to all children receiving services. Even though the visitation requirement was expanded, and many more children require monthly visits, compliance has been maintained at more than 90 percent. DHS also has made important progress with developing mechanisms for the oversight of visitations performed by contracted agencies and in monitoring the quality of face-to-face visits. The COB will continue to monitor this critical element of DHS services. The COB is particularly interested in the progress made in tracking contracted agency visitations and in the compliance of contracted agencies with the visitation policies.

The COB will request updates regarding the findings of the quality reviews performed to assess the interaction between social workers and families during these visits. The QVR process may provide insight into one of the prominent issues raised in the focus groups conducted in June. Both DHS and community participants noted that the lack of clarity between the roles of DHS and contracted agency social workers can result in contradictory guidance being given to families. Families will have the opportunity to voice such concerns during QVR visits. The QVR findings may provide important first-hand information for DHS to use as it plans for clarifying roles and responsibilities between DHS and contracted agency staff.

In addition, the COB urges DHS to develop and adopt more in-depth protocols to ensure that the quality of visits performed by DHS and contracted agency social workers are comprehensive and address all safety issues that may be present. Ensuring the quality of visits is of particular concern for younger children, who are considered to be more at-risk. The COB will work with DHS in the coming months to reviews DHS' plans and progress for ensuring the quality of visits.

DHS indicated that the 3 CWRP recommendations related to child visitation should be considered fully implemented. The COB will determine whether or not the recommendations should be considered completed as it develops its plans for monitoring and oversight for the next year. The COB will, however, continue to monitor the Department's ongoing efforts to ensure that all children are seen on a regular basis and that these visits meet the standards for quality set by DHS.

Safety Assessment Tool

The CWRP recommended that DHS implement a new child safety assessment tool to monitor the current and ongoing safety of children placed in DHS' care. The recommendation included both children remaining at home and children placed in substitute care settings:

*DHS must implement an adequate evidence-based safety assessment tool.
(2.a.i., Phase 1)*

DHS must conduct a safety assessment for every child within its care—both children at home and children in out-of-home placements. The safety assessment must be updated at each contact with the child. (2.a.ii., Phase I)

In-Home Safety Assessments

DHS developed and implemented a safety assessment tool for children receiving in-home services and for children for whom there is a current investigation of abuse and neglect. DHS also continues to monitor whether these safety assessments are completed within the required time frames, and whether supervisors are reviewing the assessments with the social workers within the specified time frames.

As discussed in the COB's August 2009 *Report on Progress*, DHS initiated a quality assurance review process during April 2008 to monitor the quality and completeness of the safety assessments. During March 2009, DHS established a dedicated unit within the Division of Performance Management and Accountability to conduct the reviews. As reported by DHS, this unit continues to review 100–150 in-home safety assessments each month. The unit also creates DHS-wide reports on the quality and timeliness of the in-home safety assessments and provides feedback to DHS managers, supervisors, and social workers to ensure continual improvement.

The in-home safety assessment tool was discussed in the focus groups held with DHS staff and in many of the community focus groups. Almost all of the participants felt that the new safety assessment improved the social worker's ability to identify safety threats and develop more targeted safety and treatment plans. Participants in the legal focus group felt that the new tool was more objective and reduced the subjectivity of the social worker in determining whether a child needed to be removed from his or her home.

The most frequently cited concern about the in-home safety assessment was that it is not used in a standardized manner among DHS social work services managers. There are inconsistencies regarding the time frames for completing the initial assessment, the frequency of subsequent assessments, and the depth of information required. While participants expressed confusion regarding the use of the safety assessment, many felt the confusion was the result of the ongoing modifications that the Pennsylvania Department of Public Welfare (DPW) has made to the tool. Many social workers stated that they received training on the safety assessment, and the DPW changed their guidance. This created confusion and a need for further training.

To help workers effectively understand and consistently apply the new in-home safety assessment, DHS has recently begun an effort to retrain all department staff on the tool. The retraining began in April 2010, starting with additional training for DHS directors and

administrators and then expanding to social work services managers. Additional training for social work staff is scheduled to be conducted February–May, 2011.

Out-of-Home Safety Assessments

One of the CWRP’s recommendations was the development and implementation of an out-of-home safety assessment. The implementation of a new out-of-home safety assessment has been delayed because DHS will implement a statewide assessment tool which is currently being developed by the DPW. The DPW was originally scheduled to roll out a new out-of-home safety assessment tool in July 2010. However, the finalization of the assessment tool has been delayed and implementation is now scheduled for July 2011.

A detailed time line for implementation of the statewide out-of-home safety assessment is presented in table 2.5.

Table 2.5 Time Line for Implementation of the Statewide Out-of-Home Placement Safety Assessment

Timeframe	Activity
May–June 2010	<ul style="list-style-type: none"> • Conduct pilot implementation
July 2010	<ul style="list-style-type: none"> • Provide pilot feedback to DPW, for use in DPW’s revision of tools and process
August 2010	<ul style="list-style-type: none"> • Identify DHS implementation team and trainers • Begin work on DHS implementation plan
September 2010	<ul style="list-style-type: none"> • Provide training for implementation team • Continue work on DHS implementation plan
October 2010	<ul style="list-style-type: none"> • Work with provider implementation leads to defining provider training and implementation needs
November 2010	<ul style="list-style-type: none"> • Conduct provider training
December 2010	<ul style="list-style-type: none"> • Submit DHS implementation plan to DPW
February–July 2011	<ul style="list-style-type: none"> • Train DHS staff
July 2011	<ul style="list-style-type: none"> • Begin operations with new out-of-home safety assessment

The new statewide assessment being developed by DPW consists of two separate yet related tools:

- A *present danger assessment* tool that is completed by a DHS social work services manager at the first point of contact with a child placed in out-of-home care
- A *comprehensive out-of-home safety assessment* tool that is completed no later than 60 days after the initial placement covering child safety in the out-of-home care setting on ten safety dimensions

For children who remain in out-of-home care settings, updated safety assessments will be completed every six months or within 72 hours after the identification of a change in the dynamics of the family (e.g., someone lives in the home who was not there before, someone dies in the home, or there is a crisis in the home).

Until the statewide DPW out-of-home safety assessment is completed, DHS will continue its current process of having social work staff complete a structured case note that assesses child safety according to DHS-developed safety guidelines. Social work staff members are required to complete a structured case note each time they visit a child.

Statewide Out-of-Home Safety Assessment Pilot

From May to June 2010, DHS and one of its provider agencies participated in a pilot of the DPW present-danger assessment and the comprehensive out-of-home safety assessment tools. At a July 2010 COB meeting, DHS provided the COB with an overview of its participation in the pilot, as well as its initial perspective on the tools. The DHS and provider agency staff who participated in the pilot felt that the proposed out-of-home safety assessment tools were helpful with ensuring consistency in the information. However DHS reported that the comprehensive safety assessment often took two or three visits to complete, as every person residing in the home where the child is placed must be interviewed.

Due to the length of the assessment, the interviews took approximately 2.5 hours to conduct and an additional 4 to 6 hours to document. DHS also reported that parents expressed concern that the proposed process was repetitive, as they were required to provide the same level of information to both DHS and provider agency social workers. It was noted that the safety assessment tool does not provide a space to record feedback from the child regarding his or her placement.

DPW is currently revising the out-of-home safety assessment tools using the feedback provided by the DHS and provider agency staff who participated in the pilot. Included with the DPW materials will be the revised tools and a reference manual that will aid staff in understanding and completing the out-of-home safety assessments.

Discussion

DHS continues to monitor whether or not in-home safety assessments are completed within the required time frames, and whether supervisors are reviewing the assessments with the social workers within the specified time frames. The COB believes that, through this process, DHS will be able to identify where the conduct of in-home safety assessments is not being implemented according to the requirements, and provide any necessary training.

The COB recognizes that DHS is unable to move forward with its implementation of the new out-of-home safety assessments until the DPW finalizes the tools and conducts the necessary training. However, the COB is concerned about the time required for social workers to complete the safety assessments for children in out-of-home care, based on the information from the pilot.

The COB recommends that DHS assemble baseline data regarding the current safety of children in placement. The COB also reiterates the recommendation made in the August 2009 *Report on Progress* regarding safety assessments conducted by provider agency social workers. The COB continues to recommend that DHS establish a quality assurance process for the safety assessments completed by contracted providers. Contracted social workers also are required to

conduct assessments for child safety and currently there is no independent review of those safety assessments. Such a review would provide a more comprehensive picture of child safety.

The COB will continue to monitor the implementation of the out-of-home safety assessment and the findings of the quality assurance process.

Clarification of Roles and Responsibilities

Addressing the CWRP's recommendation regarding clarification of the roles and responsibilities of DHS social work services managers relative to those of contracted agency social workers continues to be a COB focus area. The CWRP recommended that clarification of DHS and contracted agency staff roles and responsibilities be completed by August 31, 2007. The specific recommendation was:

DHS must clarify the roles and responsibilities of DHS workers relative to private agency workers, at both the supervisory and worker level. (2.f., Phase 1)

The need for fully implementing this recommendation and clarifying roles and responsibilities for all DHS and contracted agency staff is significant. During the focus groups with DHS and contracted agency staff conducted during June 2010, the issue of role clarity was identified as a key concern by both DHS and contracted agency social workers. Many of the contracted agency focus group participants were concerned about the ongoing lack of clarity in their day-to-day responsibilities and their lack of understanding about the responsibilities of the social work services managers assigned to their cases. Many felt that role clarity and relationships between DHS and contracted agency staff at the direct-service level have not improved over the last three years and, in some cases, have worsened. Social work services managers and managerial-level staff expressed similar concerns, and added that they often are unable to effectively monitor and manage contracted agency staff because they do not know the details of provider agency contracts, such as the scope of services that contracted agency social workers must provide.

Both DHS and contracted agency staff members also reported that the lack of clarity has decreased the degree of collaboration between DHS and contracted agencies. Lack of collaboration also was noted by participants in the focus groups conducted with members of the court and legal representatives. They noted that DHS and contracted agency social workers sometimes provide differing opinions about the family situation and the plans for services.

Improving Outcomes for Children: A Community Partnership Approach to Child Welfare

DHS has informed the COB that addressing lack of clarity is a high-level priority. DHS leadership understands that the ongoing confusion about roles and responsibilities can negatively impact the safety, well-being, and permanency of Philadelphia's children. With support from Casey Family Programs, DHS has begun a three-year initiative to create a case management model with distinct and well-defined roles for both contracted provider agency and DHS staff. The initiative is called the *Improving Outcomes for Children: A Community Partnership Approach to Child Welfare* (Improving Outcomes for Children Initiative). The core components include

- strengthening partnerships for service delivery at the neighborhood level;

- modifying current case management practices and accountability systems;
- clearly defining DHS staff and provider staff roles in case management services to children and families; and
- creating stronger quality assurance functions within DHS.

To ensure that the new case management model will address the needs of children and families, and that it will be responsive to the needs and priorities of local communities; DHS is building mechanisms for broad-based stakeholder involvement in the each of the program development phases. DHS has assembled a steering committee that broadly represents the many key stakeholders in the delivery and oversight of child welfare services. Its membership includes representatives from the Family Court, the American Federation of State, County and Municipal Employees (AFSCME), the School District of Philadelphia, Community Legal Services, the Department of Health, the University of Pennsylvania, child and family advocates, and DHS leadership.

There are three phases to this initiative: planning, design, and implementation. The time line for each of the phases is provided in table 2.6 below.

Table 2.6 Improving Outcomes for Children Initiative Time Line

Phase	Date to be Completed
Planning	August 2010–April 2011
Design	April 2011–April 2012
Implementation	April 2012–April 2013

Planning Phase

DHS is currently in the planning phase and is completing the following activities

- developing a strategic communications plan to ensure that all stakeholders understand the process as it moves forward;
- collecting and analyzing data, including a review of caseload trends, service utilization, and performance on child welfare outcomes in the current system;
- establishing geographic maps that clearly identify potential neighborhood partners and resources;
- conducting interviews with consumers and community partners to understand their needs and perspectives with respect to child welfare services;
- Conducting a community assessment in eastern North Philadelphia which represents DHS’ highest accept-for-service area within the city and aligns with DHS’ Ongoing Services Region II; and
- Developing a model for dividing key case management roles and responsibilities between DHS and contract agency social workers.

At the conclusion of the planning phase, DHS will develop a strategic plan for the design phase of the Improving Outcomes for Children Initiative.

Ongoing Efforts to Improve Clarification of Roles and Responsibilities

During the development of the Improving Outcomes for Children Initiative, DHS undertook a number of steps to help improve the clarification of roles and responsibilities of DHS and contracted agency staff. During the last year, DHS streamlined the performance standards and aligned them with the targeted outcomes of safety, permanency and well-being as outlined in the Child and Family Services Reviews. The streamlined evaluation tool, which is used by the Provider Relations and Evaluation of Programs Division, delineates the performance standards for provider agencies under contract with DHS. This helps to focus provider responsibilities and their role in service delivery. Throughout the agency, DHS continues to hold provider meetings to clarify the roles and responsibilities of providers and DHS. Examples of these meetings include:

- The Provider Relations and Evaluation of Programs Division convenes regular meetings with providers by service level to discuss roles, responsibilities, and program expectations.
- DHS convenes quarterly provider meetings with the In-Home Protective Services, Family Reunification, and Time Limited Reunification programs.
- DHS convenes bi-monthly provider meetings for Family Stabilization Services and Performance Based Contracting.
- DHS reinforces provider expectations during bi-monthly Provider Leadership meetings.
- CBPS program managers convene regularly schedule meetings with providers to discuss program expectations and issues.

Discussion

The COB appreciates that DHS leadership continues to apply significant and thoughtful effort to assessing what is necessary to successfully implement a community-based service-delivery model. The identification and review of models in other jurisdictions with child welfare populations similar to Philadelphia has provided much insight into implementation strategies, practices, and lessons learned. The COB approves of DHS' approach to implementing such a significant change in the way child welfare services are provided. The COB will continue to closely monitor and provide guidance to DHS as it works to build an improved community-based service system.

While the COB supports the long-term plans for this initiative, it believes that the department must continue to identify and implement interim steps to ensure that the respective roles and responsibilities of DHS and contracted agency staff are clear. It is important to ensure that all workers understand their responsibilities in each case and that all workers assigned to the same case know how to coordinate their planning, service delivery, and decision making activities for the family.

Local Office Presence

The CWRP recommended that DHS create a local office presence in at least one geographic location deemed highly at risk (2.c., Phase 1). In the May 2010 COB meeting, DHS reported that a possible location has been identified, but due to higher than expected renovation costs, an alternative facility may be needed. DHS currently is assessing several alternative properties in at-risk areas of Philadelphia. Further, through the Improving Outcomes for Children Initiative discussed in the previous section, DHS will achieve a critical presence in the community as it engages neighborhood stakeholders in the planning for the new case management model. Neighborhood stakeholders will work with DHS to identify community needs; establish priorities for service delivery; determine community outcome goals to supplement state-required outcomes; and plan for resource utilization.

Discussion

The COB remains concerned that DHS has yet to complete the implementation of a local office in an at-risk area of Philadelphia. The COB recommends that DHS continue with its planning to implement a local office and develop more specifics about the types of program and services offered as well as the composition of DHS staff placed at the site. In addition, the Improving Outcomes for Children Initiative (described in the preceding section) may have implications for the structure and operation of the local office. DHS should consider how the presence and operations of a local office should account for the new Improving Outcomes for Children Initiative.

Child Fatality/Near Fatality Review and Implementation of Recommendations

The CWRP recommended that DHS enhance its child fatality review process and ensure that a mechanism exists for implementing the recommendations developed during the reviews. The specific CWRP recommendation is:

DHS must enhance the fatality review process. DHS must ensure that the child fatality review is multidisciplinary, and that there is a mechanism for implementing its recommendations. (2.a.vi., Phase II)

As required by the CWRP and reported in the February 2010 *Report on Progress*, DHS has implemented a comprehensive process for reviewing fatalities and near fatalities by a multidisciplinary team, known as the Act 33 Review Team. The Act 33 Review Team reviews child protective services reports (CPS), including reports for which a determination of whether abuse occurred has not been made within 30 days of the report. Consistent with the COB's recommendation, DHS also established a Non-Act 33 Internal Fatality Review Team. The Non-Act 33 Internal Fatality Review Team reviews cases in which DHS received a report regarding a child fatality that was categorized as a general protective services (GPS) report, and the child was receiving services from DHS or was known to the Department within the 16 months prior to the child's death.

The COB has continued to monitor the fatalities and near fatalities reported to DHS, the fatality and near fatality review process, and the implementation of the recommendations developed

during the reviews. Since the February 2010 *Report on Progress*, DHS has continued to provide the COB with updates and information to support monitoring efforts.

Below are recent data on the number of fatalities and near fatalities reported to the DHS Hotline and the history of the child’s involvement with DHS; an overview of the recommendations from the child fatality/near fatality reviews; a summary of the issues raised in the focus groups conducted by the COB in June; and recommendations for future action.

Child Fatality Data

As seen in table 2.7, 205 child fatalities were reported to the Hotline from January 2008 and through December 2010. Most of these fatalities (85%) did not generate CPS reports. These child fatalities did not generate CPS reports because the allegations regarding the child’s death, if true, would not constitute child abuse as statutorily defined in the Commonwealth of Pennsylvania.

Table 2.7 Fatalities Reported to the Hotline

Year	Number of Child Fatalities Reported to Hotline	CPS Reports Generated	GPS Reports Generated	General Reports Generated	Reports Not Generated
2008	60	10	12	21	17
2009	64	9	7	18	30
2010	81	12	7	17	45
Total	205	31	26	56	92

DHS reported to the COB that co-sleeping was identified as a factor in 24 of the 64 (37%) child fatalities reported to the Hotline in 2009. From January to September 2010, 19 of the 59 (32%) deaths reported to the Hotline identified co-sleeping as a factor. Most of the child victims in these cases were not known to DHS at the time of their death. While DHS has taken a number of steps to reduce the risks of co-sleeping in cases with DHS involvement, the COB feels strongly that the issue of co-sleeping should be approached as a city-wide problem. The COB recommends that the Philadelphia Department of Public Health (DPH) develop a prevention strategy to educate parents and caretakers about the safest ways for babies to sleep.

Child Fatalities Generating CPS Reports, with DHS Involvement

As seen in table 2.8, a majority of the child fatalities reported to the Hotline for the calendar years 2008 through 2010 were not cases involving children currently receiving services from DHS; children with a pending investigation at the time of death (active cases); or children who had been known to DHS in the 16 months prior to the child’s death (inactive cases). During the last 3 years, only 4 of the 31 (13%) child fatalities generating CPS reports were active with DHS; 6 of the 31 (19%) were known to DHS in the 16 months prior to the child’s death. The remaining 21 (68%) child fatalities were instances where the child was not known to DHS in the 16 months prior to the child’s death.

Table 2.8 Fatalities for Which CPS Reports Were Generated, DHS Involvement

Year	CPS Reports Generated	Active ¹	Inactive ²	Not Known ³
2008	10	2	3	5
2009	9	1	3	5
2010	12	1	0	11
Total	31	4	6	21

¹ Active is defined as the child was receiving services or had a pending investigation at the time of death.

² Inactive is defined as the child had been known to DHS in the past 16 months (e.g., DHS received a report alleging child abuse or neglect, DHS conducted an investigation of child abuse or neglect; DHS provided services to the child within the past 16 months but was not providing services to the child at the time of death).

³ Not Known is defined as the child was not known to DHS in the past 16 months.

Child Fatalities Generating GPS Reports with DHS Involvement

The COB had indicated in past *Reports on Progress* that it was concerned that the distinction between a child death in which a CPS report was generated and a child death in which a CPS report was not generated was not always clear. Therefore, the COB has continued to inquire about child fatalities that generate GPS reports and involve children with active or inactive cases with DHS. As seen in table 2.9, the data show that three of the 26 (12%) fatalities that generated GPS reports involved children with active cases with DHS at the time of the child’s death. Sixteen of the 26 cases (62%) involved children who were known to DHS within the 16 months prior to the child’s death.

