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

April 2014

Presented to
Mayor Michael Nutter
and the Philadelphia Community

Submitted by The Philadelphia Community Oversight Board:
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ACKNOWLEDGEMENTS

The City of Philadelphia Community Oversight Board (COB) is grateful for the many groups and individuals who have continued to provide insight, support, and guidance to us. 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 support of the Department of Human Services' (DHS) efforts to build new child welfare practices in Philadelphia. His commitment has allowed DHS to continue its progress in addressing the recommendations of the Child Welfare Review Panel. DHS is implementing the Improving Outcomes for Children (IOC) initiative under his guidance.

We would like to acknowledge the contributions of Maria Walker who was a member of the COB during the time that this report covers. We appreciate her contributions to the work of the COB, her time, and her commitment to improving outcomes for Philadelphia's most vulnerable children and families.

The COB would like to thank DHS staff who have provided assistance to the COB. Without their help, the COB would not have been able to properly assess and monitor DHS' progress in implementing the recommendations of the CWRP and the status of the IOC initiative. We would especially like to thank Anne Marie Ambrose, DHS Commissioner, her leadership team, and the division of Performance Management & Accountability for their commitment to a better child welfare agency in Philadelphia.

The COB also would like to acknowledge the stakeholders, providers, and clients that have taken time to attend COB meetings, provide input, and offer suggestions. We also wish to extend our gratitude to the foundation partners that have supported the COB and DHS. Finally, we appreciate the assistance of our consultants, Walter R. McDonald & Associates, Inc., (WRMA) and Community Marketing Concepts (CMC) for supporting the work of the COB.

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EXECUTIVE SUMMARY

The Community Oversight Board (COB) was first established June 14, 2007 by Mayor John F. Street and re-established and continued by Mayor Michael Nutter in successive Executive Orders. The creation of the COB was one in a series of recommendations to improve the performance of the Department of Human Services (DHS) made by the Child Welfare Review Panel (CWRP). Those recommendations are included in the report, *Protecting Philadelphia's Children: The Call to Action*, issued on May 31, 2007. In 2010, the Child Welfare Advisory Board (CWAB) was abolished and its regulatory functions transferred to the COB. The COB is charged with:

- monitoring the implementation of the recommendations of the CWRP in *The Call to Action*
- assessing whether additional reforms are necessary to increase DHS' ability to improve the safety, permanency, and well-being of children and families
- advising the DHS on the development of the Children and Youth Division (CYD) Services Plan and Budget Estimate
- making recommendations regarding operations, programs, and policies of the CYD

During 2013, the COB focused on monitoring the 10 recommendations of the CWRP that are being addressed through the Improving Outcomes for Children (IOC) initiative and the five recommendations that have been implemented and sustained. [1] In addition, the COB has continued to monitor key outcome measures identified as indicators of DHS' performance related to child safety and well-being.

At the request of Mayor Nutter, in 2011 the COB began to include issues of well-being in their scope. As a part of this well-being work, the COB began to look closely at the issues of older youth in care. Given the large number of older youth in DHS' care and the large percentage of youth who are aging out of care, the COB determined that it was critical to identify areas of strength and areas in which improvement is needed to improve outcomes.

In June 2012, the COB created the Older Youth Work Group (OYWG) to gain a better understanding of the issues of older youth in DHS' care, to identify gaps in programs and services, and to develop recommendations for Mayor Nutter regarding the need for cross-system collaboration to improve outcomes for older youth. The OYWG defines older youth as youth and young adults 13–21 years of age. During 2013, the OYWG reviewed quantitative information from the Division of Performance Management and Accountability and conducted a literature review. Qualitative information was gathered through interviews with key informants from DHS, meetings with non-profit advocacy and service organizations including advocates for adjudicated youth; Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) youth, youth with disabilities, educators;

[1] In the April 2013 Report on Progress, the Community Oversight Board (COB) reported to Mayor Michael Nutter and the Philadelphia Community that the Department of Human Services (DHS) had successfully completed 20 of the 37 recommendations of the Child Welfare Review Panel (CWRP). During 2013, the COB determined that the recommendation regarding the development and implementation of a child fatality review process was also successfully completed.

providers of youth shelter care and child welfare services, and from older youth in several settings. A separate report on the findings of the OYWG and the recommendations from the COB based on their work will be issued.

Highlights of DHS' progress on the CWRP recommendations being implemented through the IOC initiative, and the recommendations that have been implemented and sustained but still monitored by the COB, are provided below. In addition, a summary of the data on three outcome measures being monitored by the COB is briefly discussed.

RECOMMENDATIONS BEING ADDRESSED THROUGH THE IMPROVING OUTCOMES FOR CHILDREN INITIATIVE

After almost 2 years of intensive and comprehensive planning, implementation of the IOC initiative officially began on January 28, 2013.[2] By the end of 2013, seven of the 10 Community Umbrella Agencies (CUAs) had been chosen and proposals for the final three CUAs were under review. During this first year, the first two CUAs—NorthEast Treatment Centers (NET) and Asociación Puertorriqueños en Marcha (APM)—began receiving referrals.

In addition, DHS and the CUAs began conducting Family Team Conferences (FTCs). FTCs are conducted throughout the life of a case at key decision-making points. They are intended to strengthen relationships and build supports to ensure child and youth safety, permanency and well-being. DHS is also in the process of completing the development of the FTC Database. The FTC Database will provide critical information regarding the timeliness of the conduct of the conferences and the level of participation in the conferences by parents, caregivers, the CUA worker, and other key professionals, informal family supports, and children and youth as appropriate. As part of the Child Welfare Demonstration Project, the state of Pennsylvania has contracted with the Child Welfare Resource Center (CWRC) to conduct research to measure the fidelity of the FTC model. As a result, DHS is working closely with the CWRC to measure the degree to which the individuals delivering FTC effectively and faithfully implement the elements that are thought to be the most essential to successful implementation.

The COB believes that FTCs are a significant and promising practice. They represent the critical shift in DHS practice in which families and members of the community can work together to identify what is required to ensure positive outcomes for children and families.

The COB understands that a transformation of this magnitude is extremely challenging. The transition to the new model requires running dual systems simultaneously. The COB is impressed with DHS' continued focus on the vision of transforming the system so that better outcomes for the children and families can be achieved in their own communities. At the same time, the COB is impressed with DHS' ongoing support and training of the CUAs.

What is most significant is DHS' continued development and implementation of a continuous quality improvement (CQI) system. On an ongoing basis DHS is collecting, reviewing, and using qualitative and quantitative data to monitor, understand, and improve all aspects of service delivery and outcomes. The importance of having a robust CQI system cannot be overstated for any child

[2] More information on the Improving Outcomes for Children (IOC) initiative can be found at http://dynamicsights.com/dhs/ioc/index.php.

welfare system. It is critically important for DHS as it implements the IOC initiative. For a transformation of this magnitude to be successfully, it will be important for DHS and the CUAs to have data to make sure that delivered services are relevant and contribute to positive results. It is equally important that frontline staff and supervisors are also able to see the impact that services are having on the children and families served. This CQI foundation demonstrates DHS' commitment to using data to drive decision making and to identify and address any needed changes in practice or policy.

It is also important to note that DHS has completed the long-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. On August 26, 2013, the Philadelphia Safety Collaborative (PSC) officially opened. PSC is the newly co-located site for members of the Philadelphia Police Department (PPD) Special Victims Unit (SVU), DHS Sexual Abuse Investigation Unit, Philadelphia Children's Alliance, and staff from the District Attorney's Office. The Collaborative integrates and brings under one roof the services of the partner agencies, in turn, streamlining the investigative process for incidents of sexual abuse. This is a critical achievement. It will allow DHS and its partner agencies to better serve children and families. The COB is also pleased that PSC will collect and track performance measurement data that can be used to identify any changes needed in practice or policy regarding investigations and the provision of services.

IMPLEMENTED AND SUSTAINED RECOMMENDATIONS

The COB has continued to monitor compliance with visitation requirements by DHS and private providers and the findings of the Quality Visitation Review (QVR) process.[3] The COB believes that visits are a critical component of practices for ensuring the safety of children and the well-being of families, and achieving permanency. In March 2013, a new policy for DHS social work services managers visiting children and youth was put in place.[4] With the implementation of the IOC initiative and DHS transitioning direct case management for families to CUAs, it was determined that reducing the monthly visitation requirements for DHS social work services managers was a practical change. Private provider staff are still required to visit all children on a monthly basis.

During 2013, the COB expressed concern over the reduction in compliance with visitation requirements by DHS social work services managers. In discussions with the COB, DHS indicated that the reduction in compliance with visitation requirements by DHS social work services managers in CY 2013 is due to the inability of DHS to track visits that have been conducted with children if there is not a corresponding case note entered into the Electronic Case Management System (ECMS). As of May 2012, supervisors are not allowed to record a visit until the case note has been entered. Given current caseloads, DHS social work services managers are also behind in entering the required case notes. In addition, in early 2013, DHS began tracking visitation in the ECMS instead of the previously used Visitation Tracking System (VTS). Monthly compliance rates for face-to-face visitation for all dependent children by private providers during 2013 continued to increase.

[3] The CWRP made three recommendations regarding the need for DHS to enhance both the frequency and quality of caseworker visits. These recommendations have been implemented and sustained by DHS.
[4] Philadelphia Department of Human Services, Children and Youth Division (March 1, 2013). Frequency of Ongoing Contact with Children and Youth Accepted for Services, *Policy and Procedure Guide.*

The COB continues to monitor visitation compliance very closely. The COB requested DHS provide visitation data by DHS and private providers for all children, children 5 years of age and younger, and by placement type. This will allow DHS and the COB to ensure that all children are seen monthly. The COB is confident that all children are being seen, at a minimum, on a monthly basis. This includes those most vulnerable, children 5 years of age and younger receiving in-home services.

DHS continues to use the QVR process to ensure that the quality of visits performed by DHS and private provider workers are comprehensive and address all safety issues that may be present. Quality caseworker visits are associated with a range of child welfare outcomes. Child welfare agencies that conduct quality visits on a regular basis are better positioned to assess children's risk of harm and their need for alternative permanency options, to identify and provide needed services, and to engage children and parents in planning for their future. DHS is to be commended for continuing to collect and use data to both verify and measure the effectiveness of visits and to inform program improvement efforts. The COB is pleased to see that private providers are achieving high ratings in each of the four principles for conducting quality visits. As IOC initiative implementation continues, it is critical that the private providers are able to conduct quality visits. QVRs will continue to be an important tool for DHS to use as their oversight and monitoring role is enhanced. Quality visits are foundational to achieving positive outcomes for children and families.

The CWRP also recommended that DHS conduct a background check on each member in the child's household. If an adult household member has a history with DHS or a criminal record that includes a conviction, then DHS must conduct an assessment to determine whether the household is safe and appropriate for the child. On September 2012, DHS implemented a new policy for conducting reviews.[5] DHS reported to the COB, that in the year following implementation of the policy, the number of background checks doubled. The workload of the liaison unit (responsible for the backgrounds checks) is currently very high. As part of the rollout out of the IOC initiative, DHS plans to add additional staff to ensure that the background checks continue to be conducted in a timely manner.

KEY OUTCOME MEASURES

DHS continues to report regularly to the COB on three child safety outcome measures:

1. occurrence of repeat maltreatment and length of time between incidents of child maltreatment
2. incidence of child maltreatment in placement
3. reentry into foster care and other types of placement

[5] The Philadelphia Department of Human Services, Children and Youth Division (August 31, 2012). *Required Clearances for Household Members for Temporary Moves of Children and Youth to Create or Revise a Safety Plan, and Prior to Reunification or Case Closing*, Policy and Procedure Guide.