Table 2.9 Fatalities for Which GPS Reports Were Generated, DHS Involvement

Year	GPS Reports Generated	Active ¹	Inactive ²	Not Known
2008	12	2	6	4
2009	7	1	6	0
2010	7	0	4	3
Total	26	3	16	7

¹ Active is defined as the child was receiving services or had a pending investigation at the time of death.

² Inactive is defined as that the child had been known to DHS in the past 16 months (e.g., DHS received a report alleging child abuse or neglect, DHS conducted an investigation of child abuse or neglect; DHS provided services to the child within the past 16 months but was not providing services to the child at the time of death).

³ Not Known is defined as the child was not known to DHS in the past 16 months.

Near Fatality Data

In January 2009, DHS was required by state statute to review cases of near fatalities and began tracking these cases in its Fatality Tracking Database. A review of the data provided by DHS

shows that a majority (25 out of 42, 60%) of the near fatalities reported to the Hotline were not cases involving children currently receiving services from DHS; children with a pending investigation at the time of the report (active cases); or children who were known to DHS in the 16 months prior to the report (inactive cases). (See table 2.10 below.)

Table 2.10 Near Fatalities, DHS Involvement

Year	Near Fatalities Reports to the Hotline	Active ¹	Inactive ²	Not Known
2009	17	5	2	10
2010	25	2	2	21
Total	42	7	4	31

¹ Active is defined as the child was receiving services or had a pending investigation at the time of death.

² Inactive is defined as the child had been known to DHS in the past 16 months.

³ Not Known is defined as the child was not known to DHS in the past 16 months.

Implementation of Recommendations

DHS reports that both the Act 33 Review Team and the Internal Fatality Review Team are working well. In particular, the Act 33 Review Team is completing the review of child fatalities and near fatalities in a timely manner and consistent with the legal requirements set out by the Act.

The Act 33 Review Team was established in January 2009. Since that time, 50 Act 33 Review Team meetings have been held. There have been 43 recommendations from the near fatality reviews and 19 recommendations from the child fatality reviews, for a total of 62 recommendations concerning fatalities and near fatalities. DHS reports that of those 62, 25 were assigned, implemented, and completed. The remaining recommendations are currently in progress.

Discussion

DHS has implemented a model child fatality/near fatality review process. In addition, DHS has created a system for monitoring and implementing the recommendations that result from the reviews. The COB believes that DHS must continue to evaluate fatality/near fatality data, the review process, and the recommendations from the Act 33 Review Team. Toward that end, the COB recommends that DHS take the following steps:

1. Conduct an evaluation of the Act 33 Review Team process that may include an assessment of whether they are meeting their goals and objectives, and the impact of their recommendations on policies, services, programs, and public awareness.
2. Assess the implementation of the recommendations from the Act 33 reviews and determine whether the corresponding changes to practice have impacted child safety. The assessment also should consider whether the recommendations are useful, and

how DHS can move from implementing individual recommendations to developing a multidisciplinary prevention strategy for child fatalities.

3. Conduct an analysis of the fatalities that involved children who were receiving services from DHS, or were known to DHS within the 16 months prior to the child's death, that generated either CPS or GPS reports. The analysis should identify the significant risk factors or patterns in child safety that can be linked to child fatalities. These findings should be compared to what is being learned through the Quality Service Review process and ChildStat reviews.
4. Provide training for members of the medical community regarding the criteria for determining and reporting a child near-fatality. In addition, all mandated reporters should receive education about the new criteria for accepting a case for investigation.

In the focus group with members of the medical community, participants indicated that the recommendations of the Act 33 Review Team were not disseminated to the medical community. The COB recommends that DHS identify strategies for improving the dissemination of recommendations. This communication is critical given that the medical community plays a crucial role in identifying and protecting children who may be abused and neglected.

Participants in the medical community focus group also identified a lack of clarity about the definition of a near fatality. None of the hospital doctors who participated in the focus groups were aware of the requirements for certifying a case as a near fatality. The lack of clarity about the definition of near fatality was also raised as an issue in recent reviews of near fatalities by the Act 33 Review Team. The COB advocates that the following recommendations of the Act 33 Review Team regarding near fatalities be implemented:

- The DPW and medical professionals throughout the state should meet to explore what is considered a near fatality and to establish some consistency on the types of injuries and cases that should be reported as near fatalities.
- DHS staff should receive formal training on near fatalities, including how and when to discuss near fatalities with hospital physicians.

Evidence-Based Model of Practice

The CWRP recommended that DHS develop a more analytical process, both to evaluate the effectiveness of services and to identify additional changes and improvements that could be implemented. The CWRP recommendation referred to this as evidence-based practice; the specific recommendation is:

DHS must move toward an evidence-based practice model, and take active steps to determine the effectiveness of its practices with an evaluation process that is open and informs good practice. When practices do not work, they should be replaced with a more appropriate and effective practice. (2.a.i, Phase 2)

To implement evidence-based practice, DHS must have analytical methods in place to determine the effectiveness of its services, programs, and practices. Based on the information and empirical

evidence gathered, changes that could enhance the effectiveness of DHS programs can be identified. DHS has implemented both case reviews and ongoing data analysis. The information from the case reviews and data analysis is being used to inform decision making, improve practice, and monitor outcomes. The major case reviews, data analysis, and research activities of the Performance Management and Accountability (PMA) that support the development and implementation of evidence-based practice are described below.

Case Reviews

DHS is currently conducting four types of case reviews to assess service effectiveness—ChildStat, Quality Service Reviews (QSR), reviews of child fatalities/near fatalities, and Qualitative Visitation Reviews (QVR) at the end of 2010. Each type of case review is summarized below.

ChildStat—Through ChildStat meetings, DHS staff collectively review a specific case or cases in a particular area of services (e.g., Hotline, Ongoing Services, In-Home Protective Services, etc.). The meetings include a review of each case’s detailed information, including what services were provided. Following the case presentation, attendees discuss the strengths and weaknesses of the service intervention, acknowledge exemplary services, identify potential areas for improvement, and develop recommendations to improve ongoing case practices. ChildStat meetings are held monthly. DHS will expand the ChildStat process to providers starting in March 2011. The Provider ChildStat will begin with Performance Based Contracting providers. The Provider ChildStat meetings will be held on a monthly basis.

To help the COB understand the value of the ChildStat meetings, DHS conducted two ChildStat case reviews at the July 2010 COB meeting.¹ During the meeting, the participants conducted an in-depth review of Hotline services. DHS invited the COB to participate in the discussion of findings and recommendations from the review.

Quality Service Reviews—QSRs are part of a statewide initiative by the DPW, Office of Children, Youth, and Families (OCYF). QSRs in Philadelphia are scheduled to occur six times per year. The purpose of the QSRs is to assess DHS’ performance in specific service areas and identify systemic improvements for DHS and its partner agencies. The process involves detailed and extensive review of a random sample of cases in a specific service area (e.g., congregate care, medically needy youth/children, etc.). QSRs are conducted by a team of reviewers composed of DHS staff members and staff from external agencies. The team conducts a three-day review of 12 sample cases. Interviews with social workers, supervisors, and family members also are conducted.

QSRs use a structured process and a scoring tool to evaluate cases. The scoring tool consists of family indicators (safety, permanency, and well-being factors) and practice indicators (engagement with the child, family, and caregivers; interagency teaming; cultural awareness assessment; planning; and intervention). Ratings from sample cases are assembled to show the performance on each indicator. These findings indicate where performance is acceptable, where minor refinements are required, and where significant improvements are needed. By examining

¹ Since ChildStat meetings include confidential case information, the ChildStat presentations were conducted during COB executive sessions.

the general performance on each indicator across all reviewed cases, DHS can make broader judgments about where attention should be focused on systemic change.

The QSR findings provide empirical information about outcomes and performance for specific service areas. This information is an important source of evidence used by DHS as it formulates plans for specific service improvements and modifications to Agency policy and practices.

Fatality/Near Fatality Review—As discussed earlier in this section of the report, DHS has implemented an effective process for reviewing child fatalities and near fatalities. These reviews are important as they represent another ongoing process through which DHS assesses the effectiveness of its services and identifies any needed improvements. Since the implementation of the new process in January 2009, the Act 33 Review team has made numerous recommendations for improving practice. DHS has reviewed these recommendations and has implemented, or is in the process of implementing, all of the recommendations.

Quality Visitation Review (QVR)—A new review process scheduled for implementation at the end of November 2010. The QVRs evaluate the quality of the interactions that DHS and contracted agency staff have with children and families during required child visits. The process was described in more detail earlier in this section. The findings from the QVRs will provide data to assess the effectiveness of direct casework services. They also will provide information to help identify any needed changes in service planning procedures, coordination between DHS and contracted agency staff, and general casework practice.

Data Analysis and Research

The review processes described above are mechanisms through which specific cases, or groups of cases, are reviewed to assess service effectiveness. These processes provide important information at the case level. However, DHS and the COB also require information that describes the overall quality of services to evaluate DHS' overall effectiveness and identify areas for improvement. The primary source of this information is the case- and aggregate-level data contained within the DHS FACTS information management system. PMA uses these data for development of the ongoing management reports.

PMA reports are essential to DHS for managing services and making important decisions regarding its programs and procedures. They also provide the information required by the COB to oversee DHS progress in regard to the CWRP recommendations and other issues raised by the COB. Three areas of reporting support the COB work directly, as discussed below.

Routine Data Report

Recognizing that the COB requires regular data reports to assess DHS progress, DHS has developed a standard report for review at each COB meeting. The report provides an overall status related to

- referrals received by DHS;
- outcome of abuse and neglect investigations;
- information about the changes in caseload size;
- population of children in placement; and

- statistics regarding DHS' compliance with child visitation policies.

The COB report is in development and will be finalized in 2011. A sample of the most recent version of the COB routine report is included as appendix D.

Specialized Program Reports

PMA also has developed reports that address specific issues or programs of interest to the COB. Most recently, in response to COB concerns and issues raised in the recent focus groups, PMA has begun an in-depth analysis of referrals to the Hotline. The study is examining the screen-in/screen-out decisions made at the Hotline. The study also will review the implementation of the Hotline Guided Decision Making Model (HGDM) for consistency. From the initial analysis of HGDM, PMA identified additional data that needs to be captured by Hotline staff. PMA is currently implementing a plan to provide the tools to the Hotline to collect the data.

In the future, PMA will address other areas of COB interest including follow-up on the status of Family Group Decision Making, Alternative Response and prevention programs.

Key Outcome Measures

PMA has worked with the COB to define and develop reports that examine key outcome measures identified by the COB. The current reports and status of these measures is described in section 3 of this report.

Discussion

DHS implemented strong mechanisms to support the identification and implementation of evidence-based practice. The review processes and the enhanced reporting by PMA are positive developments. To fully benefit from the information gained through these processes and to ensure data-driven practice, the COB recommends that DHS carry out the following actions:

- *Consolidate findings and recommendations from the various review processes into one tracking system.* The various review processes generate multiple findings and recommendations, many of which overlap. The COB recommends that DHS develop a system to consolidate the multiple recommendations and to coordinate the follow-up in an integrated fashion. DHS can address the changes in a more integrated and consistent manner once the recommendations are tracked in one repository. The COB recommended that the consolidated system for tracking recommendations for improvement include a clear statement of the reason for each recommended change. This is critical to ensuring that staff affected by a new process or procedure are fully cognizant of the reason for the change.
- *Implement the long-planned case management information system.* PMA has worked diligently to expand and strengthen DHS' data analysis and reporting capabilities. PMA has been very responsive to the COB's requests, however, efforts have been hampered by gaps in needed data and the difficulty of working with various data sources. DHS has been pursuing a new or enhanced information system for quite some time and the plans for implementing an alternative or enhancement to the FACTS system have changed repeatedly. DHS has informed the COB that the City's

Office of Technology has developed a new plan for implementing a case management system for DHS. The COB will monitor the efforts to put in place a case management system as it is critical to DHS' ability to better manage and evaluate its critical services.

Expanded Use of Family Case Conferences

In March 2009, DHS began implementing Family Group Decision Making (FGDM) in response to the following recommendations of the CWRP:

DHS must implement a team decision making process to determine service plans for all children 5 years of age or younger. (2.d., Phase 1).

DHS must ensure that ongoing team case conferencing occurs routinely every three months, for cases involving a child age 5 years and younger after the initial pre-placement conference. (2.e., Phase 1)

DHS must expand the use of team decision making to all children and utilize specialized resources in the case-planning process. (2.a.ii., Phase 2)

DHS implemented FGDM agency-wide during March 2009. As reported in the COB's August 2009 *Report on Progress*, the DHS plan for implementation is to provide FGDM for all children who are at-risk of placement; have a change in placement level; are at-risk of placement disruption; are being discharged from placement; participate in older youth permanency meetings; and/or have other critical issues.² Referrals to the FGDM program are initiated by social work services managers and approved by their supervisors and FGDM program staff. Through a competitive procurement process, A Second Chance, Inc. was selected as the provider agency responsible for receiving the referrals from DHS, coordinating services with the families, and facilitating the family conferences.

FGDM Evaluation and Preliminary Results

Since the inception of FGDM, The Jerry Lee Center of Criminology at the University of Pennsylvania (Jerry Lee Center) has conducted an analysis of the FGDM program. The Jerry Lee Center's analysis has been based upon data provided by A Second Chance, Inc.

The COB's August 2009 *Report on Progress* described the FGDM program at a very early stage in its development. The report presented FGDM statistics through the middle of May 2009. At that time, the COB noted that DHS referrals to the program began slowly and were just beginning to increase. It was further noted that few family conferences had been held prior to May 2009, and that there was concern about the "drop-out" rate for the referrals that had been made (i.e., referrals that did not result in a family conference).

During July 2010, DHS provided an updated FGDM report to the COB that was developed by the Jerry Lee Center. The report showed that referrals to FGDM increased significantly after May 2009 and that, for the first three months of 2010, there were approximately 100 referrals per month. At the current rate, the Jerry Lee Center estimated that more than 1,100 referrals would

² Philadelphia DHS/CYD Policy and Procedure Guide, Issue Date March 23, 2009.

be made in 2010, which represents an increase of 66 percent over 2009. Based on these estimates, there are still many cases that meet the criteria, but are not being referred to FGDM.

The Jerry Lee Center's report also indicated that many referrals do not result in completed family conferences. Although more recent data show that a higher proportion of referrals are leading to family conferences, the majority of referrals still do not result in a family conference. The report cited two reasons that FGDM conferences were not held for referred cases. First, in many cases, the family refused to participate. Second, the family could not be contacted, despite multiple attempts by the FGDM facilitator. In some cases, conferences were held but did not result in an agreed-upon case plan.

Discussion

In 2010, the COB met with DHS to review the status of FGDM. Both the COB and DHS are concerned about the relatively small number of referrals to FGDM that are resulting in completed family conferences. DHS has informed the COB that the PMA will assume responsibility for gathering data and analyzing FGDM performance. It is the COB understands that PMA will gather more information to help DHS better understand the reasons for the low number of completed family conferences, and work with staff to identify strategies for overcoming barriers.

The COB requests additional information about the program and plans to confer with DHS regarding the issues that have been raised about FGDM implementation. These include issues such as the capacity to respond to the large and increasing number of referrals, and the misunderstanding of the process by some DHS and contract agency social workers, as reported in the focus groups. The COB also is interested in learning more about the outcomes of cases with completed family conferences. In addition, the COB will work with DHS to gain a better understanding of the most effective use of FGDM and how the FGDM program fits with the other DHS policies and procedures for team service planning.

Criminal Background Checks

The CWRP recommended that DHS conduct a criminal background check on each adult member in the child's household during the investigation and assessment process and prior to any reunification. The specific CWRP recommendation is as follows:

DHS must conduct a background check on each member in the child's household. If an adult household member has prior involvement with DHS or a criminal record that includes convictions for a felony that suggest danger for a child, then DHS must conduct an assessment to determine whether the household is safe and appropriate for the child.
(2.a.ii.2, Phase 2)

DHS has made progress in implementing this recommendation. Since the COB's February 2010 *Report on Progress*, DHS has met with the supervisory judges of both the Domestic Relations and Dependency branches of the Family Court regarding the possibility of gaining access to the Court's BANNER database. BANNER contains information on Protection from Abuse and custody orders. As a result of these discussions, the Family Court has agreed to give DHS staff

access to BANNER. The next step is for DHS to establish a connection to the BANNER database and train staff on its use and integration into ongoing practice.

DHS previously gained access to the Pennsylvania Justice Network (JNET) and began training staff on its use. JNET is the state's integrated justice portal that provides public safety and criminal justice information from various contributing municipal, county, state, and Federal agencies. The District Attorney's (DA) office agreed to provide training for DHS staff on reading and interpreting the results of a criminal background history search.

Discussion

The COB understands that DHS had planned to complete a pilot for conducting criminal background checks for reunification cases during 2010. DHS has yet to take all the necessary steps to begin the pilot. The COB anticipated that DHS would have made greater progress toward completing the pilot, including completing activities such as

- finalizing a draft policy and procedure guide about criminal history clearances for investigations;
- developing a form or forms for requesting and responding to criminal history searches; and
- conducting training for DHS social work staff about how to use information from criminal background checks for reunification, including a special curriculum on confidentiality issues.

The COB will continue to monitor the implementation of this recommendation. The COB suggests that DHS develop an action plan for implementing this recommendation. The action plan should include a complete list of each step required to conduct, monitor, and evaluate the pilot.

Once the action plan is approved, DHS should then implement the pilot for all types of investigation cases. Based on discussions of some of the fatality/near fatality cases reviewed and recommendations made by the Act 33 Review Team, the COB recommends that DHS reassess the types of cases that it focuses on in implementing the pilot. The COB also reiterates its recommendation made in the August 2009 *Report on Progress* regarding the development of a mechanism for tracking data on the findings from the criminal background checks and actions taken by social work services managers in response to the findings. This information will support DHS in its efforts to become a "learning organization" as well as in continuing to refine its policies and practices in this area.

Co-Location

The CWRP recommended that DHS provide a site where a multidisciplinary team could be located for conducting investigations. The specific CWRP recommendation is as follows:

DHS [must] complete the long-planned co-location of DHS, police, and medical and forensic interview personnel at a community site to facilitate collaborative decision making in the investigative phase of casework. (2.a.ii.6, Phase 2)

DHS identified the Germantown Army Reserve Center as the site for the co-location initiative. Title to the property is expected to be secured in July 2011. DHS allocated funding in its fiscal year 2010–11 budgets for the initiative. The Commissioner of DHS is planning to convene a meeting with the City’s Capital Program Office and other departments involved in the initiative to determine next steps. DHS expects that the co-location initiative will be ready to launch by 2013. The three-year time line reflects the time needed to conduct the required planning, obtain the necessary funding, and complete the modifications to the site. In addition, The Philadelphia Children’s Alliance (PCA) cannot move to the new site until 2013, when the lease on its current facility expires.

It is expected that the entire DHS Sex Abuse Unit, including investigations, PCA, and the Police Department’s Special Victims Unit will be located at the new site. DHS expects that approximately 30 DHS staff will be housed at the new site. The District Attorney’s office also will have staff located at the site.

Discussion

The COB will continue to monitor DHS progress in moving forward with this recommendation. The COB believes that the co-location initiative is critical to DHS’ overall goal of enhancing and supporting a community-based service system. Research has shown that having representatives from many disciplines work together, conducting joint forensic interviews, and making team decisions about the investigation, treatment, management, and prosecution of child abuse results in a more complete understanding of case issues and the most effective, child- and family-focused response.

REALIGNMENT OF COMMUNITY-BASED PREVENTION SERVICES

While not a specific area of focus during the time frame of this report, the COB also would like to acknowledge DHS efforts regarding the CWRP’s recommendation to align its prevention programs with the new mission and values. The specific CWRP recommendation is as follows:

DHS must align prevention programs and resources with mission and values developed in Phase One, and also with the core principle of ensuring child safety. (1a., Phase 2)

DHS provided an update and report to the COB at the March 2010 COB meeting.³ DHS has reorganized the Division of Community Based Prevention Services (CBPS) to more effectively target and serve the most at-risk children and families, particularly those receiving or transitioning from DHS mandated or protective services. Throughout the process, and to inform the redesign, CBPS engaged community and system stakeholders to get their input on what was needed in the community. The accomplishments of DHS include the following areas:

³ Philadelphia Department of Human Services, Division of Community Based Prevention Services (CBPS) (February 2010). Alignment Progress Report.

- *Parenting Education*—CBPS has improved the alignment of parenting education services with other services and system partners. For example, CBPS developed a directory of Parenting Collaborative classes by geographic region that matches In-Home Protective Services regions, School District Empowerment Schools, and low-attendance schools. This directory has been widely distributed across City departments, School District offices, and providers.
- *Domestic Violence*—CBPS implemented domestic violence programming in FY 2010. The providers offer an array of services including: after care case management service to women with children transitioning from a domestic violence shelter or transitional housing unit to reduce recidivism to the abuse relationship; teen education in school based settings to address teen dating violence; and counseling and support group services to mothers who are formally involved in the child welfare system.
- *Education Support Center*—The DHS Education Support Center is designed to improve the educational stability and outcomes of children in DHS care. The Education Support Center team helps identify educational barriers and offers a streamlined point of access to address and resolve them. Staff focus on: providing educational consultations to and coordinating communication with DHS and provider case managers; training child welfare and school district practitioners on the educational needs of youth in DHS care; advocating for academic enrichment programs; tracking educational indicators for youth in DHS care; leading the integration of education well-being measures in practice; and developing inter-agency communication and practice protocols between DHS, School District of Philadelphia, and other schools.
- *Alternative Response System*—Engages and supports families in enhancing their abilities to meet the basic and well-being needs of their children in the least intrusive, time-limited manner through the use of community resources. DHS Family Assessment staff complete a comprehensive safety assessment and upon determining that no safety threats exists, but there is still a need for services, the family is referred to one of the contracted Alternative Response System service providers for in-home case management support services. Within 72 hours of receiving the referral, the ARS service provider and DHS staff conduct a joint visit in the family's home. This visit serves as DHS' closing visit. By referring the family to the Alternative Response System provider, DHS is deciding not to accept the family for CYD services and the case is closed.

Discussion

During the upcoming year, DHS will continue to build on the progress made in aligning CBPS services. In 2011, CBP activities will include identifying ways to strengthen and streamline the continuum of In-Home Protective Services; enhancing services targeted to children, youth and families active with DHS or at high risk of DHS involvement; formalizing community engagement services; and developing a city-wide plan to improve access to, and the effectiveness of, truancy services in collaboration with the School District and the Family Court.

While there have been many successes related to the realignment of CBPS, DHS is still refining the array of services provided as well as how the services are delivered. The COB will work with DHS to ensure that there are mechanisms in place to monitor the ongoing delivery of CBPS services and the safety and well-being outcomes for children and families served.

SECTION 3. KEY OUTCOME MEASURES

This section presents the current status of the key outcome measures identified by the Community Oversight Board (COB) as indicators of Department of Human Services' (DHS) performance related to child safety and well-being. The outcome measurement data have been supplied by DHS' Performance Management and Accountability Division (PMA) at the request of the COB. The COB uses the outcome measures, as well as DHS routine data reports and various specialized studies, to report DHS' overall progress related to child safety and well-being.

BACKGROUND

In its August 2009 *Report on Progress*, the COB identified six outcome measures for monitoring overall performance of DHS related to child safety and well-being. Two outcome measures were removed from the initial set of six measures—length of stay in foster care and changes in level of placement—because they were deemed less relevant to the COB's central oversight focus on issues related to child protection. The remaining measures are

- occurrence of repeat maltreatment and length of time between incidents of child maltreatment;
- severity of repeat maltreatment;
- incidence of child maltreatment in placement; and
- reentry into foster care and other placement types.

This report provides updates to the status of the outcome measures and, in some cases, expansion or refinement of the data collection and analysis. Findings that represent a significant change from the February 2010 *Report on Progress* are noted where appropriate and where comparable data exist.

OUTCOME MEASURE 1: OCCURRENCE OF REPEAT MALTREATMENT AND LENGTH OF TIME BETWEEN INCIDENTS OF CHILD MALTREATMENT

This measure examines whether or not children have experienced subsequent maltreatment after having been substantiated for maltreatment by DHS. It recognizes that the goal for protective services is to ensure the child's safety and to resolve the conditions that lead to child maltreatment. A successful outcome is the absence of subsequent child maltreatment following the initial report.

As this measure has been refined over time, the ability to provide a trend comparison using information from the previous *Reports on Progress* is limited. In the August 2009 *Report on Progress*, DHS reported on repeat maltreatment by following children who were substantiated for abuse or neglect from April 2007 through October 2008. These children were followed for a 6-month period to see if a subsequent substantiated report was received. In the February 2010

Report on Progress, the data were based on two reporting periods (July 2004–December 2005, and July 2007–December 2008). In the February 2010 *Report on Progress*, DHS identified any subsequent maltreatment that occurred within 18 months of the initial report, for both reporting periods. The COB and DHS agree that using an 18-month follow-up period is a more valid basis for assessing repeat maltreatment, recognizing that 6 months is not a long enough time for follow-up on the recurrence of maltreatment. The 18-month time frame is used in this January 2011 *Report on Progress* and will continue to be used for future reports.

Discussing child maltreatment in the Commonwealth of Pennsylvania always requires a clarification regarding the unique manner in which child abuse and neglect is classified. Pennsylvania law and regulations divide reports alleging maltreatment into two major types—Child Protective Services (CPS) and General Protective Services (GPS). The distinction is generally one of severity. For a report alleging child maltreatment to be registered as a CPS report, it must contain an allegation which, if true, would constitute child abuse as statutorily defined.⁴ A report is considered a GPS report if it alleges that a child has been abused or neglected, but the allegation does not meet the statutory definition of child abuse; is a non-incident-specific allegation of neglect; is an allegation of lack of supervision or failure on the part of parents or the person responsible for the care of the child to provide for the essentials of life; or alleges that a child is dependent as defined by the Juvenile Act.⁵

Both CPS and GPS reports can result in the provision of protective services for the child and both types of reports represent some level of risk to the child. The February 2010 *Report on Progress* examined the recurrence of maltreatment for CPS cases only. For this January 2011 *Report on Progress*, DHS has expanded the analysis on repeat maltreatment by including GPS reports and examining the recurrence of repeat maltreatment for and across both categories of maltreatment reports. DHS provided statistics that examine the initial reports (CPS and GPS) received and substantiated in State Fiscal Years (SFY) 2006 and 2009. The data identify the children reported during these periods who were involved in another substantiated incident of maltreatment within the 18 months following the initial substantiated report.

Recurrence of Maltreatment

As shown in table 3.1, the initial reports for both CPS and GPS cases received and substantiated in SFY 2009 were less likely to be followed by a subsequent substantiated report than those for children who were served by DHS in SFY 2006. For the initial substantiated reports (CPS and GPS) received in SFY 2006, approximately 11 percent resulted in a subsequent substantiated report. In SFY 2009, this decreased to less than an 8 percent recurrence of maltreatment. This is a positive finding in that it indicates that DHS has, over the 3 years between the reporting timeframes, reduced the recurrence of subsequent maltreatment.

In both years, GPS reports were substantially more likely than CPS reports to have a repeat incident within 18 months. For the initial GPS reports in SFY 2009, 8.1 percent of the initial reports were followed by either a substantiated CPS or GPS report. This compares with 5.8 percent of the CPS initial reports in SFY 2009 that resulted in another substantiated CPS or GPS

⁴ Philadelphia Department of Human Services, Children and Youth Division (January 2000). *Policy Manual*, Section 2200.

⁵ Ibid.

report. The fact that repeat maltreatment is seen more often following an initial GPS report might be expected, since GPS reports are generally of lower severity. Because they are less severe at the point of initial DHS contact, they may be less likely to be given extensive protective services.

For both fiscal years that were studied, when a subsequent report of maltreatment was received, it was more likely to be a GPS report, rather than a CPS report. Initial GPS reports were followed by a subsequent substantiated CPS report in 1.4 percent of the 2006 cases and 1.2 percent of the 2009 cases. Initial CPS reports were followed by a subsequent CPS report in 3.1 percent of the 2006 cases and 2.4 percent of the cases from 2009. Although any occurrence of repeat maltreatment is of concern, it is better that subsequent incidents are at the level of GPS reports rather than CPS. The reduction in overall repeat maltreatment seen in the comparison of SFY 2006 and 2009, as well as the fact that a majority of the repeat incidents are GPS rather than CPS, are positive findings.

Time Between Reports

In addition to recurrence of maltreatment, this outcome measure examines the time between incidents for children who are reported and whose cases are substantiated more than once to DHS within an 18-month period. Table 3.1 shows the length of time between initial reports and the subsequent report of maltreatment (6 months or less, 7–12 months, or 13–18 months). The majority of subsequent incidents of maltreatment occur within the first 6 months following the initial reports.

One concern in evaluating the recurrence of maltreatment measure is the ability to identify reports that are simply a follow-up to the initial report, rather than another occurrence of child abuse or neglect. DHS believes that, in the current data, at least some of the repeat maltreatment reports are actually additional information about the original incident rather than a new incident of child abuse or neglect. These are most likely to have been received within the first six months of the initial report. DHS has begun studying this dynamic and is planning to implement changes in data collection at the Hotline to better differentiate follow-on reports from new and separate incidents. Differentiating the reports that are related to the initial referral from those that represent new maltreatment incidents will provide a clearer picture of the repeat maltreatment outcome measure.

**Table 3.1 Repeat Maltreatment in CPS and GPS Reports Comparing Two Cohorts,
SFY 2006 and SFY 2009**

Type of Initial Report	# of Initial CPS Reports	Type of Repeat	0–6 Months	7–12 Months	13–18 Months	Total Repeat	% Repeat
2006							
Initial CPS	750						
		Repeat CPS	7	4	12	23	3.1%
		Repeat GPS	24	8	10	42	5.6%
		All Repeat	31	12	22	65	8.7%
Initial GPS	4,066						
		Repeat CPS	33	12	11	56	1.4%
		Repeat GPS	196	124	86	406	10.0%
		All Repeat	229	136	97	462	11.4%
All Reports	4,816		260	148	119	527	10.9%
2009							
Initial CPS	634						
		Repeat CPS	8	3	4	15	2.4%
		Repeat GPS	10	6	6	22	3.5%
		All Repeat	18	9	10	37	5.8%
Initial GPS	2,265						
		Repeat CPS	23	3	2	28	1.2%
		Repeat GPS	73	48	34	155	6.8%
		All Repeat	96	51	36	183	8.1%
All Reports	2,899		114	60	46	220	7.6%

As noted above, repeat maltreatment has been reported using different parameters for capturing the subsequent incidents following initial reports. Therefore the ability to compare the findings in this report to those presented in past *Reports on Progress* is limited. However, the February 2010 *Report on Progress* did examine an 18-month period for subsequent CPS reports, yielding data that are comparable at least for this category of child maltreatment. Repeat maltreatment as reported for CPS initial reports from July 2007 through December 2008 resulted in a recurrence of 0.59 percent. This was a considerably lower rate of repeat maltreatment for initial CPS incidents than was found for either of the two periods reported in the present report. This may be due to differences in the algorithms or data sources used for reporting on repeat maltreatment, or it may reflect an actual difference in recurrence of maltreatment. The COB will continue to monitor this outcome measure closely as it is an important measure upon which to judge the effectiveness of DHS’ protective service intervention. More definitive conclusions on the measure can be drawn once the COB is certain that the data presented over time are comparable.

OUTCOME MEASURE 2: SEVERITY OF REPEAT MALTREATMENT

Incidents of maltreatment can vary greatly, from extreme physical injury, chronic neglect, or sexual abuse to less serious neglect. Although any recurrence of child maltreatment is a concern, it is more troubling if the subsequent incident of maltreatment is more serious than the previous one. The legal definitions upon which CPS and GPS categorizations are made do not provide comprehensive information in regard to severity. In the February 2010 *Report on Progress*, the COB described a methodology for assessing the level of severity of maltreatment cases and for judging whether or not subsequent incidents were of higher or lower severity. As described in the February 2010 *Report on Progress*, the factors DHS implemented for rating severity were:

- type of reported allegation(s);
- whether or not DHS accepted the report for service;
- report category (CPS or GPS) and the finding of the investigation;
- response time rating (assigned upon receipt of the report); and
- victim age.

DHS has begun rating the severity of initial reports (CPS and GPS) and provided severity data for the 220 repeat reports shown in table 3.2 for the children with initial reports in FY 2009. In the preliminary results using the severity rating scale, fewer than one-half of the subsequent incidents of child maltreatment were of greater severity than the initial report. Approximately 55 percent were of equal or lesser severity than the initial report.

**Table 3.2 Severity of Repeat Maltreatment
Recurrence of Initial Incidents (CPS and GPS) in Fiscal Year 2009**

Total Repeat Incidents	Decreased Severity	%	Increased Severity	%	No Change	%
220	74	33.6	100	45.5	46	20.9

The preliminary data using DHS' severity rating scale suggest that, according to DHS' rating system, a substantial number of the subsequent reports are as serious, or more serious, than the initial reports received by the Department. Effective intervention at the time of the initial incident is essential to preventing later harm to the child, as evidenced by future incidents of maltreatment. With the implementation of the severity rating scale, the COB and DHS can now begin to monitor the severity of subsequent maltreatment and can examine the trends in this measure over time. This will enhance the overall understanding of repeat maltreatment as experienced by children reported to DHS.

OUTCOME MEASURE 3: INCIDENCE OF CHILD MALTREATMENT IN PLACEMENT

Pennsylvania's Office of Children, Youth, and Families (OCYF) is responsible for receiving and investigating reports of maltreatment of children in placement. Even though investigating these incidents is an OCYF responsibility, it is critical for the COB and DHS to obtain and evaluate this information, as it is an important measure of DHS performance relative to the safety and well-being of children in care. DHS is responsible for approving placement settings and monitoring the care received by the children while in placement.

DHS has experienced delays in acquiring the statistical data from the Commonwealth that are needed to examine the occurrence of maltreatment within its population of children in out-of-home care. Previous *Reports on Progress* have cited this as a gap in the reporting on this outcome measure. For this report, DHS was able to obtain statistics for the period January–June 2010. Although this is a small snapshot of information related to this outcome measure, it can be used as a preliminary baseline against which future information can be compared.

Table 3.3 shows the information provided by the OCYF to DHS for the period January 2010–June 2010.

**Table 3.3 Reports of Maltreatment for Children in Care of DHS
(January 2010–June 2010)**

Total Incidents Reported	Total Substantiated	% Substantiated	Foster Care	Adoption or Legal Guardians	Residential
121	21	17.4%	5	15	1

DHS will arrange to receive periodic updates from OCYF on the reports and findings related to maltreatment involving children in its care. The information available from OCYF does not provide much detail regarding the incidents or the placement settings. DHS is exploring other potential data sources to obtain timelier and more detailed information about incidents involving children in placement. In January 2011, PMA will begin to explore internal mechanisms for extracting information on maltreatment of children in care. DHS has direct access to the Commonwealth's Home and Community Services Information System, which is used for collecting information about incidents involving persons in state and county agency care, and

DHS will explore the potential to use Commonwealth’s Home and Community Services Information System information to identify abuse or neglect reports on children in DHS’ care. This information will provide a more complete perspective for the COB on the incidence of maltreatment in out-of-home care.

OUTCOME MEASURE 4: REENTRY INTO FOSTER CARE AND OTHER PLACEMENT TYPES

When a child requires temporary placement to ensure his or her safety and well-being, DHS seeks to return the child to his own home as soon as the conditions that led to maltreatment or dependency have been remedied. If a child cannot be returned to the home of the parent due to issues that cannot be resolved, the department seeks to place the child in an alternate permanent setting (adoption, permanent legal guardian, or a suitable relative). DHS’ objective is to accomplish reunification or placement in a permanent setting as soon as possible. Although moving toward permanency with all deliberate haste is important, failures of these discharges from temporary care can be as detrimental to the child as remaining in foster care longer. The Reentry into Foster Care and Other Placement Types outcome measure examines the instances in which reunification or discharge to another permanency option has failed. In these instances the child requires a return to temporary placement. The measure is a gauge of the department’s success in executing appropriate reunification and permanency placement.

DHS produced reports on this outcome measure for this *Report on Progress* that compare permanency discharges for children who were discharged from placement during SFY 2006 and SFY 2009. These results are presented in table 3.4. The reports describe the success or failure of permanency discharges during these two time frames, as well as the number of reentries to temporary placement experienced by children for whom the initial permanency discharge was not successful.

In SFY 2006, 1,756 children were discharged to permanency. Slightly more than 85 percent of these discharges were successful in that the children did not return to care within the next 18 months. This compares to the more recent discharges of 914 children in SFY 2009, of whom 82 percent did not return to care within the following 18 months. Although these are just two select time frames, the preliminary results suggest that more children are returning to care after discharge from placement than occurred in the past.

Table 3.4 Reentry of Children within 18 Months of Discharge to Permanency

FY	Number of 1st Placements	Children Discharged to Permanency	Children Reentered Dependent	Children Reentered Delinquent	Total Children Reentered	Percent Reentered
FY 2006	2,069	1,756	221	36	257	14.6%
FY 2009	1,828	914	146	17	163	17.8%

The COB compared the results in table 3.4 with those that were reported in the February 2010 *Report on Progress* for this outcome measure. In the February 2010 *Report on Progress*, significantly higher reentry into placement was noted for the time periods covered (SFY 2005 and SFY 2008). Reentries for children discharged in 2005 and 2008 were approximately 50 percent. DHS suggested that a possible reason for the significant change in reentry rates as reported in the February 2010 *Report on Progress* may have resulted because the current data are generated from a single database source whereas the data used for the February 2010 *Report on Progress* were drawn from multiple sources. In extracting child data and matching reentries from the multiple sources, it is possible that a number of duplicate counts were created. The reentry information reported in the present report is deemed to be far more accurate, but due to the data discrepancies, cannot be compared with information from earlier timeframes. This is another measure for which additional time is needed to acquire comparable data for evaluating trends related to this outcome measure.

When permanency discharges fail, it is hoped that a future permanency discharge will be successful after a period of additional services by DHS. Fortunately, this is the case for most children served. Some of DHS' children experience more than one failed reunification and/or placement in a permanent setting. Table 3.5 shows these results for the children who were initially discharged to permanency in SFY 2006 and SFY 2009. Of the 239 children who were discharged in SFY 2006 and then returned to temporary placement, 7 percent experienced multiple reentries into care within the 18 months. Children initially discharged in SFY 2009 did slightly worse with 8.6 percent having more than one reentry into care during the 18-month period.

Table 3.5 Number of Reentries Within 18 Months of Discharge to Permanency

SFY	Children Reentered	One Reentry	Percent	More than One Reentry	Percent
2006	257	239	93.0%	18	7.0%
2009	163	149	91.4%	14	8.6%

The data currently available for this outcome measure indicate that children discharged in SFY 2009 fared somewhat more poorly than children released in SFY 2006. This was true for the number of permanency discharges that failed (17.8% in 2009 compared with 14.6% in 2006), as well as the number of failed permanency discharges that resulted in multiple reentries (8.6% in 2009 compared with 7.0% in 2006). The COB and DHS will need to examine the circumstances that lead to failed reunification and permanency placement. DHS can then take appropriate measures to improve the decisions and/or services that precede these discharges.

DISCUSSION

The outcome measures are a means to examine DHS progress using quantitative measures of key areas. Many changes and adjustments have occurred since their initial presentation and this makes the examination of trends and progress difficult. PMA has worked diligently to refine the reporting on the COB outcome measures and to improve the accuracy of these reports. Reliance

on multiple data sources, as occurred in the past, and the ongoing issues related to implementing information system improvements, have hampered the efforts to capture data for these measures, as well as for other data collection and reporting activities of the department.