The outcome measures are a means to examine DHS' progress using quantitative measures of key areas. A review of the data does not provide a clear picture of the impact of the many practice and policy changes that have been implemented by DHS. Following are the key findings on the three outcome measures:

- The overall occurrence of repeat maltreatment decreased from state fiscal year (SFY) 2006 to SFY 2008 and then increased from SFY 2008 to SFY 2011. Approximately half of the occurrences of repeat maltreatment happened within 6 months of discharge.

- The total number of reports of maltreatment while in DHS care decreased from SFY 2006 to SFY 2013. The percentage of these reports that were substantiated remained about the same from SFY 2006 to SFY 2010, decreased sharply in SFY 2011, and rose in SFYs 2012 and 2013.

- The proportions of children discharged to permanency who reentered placement remained stable from SFY 2006 to SFY 2010. Data from SFY 2011 show an increase in reentries.

The COB will continue to monitor these outcome measures. Given the transition to the IOC initiative, it is not surprising that the outcomes have not improved dramatically. At the same time, the outcomes have not declined dramatically.

CONCLUSION AND NEXT STEPS

The COB commends DHS for its thoughtful implementation of the IOC initiative and its recognition of the challenges in transforming a child welfare system to improve services and supports to children and families. At the same time, DHS has developed a strong CQI system that they continue to enhance. All the right ingredients are present to implement the IOC initiative, and to continue to use data and information to identify and implement action steps to continue to improve practice and outcomes.

In concert with DHS, the COB will continue to closely monitor the outcome measures discussed and the data on child visitation. The COB understands that it may not see the impact of the changes in practice and policy until the IOC initiative is fully implemented.

SECTION 1. STATUS OF THE RECOMMENDATIONS FROM THE CHILD WELFARE REVIEW PANEL

BACKGROUND

In the April 2013 Report on Progress, the Community Oversight Board (COB) reported to Mayor Michael Nutter and the Philadelphia Community that the Department of Human Services (DHS) had successfully completed 20 of the 37 recommendations of the Child Welfare Review Panel (CWRP).[6] Since the issuance of the report, the COB determined that one additional CWRP recommendation has been successfully completed. This recommendation concerned the implementation of a child fatality review process.

The CWRP recommended that DHS enhance its child fatality review process and ensure that there is a mechanism for implementing the recommendations developed during the reviews.[7] Since 2009, DHS has had a model process for reviewing fatalities and near fatalities, known as the Act 33 Child Fatality/Near Fatality Review Team. It is a model for effective interdisciplinary and interagency coordination in examining child fatalities and near fatalities and for identifying and monitoring the implementation of recommendations to improve child safety. The Act 33 Review Team continues to review cases in a timely manner and provide constructive recommendations to DHS. In response, DHS has conducted analyses of the recommendations to identify common themes and identify strategies for addressing the issues. DHS is using the information gained from the Act 33 Review Team to inform decision making and improve practice and policy. Therefore, the COB has determined that this CWRP recommendation is completed and fully implemented.

During 2013, the COB focused on monitoring the ongoing operational changes that resulted from the completed recommendations and the implementation of the remaining 16 recommendations. The remaining recommendations fall into two categories:

- *Recommendations Being Addressed Through the Improving Outcomes for Children (IOC) Initiative*—These recommendations were integrated into the IOC initiative. The IOC initiative is currently in progress, but will not be fully implemented until December 2015.

- *Implemented and Sustained*—These recommendations were implemented by DHS. The COB determined that they have been sustained since implementation. However, the COB continues to monitor these recommendations annually, due to their importance for ensuring the continuing safety of children served by DHS.

This section provides a discussion of the first phase of implementation of the IOC initiative and the related CWRP recommendations. It also provides an assessment of four of the six implemented and sustained recommendations. These four recommendations fall into two areas of focus: child visitation and criminal background checks.

[6] The April 2013 Report on Progress provided the COB's assessment of DHS' efforts in 2011 and 2012.
[7] 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 (Phase II, Recommendation 2.a.vi. and 2.a.vi.1).

RECOMMENDATIONS BEING ADDRESSED THROUGH THE IMPROVING OUTCOMES FOR CHILDREN INITIATIVE

Ten of the 16 remaining recommendations of the Child Welfare Review Panel (CWRP) are being addressed through the implementation of the Improving Outcomes for Children (IOC) initiative (see appendix A). This section provides more detail on the COB's assessment of the first phase of the implementation of the IOC initiative. It also provides an update on key recommendations regarding co-location and expanded use of Family Team Conferences (FTC).

After almost 2 years of intensive and comprehensive planning, implementation of the IOC initiative officially began on January 28, 2013.[8] The IOC initiative is a large scale, multifaceted, integrated reform effort. The work includes the following four interrelated reform efforts:

- moving responsibility for ongoing case management to private providers in the community
- changing practice by including parents and youth in decision making through FTCs throughout the life of the case
- building protective capacities of families through implementation of the Strengthening Families framework in the community
- changing how child welfare is funded through the Title IV-E welfare waiver[9]

By the end of 2013, seven of the 10 Community Umbrella Agencies (CUAs) had been chosen and proposals for the final three CUAs were under review. During this first year, the first two CUAs—NorthEast Treatment Centers (NET) and Asociación Puertorriqueños en Marcha (APM) began receiving in-home services referrals and referrals for general and higher levels of foster care. By the end of 2013, NET received 200 cases and APM received 224 cases. DHS is managing the transition of cases by first transitioning in-home cases then cases of families with children in foster care, then cases of families whose children are in treatment foster care or congregate care. The transition and referral of all cases to the CUAs is expected to be implemented by December 2015.

Numerous other IOC initiative efforts are underway. Community-based Parent Cafés and Teen Cafés are being held, Community Advisory Boards (CABs) made up of neighborhood stakeholders are being developed, and Community Behavioral Health (CBH) liaisons are being designated for each CUA by the Department of Behavioral Health and Intellectual disAbility (DBHIDS), and FTCs are being conducted.[10,11]

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[8] More information on the Improving Outcomes for Children (IOC) initiative can be found at http://dynamicsights.com/dhs/ioc/index.php.

[9] Casey Family Programs (December 2012). *Improving Outcomes for Children in Philadelphia: one family, one plan, one case manger.* Available at http://dynamicsights.com/dhs/ioc/media.php

[10] Parent and Teen Cafés are structured support and community building sessions offered to parents and teens involved with DHS.

[11] More information on the Improving Outcomes for Children (IOC) initiative can be found at http://dynamicsights.com/dhs/ioc/index.php. See also, Casey Family Programs (December 2012). Improving Outcomes for Children in Philadelphia" one family, one plan, one case manager. Available at http://dynamicsights.com/dhs/ioc/media.php

The COB understands that a transformation of this magnitude is extremely challenging. The transition to the new model requires running dual systems simultaneously. Until the IOC initiative is fully implemented, some of DHS staff will still be working under the old, Dual Case-Management model in which DHS workers share casework responsibilities with private providers and where family conferencing is not mandatory. At the same time, DHS is working with the CUAs to transfer all cases so each family has a single case manager in the community so that children and families get the services they need in the community where they live.

The COB is impressed with DHS' continued focus on the vision of transforming the system so that better outcomes for the children and families can be achieved in their own communities. At the same time, the COB is impressed with DHS' ongoing monitoring and assessment to identify and address any issues or problems that arise. DHS is clearly prepared to make any changes that are needed along the way. DHS has significantly increased its ability to access and use data to drive decision making during the last few years. This has been demonstrated during this critical transition period. This foundation of data-driven decision making that DHS continues to build, will be important as their major responsibility transfers to monitoring the outcomes achieved by the CUAs.

As the IOC initiative was being implemented in 2013, caseloads steadily increased (see exhibit 1.1). The increase in caseload size was a result of many DHS social work managers moving to IOC positions and no longer carrying cases. In addition, staff turnover and attrition was high. Requirements in preparing for and attending court reviews also increased. Court mandated reviews are now required a minimum of every 3 months instead of every 6 months. In addition, in CY 2013, dependent placements increased (see exhibit 1.2).

Exhibit 1.1 Average Caseload Size per Social Work Services Manager by Service Type, CY 2013

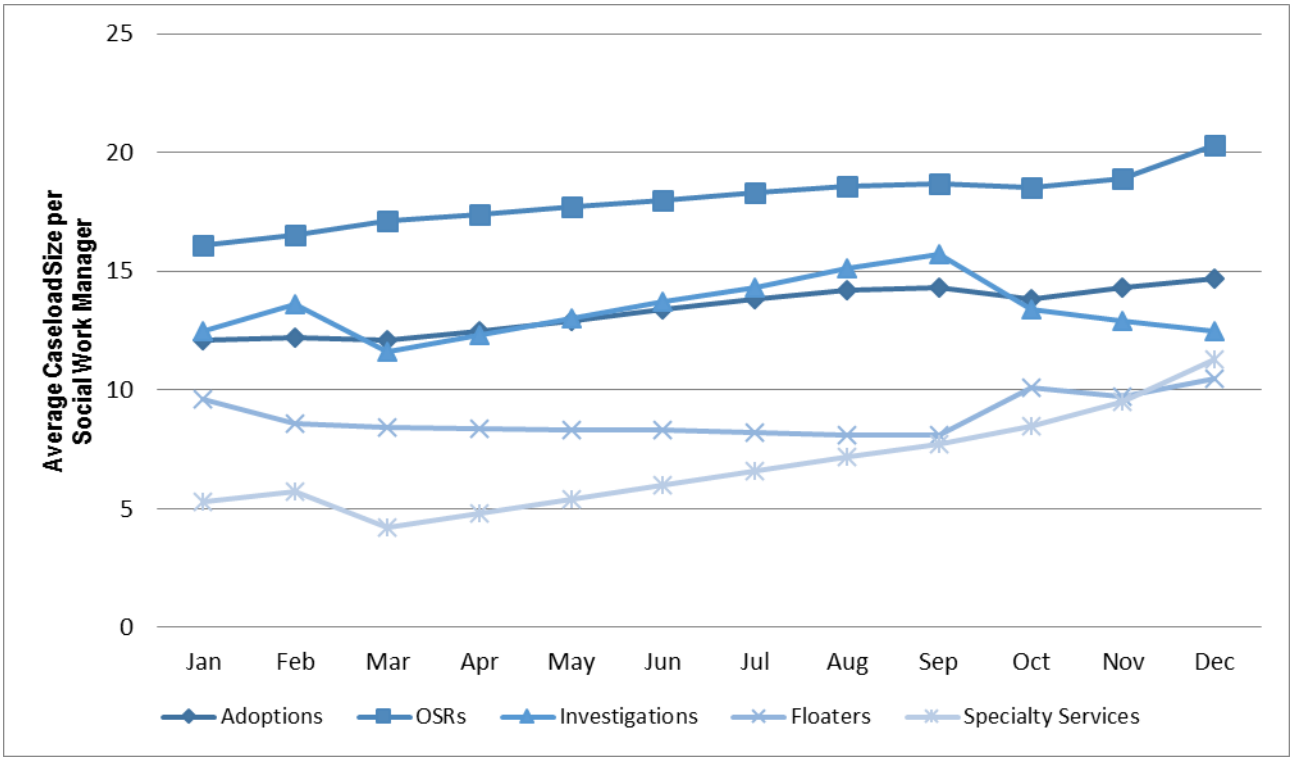
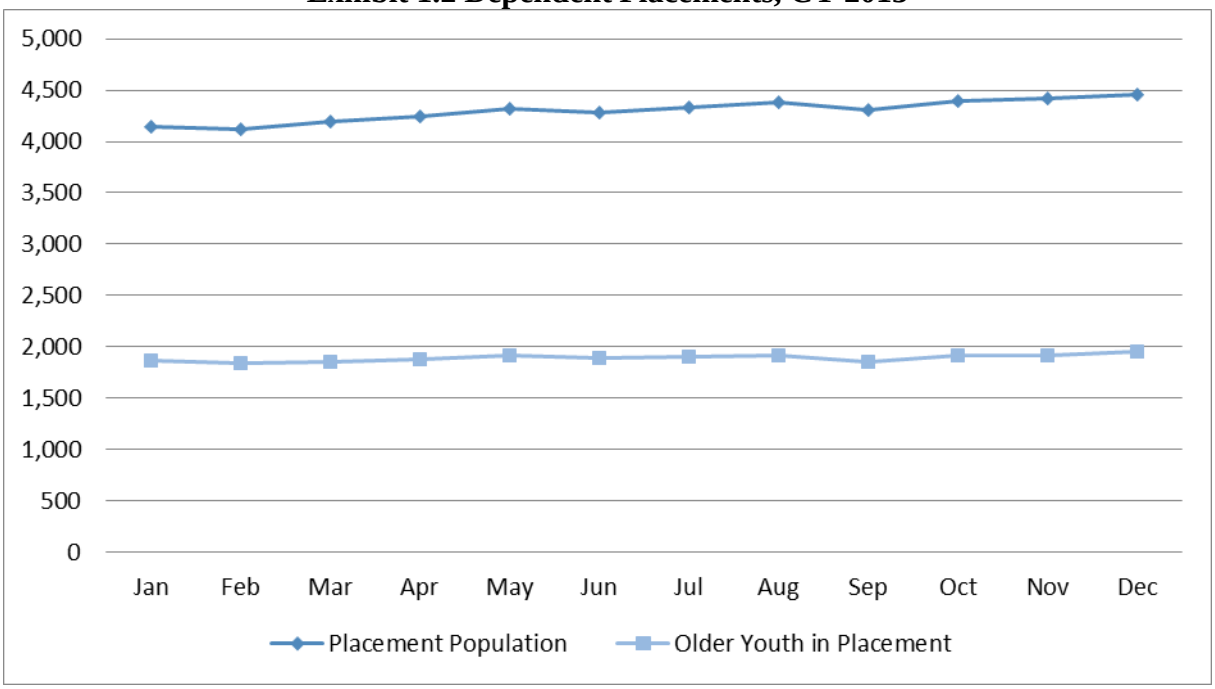