The COB encourages DHS to continue the efforts to improve the validity and comprehensiveness of reporting so that critical information is available to support the COB's oversight responsibilities and, more importantly, to inform the department's own improvement initiatives. It is also essential that the outcome data are comparable over time so that the COB can use this information to evaluate DHS' success in enhancing child safety and well-being. The COB will work with DHS so that the reporting on outcome measures is stabilized and can be used to draw conclusions about the progress made by DHS in the next *Report on Progress*.

SECTION 4. FOCUS GROUP FINDINGS

In June 2010, the Community Oversight Board (COB) conducted 14 focus groups. The purpose of the focus groups was to gain information about the impact of the reforms being implemented by DHS on day-to-day practice. The focus was on the reforms that are being implemented as a result of the recommendations issued by the Child Welfare Review Panel (CWRP) in May 2007. The COB conducted these focus groups to obtain input from individuals who are involved with DHS programs and services yet have not had an opportunity to provide their perspectives on DHS reform efforts. The focus groups were not designed to be an objective analysis of the DHS reforms implemented over the last 3 years, nor were they intended as an assessment of DHS' overall performance. The focus groups were designed to gather opinions and perspectives about the reforms and the current state of DHS practices from a sample of community professionals. The COB gained valuable insight from the focus groups that will be used to identify priorities for future reform efforts.

METHOD AND DESCRIPTION OF GROUPS

The COB, with the support of Walter R. McDonald & Associates, Inc. (WRMA), conducted 14 focus groups. One-half of the focus groups were held with professionals from the medical and legal communities, the Family Court, social service agencies, and agencies that have contracts with DHS to provide services to children and families. Seven focus groups were held with DHS staff from Hotline, Intake (Investigation/Assessment), and Ongoing Service Regions. One additional meeting also was held with a group of DHS upper management, including administrators and regional directors.

An attempt was made to bring a representative group of professionals together in each of the sessions. However, the participants cannot be considered to be a representative sample of the various service sectors participating in the focus groups. A degree of self-selection was involved in determining the composition of the focus groups. Although the COB targeted invitations to selected organizations, and in some cases specific participants, the final group of attendees was composed of agencies and people who volunteered to participate. Therefore, it cannot be presumed that attendees are fully representative of the service sector they are from, or in the case of the DHS, of the unit or program in which they work.

Parents and children receiving services from DHS were not included in the focus groups due to limited resources and the fact they have had other avenues for providing feedback during the past three years, including numerous town hall meetings where the majority of participants were individuals receiving DHS services. In addition, the quality service reviews conducted by DHS regularly include parents and children. The Commissioner's Action Line, implemented in 2007, also served as a valuable conduit for obtaining feedback from parents and children.

Table 4.1 shows the focus group sessions and the number of participants in each focus group.

Table 4.1 Scope and Participation in Focus Groups

Focus Group	Number of Participants
DHS Focus Groups	
DHS Hotline Social Work Services Managers	9
DHS Hotline Supervisors	5
DHS Intake (Investigation and Assessment) Social Work Services Managers	4
DHS Intake (Investigation /Assessment)Supervisors	5
DHS Ongoing Service Regions Social Work Services Managers	8
DHS Ongoing Service Regions Supervisors	4
DHS Management Social Work Administrators – 28 Program Directors – 8 Deputy Commissioner – 1	37
Total, DHS Participants	72
Community Focus Groups	
Medical Community	14
Legal/Advocacy Community	10
Family Court	6
Social Services Agencies 1 (Prevention)	4
Social Services Agencies 2 (Intervention and Support)	9
Contracted Agencies 1 (In-Home Services)	12
Contracted Agencies 2 (Placement Services)	11
Total, Community Participants	66
Total Focus Groups Participants	138

To ensure neutrality and objectivity in the focus groups, the COB arranged for facilitation of the community focus groups through the University of Pennsylvania (UPENN) Medical School. Staff from Walter R. McDonald & Associates, Inc. (WRMA) facilitated the DHS focus group sessions. All focus groups, with the exception of the DHS management group, were 90 minutes in length.

OVERALL THEMES

This section presents the major crosscutting themes that were discussed in multiple focus groups. Some of the themes are relevant primarily to the area of practice of the participants in the focus group. However, there were a number of recurring (crosscutting) themes that were addressed by

multiple focus groups. The crosscutting themes are grouped into the following categories and present both the positive feedback received and the concerns that were expressed by the participants:

- Overall Impact of Reforms: DHS More Focused on Safety
- Major Changes to Social Work Practice
- Communication and Transparency
- Opportunities for Further Improvement

Overall Impact of Reforms: DHS More Focused on Safety

Focus group participants from both DHS and the community agencies clearly recognized and supported DHS' efforts to refocus its mission on the primary goal of ensuring child safety and serving those children at greatest risk of abuse and neglect. DHS staff members clearly understood the need for this refinement of DHS' mission and felt that it had been widely accepted among staff. They also felt that the new mission is clearer, has been promulgated through DHS policies and procedures, and that programs are now more closely aligned with the overall goal of ensuring child safety. Community focus group participants also showed strong support for DHS' new safety model of practice and the Department's ongoing commitment to enhancing child safety through focusing efforts on identifying and addressing safety risks.

While DHS' efforts to ensure safety were lauded by community organizations, some participants expressed concerns about the overall emphasis on safety. Some individuals felt that the narrower focus on safety may decrease prevention efforts and other services such as mental and behavioral health. Others expressed concern that the definition of safety may be too limiting, noting specifically that Hotline staff are not as willing to accept reports for children that are not at current risk, even when there is a significant risk of future harm. This was specifically mentioned with regards to medically vulnerable children and juveniles with non-traditional safety risks, such as truancy issues.

Both community groups and many DHS groups cited concerns that the potential of these reforms has not yet been realized and cited multiple reasons for this. Focus group participants from many sectors, including DHS staff, believed that the speed with which changes are being implemented, and the magnitude of these changes, have led to much inconsistency in application of the new procedures and tools, insufficient communication of the changes to DHS' partners, and the need for more training for those who are implementing the changes.

Major Changes to Social Work Practice

Overall, both DHS staff and community members who participated in the focus groups were positive about DHS reforms. Most felt that DHS had taken great strides to make child safety its primary goal and were supportive of the practice-related reforms DHS has implemented. They believed that the major changes being implemented by DHS are positive and provided the building blocks for future improvements. However, among participants in both DHS and community focus groups, concerns were noted about how well many of the new programs and procedures have been implemented.

Six specific reforms and programs were mentioned across many of the focus groups, with individuals from DHS and community agencies citing various strengths and concerns. These are discussed in the following sections.

Hotline Guided Decision Making (HGDM)

Hotline social workers and supervisors believed that the HGDM tool provides clear guidance for conducting a careful and complete interview to determine whether to accept the report of abuse and neglect for investigation or assessment. The tool also helps Hotline staff more accurately document the reasons for accepting or screening out a case. Some participants also thought that the interview process using HGDM is faster than the pre-HGDM process even though it requires staff to ask more questions.

However, DHS Hotline staff did express concerns that there is variability in how the use of HGDM is applied across supervisors, shifts, and floors. Hotline staff felt that this variability sometimes leads to inconsistent decision making regarding whether to accept or screen out reports. Hotline staff also noted that they felt that the community, particularly mandated reporters, has not been informed of the implementation of HGDM and the resulting changes to the screening process. This has led to frustration by those reporting suspected abuse and neglect. They also believed that reporters are calling ChildLine, the Pennsylvania Department of Public Welfare's state-level hotline to circumvent Philadelphia's Hotline. They expressed a need for further education for community members to ensure they understand the new HGDM processes and criteria for accepting referrals.

Many community members felt that the Hotline is less willing to accept cases which would have been accepted prior to the implementation of HGDM. There was some agreement that Hotline staff are less responsive in cases where the alleged victim is older, especially with cases involving teenage children. Participants in the medical focus group had a sense that there is a higher standard for cases of medical abuse and neglect reported by physicians and felt that neglect cases are often screened out inappropriately.

The Expedited Response (ER) Unit

Both DHS and community staff members felt that the new Expedited Response Unit has substantially increased DHS' responsiveness to reports of abuse and neglect for children age 5 and younger. Response to these cases now happens within two hours, and participants noted that in the past, responses often took more than 24 hours. However, there was some confusion among the DHS staff members about whether the Expedited Response Unit would continue to be a dedicated function within DHS. Some participants believed that DHS was going to integrate Expedited Response services within existing investigation units or, alternatively, institute a policy where all workers would have a dedicated day per month where they would perform expedited response visits. Generally, DHS staff felt that the Expedited Response Unit should remain intact and other workers, who do not currently have Expedited Response responsibility, should not be assigned this function.

In-Home Safety Assessment

Focus group participants felt that the new in-home safety assessment is a more effective tool for identifying safety threats, developing appropriate safety and treatment plans, and generally enhancing the focus on child safety throughout the life of a case. They also felt that the tool minimizes the subjectiveness of the decision to remove a child from his or her home. Some participants also noted that the quality of safety plans has improved, although others indicated that boilerplate language was still used in many of the safety plans.

There were some concerns about the new in-home safety assessment, particularly among DHS staff. Many DHS staff members felt that the new safety assessment tool requires an unnecessarily broad and complex set of information—much of it redundant—and is too focused on documenting factors that do not necessarily affect a child's safety. Some DHS staff noted that the tool often results in social workers focusing more on completing the assessment than answering the fundamental question of whether or not the child is safe. It also was noted that the implementation of the in-home safety assessment had been difficult, as it has been continually revised by Pennsylvania Department of Public Welfare (DPW), and this has created ongoing confusion, required multiple trainings, and resulted in some degree of variability in how the tool is used across DHS.

Family Group Decision Making (FGDM)

The FGDM was cited by DHS, contracted agencies, and social services agencies staff as a positive practice with significant potential for fostering greater family involvement and inter-agency collaboration in service planning. Several DHS and contracted agency staff noted that they have seen positive outcomes for some of the participating families. Many stated that the practice should be expanded and its use clarified. DHS staff, however, noted that there is varied understanding of when FGDM should be recommended—some staff have been told it is available only to new families whereas other social workers reported that their supervisors had told them that all families are required to participate.

Nursing Unit

There was general consensus that creating the Nursing Unit within DHS was an important and positive development for ensuring the safety and well-being of medically vulnerable children. The Nursing Unit also has been critical to the development of appropriate service plans to meet the needs of these children. There was a belief that much has been done to enhance the understanding of medical child abuse and neglect, but a gap still remains in understanding how medical language relates to the language of child abuse and neglect. It was also recommended that additional nurses be hired to provide consultation to Hotline and Intake staff in cases involving allegations of medical abuse and neglect.

Continuum of Services

DHS has made a more conscious effort to create a broader continuum of care to serve children and families. The Alternative Response Services (ARS) was repeatedly mentioned as a program to help children in families where there was not an imminent safety threat, but there was still a need for services. Participants also mentioned HIV prevention services for children who are born drug-exposed, an increase in services for victims of domestic violence, and greater support for parents available through enhanced parenting classes and counseling.

Communication and Transparency

Many members of the focus groups, particularly participants in the community focus groups observed that DHS had become a more open Agency at the administrative level, with more emphasis on communicating and coordinating with their service partners. Many individuals noted that DHS had made a concerted effort during early reform efforts to reach out and obtain community input through town hall meetings. In particular, the DHS Commissioner was praised for her efforts to enhance communication and collaboration with a number of community partners, notably the Family Court and members of the medical community. Focus group members also felt that these efforts had gone a long way toward increasing the transparency of DHS.

Opportunities for Further Improvement

The changes brought about by the reform efforts had not been without challenges for both Social work services managers and professionals from community agencies that work with children and families involved with DHS. While the focus group participants identified many improvements, they also observed that additional work remained to fully incorporate the reforms into daily practice and further increase the safety, permanency, and well-being of the children served by DHS. Some of the themes that were heard across multiple focus groups are discussed below.

Clarification of Roles and Responsibilities

Most participants in the DHS and contracted agency focus groups stated that DHS had not adequately addressed the CWRP recommendation to clarify their roles and responsibilities. There was a general sense that the roles were no clearer than before the reforms began. Similarly, participants did not indicate any increased efforts to enhance collaboration between DHS and contracted agencies.

Although both DHS and community agency staff members expressed support for the new assessment and service planning processes, they also believed that these programs are not being implemented optimally due to lack of clarity in roles and responsibilities. Participants stated that team decision making, communication between workers regarding cases, and collaboration on service planning and implementation are not occurring nearly enough to fully realize the benefits of the reforms.

The lack of coordination and clarity among DHS and contracted agency staff was also evident to members of some community organizations. Participants in the legal focus group felt that there was often a poor exchange of information between DHS and contracted agencies and, in some cases, lack of a coordinated service planning effort for the child and family. Participants in the Court focus group noted that judges often receive conflicting information from Social work services managers and contracted agency social workers on the same case.

Practice Standards

A common theme from DHS and community focus group participants was that DHS has not consistently applied standards for casework and practice. Participants noted that requirements and directions for completing forms often varied from unit to unit, and sometimes varied within a unit. The Safety Assessment Tool was the most common example, with DHS staff indicating that

they repeatedly received different, sometimes conflicting instructions on how it should be completed. Other examples of where varied interpretations of standards practice exist included FGDM, HGDM, and protocols for interacting with contracted agencies.

Some DHS staff members and managers, and to a lesser extent the community participants, attributed the lack of consistency both to the magnitude of the changes and the speed with which they are being implemented. Because of the constantly changing environment, rapid introduction of new programs, and ongoing modification of existing programs, staff reported that they simply have a hard time keeping current with the most up-to-date requirements and DHS policies.

Communication

While many focus group members observed that DHS was more communicative and transparent than it was three years ago, several participants suggested that DHS make a concerted effort to improve its communication with partners, staff, and the community. Some noted that DHS leadership did an admirable job with regard to soliciting input from the community through activities such as the town hall meetings. However, participants stated that more efforts should be made to provide information to the community, including the way in which community input has been addressed.

Many focus group participants also indicated that there is still a need for enhanced communication at the supervisory and social worker levels. They recommended that DHS increase its efforts to communicate with direct service staff and provide a structured mechanism for social workers and supervisors to provide input for ongoing and future changes.

Case Documentation

There was a general consensus that paperwork has increased as the result of the reforms. Specific comments noted that there was a redundancy of forms, a lack of relevancy of some forms for certain cases, and an insufficient amount of automated support to assist with completing required paperwork. While these comments were heard primarily from DHS social work staff, social workers from contracted agencies had similar views, indicating that the paperwork they must complete for DHS had increased during the last few years.

Organizational Culture and Staff Morale

While DHS staff understood the need for change and supported the reform efforts, it was clear that the scale and rapidity of the changes has affected DHS' organization culture and impacted staff morale. In virtually every focus group, participants recognized the impact of the Danieal Kelly case on the programs, operations, and staff of DHS. Social workers, supervisors, and more senior-level managers expressed concern about being held personally responsible for any future incident related to a child's safety while in the DHS' care. They indicated that the organizational culture has become one of self-protection, increased documentation, and justification of casework practice. In turn, this has negatively impacted services, largely by decreasing the amount of time social work staff have to spend with children and families and to work with service partners to coordinate services.

In addition to the shift in the organizational culture at DHS, many staff members also reported feeling overwhelmed by the speed at which the reforms of the last three years have been

implemented. Some cited examples such as the implementation of the safety assessment, which has been revised repeatedly and resulted in confusion and frustration. Participants in the community focus groups also felt that DHS' workers are overwhelmed by the overall magnitude of changes.

Several DHS staff members also spoke about how the negative public perception of DHS has impacted staff morale. They feel the public only hears about the relatively few tragedies that occur and does not see the high rate of success DHS has with protecting children and reunifying them with their families. Several staff members voiced disappointment that DHS leadership has not been more vocal in defending the agency publicly.

SECTOR-SPECIFIC FINDINGS

The major input provided to the COB in each of the focus groups—medical community, legal/advocacy community, Family Court, social services agencies, DHS contracted agencies, DHS Hotline, DHS Intake (Investigation/ Assessment), DHS Ongoing Service Regions, and DHS Management—is provided in the following sections.

Medical Community

An overarching theme from the medical focus group was that the investigation process had significantly improved. Many participants stated that, once the referrals were accepted, DHS staff commenced the investigations more quickly, arrived at the hospital faster, spent more time with the child and family, and were generally more communicative and responsive to input from physicians. Participants also noted DHS' improved ability to work with the physicians, nurses, hospitals, and to more effectively integrate medically relevant information into the investigation process. However, there was concern that once a case is accepted for service, social workers in ongoing units do not always continue the open dialog with the appropriate community medical personnel.

The medical focus groups also commended DHS for the establishment of the Nursing Unit within DHS. There was general consensus that the creation of the Nursing Unit had been both a critical and positive development for ensuring the safety and well-being of children in cases involving medical abuse and neglect, and medically fragile children. Positive and systemic changes in the area of HIV prevention for children who are born drug-exposed also were noted.

Physicians expressed a general concern regarding the handling of cases reported to the Hotline. Some participants stated that there was a higher threshold for intervention in medical cases reported for suspected child abuse and neglect than in the past. Participants also indicated that there was a lack of clarity about how Hotline staff was making determinations regarding child safety and when cases required further investigation. It was recommended that DHS provide training for the medical community regarding the requirements for determining a finding of abuse and neglect.

While the medical group mentioned that communication had improved in regard to investigations, many participants observed that, once the case was accepted for service, there was still a need for greater ongoing communication between DHS and the medical community, in

order to continually monitor the child's improvement and progress. Some participants recommended that DHS examine whether the hospital social workers could be used to help bridge the communication gap between the physicians and DHS and contracted agency social workers providing ongoing services. Some participants also felt that while DHS has done a commendable job of communicating with hospitals, there was still room for improvement with regard to communicating with the broader medical community.

Finally, many of the medical focus group participants expressed confusion over the new requirements for certifying cases as "near fatalities." Collectively, participants felt that DHS needed to work with a group of physicians to define the standards more clearly.

Legal/Advocacy Community

Participants in the legal/advocacy focus group observed that DHS leadership had set a tone of accountability, transparency, and collaboration. They felt that DHS' current leadership understood the value of creating a culture of accountability, was receptive to input from outside stakeholders, and invited constructive criticism and ideas for improvement. However, participants were concerned that there is not the same universal level of commitment to the reform efforts among supervisors and social workers as there is at the executive levels of DHS.

The legal/advocacy focus group overwhelmingly indicated that the DHS reforms of the last three years had led to increased child safety and to improved fairness in the decision-making process for families. In particular, the implementation of the new in-home safety assessment tool was identified as an important reform effort for both children and families. The group felt that the new tool had improved social workers' ability to more effectively identify the significant issues related to child safety. The group also thought that the development of a written safety plan was an important change in practice, as it provided clarity about the expectations of the family and others to ensure continued child safety.

However, participants expressed concern about the safety and risk assessment process at the Hotline. They noted that there seemed to be a higher standard being used by the Hotline than previously for accepting cases for investigation or assessment. The group recommended that DHS review screened-out cases to determine whether there is any correlation between Hotline decision making and subsequent harm to the children in screened-out cases.

The legal/advocacy focus group identified the Commissioner's Action Response Office (CARO) as an important development. Participants agreed that CARO provided an important avenue for identifying issues and ensuring that they are addressed. Participants agreed that when complaints were reported to CARO they were investigated and plans were developed for addressing the complaint.

Although the group indicated that DHS had become more transparent and accountable, there was still room for improvement. Participants suggested that DHS use its website to more effectively distribute basic information. They suggested that the website include DHS policy and procedures, information about services available for children and parents, and organizational and contact information. The group also recommended that DHS publicize more statistical

information, including performance indicators, so that the Department is more accountable to the public.

The legal/advocacy focus group had mixed perceptions regarding improvement in court-related practice. There was a general sense that DHS had improved its efforts to collaborate with attorneys prior to court hearings, but that there was still a need for greater communication between the parties. Participants also reported a greater DHS presence at court hearings, though they felt that social workers were not always adequately prepared.