Exhibit 1.2 Dependent Placements, CY 2013



In consultation with the COB, DHS decided to hire additional intake staff in early 2013 to free up the floater units to handle the additional cases that needed coverage during the transition to CUAs. DHS continues to review and determine if additional DHS staff is needed during the transition to ensure that the safety and well-being of children and families is not compromised during the transitions to IOC. The COB will continue to monitor and assess the impact of the implementation of the IOC initiative on caseloads and work with DHS to identify any issues that need to be addressed.

The success of the IOC initiative will depend on the availability of real-time data to make informed decisions. The COB understands that all CUAs will use DHS' Electronic Case Management System (ECMS). During 2013, DHS began identifying key outcome measures for the CUAs. The COB is working with DHS in finalizing these outcomes. A draft has been reviewed and will be finalized in early 2014. The areas of focus include:

- safety
- reunification or other permanence
- reduction in the use of congregate care
- improved child, youth and family functioning

The COB is confident that DHS and the CUAs will use and share data to make informed decisions and for continuous quality improvement.

Co-Location

The CWRP recommended that DHS complete the long-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. On August 26, 2013, the Philadelphia Safety Collaborative (PSC) officially opened. PSC is the newly co-located site for members of the Philadelphia Police Department (PPD) Special Victims Unit (SVU), Department of Human Services (DHS) Sexual Abuse Investigation Unit, Philadelphia Children's Alliance, and staff from the District Attorney's Office. The Collaborative integrates and brings under one roof the services of the partner agencies, in turn, streamlining the investigative process for incidents of sexual abuse.

Prior to the opening of the PSC, children and their families were required to visit multiple locations throughout the city. The Collaborative's team approach reduces the number of staff-victim interactions by coordinating the efforts of all partner agencies involved. This results in lessening the trauma of the investigative process for children and their families. The PSC will accommodate a staff of approximately 120 full- and part-time personnel from social services, the health/medical community, the police department, and child advocates. The PSC now sees between 150 and 180 children monthly.

Each morning a meeting is held with all PSC members. The morning meeting is a major component of co-location. Every case that comes in with allegations of sex abuse from DHS or the PPD is presented at the morning meeting and triaged with a multidisciplinary team. Cases are assigned and issues are discussed. This has resulted in improved investigations and service provision.

The COB applauds DHS and its partner agencies for working together and making co-location a reality. This is a critical step that enables DHS and its partner agencies to better serve children and families. The COB was also pleased to learn that PSC will collect and track performance measurement data that can be used to identify any changes needed in practice or policy regarding investigations and the provision of services.

Family Team Conferencing

DHS presented the new FTC model to the COB in December 2012. This model was described in detail in the *April 2013 Report on Progress*. Conferences (known as teamings) are conducted throughout the life of a case at key decision making points. They are intended to strengthen relationships and build supports to ensure child and youth safety, permanency, and well-being. They are child-centered, family-focused gatherings of family members, friends, and community resources; the CUA case manager; other child, youth, and family serving agencies; and other professionals involved in the case. The model involves four key conferences (defined in appendix B):

1. Child Safety Conferences
2. Family Support Conferences
3. Permanency Conferences
4. Placement and Stability Conferences

In 2013, DHS and the CUAs began conducting FTCs. DHS is in the process of completing the development of the FTC Database. The FTC Database will provide critical information regarding the timeliness of the conduct of the conferences and the level of participation in the conferences by parents, caregivers, the CUA worker, and other key professionals, informal family supports, and children and youth as appropriate.

As part of the Child Welfare Demonstration Project, the state of Pennsylvania has contracted with the Child Welfare Resource Center (CWRC) to conduct research to measure the fidelity of the FTC model. As a result, DHS is working closely with the CWRC to measure the degree to which the individuals delivering FTC effectively and faithfully implement the elements that are thought to be the most essential to successful implementation. The common core intervention elements include:

- conferences are facilitated by neutral and trained staff
- effective partnerships are promoted among the child welfare agency and private/community services
- outreach to kin or other supportive people to be potential caregivers or supports to the birth parent
- families and supports are prepared for the conference/meeting
- families are helped to identify and access appropriate and meaningful services

Measuring each element requires collecting data at multiple levels and then combining the information to yield a full understanding of each element and ultimately, family engagement as a whole. Data will be collected through the Family Conference Survey. This is a brief fidelity survey that will be completed by all participants after each conference. The CWRC evaluation team will observe a small sample of meetings and complete an observation protocol that will assess the level of family participation and facilitator's fidelity to the five common principles. Focus groups with family and youth will be conducted to gather more information about their experiences with the FTCs.

The COB believes that FTCs are a significant and promising practice. They represent the critical shift in DHS practice in which families and members of the community can work together to identify what is required to ensure positive outcomes for children and families. The COB recommended that DHS develop a database to track the implementation of the FTCs. DHS went further and decided that an evaluation of the process was also critical to inform decisions about how to improve the process. This is just one more indication that DHS understands the importance of having data to drive decision making and track progress. The COB will monitor and evaluate the implementation of FTCs.

IMPLEMENTED AND SUSTAINED RECOMMENDATIONS

Appendix C provides a list of the six recommendations that were implemented and sustained by DHS.[12] In the last year, the COB focused on four of these recommendations. These four

[12] In the April 2013 Report on Progress there were seven recommendations that were identified as implemented and sustained. The COB has determined that one of these recommendations should be categorized as a recommendation being addressed through the IOC initiative since outcome measures are a critical piece of the IOC initiative. The recommendation is: 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.

recommendations fall into two areas of focus: (1) child visitation, and (2) criminal background checks. This section provides a discussion of DHS' progress in sustaining the Child Welfare Review Panel (CWRP) recommendations regarding child visitation and the conducting of criminal background checks.

Child Visitation[13]

The CWRP made three recommendations regarding the need for DHS to enhance both the frequency and quality of caseworker visits (see appendix C, recommendations 1-3). The COB believes that visits by DHS social work services managers and contracted agency staff are a critical component of practice. These visits are a key strategy for ensuring the safety of children and the well-being of families while pledging that children receive timely permanency.

After consultation with the COB, DHS issued a new policy for DHS social work services managers visiting children and youth who are receiving services from the Children and Youth Division (CYD).[14] With the implementation of the Improving Outcomes for Children (IOC) initiative and DHS transitioning direct case management for families to Community Umbrella Agencies (CUAs), it was determined that reducing the monthly visitation requirements for DHS social work services managers was a practical change. Private provider staff are still required to visit all children on a monthly basis.

The new requirements became effective March 1, 2013. Prior to the issuance of this new policy, DHS social work services managers were required to visit all children with an active case in CYD and receiving services, regardless of age or program, at least monthly. DHS social work services managers are no longer required to provide monthly visits except for children younger than 6 years of age. The new requirements are provided in exhibit 1.3.

[13] Visitation data are based on calendar years (January to December).
[14] Philadelphia Department of Human Services, Children and Youth Division (March 1, 2013). Frequency of Ongoing Contact with Children and Youth Accepted for Services, *Policy and Procedure Guide.*

Exhibit 1.3 Visitation Requirements for DHS Social Work Services Managers

Type of Service and Age of Child	Frequency of Contact Required
In-Home Service Cases with Household Children Under 6	• One face-to-face contact with the child under 6 and their caregiver monthly in the home of origin. • Household children and youth 6 and over must be seen every 3 months in the home of origin.
In-Home Service Cases with No Children Under 6	• One face-to-face contact with all household children and youth and their caregiver at a minimum of every 3 months in the home of origin. • If there is no contracted service in the home and the at-risk level is high, weekly face-to-face contacts are required until a service is in place. If the risk level is moderate or low, monthly contacts are required until a service is in place. Seen every 3 months in the home of origin.
Children Under 6 in Placement	• One face-to-face contact with children under 6 and their caregiver monthly and not less than every other month in the location where the children reside.
Children and Youth 6 and Over in Placement	• One face-to face contact with the children and youth 6 and over and their caregiver every 6 months in the location where the children and youth reside.
Children and Youth at Home and Closed with Siblings in Placement	• One face-to-face contact every 6 months in the family home with all household children and youth and their caregivers is the minimum in conjunction with the required Safety and Risk Assessments.
Youth on Runaway Status	• Continuing and appropriate efforts to locate must be made at least monthly.
Youth on Board Extensions and in College	• One face-to-face contact with the youth every 6 months at a mutually agreed upon location.

Exhibit 1.4 presents data for 4 years on the percent of child visitations performed by DHS social work services managers out of the total number of children requiring visits. This table measures the visit ratio for all children receiving services, both in-home and dependent placement. Compliance by DHS staff with visitation requirements has decreased from an average monthly compliance rate of 93.7 percent in calendar year (CY) 2010 to 74.4 percent in CY 2013.