Many participants in the legal/advocacy focus group expressed concern about DHS and contracted agency social worker practice. Some of the specific practice-related concerns included high rate of staff turnover; lack of clarity in roles and responsibilities; variation in the implementation of the safety assessment tool; need for enhanced supervisory support for DHS social workers; and the lack of involvement of lawyers and other members of the legal community in family-service planning and the decision-making process.

Family Court

The judges of the Family Court stated that the relationship between the Court and DHS had improved significantly over the last 3 years, stating that the relationship has become more positive and collaborative. The group indicated that the animosity that had previously existed between DHS and the Courts had been eliminated, largely due to the efforts of the DHS Commissioner to meet with each of the judges, listen to their opinions, and address issues of mutual concern.

Participants noted that DHS was clearly focusing on improving child safety and moving towards a more professional and evidence-based model of practice. The judges stated that Social work services managers were more prepared for court hearings and proceedings, investigations were being completed in a timelier manner, and more effort was being made to ensure comprehensive family-based planning.

While the court focus group members indicated that the quality of practice had improved overall, they made several suggestions for improvement:

- DHS should enhance its technology to provide social workers with more sophisticated tools and better access to data, and should reduce the amount of time required to complete paperwork. Further, DHS and the Court must find a way to share data.
- Social workers and lawyers should be more prepared for scheduled proceedings so that court continuances can be reduced.
- Greater clarity in the roles and responsibilities of DHS and contracted agency social workers is needed to avoid conflicting information being presented in Court.
- More information on visitation must be provided to the Court.
- Social workers need training on what documents to submit for various types of hearings, (e.g., safety assessment, Family Service Plans, progress reports, etc.).

The judges thought that, to improve the working relationship between DHS and the Court, it would be helpful for DHS to provide training on the Children and Youth Division (CYD) *Policy Manual* and also on the roles and responsibilities of DHS and contracted agency social workers. It also was suggested that the *Policy Manual* be posted on the DHS website as part of DHS' effort to be a more transparent Agency.

Members of the Family Court focus group did not think that there had been an expansion of services since the reforms began. They expressed concern that there were limited services for families with truancy or mental health issues. Preventive services were not always available which could result in delayed permanency for children in placement. They mentioned that DHS should look at ways to expand services to these types of families.

Social Services Agencies

Two focus groups were held with staff from social services agencies. The first focus group was with agencies that provide prevention services. The second group was with agencies that provide intervention and support services.

Both focus groups indicated that DHS had improved the care of children and families by expanding the array of available services and creating a more appropriate and holistic continuum of care. The participants specifically noted an increase in services for victims of domestic violence, greater support for parents available through enhanced parenting classes and counseling, and an increase in the availability of prevention programs such as ARS.

A second common theme was that investigations took place much more quickly than in the past. The group mentioned that this was particularly true for populations that are highly at risk, such as infants, children younger than 5 years of age, and children who are the subject of allegations of severe physical and sexual abuse. Most of the participants expressed that this change was directly attributable to the CWRP recommendations related to serving younger children.

Social service agency focus group participants expressed concern about the lack of communication between DHS staff and contracted agency staff. The most common comment was that social work services managers often fail to communicate with the contracted service agency social worker prior to a court proceeding. This had resulted in mixed messages to the Court about what was best for the child. Additional examples of the lack of communication included social work services managers who left contracted agency caseworkers out of team-based decision-making meetings and who generally failed to provide relevant case updates. It was noted repeatedly, however, that the quality of communication was dependent upon the specific DHS social worker.

Focus group participants also expressed concern regarding the cases that were accepted for investigation by the Hotline. Many participants identified difficulties in getting the Hotline to accept a referral for investigation. This was particularly true for reports in which the subject was a teenage child. Many individuals recommended that DHS consider reviewing their current policies and procedures related to screened-in and screened-out cases.

Participants also suggested that DHS work with the community to garner support for reforms and to engage the community as a partner. The groups indicated that the community viewed DHS in a negative light, despite the fact that the Department had done a great deal to ensure the safety and well-being of Philadelphia's children. There was a sense that the DHS information flow was all one way, which, in turn, contributed to the general sense that DHS was not a transparent agency. Suggestions for increasing DHS' community involvement included reinstating the town hall meetings and having targeted focus groups with community representation on a regular basis.

DHS Contracted Agencies

Two focus groups were held with staff from agencies that contract with DHS to provide direct services to children. The first focus group was with representatives of agencies that provide in-home services. The second was with representatives of agencies that provide placement services.

Many participants felt that the direction of reforms had been positive and had great potential for improving collaboration between DHS and its contracted agencies. Participants expressed support for many of the practice reforms, including the implementation of the new safety assessment model, enhanced family-based service planning, and the implementation of team-based decision making. Participants also mentioned the In-Home Protective Services (IHPS) program as one with great potential to improve safety and allow children to remain at home. Participants also indicated that the greater availability of emergency funds through DHS was a positive resource for helping families.

The focus groups with contracted agency staff also revealed that there was high regard for the specialized units DHS had created in the last several years. The new Nursing Unit was cited as being particularly effective in getting children's medical needs addressed. Participants also related positive experiences in working with DHS staff members in the specialized units, including the Sex Abuse Unit and the Court-truancy Unit.

Communication and coordination of service delivery between DHS and contracted agencies was cited as a concern by members of the contracted agency focus groups. Most participants reported that they were not well informed of the DHS reforms and, as a result, they did not always have a sufficient understanding of current programs, policies, and procedures.

Also of concern to the participants in the contracted agency focus groups was the lack of role clarity for DHS and contracted agency social workers. Participants expressed significant confusion over who was responsible for specific activities (e.g., transportation, visits.) and how DHS and contracted agency staff should collaborate in decision making. There was a general sense that the roles between contracted agency social workers and social work services managers were no clearer than prior to the reforms. Contracted agency staff also observed that social work services managers did not understand the division of roles and responsibilities and that they often were not knowledgeable about what was in each agency's contract.

The contracted agency participants raised concerns about the increased documentation requirements. Although the participants understood the need for enhanced accountability, many expressed frustration with the way they were implemented. Some felt that the tool used to

measure contracted agency performance was unrealistic in that it focused on processes and not quality of service or the ultimate outcomes for children and families. Some also felt that the associated documentation was unnecessary and reduced the time social workers had available for providing direct services. Others simply stated that they felt standards for contracted agency workers were higher than those for DHS social workers.

Although participants agreed that the philosophy behind the safety model and the specific tools for safety assessments and safety plans had merit, many believed that there were significant implementation issues and that Social work services managers needed additional training. Participants thought that the safety assessment and plans were developed to standardize assessments and decisions, but they did not think this was occurring. Participants also expressed concern that safety plans were often boilerplate text, rather than individualized plans targeted for the specific situation.

Placement agency participants also indicated that they believe that they are getting many more inappropriate placements, including many children who require residential treatment facilities and children who require intensive medical services. Participants suggested that better assessments of the required level of care are needed for children in placement. They believe that, in the interest of keeping children in the city and reducing the cost of care, DHS sometimes does not realistically assess the level of services needed. Participants said they have a sense that DHS staff is manipulating the level of care assessment to avoid residential services. There also was a comment that Social work services managers sometimes use the emergency placement process to make an inappropriate placement and then continue to renew the emergency status to maintain the placement. Participants indicated that they have concerns that some of these children do not receive the services they need and that their placements are sometimes detrimental to other children in the placement setting.

When asked for suggestions for improvement, participants gave a number of ideas that they believed would improve services and enhance the coordination between DHS and the contracted agencies:

- Enhance training for DHS staff, especially in regard to safety plans and level-of-care assessments;
- Include contracted social workers in the on-the-job training at DHS so that everyone hears the same guidance;
- Develop an overall plan for where the Department is trying to go and then adhere to it so that everyone is on the same page; and
- Enhance services for specialized populations including increased mental health services in the community and the development of a psychological services unit within DHS.

DHS Hotline

Two focus groups were held with DHS Hotline staff. One focus group was with Hotline social workers and a second was with Hotline supervisors.

Participants in both social worker and supervisor focus groups stated that the new Hotline Guided Decision Making (HGDM) model is effective. It has increased the amount of information Hotline staff obtain and use for screening reports. It also provides clearer guidance for determining which calls to screen in or screen out. The tool also assists Hotline staff in more effectively documenting the reasons for their decisions. Staff also reported that, while the new tool has more questions, it has resulted in a more expeditious screening process.

Participants raised two primary concerns about the implementation of HGDM. These included inconsistent guidance from supervisors as well as the amount of negative reactions from the community regarding the new Hotline processes and decisions. Participants indicated that there is inconsistency among the supervisors and administrators in how they believe the HGDM tool should be used. Hotline staff noted that there are often reversals in the screen in/screen out decisions they make and that different supervisors seem to have different standards for accepting a case. Hotline staff noted that there are major differences from shift to shift and even across the Hotline floors in how decisions are made.

Participants also recognized that community members, particularly mandated reporters, had not been informed about the changes in the way the Hotline staff took calls and made decisions about accepting or rejecting reports of abuse and neglect. As a result, there is often a great deal of frustration on the part of reporters and Hotline staff spends significant time educating the callers. Hotline staff indicated that they believed that in some cases callers may be embellishing the facts of the case in order to increase the potential that the report is opened for investigation. The participants felt that further education of community stakeholders is needed.

Hotline staff members reported positive changes in other DHS practices. All participants were supportive of the general policy of responding within 2 hours for children age 5 and younger (Expedited Response). Many participants also stated that the new Alternative Response Services (ARS) unit enabled DHS to provide needed services to cases where extreme safety concerns did not exist. Most participants also mentioned that the new FACTS2 system was a more user-friendly information system than FACTS. FACTS2 was a valuable tool that they used in their day-to-day work. However, FACTS2 does not contain the historical information about families served previously by DHS. Hotline staff recommended that this information be brought into the new system to avoid their having to query two separate databases.

Generally, participants in the DHS Hotline focus groups felt that morale was very low and attributed this to a number of factors. Many stated that the negative press DHS has received and hostile interactions with community members have impacted morale. Others noted that the rapid and frequent implementation of changes has caused frustration, confusion, and the need for excessive training that detracts from actual social work. In addition, most participants feel that they are not being recognized for the overall quality of their day-to-day work.

DHS Intake (Investigations/Assessment)

Two focus groups were held with DHS Intake staff. One focus group was with Intake staff and a second was with Intake supervisors. It was clear in both the social worker and supervisory focus groups that the Intake are strongly committed both to their jobs and their clients. Many of the participants indicated that the job was extremely challenging, but very rewarding.

Intake staff reported favorably on many of the practice reforms as having the ability to significantly improve child safety, but the benefits have yet to be fully realized. In particular, they indicated that implementation of the new safety assessment tool has been difficult due to the continual changes in the tool and the ongoing need for re-training and clarification. Many participants in this focus group also felt that the tool was too long; that some of the information required was unrelated to safety concerns; and that the time required to complete the assessment sometimes redirects focus away from the fundamental question of whether children are safe. In addition, some workers noted that there is variation with how the safety assessment is administered within DHS units, and this has led to confusion about the use of the tool.

Focus group participants indicated that there has been a decrease in the overall morale of the DHS workforce. Some indicated that the increase in case documentation requirements has impacted morale. Many participants stated that case documentation requirements are so substantial that they are impacting the ability of social workers and supervisors to effectively perform their jobs. Further, some participants felt that the increase in documentation requirements does not necessarily correlate with improving service delivery, but is merely in place to document what actions have been taken. Other factors identified as contributing to decreased morale included increasing caseloads, lack of adequate training, and lack of support from supervisors and executive-level DHS staff.

DHS Ongoing Service Regions Social Work Services Managers

Two focus groups with DHS Ongoing Service Regions (OSR) staff were held. One focus group was with OSR social work services managers and the second was with OSR supervisors.

OSR participants in the focus groups were overwhelming positive about the rewards that working at DHS can sometimes bring. Many individuals spoke about the rewards of being a positive and helpful force in the lives of their clients. Several of the supervisors noted that they enjoyed watching younger staff grow into their roles as social workers, and took great pride in helping social workers develop and improve their social work skills.

One of the most significant concerns raised both by social work services managers and supervisors was the lack of appropriate communication between DHS management, its staff, and stakeholders and partners. Participants observed that this lack of communication had resulted in reduced service quality. DHS staff indicated that information from the fatality reviews was not disseminated and social workers were not always provided with DHS-wide information on outcomes. As a result, some participants felt that this limited the opportunities to identify best practices and incorporate them into future casework.

Clarity regarding the respective roles and responsibilities of DHS and contracted agency social workers was reported as an issue. Focus group participants did not always understand what

services contracted agencies were required to provide and, as a result, they were not always able to monitor performance. Participants stated that there was a pressing need for DHS to clarify these roles and responsibilities so that services to families and children could be more effectively coordinated. Many felt that the lack of understanding about roles and responsibilities is jeopardizing the ability of DHS and contracted workers to collaborate on common activities such as case planning, court appearances, and family meetings.

As with many other DHS focus groups, the OSR social work services managers repeatedly cited a lack of consistency in casework standards and practices. Focus group members mentioned that DHS did not enforce universal standards for some practices, with the new in-home safety assessment and FGDM program cited as examples. Finally, both social workers and supervisors indicated that there was lack of consistency and standards for completing paperwork.

Participants also indicated that there had been a significant increase in case documentation requirements which had impacted the social workers' ability to provide service and supervisors' ability to adequately supervise and provide support to social workers. OSR social workers felt that paperwork had increased, that it was not always relevant for certain cases, that it was often redundant (i.e., multiple forms requiring the same information), and that it reduced the time that social workers had to spend with families. Supervisors commented that they were required to document all interactions with workers, and this has led to a reduced ability to truly mentor staff and help them develop their social work skills.

OSR staff also expressed concern about decreased staff morale. They indicated that morale had been negatively impacted by the rapid and frequent implementation of changes, the inconsistency in guidance about the new procedures, and a sense they were not fully recognized for their efforts. Many of the social workers stated that DHS is too strongly focused on documenting every case action. They also indicated that they feel that managers are more interested in finding mistakes than in identifying successes. Some participants also indicated that they believe that supervisors, DHS executive staff, and external oversight entities are not interested in their opinions or ideas for improvement. Lastly, many participants expressed their disappointment that DHS management has not been supportive of the social work staff and has not made public comments about all of the excellent work that is being done by DHS.

DHS Management

The DHS management staff who participated in the focus group expressed that many of the reforms implemented within the last 3 years had been positive. The group thought that DHS has made significant progress in many areas, such as increasing the clarity of DHS' mission, improving child safety with the new safety assessment model, increasing the quality and timeliness of the decision-making process through programs like FGDM, and expanding the continuum of services available through programs such as IHPS and ARS. As well, the group felt that DHS is moving toward a more analytical approach to program evaluation and using data to understand what services are effective and where improvements need to be made. Overall, the managers observed that DHS had come a long way in aligning its mission, programs, and focus with the overarching objectives of child safety, permanency, and well-being.

The management group indicated that, while the overall reform effort had been very positive, the number and complexity of changes implemented in such a short time had been problematic for some staff members and for DHS as a whole. They thought that the volume of reforms in the last 3 years had created some confusion and frustration during the implementation process. Frustration also had been caused by the implementation of some changes in a piecemeal fashion. As an example, because DPW made continual revisions to the in-home safety assessment, many staff received training each time. In general, it was felt that going through multiple iterations of an important process can result in confusion at all levels of the organization.

Similarly, while the reforms were seen as mostly positive, some participants said that it will take time for the new processes and programs to be fully assimilated throughout DHS. Virtually all managers acknowledged that the reforms represented significant changes to DHS practices, and will need to be refined over time. It was noted that ongoing monitoring and refinement was necessary, but that this fact may not be understood by stakeholders outside of DHS.

Participants in the DHS management focus group also expressed some of the same concerns regarding staff morale that were expressed in the other DHS focus groups. The DHS managers acknowledged that staff were having a difficult time adjusting to all of the changes and the intense scrutiny that the agency has been under for the last 3 years. This has had a significant impact on staff morale throughout the organization.

Finally, management participants expressed concern that the members of the community, including professionals that work with DHS, did not understand the reforms implemented by DHS and, specifically, that DHS was now more focused on children at risk. As a result, many of these community members did not understand that DHS had changed its standards and practices for accepting cases.

FOCUS GROUP CONCLUSIONS AND NEXT STEPS

DHS has embarked on a major reform effort and has worked diligently to address the recommendations developed by the CWRP. By its very nature, a major reform effort creates both positive and negative reactions and leads to an amount of upheaval as major changes are implemented. To some extent, the focus groups reflected common reactions to a system in the midst of major change. However, the focus groups provide a valuable point-in-time assessment of how the reforms are currently perceived by DHS staff and community professionals who are directly touched by the reform effort.

The COB gained important information from the DHS and community focus groups. It was clear from the focus groups that both DHS staff and community stakeholders believed that DHS had made significant progress, not only in implementing the CWRP recommendations, but in improving the quality, timeliness, and responsiveness of DHS social work practice.

It was clear that it is believed that child safety has been enhanced as a result of the implementation of a number of key programs recommended by the CWRP, including Expedited Response, the new safety assessment, HGDM, and FGDM. Representatives from the City of

Philadelphia's child welfare community who participated in the focus groups had seen many improvements in DHS practice.

It also was clear that there was still progress to be made. Areas in which DHS has room for improvement include consistently applying the new policies across the Department clarifying roles and responsibilities for DHS and contracted agency staff, and implementing new tools to reduce the administrative burden on staff. DHS must also address the issue of staff morale. In each of the DHS focus groups, staff morale was cited as a key concern.

Apart from practice-related concerns, it was clear that DHS had improved its ability to communicate and collaborate with other actors in the Philadelphia child welfare community. At the same time, there was still a need for DHS to continue its interactions with community groups to ensure that information flows in both directions, and that detailed information on new programs, policies, and procedures is communicated to community members that have a need for the information.

Based on the information obtained from the focus groups, the COB recommends that DHS create an overall plan for completing the reform efforts and sustaining the resulting changes in practice. DHS should then communicate this plan to, and implement it with, DHS staff, the community agency partners, and the public.

APPENDICES

APPENDIX A. DHS STATUS REPORT: IMPLEMENTATION OF CHILD WELFARE REVIEW PANEL RECOMMENDATIONS

The information presented in the following table was provided by DHS in its November 2010 status report to the COB. Minor editorial changes have been made for consistency with the rest of this report. The information presented in the “*Status, January 2010*” column was obtained from the COB’s February 2010 *Report on Progress*, Appendix A.

Recommendation Text	Time Frame	Status, January 2010	Status, November 2010	November 2010 Update, as Reported by DHS
Phase 1—Mission and Values				
Recommendation 1.a. (Page iv) DHS must develop a mission statement and core values that are centered on child safety.	Recommended by panel: December 31, 2007	Completed	Completed	Recommendation completed; no additional update required by COB.
Recommendation 1.b. (Page iv) DHS core values must embody, at a minimum, the following principles: <ul style="list-style-type: none"> i. Creating a culture of respect, compassion and professionalism; ii. Enhancing communication with, and responsiveness to, stakeholders; iii. Instilling a greater sense of urgency among DHS staff and providers; iv. Providing services that are readily accessible; v. Fostering a culture of 	Recommended by panel: December 31, 2007	Completed	Completed	Recommendation completed; no additional update required by COB.

Recommendation Text	Time Frame	Status, January 2010	Status, November 2010	November 2010 Update, as Reported by DHS
collaboration; vi. Providing culturally competent services; and vii. Creating a transparent agency.				
Phase 1—Practice				
Recommendation 2.a.i. (Page iv) DHS must implement an adequate evidence-based safety assessment tool	Recommended by Panel: June 30, 2007	In-home tool: Completed Placement tool: In progress	In-home tool: Completed Placement tool: In progress	See Section 2—Areas of Focus .
Recommendation 2.a.ii. (Page iv) DHS must conduct a safety assessment for every child within its care—both children at home and children in out-of-home placements. The safety assessment must be updated at each contact with the child.	Recommended by Panel: September 30, 2007	In home safety visits: Completed and Ongoing Placement safety visits: Completed and Ongoing	In home safety visits: Completed Placement safety visits: Completed	See Section 2—Areas of Focus .
Recommendation 2.b.i. (Page iv) DHS must conduct immediate (within 2 hours) face-to-face visits for every child 5 years of age or younger for whom a report of suspected abuse or neglect is received by the Hotline. This face-to-face contact must be made regardless of whether the Hotline	Recommended by Panel: June 30, 2007	Completed	Completed	Recommendation completed; no additional update required by COB.