Exhibit 1.4 Average Monthly Child Visitation Compliance by DHS Social Work Services Managers, CYs 2010–2013

Year	Average Number of Children Visited	Average Number of Children Requiring Visits	Average Percent Visited
2010	5,464	5,829	93.7%
2011	6,107	6,497	94.0%
2012	5,885	6,542	90.0%
2013	3,107	4,231	74.4%

Notes: This table measures the visit ratio for all children receiving dependent services, both in-home and in dependent placement. The visit ratio includes children age 5 years and under being visited monthly, children (ages 6 years and older) receiving in-home services being visited every 3 months, and children (ages 6 years and older) who are receiving dependent placement services being visited every 6 months.
Prior to March 1, 2013, DHS social work services managers were required to visit all children with an active case in CYD and receiving services, regardless of age or program, at least monthly. Effective March 1, 2013, visitation requirements changes based on age and placement type.

Exhibit 1.5 displays the visitation compliance for the population of children ages 5 and younger performed by DHS social work services managers from 2010–2013. This table measures the visit ratio for all children receiving services, both in-home and dependent placement. The visit ratio includes children age 5 years and under being visited monthly.

Compliance by DHS staff with visitation requirements for children younger than 5 years of age increased from an average monthly compliance rate of 91.3 percent in CY 2010 to 95.4 percent in CY 2011, and then decreased to an average of 91.1 percent in CY 2012 and then decreased to 69.0 percent in CY 2013.

Exhibit 1.5 Average Child Visitation Compliance by DHS Social Work Services Managers for Children 5 Years of Age and Younger, CYs 2010–2013

Year	Average Number of Children Visited	Average Number of Children Requiring Visits	Average Percent Visited
2010	2,105	2,305	91.3%
2011	1,999	2,096	95.4%
2012	1,985	2,179	91.1%
2013	1,369	1,984	69.0%

Notes: This table measures the visit ratio for children receiving dependent services, both in-home and in dependent placement.
Prior to March 1, 2013, DHS social work services managers were required to visit all children with an active case in CYD and receiving services, regardless of age or program, at least monthly. Effective March 1, 2013, visitation requirements changed based on age and placement type.

Private providers are still required to conduct monthly face-to-face visits with all children and youth involved receiving services regardless of age or program. The data are shown separately for children in dependent placement and children receiving in-home services.

For children in dependent placement, compliance with visitation by private agencies continues to improve (see exhibit 1.6). By the end of 2013, on average, 89.7 percent of the children in dependent placement received a monthly visit.

Exhibit 1.6 Average Monthly Child Visitation Compliance by Private Providers, CYs 2011–2013

Year	Average Monthly Number of Agencies Entering Visits	Average Monthly Number of Children Visited	Average Monthly Number of Children Requiring Visits	Average Monthly Percent Visited
2011*	59	3,277	4,462	74.4%
2012*	56	3,618	4,345	83.3%
2013	57	3,978	4,434	89.7%

Note: This table measures the visit ratio for children in dependent placement and does not include children receiving in-home services.

Exhibit 1.7 shows the visitation compliance for the population of children 5 years of age and younger in dependent placement performed by private providers for CY 2013. Prior to CY 2013, visitation data was not tracked separately for children 5 years of age and younger by private providers. Compliance by private providers with visitation requirements for children 5 years of age and younger is high at 97.1 percent for CY 2013.

Exhibit 1.7 Average Monthly Child Visitation Compliance by Private Providers, CYs 2011–2013 for Children Younger 5 Years of Age and Younger, CYs 2011–2013

Year	Average Monthly Number of Agencies Entering Visits	Average Monthly Number of Children Visited	Average Monthly Number of Children Requiring Visits	Average Monthly Percent Visited
2011				
2012				
2013	57	1,429	1,472	97.1%

Note: This table measures the visit ratio for children in dependent placement and does not include children receiving in-home services.

Exhibit 1.8 shows the visitation compliance for all children receiving in-home services by private providers for CY 2013. Prior to CY 2013, visitation data for children receiving in-home services was not tracked separately by private providers. Compliance by private providers with visitation requirements is high at 96.0 percent for CY 2013.

Exhibit 1.8 Average Monthly Child Visitation Compliance by Private Providers, CYs 2011–2013 for Children, CYs 2011–2013

Year	Average Monthly Number of Children Visited	Average Monthly Number of Children Requiring Visits	Average Monthly Percent Visited
2013	1,919	1,998	96.0%

Note: This table measures the visit ratio for children receiving in-home services and does not include children in dependent care.

Exhibit 1.9 shows the visitation compliance for the population of children 5 years of age and younger receiving in-home services by private providers for CY 2013. Prior to CY 2013, visitation data was not tracked separately for children 5 years of age and younger by private providers. Compliance by private providers with visitation requirements for children 5 years of age and younger is high at 98.6 percent for CY 2013.

Exhibit 1.9 Average Monthly Child Visitation Compliance by Private Providers, CYs 2011–2013 for Children Younger 5 Years of Age and Younger, CYs 2011–2013

Year	Average Monthly Number of Children Visited	Average Monthly Number of Children Requiring Visits	Average Monthly Percent Visited
2013	648	657	98.6

Note: This table measures the visit ratio for children receiving in-home services and does not include children in dependent care.

Discussion

The COB has expressed concern over the reduction in compliance with visitation requirements by DHS social work services managers in CY 2013. Between January 2013 and December 2013, the monthly compliance rate for visitation for all children decreased from 86 percent to 66 percent. During the same time period, the monthly compliance rate for visitation for children 5 years of age and younger decreased from 86 percent to 64 percent (See appendix D). However, during the same period, monthly compliance rates for face-to-face visitation for all dependent children by private providers continued to increase. Between January 2013 and December 2013, monthly compliance rates increased from 87 percent to 92 percent. Data regarding monthly compliance rates for children 5 years of age and younger in dependent care by private providers was first tracked in October 2013. Compliance rates for visitation of children 5 years of age and younger from October 2013 to December 2013 remained at 97 percent for private providers (see appendix E). In addition, visitation for children 5 years of age and younger receiving in-home services by private providers was at 96 percent. The COB is confident that all children in dependent placement are being seen, at a minimum, on a monthly basis. In addition, it is clear that the most vulnerable, children 5 years of age and younger receiving in-home services, are also being seen at a minimum, on monthly basis (see appendix E).

In discussions with the COB, DHS indicated that the reduction in compliance with visitation requirements by DHS social work services managers in CY 2013 is due to the inability of DHS to track visits that have been conducted with children if there is not a corresponding case note entered into the Electronic Case Management System (ECMS). As of May 2012, supervisors are not allowed to record a visit until the case note has been entered. Given current caseloads, DHS social work services managers are also behind in entering the required case notes. In addition, in early 2013 DHS began tracking visitation in the ECMS instead of the previously used Visitation Tracking System (VTS).

After consultation with the COB, DHS identified and is implementing strategies to address the issues regarding visitation by DHS social work services managers. DHS hired additional staff to address the caseload issue and is continuing to monitor caseload issues. In addition, DHS is updating ECMS so that data on visits conducted can be obtained even when a corresponding case note is not entered. At the same time, they are updating ECMS so that the number of visits without case notes is identified.

The COB will continue to closely monitor visitation by DHS social work services managers and the caseload issues as DHS continues to transition cases to the Community Umbrella Agencies (CUAs). The COB has requested that DHS provide visitation data by DHS and private providers for all children, children 5 years of age and younger, and by placement type. This will allow DHS and the COB to ensure that all children are being seen monthly.

Quality Visitation Review

The Quality Visitation Review (QVR) was developed to increase accountability as part of a larger continual quality improvement process surrounding practice at the DHS. The QVR process was implemented in July 2011. During this process children and caregivers are interviewed to ensure that visitation documented by both county and private provider staff is occurring and that the case file documentation accurately reflects the services being provided to the family.

The staff conducting the reviews uses a QVR tool. The tool measures the safety of the children and ensures that the information in the case record is accurate (e.g., visitation is occurring for the documented duration, and the frequency and content of the visit is consistent with the case narrative). The tool looks at the extent to which the child and family are engaged and working together to problem solve, identify service needs, and how to best achieve positive outcomes. The tool also guides the assessment of the process used by social work staff to assess the strengths and needs of the child and family, develop an individualized plan, and ensure that interventions and supports will address current needs and achieve safer permanency. The findings from the semi-annual reports that are developed are incorporated into the ChildStat process.[15]

[15] Through ChildStat meetings, DHS staff collectively review a specific case or cases in a particular area of services (e.g., Child Abuse or Neglect Hotline, Ongoing Services, In-Home Protective Services). A review of each case's detailed information, including what services were provided is conducted. 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.

DHS provided the COB with a semi-annual report that provides an analysis of the findings of the QVR of In-Home Protective Services (IHPS) cases since the reviews began in July 2011.[16] These reviews included cases from 14 DHS sections and 11 IHPS providers. Exhibit 1.10 provides an overview of the number of IHPS cases that have been reviewed in 6-month increments.

Exhibit 1.10 QVRs of In-Home Protective Services Cases[17]

Review Period	Number of Cases Reviewed
July—December 2011	166
January—June 2012	194
July—December 2012	127
January—June 2013	91

During the QVR process, each practice principle is measured using four possible ratings (see appendix F for definitions of each principle). For DHS staff, the four principles of engagement, teaming, assessment, and planning, are reviewed. For the provider staff, the four practice principles of engagement, assessment, planning, and intervention are reviewed. Ratings of 3 are considered to be optimal, indicating ongoing excellent quality visitation. Ratings of 2 are considered acceptable, indicating adequate visitation. Ratings of 1 indicate that minimal standards were not met. Ratings of 0 indicate substantially inadequate visitation or the falsification of documentation.

As shown in exhibits 1.11 and 1.12, the percentage of cases that received an acceptable rating on the four practice principles has fluctuated from July 2011 through June 2013. Teaming is the most notable practice principle in which improvement is needed by DHS. In general private provider ratings have been consistently higher than the DHS ratings. Overall, private providers have received ratings of acceptable or above on 80 percent or more of each of the four practice principles of engagement, assessment, planning, and intervention.

[16] Philadelphia Department of Human Services, Division of Performance Management and Accountability (September 2013). *Semi-Annual Report, Quality Visitation Review: January 2013–2013.*
[17] Ibid.