Recommendation Text	Time Frame	Status, January 2010	Status, November 2010	November 2010 Update, as Reported by DHS
classifies the case as General Protective Services (GPS) or Child Protective Services (CPS).				
<p>Recommendation 2.b.ii. (Page v)</p> <p>DHS staff must—on at least a monthly basis—conduct face-to-face contacts with all families receiving any service supported through the Children and Youth Division (CYD) that have a child 5 years of age or younger and physically observe the condition, safety and behavior of any such child, as well as parental capacity.</p>	<p>Recommended by Panel: June 30, 2007</p>	<p>Completed and Ongoing</p>	<p>Completed</p>	<p>See Section 2—Areas of Focus.</p>
<p>Recommendation 2.c. (Page v)</p> <p>DHS must establish a local office presence in a least one geographic location deemed highly at risk.</p>	<p>Recommended by Panel: May 31, 2008</p>	<p>In planning</p>	<p>In progress</p>	<p>See Section 2—Areas of Focus.</p>
<p>Recommendation 2.d. (Page v)</p> <p>DHS must implement a team decision making process to determine service plans for all children 5 years of age or younger. A pre-placement conference must be held for all non-emergency cases where a child 5 years of age</p>	<p>Recommended by Panel: August 31, 2007</p>	<p>In progress</p>	<p>In progress</p>	<p>See Section 2—Areas of Focus.</p>

Recommendation Text	Time Frame	Status, January 2010	Status, November 2010	November 2010 Update, as Reported by DHS
<p>or younger may need to be placed into a substitute care setting. The pre-placement conference must include the child's family, including potential kinship placement resources; the DHS worker; the provider agency worker (where applicable); a physician or nurse; and individuals representing mental health, substance abuse, and domestic violence services, as needed, who have the authority to commit resources of their respective agencies; and individuals requested by the family representing their social support network. When feasible, the supervisors of both the DHS and provider agency workers should participate in the team decision making conference. The initial Family Service Plan (FSP) must be developed during this process.</p>				
<p>Recommendation 2.e. (Page v)</p> <p>DHS must ensure that ongoing team case conferencing occurs routinely every three months, for cases involving children age 5 years or younger, after the initial pre-placement conference, and the child's family, the DHS worker, the provider agency worker, and other interdisciplinary resources must be included as appropriate. Monitoring</p>	<p>Recommended by Panel: November 30, 2007</p>	<p>FGDM Implementation —Completed and Ongoing</p>	<p>Completed</p>	<p>See Section 2—Areas of Focus.</p>

Recommendation Text	Time Frame	Status, January 2010	Status, November 2010	November 2010 Update, as Reported by DHS
<p>of service provided, progress, and revisions to the FSP must be made as part of this process.</p> <p>Please note: the FGDM Model does not include case conferencing every three months for children age 5 years or younger. The case progress is reviewed within 90 days, but does not necessarily result in a group meeting.</p>				
<p>Recommendation 2.f. (Page v)</p> <p>DHS must clarify the roles and responsibilities for DHS workers relative to private agency workers, at both the supervisory and worker level.</p>	<p>Recommended by Panel: November 30, 2007</p>	<p>In progress</p>	<p>In progress</p>	<p>See Section 2—Areas of Focus.</p>
Phase 1 – Outcomes and Accountability				
<p>Recommendation 3.a.i. (Page vi)</p> <p>DHS must develop an annual report card that measures and communicates its performance on outcomes of interest, including, at a minimum, those outcomes specified in Chapter 4 of the Report.</p>	<p>Recommended by Panel: Strategy developed by November 30, 2007 and report card delivered by May 31, 2008</p>	<p>In progress</p>	<p>Completed</p>	<p>DHS completed report cards for Performance Based Contracting (PBC) of General Foster Care Providers and Treatment Foster Care (TFC) Providers. The reports are posted on the PMA webpage at DHS Central (intranet) under PREP. The second report card for PBC providers and the first for In-Home Protective Services (IHPS) are in development.</p> <p>PMA is developing protocols for an internal report card linked to the ChildStat process. In January 2011, DHS will present a 2-year summary of ChildStat performance measures.</p>

Recommendation Text	Time Frame	Status, January 2010	Status, November 2010	November 2010 Update, as Reported by DHS
				PMA also will develop a report card that links internal and external performance once the Electronic Case Management system is rolled out and the data from both sides are in place.
<p>Recommendation 3.a.ii. (Page vi)</p> <p>DHS must develop a comprehensive strategy for internal monitoring of its performance. DHS must be able to monitor the performance of regions, units and workers, and must use performance information to identify weaknesses and areas for improvement.</p>	<p>Recommended by Panel: Strategy developed by November 30, 2007 and Tracking to begin May 31, 2008</p>	<p>Completed</p>	<p>Completed</p>	<p>Recommendation completed; no additional update required by COB.</p>
<p>Recommendations 3.b. (Page vi)</p> <p>DHS must enhance oversight of contracted agencies.</p>	<p>Recommended by Panel: No overall time frame given</p>	<p>Completed and Ongoing</p>	<p>Completed and Ongoing</p>	<p>PMA recently completed an overhaul of evaluation protocols under its PREP unit. All evaluation tools were streamlined and contract standards updated to ensure that providers are evaluated according to current standards and that the evaluation tool reflects provider practice. DHS is also in the process of converting all evaluation tools to a web-based system so that program analysts can quickly and efficiently document evaluation outcomes while still onsite, ensuring that both DHS and provider agencies are in agreement on those outcomes. DHS plans to implement the new evaluation process in</p>

Recommendation Text	Time Frame	Status, January 2010	Status, November 2010	November 2010 Update, as Reported by DHS
				January-February 2011 when the web-based system is completed.
<p>Recommendation 3.b.i. (Page vi)</p> <p>DHS must create an annual outcome report card for contracted agencies. At a minimum, the report card will focus on measures of child safety, which are detailed in Chapter 4 of the Report.</p>	<p>Recommended by Panel: May 31, 2008</p>	<p>In progress (draft completed)</p>	<p>Completed</p>	<p>Annual Provider Report Card—completed and ongoing—please see response to recommendation 3.a.1 above.</p>
<p>Recommendation 3.b.ii (Page vi)</p> <p>DHS must validate that contracted agencies are making face-to-face contact with children, that they are performing safety assessments at each contact, and that the contacts</p>	<p>Recommended by Panel: June 30, 2007</p>	<p>Completed and Ongoing</p>	<p>Completed</p>	<p>See Section 2—Areas of Focus.</p>

Recommendation Text	Time Frame	Status, January 2010	Status, November 2010	November 2010 Update, as Reported by DHS
are sufficiently frequent and adequate to determine the safety of the child.				
<p>Recommendation 3.c. (Page vi)</p> <p>DHS must establish Commissioner's Action Line (CAL).</p>	<p>Recommended by Panel: August 31, 2007</p>	<p>Completed</p>	<p>Completed</p>	<p>Recommendation completed; no additional update required by COB.</p>
<p>Phase 1 – Leadership and Infrastructure</p>				
<p>Recommendation 4.a. (Page vi)</p> <p>DHS must establish a mechanism and process to establish ongoing community oversight. At a minimum, the City must establish a Community Oversight Board.</p>	<p>Recommended by Panel: The Board must be appointed no later than June 30, 2007</p>	<p>Completed</p>	<p>Completed</p>	<p>Recommendation completed; no additional update required by COB.</p>
<p>Recommendation 4.b. (Page vii)</p> <p>DHS must ensure ongoing community participation and input into the improvements undertaken by DHS. This participation shall include, at a minimum, a series of ongoing town hall meetings, focus groups, and other events that facilitate the input of community members, private provider agencies, parents, clients, and other stakeholders.</p>	<p>Recommended by Panel: Plan of action must be in place by July 31, 2007</p>	<p>Completed and Ongoing</p>	<p>Completed and Ongoing</p>	<p>The Commissioner began a series of stakeholder meetings this past year bringing together the DHS Executive Team with stakeholder groups in order to share information, improve collaboration, and discuss areas of mutual concern. The first of these meetings, held on December 7, 2009, at the Police Academy, was with the Philadelphia Police Commissioner and his top management team. The second stakeholder meeting, held on March 19, 2010, at the School District Administration building, was with the management team of the School District. At this meeting smaller groups were convened based on geographic location</p>

Recommendation Text	Time Frame	Status, January 2010	Status, November 2010	November 2010 Update, as Reported by DHS
				<p>of both the District's and Department's Regions. These groups have had ongoing collaboration since this stakeholder meeting. The most recent stakeholder meeting was with the faith-based community. It was held July 22, 2010, at Palmer Theological Seminary with more than 50 inter-faith clergy members. At this meeting the Commissioner asked the inter-faith group to partner with DHS by helping to recruit foster parents, adoptive parents, and mentors. The group vowed to help and agreed to another meeting with DHS staff. DHS is scheduled to convene another meeting with the School District of Philadelphia leadership team on December 10, 2010. These meetings serve to increase system awareness and collaboration.</p> <p>In addition to the town hall meetings coordinated by DHS, the Commissioner and her team have developed a number of communication initiatives to improve participation in, and input into, the improvement undertaken by DHS. These include the following meetings and activities:</p> <ul style="list-style-type: none"> • Provider Leadership Team meetings • Provider participation in the Quality Service review • Youth Advisory Board meetings • Focus groups conducted with providers and stakeholders per COB request

Recommendation Text	Time Frame	Status, January 2010	Status, November 2010	November 2010 Update, as Reported by DHS
				<ul style="list-style-type: none"> • CBPS Alignment Advisory Committee Part of the Improving Outcomes for Children initiative will require DHS to engage consumers, neighborhood residents, providers, grassroots organizations, community resources, and system stakeholders in identifying community needs in an effort to develop a system that effectively organizes resources and improves accessibility.
Phase 2 – Mission and Values				
<p>**Recommendation 1.a. (Page vii)</p> <p>DHS must align prevention programs and resources with mission and values developed in Phase One, and also with the core principle of ensuring child safety.</p>	<p>Recommended by Panel: Analysis to begin by November 30, 2007 and alignment to begin by November 30, 2008</p>	<p>In progress</p>	<p>Completed</p>	<p>A complete prevention alignment report was submitted February 2010 and presented to the COB. Highlights include</p> <ul style="list-style-type: none"> • alignment, streamlining, and repurposing of Community Based-Prevention Services (CBPS) services and contracts. • development and implementation of the Education Support Center. • transfer of housing unit and services to CBPS. • transfer of Alternative Response Services provider oversight to CBPS. • development of a Child Care Eligibility unit in CBPS to manage new requirements for childcare resources for children in CYD. • development of a Truancy Intervention plan with the School District of Philadelphia and Family Court. • development and wide-spread

Recommendation Text	Time Frame	Status, January 2010	Status, November 2010	November 2010 Update, as Reported by DHS
				distribution of a CBPS directory of services. <ul style="list-style-type: none"> streamlining CBPS' referral process through the Information Referrals and Support Services (IRSS) Unit. Focus for FY11 is the enhancement of the Truancy Intervention System and the resources supporting these interventions.
**Recommendation 1.b. (Page vii) DHS must align more effectively in-home service programs and their utilization with the mission and values of DHS and with child safety.	Recommended by Panel: Analysis to begin by July 31, 2007 and alignment and revisions to SCOH by March 31, 2008	Completed	Completed	Recommendation completed; no additional update required by COB.
Phase 2 – Practice				
**Recommendation 2.a. (Page vii) DHS must develop a comprehensive model for social work practice that is based on DHS' core mission and values; includes a stronger focus on child safety, permanency and well-being; is family-focused and community-based; and allows for individualized services.	Recommended by Panel: May 31, 2008	In progress	Completed	See Section 2—Areas of Focus.
Recommendation 2.a.i	Recommended by Panel:	In progress	Completed	See Section 2—Areas of Focus.

Recommendation Text	Time Frame	Status, January 2010	Status, November 2010	November 2010 Update, as Reported by DHS
<p>(Page viii)</p> <p>DHS must move toward an evidence-based practice model and take active steps to determine the effectiveness of its practice with an evaluation process that it open and informs good practice.</p>	<p>May 31, 2008</p>			
<p>Recommendation 2.a.ii.1 (Page viii)</p> <p>DHS must revise polices for case openings and closures—DHS must enhance the focus on team decision making to include team decision making for reviewing case closures. DHS must develop guidance for staff, and train them to work with cases where parents are uncooperative.</p>	<p>Recommended by Panel: December 31, 2008</p>	<p>Completed and Ongoing</p>	<p>Completed and Ongoing</p>	<p>The safety assessment tool continues to be the guiding force around case closure decisions.</p>
<p>Recommendation 2.a.ii.2. (Page viii)</p> <p>DHS must conduct a background check on each member in the child’s household. If an adult household member has prior involvement with DHS or a criminal record that includes convictions for a felony that suggests danger for a child, then DHS must conduct an assessment to determine whether the household is safe and appropriate for the child.</p>	<p>Recommended by Panel: December 31, 2008</p>	<p>In progress</p>	<p>In progress</p>	<p>See Section 2—Areas of Focus.</p>
<p>Recommendation 2.a.ii.3 (Page viii)</p>	<p>Recommended by Panel:</p>	<p>Completed and Ongoing</p>	<p>Completed and Ongoing</p>	<p>DHS has made the following progress:</p>

Recommendation Text	Time Frame	Status, January 2010	Status, November 2010	November 2010 Update, as Reported by DHS
<p>DHS must improve integration with physicians, nurses, and behavioral health specialists to ensure that each child's medical and behavioral health is appropriately assessed.</p>	<p>December 31, 2008</p>			<ul style="list-style-type: none"> • Hired COB Member, Cindy Christian, M.D., as its Medical Director. • Improved (ongoing) communication with the children's hospitals when a child is admitted with abusive injuries; having nurses serve as liaisons between DHS and the hospitals. • Developed policy for addressing palliative care issues for children with extraordinary medical problems. • Worked with children's hospitals and health department providers to improve communication regarding medical status during child maltreatment investigations. • Provided education for social work staff regarding medical issues confronted by dependent children (e.g., failure to thrive, cerebral palsy, HIV). • Consolidated the CAPTA unit into DHS in order to improve coordination of DHS's response to drug-exposed newborns.
<p>**Recommendation 2.a.ii.4 (Page viii)</p> <p>DHS must reexamine the risk assessment in the context of the new safety assessment and integrate it into the new team decision making model for placement and services.</p>	<p>Recommended by Panel: December 31, 2008</p>	<p>Completed and Ongoing</p>	<p>Completed and Ongoing</p>	<p>Recommendation remains completed (no additional update provided).</p>

Recommendation Text	Time Frame	Status, January 2010	Status, November 2010	November 2010 Update, as Reported by DHS										
<p>**Recommendation 2.a.ii.5 (Page ix)</p> <p>DHS must eliminate “boilerplate” referrals and ensure that each child receives appropriate referrals that are specifically tailored for his or her unique needs. DHS will follow-up and act to ensure that the services are actually obtained.</p>	<p>Recommended by Panel: December 31, 2008</p>	<p>Completed and Ongoing</p>	<p>Completed and Ongoing</p>	<p>DHS continues to strive to individualize family service planning. Below is a comparative analysis of DHS’ advancement in this area of practice. Through electronic case management, DHS intends to ensure that information is available at vital decision-making points to ensure that individualized plans are being developed.</p>  <table border="1" data-bbox="1444 902 1822 1243"> <tr> <td colspan="2" data-bbox="1444 902 1822 1000">Family Service Plan was crafted to meet the individual needs of the family.</td> </tr> <tr> <td data-bbox="1444 1000 1642 1068">In Compliance</td> <td data-bbox="1642 1000 1822 1068">52</td> </tr> <tr> <td data-bbox="1444 1068 1642 1127">Error</td> <td data-bbox="1642 1068 1822 1127">1</td> </tr> <tr> <td data-bbox="1444 1127 1642 1185">Not Applicable</td> <td data-bbox="1642 1127 1822 1185">65</td> </tr> <tr> <td data-bbox="1444 1185 1642 1243">Total</td> <td data-bbox="1642 1185 1822 1243">118</td> </tr> </table>	Family Service Plan was crafted to meet the individual needs of the family.		In Compliance	52	Error	1	Not Applicable	65	Total	118
Family Service Plan was crafted to meet the individual needs of the family.														
In Compliance	52													
Error	1													
Not Applicable	65													
Total	118													
<p>Recommendation 2.a.ii.6 (Page ix)</p> <p>DHS must complete the long-</p>	<p>Recommended by Panel: December 31, 2008</p>	<p>In planning</p>	<p>In progress</p>	<p>See Section 2—Areas of Focus.</p>										

Recommendation Text	Time Frame	Status, January 2010	Status, November 2010	November 2010 Update, as Reported by DHS
<p>planned co-location of DHS, police, medical and forensic interview personnel at a community site to facilitate collaborative decision making in the investigative phase of casework.</p>				
<p>Recommendation 2.a.iii. (Page ix)</p> <p>DHS must enhance the frequency of face-to face contacts with children of all ages.</p> <p>Since face-to face contacts are the most important actions to ensure child safety, DHS staff must conduct a minimum of one face-to-face contact per month with each child in its care. More frequent contact may be warranted depending on the specific safety and risk factors in each case.</p>	<p>Recommended by Panel: May 31, 2008</p>	<p>Completed and Ongoing</p>	<p>Completed</p>	<p>See Section 2—Areas of Focus.</p>
<p>Recommendation 2.a.iv. (Page ix)</p> <p>DHS must clarify the role of supervisors to support the DHS practice model being implemented.</p>	<p>Recommended by Panel: March 31, 2008</p>	<p>In progress</p>	<p>In progress</p>	<p>DHS is currently examining supervisor training evaluations to determine whether to modify the training curriculum.</p>
<p>Recommendation 2.a.v. (Page ix)</p> <p>DHS must streamline its paperwork</p>	<p>Recommended by Panel: August 31, 2008</p>	<p>In progress</p>	<p>In progress</p>	<p>DHS' new Electronic Case Management system is on track to replace the proprietary LIBERA framework and Structured Progress Notes effective November 22, 2010. The Contact Log</p>

Recommendation Text	Time Frame	Status, January 2010	Status, November 2010	November 2010 Update, as Reported by DHS
and records management practices.				<p>will be part of the release. The new framework will use industry standard Microsoft technology and will allow the City to leverage its existing skill set to deliver the rest of the project in a timely manner. The end product will be fully owned by the City of Philadelphia with no limitations on usage or licensing required. Development of Forms Management within FACTS2 has several advantages:</p> <ul style="list-style-type: none"> • Users already familiar with FACTS2 • Full application and data integration between FACTS2 and forms management • Faster development time • Development team experienced with DHS business practice <p>This achievement would not have been possible without the close partnership between the Division of Technology and DHS.</p> <p>Detailed below is the Department's time line. This aggressive time line includes automating the state-required Safety Assessment as well as the Risk Assessment and Referral Forms. This process allows DHS to replace many antiquated systems and bring DHS closer to its goal of a single source for all social worker computer interactions.</p> <p>Time line:</p> <ul style="list-style-type: none"> • Structured progress notes, contact log: 11/19/10

Recommendation Text	Time Frame	Status, January 2010	Status, November 2010	November 2010 Update, as Reported by DHS
				<ul style="list-style-type: none"> • Safety assessment: 3/18/2011 • Mother form and all referrals: 7/15/2011 • Fsp, cpp (ris), risk assessment: 11/18/2011 • CPS, CY-48: 12/30/2011
<p>Recommendation 2.a.vi. and 2.a.vi.1. (Page x)</p> <p>DHS must enhance the child fatality review process. DHS must ensure that the child fatality review is multidisciplinary and that there is a mechanism for implementing its recommendations.</p>	<p>Recommended by Panel: December 31, 2008</p>	<p>Completed and Ongoing</p>	<p>Completed</p>	<p>See Section 2—Areas of Focus.</p>
Phase 2 – Outcomes and Accountability				
<p>Recommendation 3.a (Page x)</p> <p>DHS must revisit and expand the list of outcomes to be measured—whereas Phase One was largely focused on child safety, Phase Two will expand the focus to include permanency and well-being measures.</p> <p>DHS articulated five practice areas/measures (repeat maltreatment, severity of repeat maltreatment and time between incidents of maltreatment, length of</p>	<p>Recommended by Panel: Beginning June 1, 2008, following the development of the first DHS annual report card</p>	<p>Completed</p>	<p>Completed</p>	<p>Recommendation remains completed (no additional update provided).</p>

Recommendation Text	Time Frame	Status, January 2010	Status, November 2010	November 2010 Update, as Reported by DHS
stay, changes in levels of care, and reentry).				
<p>Recommendation 3.b (Page x)</p> <p>DHS must link its performance and the performance of its contracted providers to outcomes of accountability, including financial incentives.</p>	<p>Recommended by Panel June 1, 2008:</p>	<p>In progress</p>	<p>In progress</p>	<p>DHS' Division of Performance Management and Accountability (PMA) recently added a new unit for Performance-Based Contracting (PBC). This unit is tasked with working closely with Finance to expand PBC from General Foster Care to all other levels of care throughout the agency. This unit will concentrate on developing specific outcomes for each level of care, tracking those outcomes, and assessing the financial implications of those outcomes.</p>
Phase 2 – Leadership and Infrastructure				
<p>Recommendation 4.a. (Page x)</p> <p>DHS must continue to expand its emphasis on making DHS a more transparent agency.</p>	<p>Recommended by Panel: Develop plan by June 30, 2008 and implementation to begin by August 1, 2008</p>	<p>In progress</p>	<p>In progress</p>	<p>See Recommendation 4.b (Phase 1), above.</p>
<p>Recommendation 4.b. (Page x)</p> <p>DHS must take positive steps to enhance the healthiness of infrastructure and staff morale.</p>	<p>Recommended by Panel: March 31, 2008</p>	<p>In progress</p>	<p>In progress</p>	<p>DHS continues to explore a variety of approaches to increase staff morale. One of the primary concerns raised by staff when discussing morale is the lack of communication. For example, employees are not always aware of changes/issues that impact the organization. To address this concern, DHS has implemented a newsletter that is distributed to employees. Other morale-building activities include, but are</p>

Recommendation Text	Time Frame	Status, January 2010	Status, November 2010	November 2010 Update, as Reported by DHS
				<p>not limited to, the identification of a "Safe/Sanctuary" room which staff can utilize when they feel stressed. Discussions are underway to develop an employee recognition program to acknowledge staff for their efforts in carrying out the DHS's mission. DHS also recently established a committee that consists of DHS employees and Union representatives to begin to develop processes and guidelines for implementing a 4-day work week. DHS also will recognize staff at an awards ceremony on January 18, 2011.</p>
<p>Recommendation 4.c. (Page xi)</p> <p>DHS must enhance its ability to proactively and transparently manage crisis, including strengthening process related to child death reviews and increasing public access to information.</p>	<p>Recommended by Panel: March 31, 2008</p>	<p>Completed and Ongoing</p>	<p>Completed and Ongoing</p>	<p>Completed. Information remains unchanged from last update on May 3, 2010.</p>

APPENDIX B. PRESENT DANGER ASSESSMENT: OUT-OF-HOME CARE SETTINGS

Refer to the definition of each safety concern before checking yes or no. The presence of any of these safety concerns as uniquely manifested in the family/situation should be fully studied and understood and guide the decision about approving/continuing the placement.

Present Danger Concern	Yes	No
1. Out of home caregiver(s) (or others in the home) in the home are acting violently or out of control.		
2. Out of home caregiver(s) describe or act toward the child in predominantly negative terms or have extremely unrealistic expectations of the child.		
3. Out of home caregiver(s) communicate or behave in ways that suggest that they may fail to protect child(ren) from serious harm or threatened harm by other family members, other household members, or others having regular access to the child(ren).		
4. The out of home caregiver(s)/family refuses access to the child or there is reason to believe that the family is about to flee.		
5. Out of home caregiver(s) are unwilling or unable to meet the child's immediate needs for food, clothing or shelter.		
6. Out of home caregiver(s) are unwilling or unable to meet the child's medical needs.		
7. Out of home caregiver(s) has not, will not, or is unable to provide supervision necessary to protect child from potentially serious harm.		
8. Child is unusually fearful/anxious of the kin or foster home situation.		
9. Out of home caregiver(s) have previously maltreated a child, and the severity of the maltreatment or the caregivers' response to the previous incident(s) suggests that safety may be an immediate concern.		
10. The physical living conditions are hazardous and immediately threatening.		
11. The out of home caregivers' drug or alcohol use seriously affects his/her ability to supervise, protect, or care for the child.		
12. Out of home caregivers' emotional instability or developmental delay affects ability to currently supervise, protect, or care for the child.		
13. Domestic violence exists in the home and poses a risk of serious physical and/or emotional harm to the child(ren).		
14. Child has exceptional needs or behaviors which out of home care caregiver(s) cannot/will not meet or manage.		
15. Child is seen by either out of home care caregiver as responsible for the child's parents' problems or for problems that the out of home caregivers are experiencing or may experience.		
16. One or both of the out of home caregiver(s) are sympathetic toward the child's parents, justify the parents' behavior, believe the parents rather than CPS and/or are supportive of the child's parents' point of view.		
17. One or both of the out of home care caregiver(s) indicate the child deserved what happened in the child's home.		
18. Out of home caregiver(s) history of or active criminal behavior that affects child safety, such as DV, drug trafficking or addiction, sex crimes, other crimes of violence against people or property.		
19. Out of home caregiver(s) or family members will likely allow parents unauthorized access to the child.		
20. Active CPS case, or a history of reports and/or CPS involvement that indicates that history will compromise the safety of the child if placed in this home.		
Worker Summary of Findings/Analysis:		
Date Completed:	Worker signature:	Supervisor signature:

APPENDIX C. OUT-OF-HOME SAFETY ASSESSMENT

I. IDENTIFYING INFORMATION ON PLACED CHILD(REN) BEING ASSESSED					
Family Name:		Case #:		Caseworker:	
Out of Home Family Name:		Address:			Phone:
Placed Child's Name: (Siblings may be listed on same form)	Age:	Date placed in This Setting:	Date Last Seen	Type of Setting:	Interval
				<input type="checkbox"/> Agency Home Kinship <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Provider Home Kinship <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Informal Arrangement	
				<input type="checkbox"/> Agency Home Kinship <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Provider Home Kinship <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Informal Arrangement	
				<input type="checkbox"/> Agency Home Kinship <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Provider Home Kinship <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Informal Arrangement	
II. HOUSEHOLD MEMBER INFORMATION					
Household Member's Name - Identify all household members. For children identify first name, last initial only	Age	Role in Household	Date Last Seen	Affiliated County For children under CYS supervision, list the county name	
III. PRIVATE PROVIDER INFORMATION (IF APPLICABLE):					
Private Provider Agency Name and Address		Private Provider Caseworker / Case Manager		Agency Phone Number	
IV: SAFETY INDICATORS					
For each child listed in Section I, list the name in the space provided. Then determine if each indicator is: P= Positive, C= Concerning, or N= Negative for each child.	Name	Name	Name	Provide a summary of the information gathered to inform your rating.	
1. Child Functioning: How are the children functioning cognitively, emotionally, behaviorally, physically, and socially?					
2. Adult Functioning: How are the adult out of home family members functioning cognitively, emotionally, behaviorally, physically, and socially?					
3. Caregiver Supervision: How are out of home caregiver(s) actively caring for, supervising, and protecting the children in the home?					
4. Discipline: How are discipline strategies used with the children in the home?					
5. Acceptance: How do the out of home family members demonstrate in observable ways that they accept the identified child into the home?					
6. Community Supports: How do the out of home family members access/use community supports to help assure child safety?					
7. Current Status: How do the out of home family members respond to the current issues, demands, stressors within the home that affect the child's safety?					
8. Placed Child's Family– Out of Home Family Dynamics: How does the dynamics between					

the family of origin and the out of home family support the safety of the child?				
9. Oversight: How does the out of home family demonstrate that they are agreeable to and cooperative with CYS and other formal resources?				
10. Planning: How do the out of home caregiver(s) demonstrate that they are capable of and actively engaged in planning for the identified child's day to day safety?				

V. SAFETY ANALYSIS: RESPOND TO THE FOLLOWING ANALYSIS QUESTIONS

1. Have any changes (positive or negative) occurred within the out of home family since your last assessment? Describe the changes and explain what prompted the change. Include in the explanation whether or not the change in the family resulted in a change in response to the ten (10) safety indicators. (Note: if this is the initial assessment, check here).
2. Considering all of the ten (10) safety indicators, are there sufficient positive indicators present and in operation that give you confidence that the child will remain safe in the setting? Provide your rationale for this judgment.
3. Describe in behavioral terms, any negative indicators that are present. Include intensity, frequency and duration of the characteristic and the impact on this child. If there are negative Indicators and the decision is to leave the child in this home, describe the rationale and justification for this decision. **Supervisory signature below indicates agreement with this rationale.**
4. A) Consider and describe any indicators that are rated as "concerning". B) Are there supports (e.g. respite care, child care, training on the child's specific needs, etc.) that will enhance the resource family's ability to provide a safe environment for the child? Provide your rationale for this judgment. For supports already in place, describe the effectiveness/impact/continued need for that support.
5. If another county has a child(ren) placed in this setting and concerning or negative indicators have been identified for either your identified child(ren) or the other children in the home, the Alert Document should be completed/provided to the agencies below. Record, in the space provided, the date that the Alert Document was sent to:

Other county agency Provider agency Regional Office

VI. SAFETY DECISION: *The following decisions should be made in conjunction with your supervisor.*

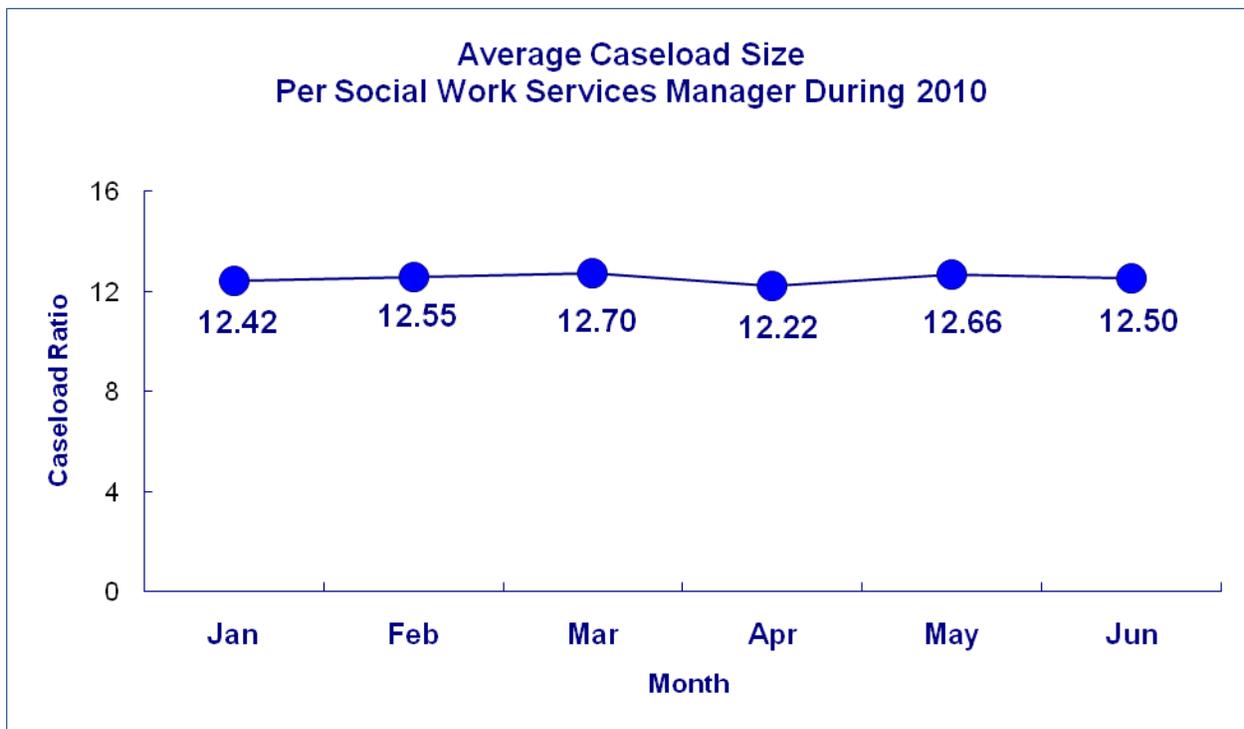
Indicate your safety decision by recording the name of each child (one child per column) next to the applicable safety decision.	Name	Name	Name
Safe: Sufficient indicators exist that cause the undersigned persons to confirm that the setting remains safe for this child.			
Unsafe: Sufficient indicators exist that cause the undersigned persons to conclude that the setting does not remain safe for this child. Child must be removed from the setting. When this decision is made the following additional steps must occur within the designated timeframe: <ul style="list-style-type: none"> • Review the child's current Safety Plan to determine modifications needed and document any and all necessary changes. • If other children from another county are placed children in the home, contact the other county agencies, provider agencies, and Regional Office to inform them of the safety concerns. 			
<input type="checkbox"/> Check here if the agency determines that the child is unsafe but remains in this setting as a result of a court order.	Date of Order:	Date of Order:	Date of Order:
	Date of Appeal:	Date of Appeal:	Date of Appeal:

VII. SIGNATURE OF APPROVAL (requires supervisory discussion)			
	County Caseworker Name	Signature	Date
	County Supervisor Name	Signature	Date

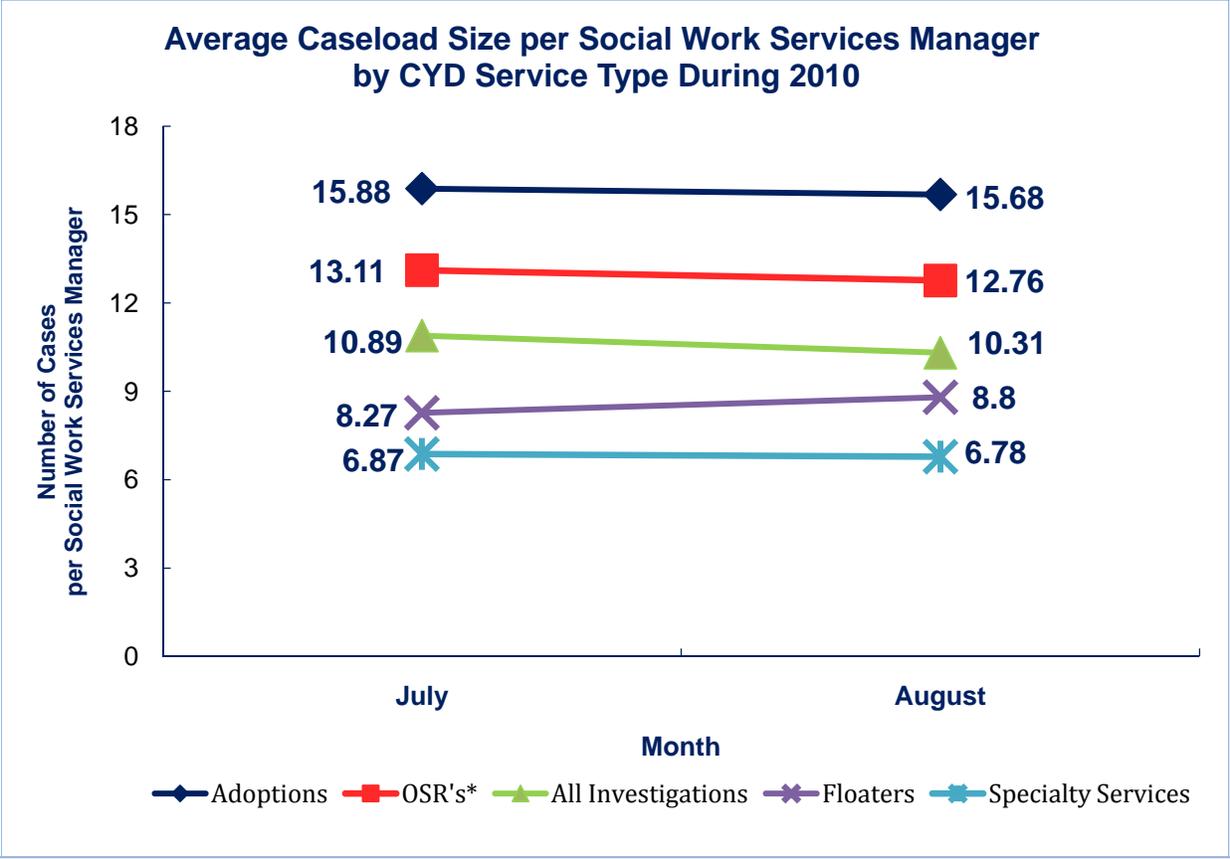
**APPENDIX D. DHS Division of Performance Management and Accountability
Data Report to the Community Oversight Board**

**DEPARTMENT OF HUMAN SERVICES
DIVISION OF PERFORMANCE MANAGEMENT AND ACCOUNTABILITY
DATA REPORT TO THE COMMUNITY OVERSIGHT BOARD
OCTOBER 18, 2010**