Exhibit 1.11 Percentage of Cases with Acceptable Ratings, DHS 2011-2013

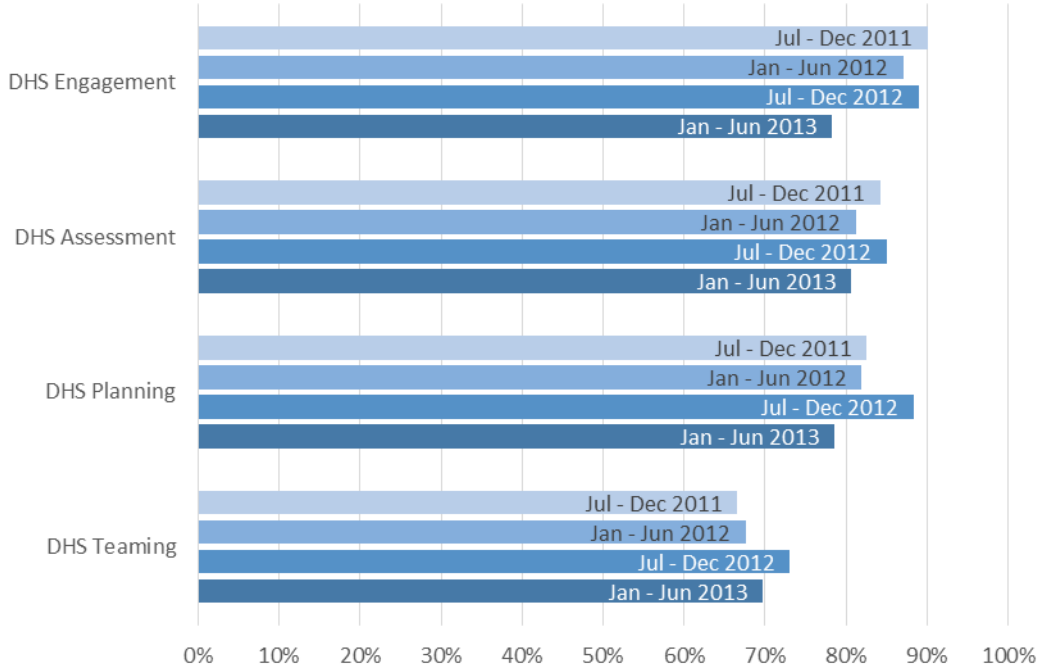
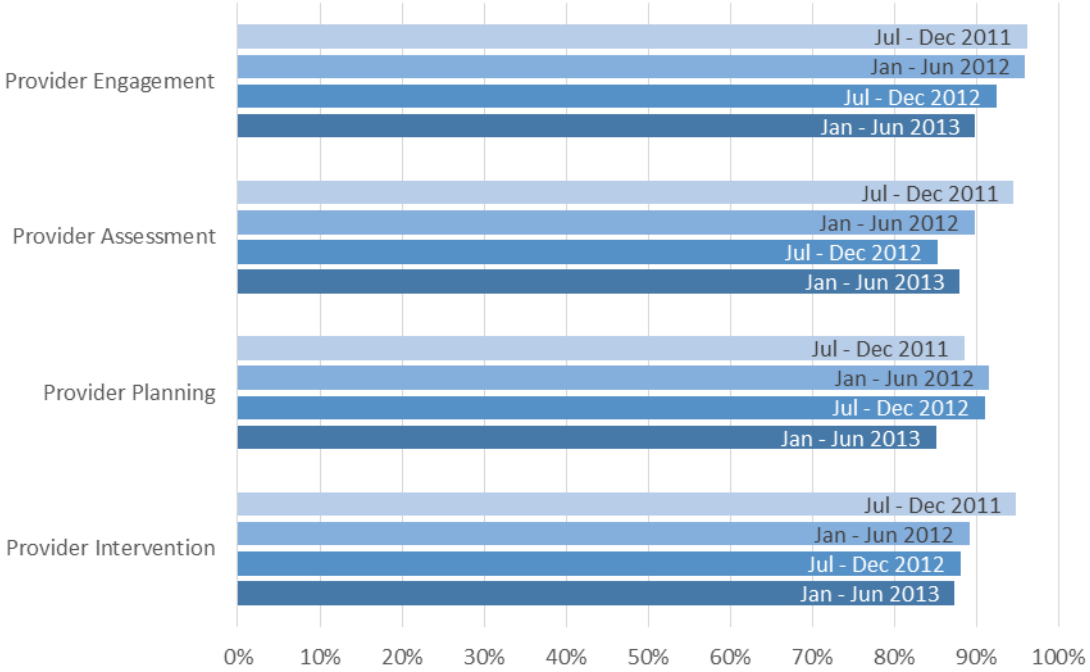


Exhibit 1.12 Percentage of Cases with Acceptable Ratings, Private Providers 2011-2013



Discussion

DHS implemented the QVR process to ensure that the quality of visits performed by DHS and private provider workers are comprehensive and address all safety issues that may be present. Quality caseworker visits are associated with a range of child welfare outcomes. Child welfare agencies that conduct quality visits on a regular basis are better positioned to assess children's risk of harm and need for alternative permanency options, to identify and provide needed services, and to engage children and parents in planning for their future. DHS is to be commended for continuing to collect and use data to both verify and measure the effectiveness of visits and to inform program improvement efforts. The COB is pleased to see that private providers are achieving high ratings in each of the four principles for conducting quality visits. As IOC initiative implementation continues, it is critical that the private providers are able to conduct quality visits. QVRs will continue to be an important tool for DHS to use as their oversight and monitoring role is enhanced. Quality visits are foundational to achieving positive outcomes for children and families.

Criminal Background Checks

The CWRP recommended that DHS conduct a background check on each member in the child's household. If an adult household member has a history with DHS or a criminal record that includes a conviction, then DHS must conduct an assessment to determine whether the household is safe and appropriate for the child."

After review and consideration of the challenges and drawbacks associated with conducting clearances on family members in all cases, the COB concluded that clearances should be conducted in specific critical situations including temporary moves associated with safety plans, prior to reunification, and prior to case closing. On September 2012, DHS implemented a new policy consistent with the COB's directive. This policy includes requirements for obtaining and considering past DHS involvement with the family, including reviewing ChildLine reports,[18] criminal history information, and Domestic Relations Court involvement of parents, and other household members.[19] In addition, the policy provides guidance to staff on how to use the information once it is obtained.

DHS reported to the COB, that in the year following implementation of the policy, the number of background checks doubled. The workload of the liaison unit (responsible for the backgrounds checks) is currently very high. As part of the rollout out of IOC, DHS plans to add additional staff to ensure that the background checks continue to be conducted in a timely manner.

DHS does not collect individual or aggregate data on the impact on case practice that occurs as a result of conducting the clearances. Anecdotally, DHS management reports that conducting the clearances is extremely helpful in guiding practice decisions. The COB will discuss with DHS the feasibility of capturing more information on the background checks conducted and the impact of these background checks. This information could be used to inform any changes in practice or policy that may be required and for determining staffing requirements.

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[18] The Pennsylvania ChildLine and Abuse Registry is known as "ChildLine." ChildLine accepts and assigns reports of child and student abuse to county children and youth agencies for investigation.

[19] The Philadelphia Department of Human Services, Children and Youth Division (August 31, 2012). *Required Clearances for household Members for Temporary Moves of Children and Youth to Create or Revised a Safety Plan, and Prior to Reunification or Case Closing*, Policy and Procedure Guide.

SECTION 2. KEY OUTCOME MEASURES

This section presents the status of the key outcome measures identified by the Community Oversight Board (COB) as indicators of the Department of Human Services' (DHS') performance related to child safety and well-being. The outcome measurement data were supplied by DHS' Division of Performance Management and Accountability (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 on DHS' overall progress related to child safety and well-being.

For the 2014 *Report on Progress*, the following measures are being reported:

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

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

This measure examines whether or not children experience 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 led to child maltreatment. A successful outcome is the absence of subsequent child maltreatment following the initial incident. An 18-month follow-up period is the used for assessing repeat maltreatment. This report examines trends in repeat maltreatment from state fiscal year (SFY) 2006 through SFY 2011.[20]

Pennsylvania law and regulations divide reports alleging maltreatment into two major types: (1) Child Protective Services (CPS), and (2) 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 that, if found true, would constitute child abuse as statutorily defined.[21] A report is considered a GPS report if it: (1) alleges that a child has been abused or neglected, but the allegation does not meet the statutory definition of child abuse; (2) is a non-incident-specific allegation of neglect; (3) 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 (4) alleges that a child is dependent as defined by the Juvenile Act.[22]

Both CPS and GPS reports can result in the provision of protective services for the child. Both types of reports represent some level of risk to the child. This Report on Progress examines the occurrence of repeat maltreatment for and across both CPS and GPS maltreatment reports. The data identify the number of children reported during each SFY who were involved in another substantiated incident of maltreatment within 18 months of the initial substantiated report.

[20] SFY 2012 data are not examined in this report because data through the 18-month follow-up period were not available at the time of the analysis.
[21] Philadelphia Department of Human Services, Children and Youth Division (January 2000). *Policy Manual*, Section 2200.
[22] Ibid.

Occurrence of Repeat Maltreatment

As shown in exhibit 2.1, the occurrence of repeat maltreatment was 10.7 percent in SFY 2006 and declined to 7.0 percent in SFY 2008. This represents a 34.6 percent decrease in the occurrence of repeat maltreatment from SFY 2006 to SFY 2008. The occurrence of repeat maltreatment increased from 7.0 percent in SFY 2008 to 9.9 percent in SFY 2011. This represents a 29.3 percent increase in the occurrence of repeat maltreatment from SFY 2008 to SFY 2011. Although the rate of repeat maltreatment was lower in SFY 2011 than in SFY 2006, it has been steadily increasing in recent years.

Exhibit 2.1 Repeat Maltreatment within 18 Months by Type of Initial Report, SFYs 2006–2011

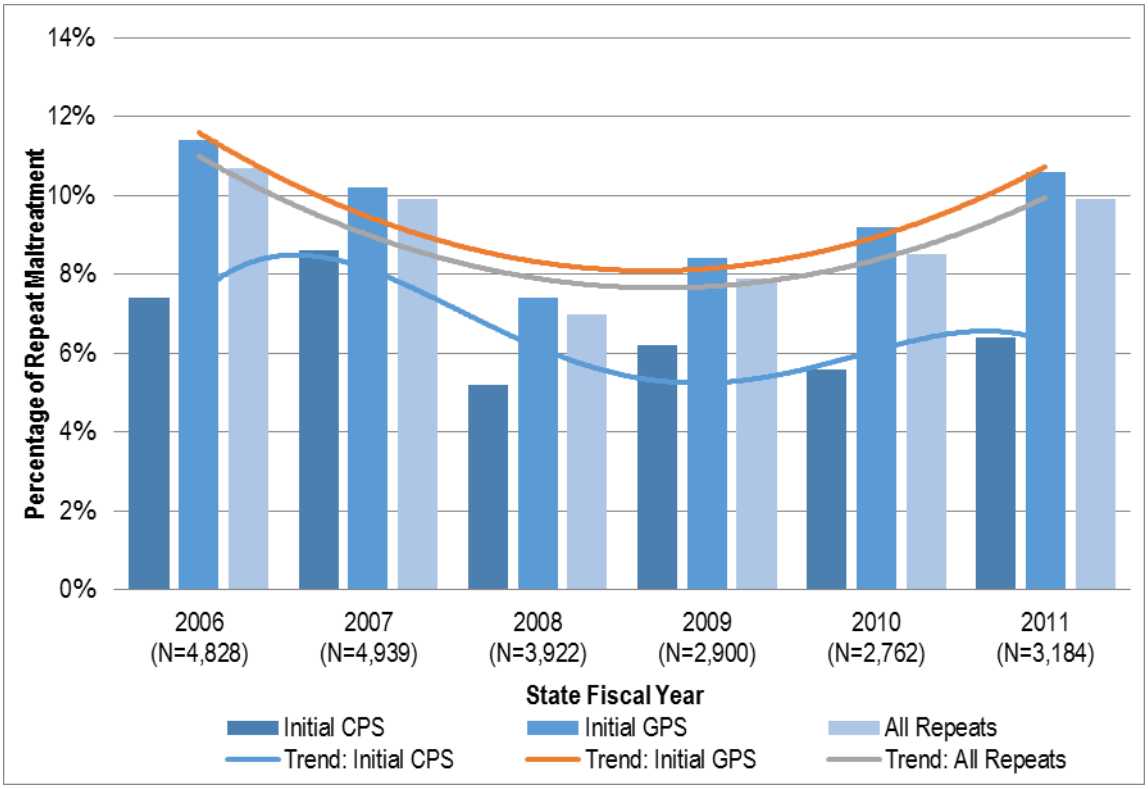
Type of Initial Report	# of Initial Reports	Type	Repeats	
			Number	Percent
2006				
Initial CPS	748	All Repeats	55	7.4%
		Repeat CPS	13	1.7%
		Repeat GPS	42	5.6%
Initial GPS	4,080	All Repeats	464	11.4%
		Repeat CPS	56	1.4%
		Repeat GPS	408	10.0%
All Reports	4,828		519	10.7%
2007				
Initial CPS	723	All Repeats	62	8.6%
		Repeat CPS	20	2.8%
		Repeat GPS	42	5.8%
Initial GPS	4,216	All Repeats	428	10.2%
		Repeat CPS	54	1.3%
		Repeat GPS	374	8.9%
All Reports	4,939		490	9.9%
2008				
Initial CPS	635	All Repeats	33	5.2%
		Repeat CPS	11	1.7%
		Repeat GPS	22	3.5%
Initial GPS	3,287	All Repeats	242	7.4%
		Repeat CPS	50	1.5%
		Repeat GPS	192	5.8%
All Reports	3,922		275	7.0%
2009				
Initial CPS	632	All Repeats	39	6.2%
		Repeat CPS	17	2.7%
		Repeat GPS	22	3.5%
Initial GPS	2,268	All Repeats	190	8.4%
		Repeat CPS	27	1.2%
		Repeat GPS	163	7.2%
All Reports	2,900		229	7.9%