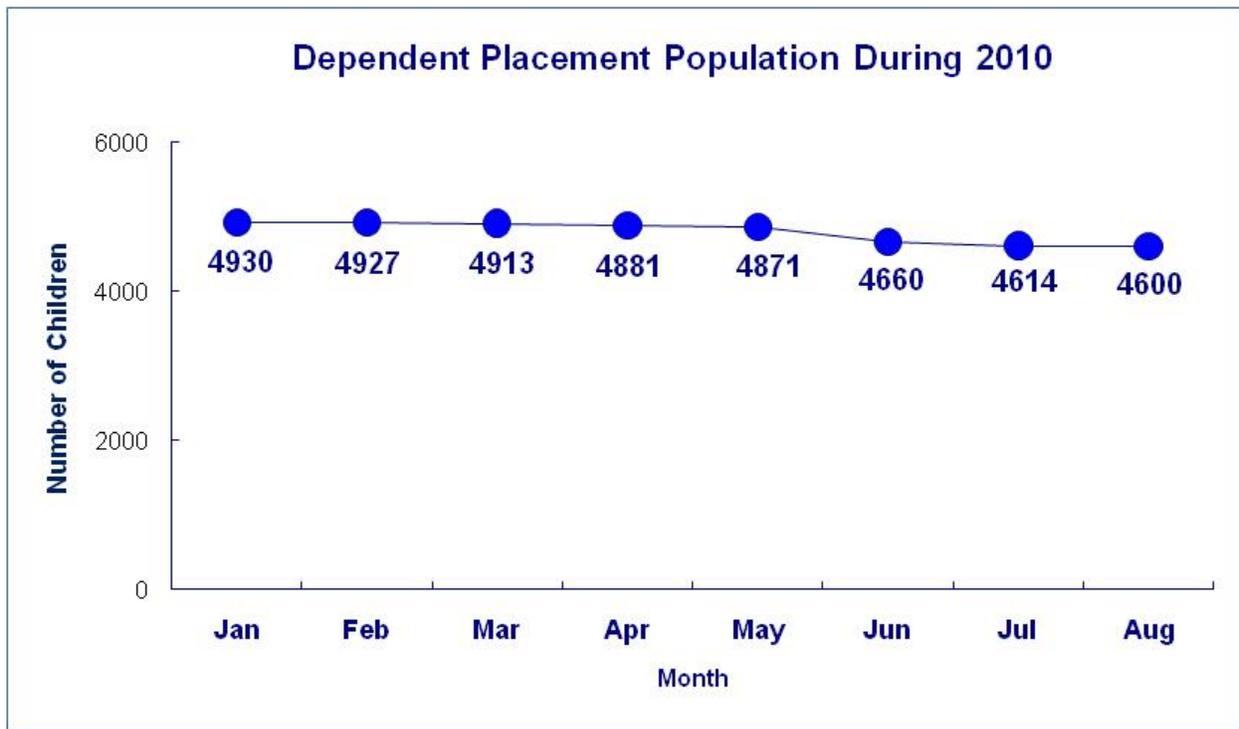
AGGREGATE MONTHLY DATA



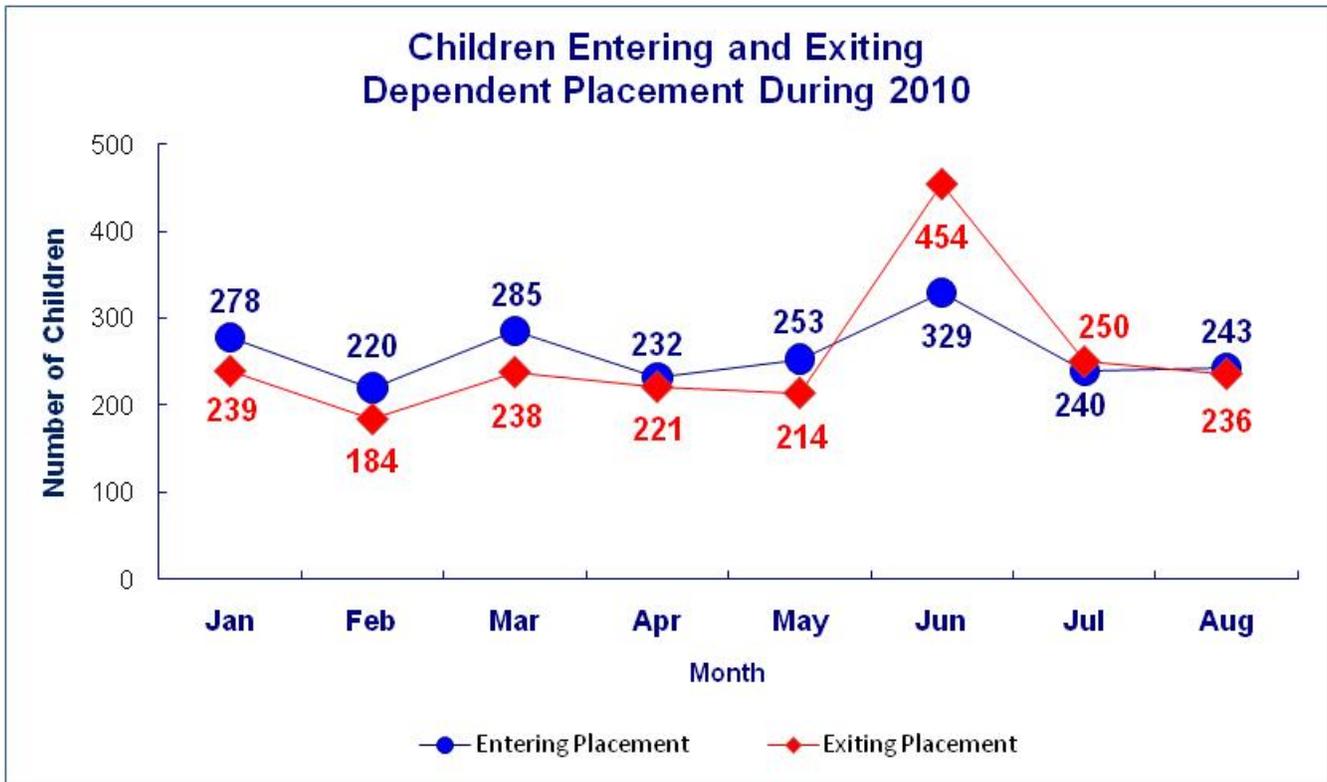
*Data Source: Caseload Statistical Report, run dates 2/9/10; 3/9/10; 4/12/10; 5/11/10; 6/9/10; 7/13/10.



*Ongoing Service Regions. Data Source: Caseload Data Report, run dates 8/10/10; 8/12/10; 9/10/10 and 9/16/10.

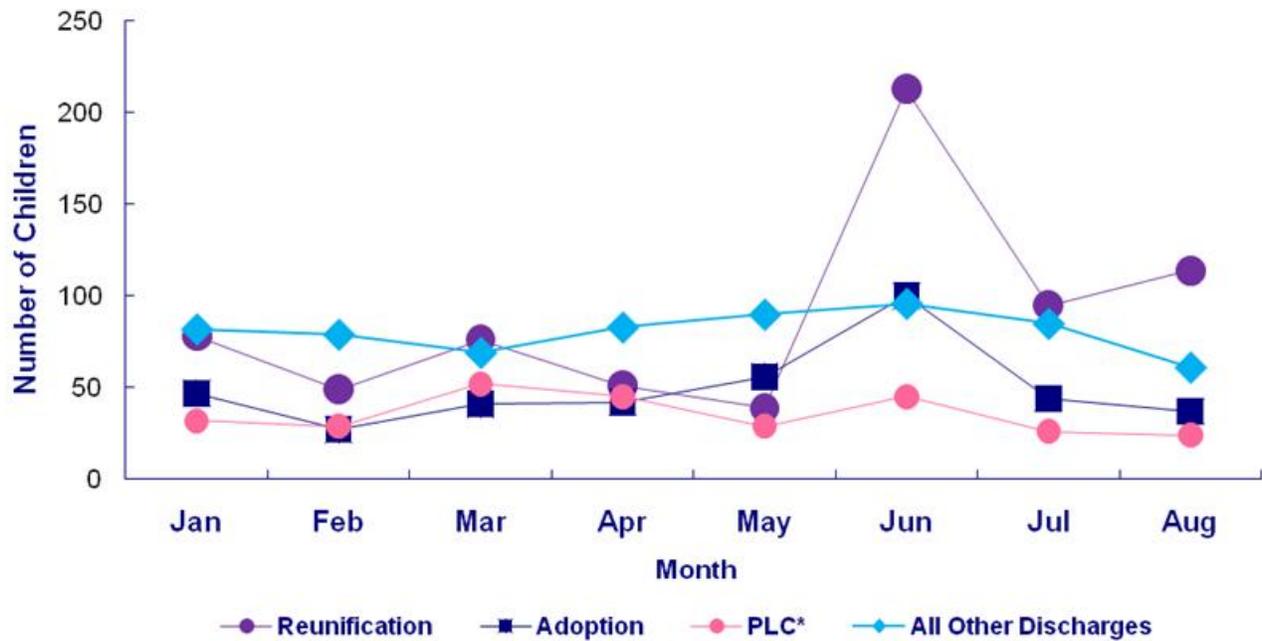


*Placement population is as of the last day of each month. Data Source: Cognos Web Reports, run dates 6/17/10, 9/15/10.



*Data Source: Cognos Web Reports, run dates 6/17/10; 9/15/10. Esperant query of FACTS Data Warehouse, 9/15/10.

Discharges by Type During 2010



Discharge Type per Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Reunification	78	49	76	51	39	213	95	114
Adoption	47	27	41	42	56	100	44	37
*Permanent Legal Custody	32	29	52	45	29	45	26	24
All Other Discharges	81	79	69	83	90	96	85	61
Total Discharges per Month	238	184	238	221	214	454	250	236

All Other Discharges

Court Ordered*	Hospitalized - Not returned to placement
Died	Placed with legal guardian
Discharged to an adult facility	Runaway - Not returned
Emancipation	

CHILD MALTREATMENT DATA

CPS REPORTS, FINDINGS AND SERVICE ACCEPTANCE

	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Total
Total # CPS Reports	390	446	446	403	419	330	2278
Indicated	77 (19.7)	52 (17.9)	78 (17.5)	76 (18.8)	60 (14.3)	70 (21.2)	413 (18.1)
Not indicated	308 (78.9)	233 (80.3)	364 (81.6)	319 (79.2)	351 (83.8)	257 (77.9)	1832 (80.4)
INDICATED							
# (%)accepted for service	23 (29.9)	19 (36.5)	28 (35.9)	23 (30.3)	16 (26.7)	21 (30.0)	130 (31.5)
# (%)already open for service	18 (23.4)	3 (5.8)	4 (5.1)	16 (21.1)	13 (21.7)	10 (14.3)	64 (15.5)
#(%) accepted for service	36 (46.8)	29 (55.8)	44 (56.4)	36 (47.4)	30 (50.0)	37 (52.9)	212 (51.3)
NOT INDICATED							
# (%)accepted for service	41 (13.3)	25 (10.7)	59 (17.3)	24 (7.5)	35 (10.0)	24 (9.3)	208 (11.4)
# (%)already open for service	27 (8.8)	10 (4.3)	14 (4.1)	19 (6.0)	23 (6.6)	19 (7.4)	112 (6.1)
#(%) not accepted for service	238 (77.3)	187 (80.3)	267 (78.3)	256 (80.3)	287 (81.8)	202 (78.6)	1437 (78.4)

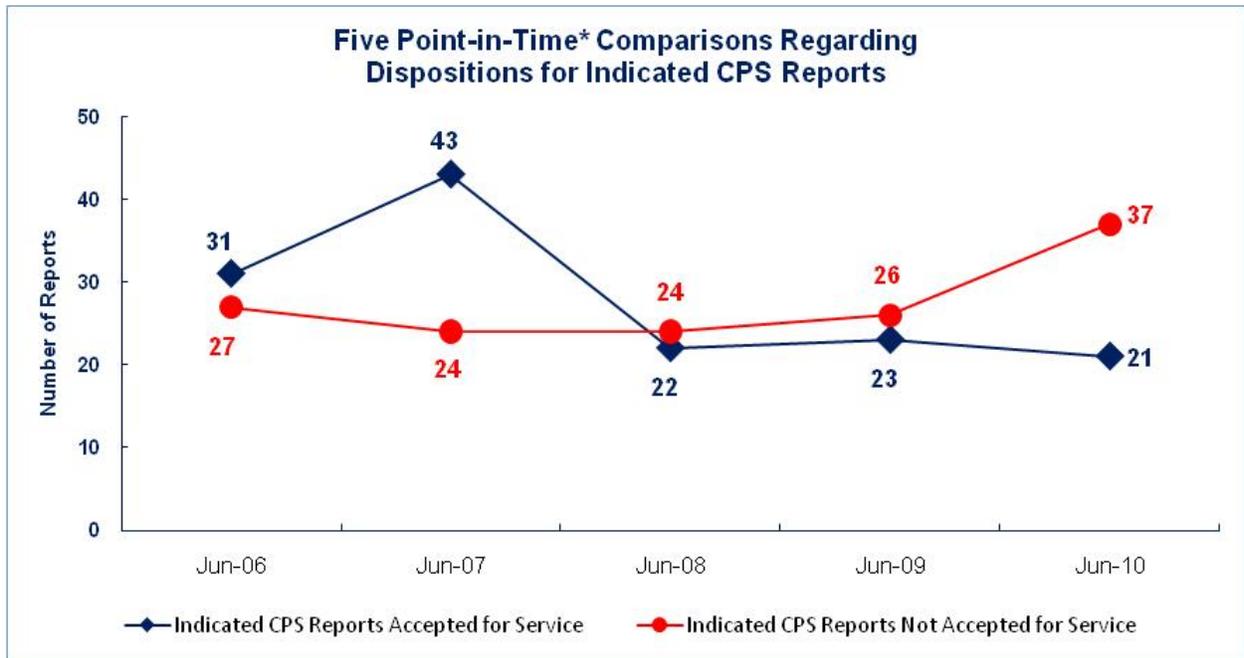
*Data Source: Esperant query of FACTS Data Warehouse, run date 06/11/10; 7/26/10; 09/23/10; AND 09/24/10.

**Note: The numbers do not always add up to the total because some investigations are still pending or not yet transferred to service regions.

RELATIONSHIP BETWEEN FINDINGS AND ACCEPT FOR SERVICE

Because 51% of indicated reports were not accepted for service, we looked at changes over time in the relationship between indications and accept for service. We first looked at whether the age of the child or a history of prior reports played any part in changes over time but found no relationship.

However, as illustrated in the chart below, the relationship changed in June '08 as the safety model of practice rolled out. It seems that the focus on safety diminished the importance of indicated findings and severed the connection between findings and accepts for service. We do not currently document the results of the safety assessments electronically, making it impossible to determine what the connection between safety and accept for service actually is, although we would expect it to be much closer that the connection with findings.



* Data is from first day through the last day of each month. Data Source: Esperant query of FACTS Data Warehouse, run date 10/7/10.

We then looked at where the majority of indicated reports with no service in June '10 came from and found almost half (16 out of 37) in the sex abuse unit. Although the decision in these cases not to accept for service may be linked to the fact that the perpetrator is no longer a threat, the question raised is whether the removal of the perpetrator really means the family needs no help.

We are going to look at one of these cases in ChildStat (Oct.22) and audit the remainder to understand whether decisions based solely on present safety are adequate to the complexity of the cases. We are also going to look at the severity of the allegations and the relationship with the perpetrator to determine whether some of these cases might have potentially impacted the family more traumatically than others.

GPS REPORTS, FINDINGS, AND SERVICE ACCEPTANCE

	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Total
Total # GPS Reports	711	470	806	717	703	657	4064
With Findings	198 (27.8)	125 (26.6)	208 (25.8)	188 (26.2)	224 (31.9)	193 (29.4)	1136 (28.0)
Without Findings	462 (64.9)	297 (63.1)	432 (53.6)	521 (72.7)	470 (66.9)	(457) (69.6)	2639 (64.9)
GPS WITH FINDINGS							
# (%)accepted for service	74 (37.4)	48 (38.4)	78 (37.5)	99 (52.7)	119 (53.1)	107 (55.4)	525 (46.2)
# (%)already open for service	49 (24.7)	33 (26.4)	71 (34.1)	36 (19.1)	25 (11.2)	21 (10.9)	235 (20.7)
# (%)not accepted for service	73 (36.9)	44 (35.2)	56 (26.9)	51 (27.1)	80 (35.7)	65 (33.7)	369 (32.5)
GPS WITHOUT FINDINGS							
# (%)accepted for service	47 (10.2)	18 (6.1)	38 (8.8)	37 (7.1)	44 (9.4)	17 (3.7)	201 (7.6)
# (%) already open for service	36 (7.8)	28 (9.4)	32 (7.4)	28 (5.4)	28 (6.0)	32 (7.0)	184 (7.0)
# (%)not accepted for service	377 (81.6)	247 (83.2)	358 (82.9)	322 (61.8)	358 (76.2)	325 (71.1)	1987 (75.3)

Data Source: Esperant query of FACTS Data Warehouse, run dates 06/11/10; 07/26/10; 09/23/10 and 09/24/10.

Note: The numbers do not always add up to the total because some investigations are still pending or not yet transferred to service regions.

MALTREATMENT IN FOSTER CARE (STATE REPORT) January 6, 2010 through June 6, 2010

- Between January and June 2010, the State investigated 121 report of maltreatment in foster care.
- Of those reports, 21 were substantiated (17.4%).
- Of the substantiated reports, 5 were living in foster homes; 15 were living in adopted homes or with legal guardians; one was living in a residential facility.

CPS/GPS: TIME TO COMPLETION OF INVESTIGATION

	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10
# of indicated CPS reports	77	52	78	76	60	70
avg. # of days to complete investigation	29	27	26	30	29	28
# of investigations pending	2	8	23	16	5	7
# of GPS reports with findings	198	125	208	188	224	193
avg. # of days to complete assessment	51	42	34	44	48	45
# of investigations pending	33	42	154	125	32	77

Data Source: Esperant query of FACTS Data Warehouse, run dates 06/11/10; 7/26/10; 09/23/10 and 09/24/10.

Note: The numbers do not always add up to the total because some investigations are still pending or not yet transferred to service regions.

Reports Referred to the Division of Community-Based Prevention Services (CBPS)

	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Total
Total # of General Reports	53	44	48	60	63	61	329
# (%) Reports referred to DCBPS	28 (52.8)	14 (31.8)	12 (25.0)	19 (31.7)	11 (17.5)	14 (22.9)	98 (29.8)

CHILD VISITATION DATA: DHS VISITS

Data source is the Visitation Tracking System (VTS) monthly reports as of Oct. 3, 2010
Compliance calculated as # visits made divided by # visits required by policy.

As of July 1, monthly visits were required for all levels of care. This is the reason for the big jump in numbers in July.

Visitation: All Children

Month	# Workers	# Visits Made	# Visits Required	% Compliance
Jan	17	4619	4914	94%
Feb	17	3961	4324	92%
March	17	4671	4947	94%
April	17	4487	4811	93%
May	15	3806	4063	94%
June	17	4851	4611	95%
July	17	6972	7507	93%
August	17	7075	7075	96%

It is important to note that we moved to monthly visitations for all children in June and our compliance rate actually increased by August. We did not track the children under 5 separately because our systems staff did not think it needed to do this anymore and changed some of the parameters in the dataset. We are asking them to fix this because it still seems we should look at them as a separate population to ensure that visiting all children once a month has not impaired our ability to visit this special group once a month.

**PROVIDER VISITATION WEB APPLICATION
JANUARY THROUGH SEPTEMBER 2010**

- Total Number of Agencies with Active Clients (according to FACTS) – **89**
- Agencies Trained to Use P-Web – **58**
- Total Number of Agencies Using P-Web – **54**
- Total Number of Agencies Not Using P-Web – **35 (exploring this)**
- Total Number of Visits Entered (July 2010 – Sept. 2010) – **9282**
 - Signed Quality Monthly Visits (July 2010 – Sept. 2010) – **6869**
 - Unsigned Quality Monthly Contacts (January 2010 – Sept. 2010) – **2413**
- Number of Agencies Uploading Information – **6**
- Number of Agencies Entering Data Directly – **48**

PILOT PHASE

Month	Signed Visits Entered	Unsigned Visits Entered	Total Visits	Number of New Agencies Entering Visits	Milestones
January	7	0	7	1(same agency)	
February	8	1	9		
March	7	0	7		
April	8	0	8		
May	231	0	231	3	Successful Upload
June	491	46	538	9	DHS started to provide training sessions to providers on how to enter quality monthly visits (June and July)
Total	752	47	799	13	

IMPLEMENTATION PHASE

Month	Signed Visits	Unsigned Visits	Total Visits	Total Number of Agencies Entering Visits	Milestones
July	3145	1092	4207	53	Start of mandatory quality monthly visit note entry directly into P-Web or upload batched quality monthly visit info
August	3676	826	4502	54	Time for Supervisors to review, send and sign changed from 72 hours to 2 weeks (as requested by providers)
September	2285	972	3255	44	Form changes to answer safety question. Expanded client details (as requested by providers)
Total	9106	2890	11,996		
GRAND TOTAL	9858	2937	12,785		

We think that the reason the visits seem so much lower in September is that, although providers are required to submit visitation documentation by the 10th of each month, they may often be late. We ran these numbers on October 12th, which given the holiday, was their due date this month. As you can see, all visits are not recorded. If we run September numbers next week, we might find many more visits have been entered. However, we need to address the issue of timeliness of documentation.

We are looking at the 35 agencies that are not currently using the system and suspect that at least some of them are congregate care/institutions that do not require monthly visits as the children are housed with them. For agencies that should be inputting visits and aren't, we will reach out and bring them into the fold.

There are still questions we need to answer that the system is currently unable to answer. We are working on being able to report out as the chart below indicates.

FUTURE REPORTING VISION

Month	Agency	Children Placed	Visits Completed	Unique Visits Completed	Unique Visits Missed	% Completed
	= # of agencies that entered or uploaded info	= # of children placed	= # of visits completed	= # of unique visits completed	= # of unique visits missed	