Exhibit 2.1 Repeat Maltreatment within 18 Months by Type of Initial Report, SFYs 2006–2011, *continued*

Type of Initial Report	# of Initial Reports	Type	Repeats	
			Number	Percent
2010				
Initial CPS	570	All Repeats	32	5.6%
		Repeat CPS	12	2.1%
		Repeat GPS	20	3.5%
Initial GPS	2,192	All Repeats	202	9.2%
		Repeat CPS	18	0.8%
		Repeat GPS	184	8.4%
All Reports	2,762		234	8.5%
2011				
Initial CPS	531	All Repeats	34	6.4%
		Repeat CPS	17	3.2%
		Repeat GPS	17	3.2%
Initial GPS	2,653	All Repeats	282	10.6%
		Repeat CPS	33	1.2%
		Repeat GPS	249	9.4%
All Reports	3,184		316	9.9%

The trends in the percentages of repeat maltreatment are different depending on whether the initial report was CPS or GPS (see exhibit 2.2). GPS reports were substantially more likely than CPS reports to have a repeat incident (either GPS or CPS) within 18 months, in every year. This influences the trend of all repeat maltreatment reports because there are many more GPS reports than CPS reports. Among initial CPS reports, the occurrence of repeat maltreatment decreased from SFY 2006 to SFY 2011 overall. The occurrence of repeat maltreatment decreased substantially from 2006 to 2008 and then began increasing from 2009 to 2011. Among initial GPS reports, the occurrence of repeat maltreatment decreased from 11.4 percent in SFY 2006 to a low of 7.4 percent in SFY 2008 before increasing to 10.6 percent in SFY 2011.

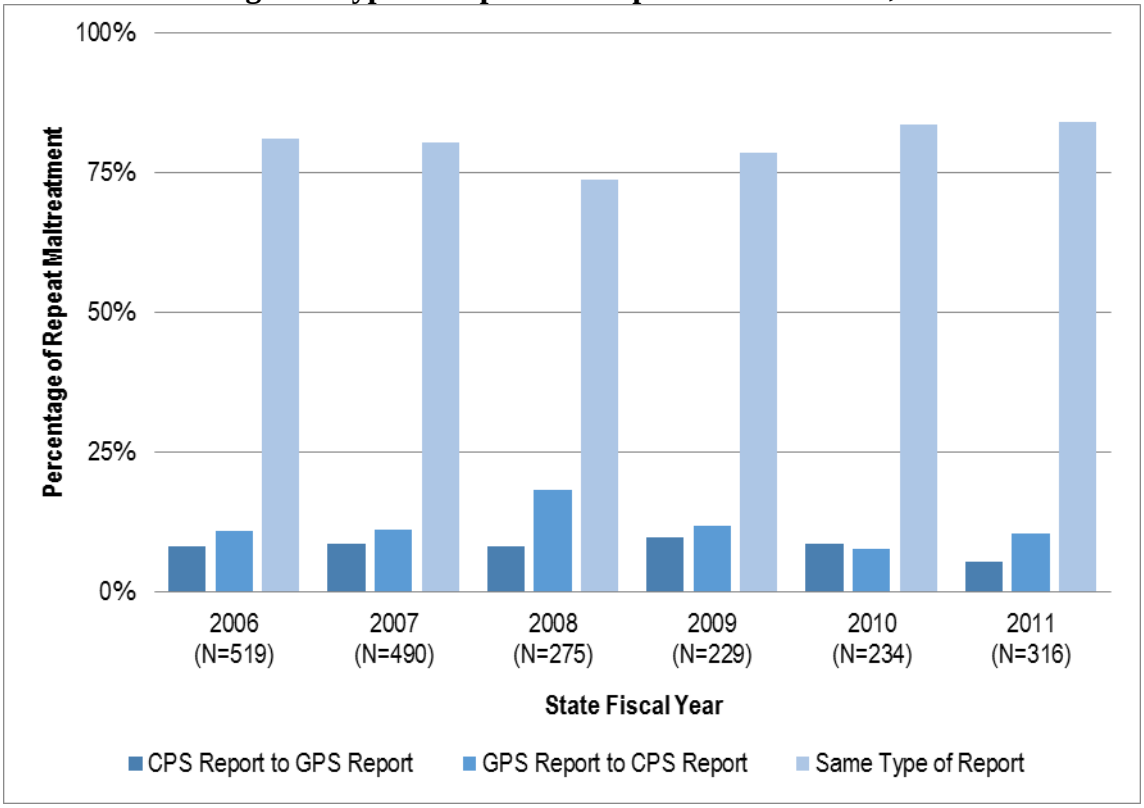
Exhibit 2.2 Repeat Maltreatment within 18 Months by Type of Initial Report, SFYs 2006–2011



N = Total number of initial reports in each SFY.

An examination of the types of repeat maltreatment relative to the type of initial report shows that there were more instances of an initial GPS report with a subsequent CPS report than instances of an initial CPS report with a subsequent GPS report, in every year except SFY 2010 (see exhibits 2.3 and 2.4). However, most instances of repeat maltreatment were of the same type as the initial report. The trends from SFY 2006 to SFY 2011 were generally flat, although there was a spike in SFY 2008 in the percentage of occurrences of repeat maltreatment that went from an initial GPS report to a subsequent CPS report.

Exhibit 2.3 Changes in Type of Report for Repeat Maltreatment, SFYs 2006–2011



Note: N = Total number of occurrences of repeat maltreatment in each SFY.

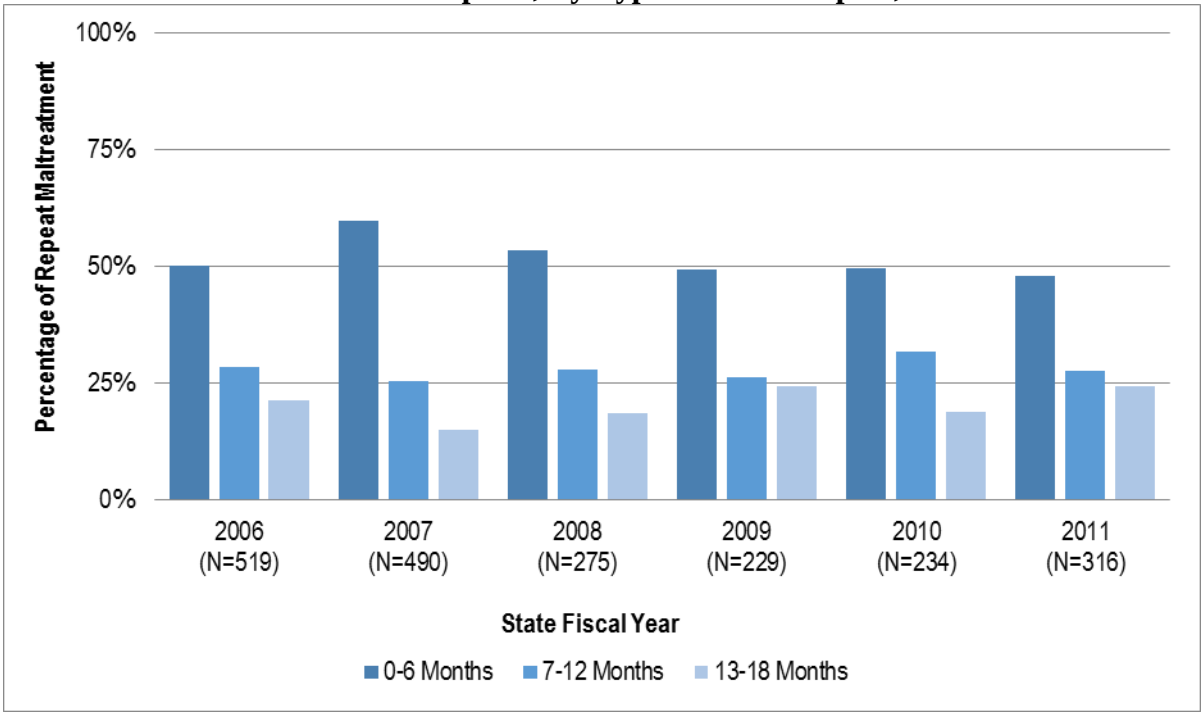
Exhibit 2.4 Changes in Type of Report for Repeat Maltreatment, SFYs 2006–2011

Fiscal Year	Total # Repeats	Repeats with Change from CPS Report to GPS Report		Repeats with Change from GPS Report to CPS Report		Repeats with Same Type of Report	
		N	%	N	%	N	%
2006	519	42	8.1%	56	10.8%	421	81.1%
2007	490	42	8.6%	54	11.0%	394	80.4%
2008	275	22	8.0%	50	18.2%	203	73.8%
2009	229	22	9.6%	27	11.8%	180	78.6%
2010	234	20	8.5%	18	7.7%	196	83.8%
2011	316	17	5.4%	33	10.4%	266	84.2%

Time Between Reports

This outcome measure examines the time between recurrent incidents (6 months or less, 7-12 months, or 13-18 months). Approximately half of subsequent incidents of maltreatment occurred within the first 6 months following the initial report (see exhibits 2.5 and 2.6). The percentage of repeat maltreatment that occurred within 6 months of the initial report was approximately the same from SFY 2006 to SFY 2011. The percentage of repeat maltreatment that occurred 7-12 months or 13-18 months after the initial report also remained approximately the same.

Exhibit 2.5 Time between Reports, By Type of Initial Report, SFYs 2006–2011



Note: N = The total number of occurrences of repeat maltreatment in each SFY.

Exhibit 2.6 Time Between Reports, By Type of Initial Report, SFYs 2006–2010

Type of Initial Report	Type of Repeat	0-6 Months	7-12 Months	13-18 Months	Total Number of Repeats
2006					
Initial CPS	All Repeats	31	12	12	55
	Repeat CPS	7	4	2	13
	Repeat GPS	24	8	10	42
Initial GPS	All Repeats	230	135	99	464
	Repeat CPS	34	11	11	56
	Repeat GPS	196	124	88	408
All Reports		261 (50.3%)	147 (28.3%)	111 (21.4%)	519
2007					
Initial CPS	All Repeats	29	19	14	62
	Repeat CPS	8	5	7	20
	Repeat GPS	21	14	7	42
Initial GPS	All Repeats	264	105	59	428
	Repeat CPS	28	11	15	54
	Repeat GPS	236	94	44	374
All Reports		293 (59.8%)	124 (25.3%)	73 (14.9%)	490

Exhibit 2.6 Time Between Reports, By Type of Initial Report, SFYs 2006–2010, *continued*

Type of Initial Report	Type of Repeat	0-6 Months	7-12 Months	13-18 Months	Total Number of Repeats
2008					
Initial CPS	All Repeats	16	13	4	33
	Repeat CPS	5	3	3	11
	Repeat GPS	11	10	1	22
Initial GPS	All Repeats	131	64	47	242
	Repeat CPS	27	8	15	50
	Repeat GPS	104	56	32	192
All Reports		147 (53.5%)	77 (28.0%)	51 (18.5%)	275
2009					
Initial CPS	All Repeats	17	9	13	39
	Repeat CPS	8	3	6	17
	Repeat GPS	9	6	7	22
Initial GPS	All Repeats	96	51	43	190
	Repeat CPS	22	3	2	27
	Repeat GPS	74	48	41	163
All Reports		113 (49.3%)	60 (26.2%)	56 (24.5%)	229
2010					
Initial CPS	All Repeats	13	10	9	32
	Repeat CPS	5	5	2	12
	Repeat GPS	8	5	7	20
Initial GPS	All Repeats	103	64	35	202
	Repeat CPS	15	1	2	18
	Repeat GPS	88	63	33	184
All Reports		116 (49.6%)	74 (31.6%)	44 (18.8%)	234
2011					
Initial CPS	All Repeats	18	10	6	34
	Repeat CPS	9	6	2	17
	Repeat GPS	9	4	4	17
Initial GPS	All Repeats	134	77	71	282
	Repeat CPS	17	8	8	33
	Repeat GPS	117	69	63	249
All Reports		152 (48.1%)	87 (27.5%)	77 (24.4%)	316

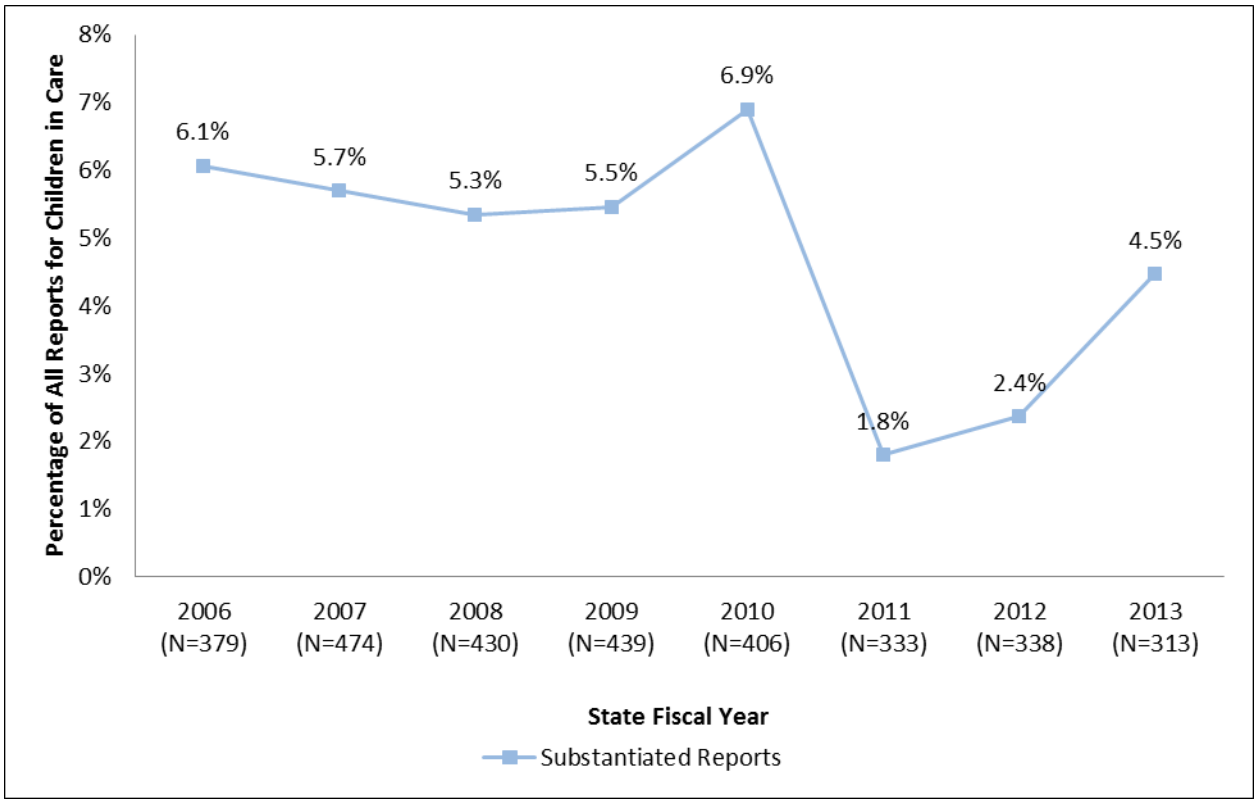
OUTCOME MEASURE 2: INCIDENCE OF CHILD MALTREATMENT IN PLACEMENT

Pennsylvania's Office of Children, Youth, and Families (OCYF) is responsible for receiving and investigating reports of maltreatment of children in placement. The following annual data on the incidence of child maltreatment in placement in Philadelphia was provided to DHS by OCYF.

Exhibits 2.7 and 2.8 present these data for state fiscal year (SFY) 2006 through SFY 2013. The total number of reports of maltreatment of children in DHS care decreased from SFY 2006 (379) to SFY 2013 (313). The percentage of substantiated reports of maltreatment of children in care remained

about the same from SFY 2006 to SFY 2009 (ranging between 5.5 percent and 6.1 percent). There was an increase in SFY 2010 to 6.9 percent, followed by a substantial decrease to 1.8 percent in SFY 2011. After SFY 2011, the percent of children maltreated in care increased to 4.5 percent.

Exhibit 2.7 Substantiated Reports of Maltreatment for Children in Care of DHS, SFYs 2006–2013



Notes: N = Total number of reports of maltreatment for children in DHS care in each SFY
This data was corrected in 2014 to reflect SFY reporting for all reporting years. Previously, these data was reported by calendar year (CY).

Exhibit 2.8 Reports of Maltreatment for Children in Care of DHS, SFYs 2006–2013

Results	2006	2007	2008	2009	2010	2011	2012	2013
Founded	0	1	1	1	1	0	1	0
Indicated	23	26	22	23	27	6	7	14
Substantiated Subtotal	23 (6.1%)	27 (5.7%)	23 (5.3%)	24 (5.5%)	28 (6.9%)	6 (1.8%)	7 (2.4%)	14 (4.5%)
Pending Juvenile Court	0	0	0	0	0	0	0	0
Pending Criminal Court	0	1	1	0	2	0	2	1
Pending Subtotal	0	1	1	0	2	0	2	1
Unfounded Subtotal	356	446	406	415	376	327	328	298
All Reports	379	474	430	439	406	333	338	313

OCYF has begun to provide data on maltreatment in placement to DHS on a monthly basis (see exhibit 2.9). Complete data for CY 2013 was not available at the time of this report.

Exhibit 2.9 Reports of Maltreatment for Children in Care of DHS by Month, CY 2013

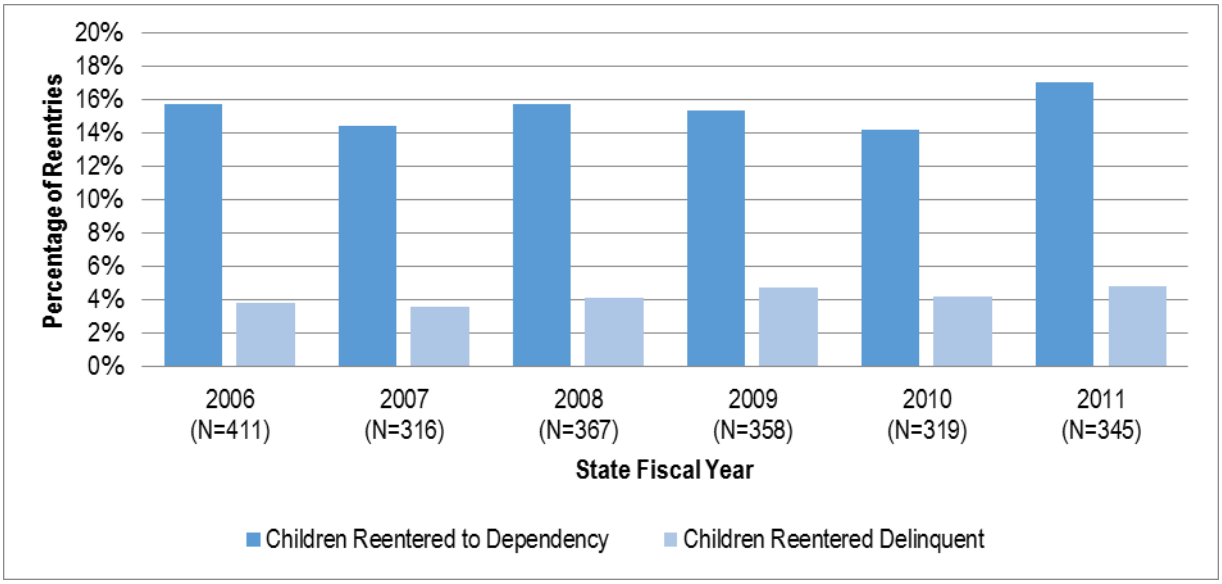
	Founded	Indicated	Substantiated	Pending Juvenile Court	Pending Criminal Court	Pending	Unfounded
Jan	0	2	2	0	0	0	23
Feb	0	1	1	0	0	0	16
Mar	0	1	1	0	0	0	35
Apr	0	2	2	0	0	0	30
May	0	0	0	0	0	0	30
Jun	0	3	3	0	0	0	27
Jul	0	2	2	0	0	0	24
Aug	0	0	0	0	1	1	1
Sep	0	0	0	0	0	0	0
Oct	N/A						
Nov	N/A						
Dec	N/A						

OUTCOME MEASURE 3: REENTRY INTO FOSTER CARE AND OTHER PLACEMENT TYPES

When a temporary placement is required to ensure the safety and well-being of a child, DHS seeks to return the child home as soon as the conditions that led to maltreatment or dependency have been remedied. If the issues 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 into a permanent setting as soon as possible. The outcome measure examining reentry into foster care and other placement types examines the instances in which reunification or discharge to an alternate permanency option has failed. In these instances, the child requires a return to a temporary placement. The measure is a gauge of the DHS' success in executing appropriate reunification and permanency placements.

Some children discharged to permanency during SFYs 2006–2011 reentered placement within 18 months. The total number of reentries fell from 411 in SFY 2006 to 319 in SFY 2010. In SFY 2011, the total number of reentries increased to 339. Some of these children reentered to dependency placements and some reentered to delinquency placements. The percentage reentering to dependency placements in each SFY was approximately four times greater than the percentage reentering to delinquency placements (see exhibits 2.10 and 2.11). The sum of the two percentages displayed in exhibit 2.10 for each SFY equals the total percentage of all children discharged to permanency in that SFY who reentered placement within the following 18 months. Between 2006 and 2010, approximately 20 percent of all children discharged to permanency reentered placement within 18 months. The proportions of children discharged to permanency who reentered placement remained about the same during those same years, with approximately 15 percent reentering to dependency placements and approximately 4 percent reentering to delinquency placements. In 2011, there was a decrease in the number of children and youth discharged to permanency. There was an increase in the number of reentries, specifically to dependency.

Exhibit 2.10 Reentry of Children and Youth within 18 Months of Discharge to Permanency, SFYs 2006–2011



Note: N = Total number of children and youth reentering placement during each SFY.

Exhibit 2.11 Reentry of Children and Youth within 18 Months of Discharge to Permanency, SFYs 2006–2011

Fiscal Year	Number Discharged to Permanency	Children and Youth Reentered		Children Reentered to Dependency		Children Reentered Delinquent	
		N	%	N	%	N	%
2006	2,099	411	19.6%	331	15.8%	80	3.8%
2007	1,748	316	18.1%	253	14.5%	63	3.6%
2008	1,848	367	19.9%	291	15.7%	76	4.1%
2009	1,775	358	20.2%	273	15.4%	85	4.8%
2010	1,731	319	18.4%	246	14.2%	73	4.2%
2011	1,579	345	21.8%	269	17.0%	76	4.8%

When permanency discharges fail, it is hoped that a future permanency discharge will be successful after a period of additional services provided by DHS. Fortunately, this is the case for most children served (see exhibit 2.12). A very small proportion of children who reentered placement after being discharged to permanency experienced more than one failed reunification or placement in a permanent setting. The percentage of children who reentered multiple times within 18 months increased from 0.5 percent of all reentries in SFY 2006 to 3.8 percent of all reentries in SFY 2010 and then decreased to 1.8 percent in 2011.

Exhibit 2.12 Single or Multiple Reentries within 18 Months of Discharge to Permanency, SFYs 2006–2011

Fiscal Year	Total Number of Reentries	Single Reentry		Multiple Reentries	
		N	%	N	%
2006	411	409	99.5%	2	0.5%
2007	316	313	99.1%	3	0.9%
2008	367	362	98.6%	5	1.4%
2009	358	348	97.2%	10	2.8%
2010	319	307	96.2%	12	3.8%
2011	339	333	98.2%	6	1.8%

SUMMARY

The outcome measures are a means to examine DHS' progress using quantitative measures of key areas. A review of the data does not provide a clear picture of the impact of the many practice and policy changes that have been implemented by DHS.

Regarding Outcome Measure 1, the overall occurrence of repeat maltreatment decreased from SFY 2006 to SFY 2008 and then increased from SFY 2008 to SFY 2011. Approximately half of the occurrences of repeat maltreatment happen within 6 months of discharge.

Regarding Outcome Measure 2, the total number of reports of maltreatment while in DHS care decreased from SFY 2006 to SFY 2013. The percentage of these reports that were substantiated remained about the same from SFY 2006 to SFY 2010, decreased sharply in SFY 2011, and rose in SFY 2012 and 2013.

Regarding Outcome Measure 3, the proportions of children discharged to permanency who reentered placement remained stable from SFY 2006 to SFY 2010. Data from 2011 show an increase in reentries.

DISCUSSION

The COB will continue to monitor these outcome measures. Given the transition to the IOC initiative, it is not surprising that the outcomes have not improved dramatically. They have not, however, declined dramatically. It is important to note that it is significant that DHS continues to improve its data collection and use for continuous quality improvement.

Appendixes

APPENDIX A. CWRP RECOMMENDATIONS BEING IMPLEMENTED THROUGH THE IMPROVING OUTCOMES FOR CHILDREN INITIATIVE

LOCAL OFFICE PRESENCE
1. DHS must establish a local office presence in a least one geographic location deemed highly at risk (Phase I, Recommendation 2.c).
FGDM/TEAM CONFERENCING
2. 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 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 (Phase I, Recommendation 2.d).
3. 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 of service provided, progress, and revisions to the FSP must be made as part of this process (Phase I, Recommendation 2.e).
CLARIFY ROLES AND RESPONSIBILITIES
4. DHS must clarify the roles and responsibilities for DHS workers relative to private agency workers, at both the supervisory and worker level (Phase I, Recommendation 2.f).
COMPREHENSIVE MODEL OF SOCIAL WORK PRACTICE
5. 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 (Phase II, Recommendation 2.a).
CO-LOCATION
6. DHS must complete the long-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 (Phase II, Recommendation 2.a.ii.6).
PERFORMANCE AND ACCOUNTABILITY
7. DHS must link its performance and the performance of its contracted providers to outcomes of accountability, including financial incentives (Phase II, Recommendation 3.b).
8. DHS must continue to expand its emphasis on making DHS a more transparent agency (Phase II, Recommendation 4.a).
9. 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 (Phase I, Recommendation 4.b).
10. DHS must revisit and expand the list of outcomes to be measured—whereas Phase One was largely focus on child safety, Phase Two will expand the focus to include permanency and well-being measures.

APPENDIX B. DEFINITIONS OF THE FOUR TYPES OF CONFERENCES IN THE FAMILY TEAM CONFERENCE MODEL

1. Child Safety Conference—The purpose of this conference is to create a viable safety plan to ensure children and youth are protected from identified safety threats.

2. Family Support Conference—This conference will assist with the development, review, and modification of goals, objectives, and action steps for the Single Case Plan (SCP) for families receiving in-home services.

3. Permanency Conference—The purpose of this conference is to develop, review, and modify the goals, objectives, and action steps for the Single Case Plan for families receiving out-of-home services.

4. Placement and Stability Conference—This conference is designed to increase placement stability and prevent moves. This conference will be held within 72 hours of a child's move.

APPENDIX C. IMPLEMENTED AND SUSTAINED CWRP RECOMMENDATIONS

CHILD VISITATION
1. 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 (Phase I, Recommendation 2.b.ii).
2. 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 (Phase II, Recommendation 2.a.iii).
3. 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 (Phase I, Recommendation 3.b.ii).
CRIMINAL BACKGROUND CHECKS
4. 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 (Phase II, Recommendation 2.a.ii.2).
CHILD HEALTH AND WELL-BEING
5. DHS must improve integration with physicians, nurses, and behavioral health specialists to ensure that each child's medical and behavioral health is appropriately assessed (Phase II, Recommendation 2.a.ii.3).
IMPLEMENTATION OF ELECTRONIC CASE MANAGEMENT SYSTEM
6. DHS must streamline its paperwork and records management practices (Phase II, Recommendation 2.a.v.).

APPENDIX D. MONTHLY CHILD VISITATION COMPLIANCE BY DHS SOCIAL WORK SERVICES MANAGERS, CY 2013

	Monthly Number of Children Visited	Monthly Number of Children Requiring Visits	Monthly Percent Visited
Jan	4,780	5,580	85.7%
Feb	3,981	5,604	71.0%
Mar	2,786	3,461	80.5%
Apr	2,664	3,611	73.8%
May	2,869	3,894	73.7%
Jun	2,669	3,739	71.4%
Jul	2,853	4,105	69.5%
Aug	3,102	4,296	72.2%
Sep	2,999	4,160	72.1%
Oct	3,036	4,218	72.0%
Nov	2,909	4,078	71.3%
Dec	2,639	4,028	65.5%
Average	3,107	4,231	73.4%

	Monthly Number of Children 0–5 Visited	Monthly Number of Children 0–5 Requiring Visits	Monthly Percent Visited
Jan	1,615	1,876	86.1%
Feb	1,354	1,884	71.9%
Mar	1,285	1,866	68.9%
Apr	1,233	1,942	63.5%
May	1,306	2,014	64.8%
Jun	1,220	1,921	63.5%
Jul	1,325	2,041	64.9%
Aug	1,409	2,017	69.9%
Sep	1,478	2,088	70.8%
Oct	1,446	2,072	69.8%
Nov	1,425	2,022	70.5%
Dec	1,330	2,063	64.5%
Average	1,369	1,984	69.0%

APPENDIX E. MONTHLY CHILD VISITATION COMPLIANCE BY PRIVATE PROVIDERS, CY 2013

	Monthly Number of Children Visited	Monthly Number of Children Requiring Visits	Monthly Percent Visited
Jan	3,797	4,347	87.3%
Feb	3,797	4,323	87.8%
Mar	3,896	4,384	88.9%
Apr	4,006	4,440	90.2%
May	4,030	4,521	89.1%
Jun	4,050	4,542	89.2%
Jul	4,070	4,535	89.7%
Aug	4,032	4,547	88.7%
Sep	4,058	4,410	92.0%
Oct	4,071	4,408	92.4%
Nov	3,933	4,385	89.7%
Dec	3,998	4,363	91.6%
Average	3,978	4,434	89.7%

Note: Dependent care population only.

	Monthly Number of Children 0–5 Visited	Monthly Number of Children 0–5 Requiring Visits	Monthly Percent Visited
Jan			
Feb			
Mar			
Apr			
May			
Jun			
Jul			
Aug			
Sep	1,461	1,507	96.9%
Oct	1,431	1,473	97.1%
Nov	1,424	1,468	97.0%
Dec	1,399	1,440	97.2%
Average	1,429	1,472	97.1%

Note: Dependent care population only.

	Monthly Number of Children Visited	Monthly Number of Children Requiring Visits	Monthly Percent Visited
Jan	1,864	1,918	97%
Feb	1,890	1,938	98%
Mar	1,841	1,889	97%
Apr	1,861	1,914	97%
May	1,930	1,989	97%
Jun	1,925	1,992	97%
Jul	1,940	2,025	96%
Aug	1,900	1,998	95%
Sep	1,972	2,052	96%
Oct	1,974	2,083	95%
Nov	1,962	2,088	94%
Dec	1,970	2,094	94%
Average	1,919	1,998	96%

Note: In-home services population only.

	Monthly Number of Children 0–5 Visited	Monthly Number of Children 0–5 Requiring Visits	Monthly Percent Visited
Jan	640	651	98%
Feb	631	644	98%
Mar	619	627	99%
Apr	630	642	98%
May	663	672	99%
Jun	648	653	99%
Jul	660	667	99%
Aug	644	649	99%
Sep	671	683	98%
Oct	668	672	99%
Nov	656	665	99%
Dec	640	653	98%
Average	648	657	99%

Note: In-home services population only.

APPENDIX F. FIVE PRINCIPLES OF QUALITY VISITATION REVIEWS

The five practice principles of Quality Visitation Reviews (QVRs) include (1) Engaging, (2) Teaming, (3) Assessment, (4) Planning, and (5) Intervention. Below are brief descriptions of the five principles.

Engaging—The practice of engagement focuses on the degree to which those working with the child and family are able to connect in a meaningful way with family members who can provide support and permanency to the identified child.

Teaming—The practice of teaming focuses on the formation and functional performance of the family team in conducting ongoing collaborative problem solving, providing effective services, and achieving positive results with the child and family. Team functioning and decision-making processes should be consistent with principles of family-centered practice and system of care operations.

Assessing—The practice of assessing focuses on the degree that the team has gathered sufficient information to have an accurate and comprehensive understanding of the child and family's strengths and needs. All of this must be understood in the context of the family's culture, hopes, and vision for the future.

Planning—The practice of planning focuses on the degree that the planning process is individualized and relevant to meet the needs and goals of the child and family.

Intervening—The practice of intervening focuses on the degree to which planned interventions, services, and supports being provided to the child and family have sufficient power and beneficial effect to produce the results necessary to meet the present needs and achieve outcomes that fulfill the long term view for safe case closure.