

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

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Presented to
Mayor Michael Nutter
and the Philadelphia Community

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Executive Summary

Executive Summary

Over the last year the Community Oversight Board (COB), established by Mayor Nutter in January 2008, has been monitoring the reform effort of the Department of Human Services (DHS) consistent with the recommendations of the Child Welfare Review Panel (CWRP). This report provides an update on progress on each recommendation and reports in detail in the areas of DHS monthly visits with children, Hotline Guided Decision Making (HGDM), child fatality response, and criminal background checks.

DHS made several notable achievements with regard to the reform efforts, which have significantly increased the focus on the safety of children in Philadelphia:

- **HGDM and the safety assessments.** This structured decision making process focuses the work of the agency on safety and appears to be reducing the acceptance of cases that do not involve safety issues. Preliminary data suggest that the number of protective supervision cases is declining and the number of families being referred to prevention by DHS is increasing.
- **Expedited visits for children birth to 5 years old.** This practice of visiting young children within 2 hours has allowed seeing the most vulnerable children immediately; triaging cases; reducing unneeded investigations; reducing the backlog of pending investigations; and most importantly, reviewing open cases by a worker who is not involved in the case.

In addition to these two notable achievements, several reforms are currently underway that hold great promise:

- **Safety focused model of practice.** A number of the new policies and practices that have been introduced provide the foundation for the development of a comprehensive model of practice. Safety Assessment, Hotline Guided Decision Making, Family Group Conferencing—when incorporated with risk assessment, family service plans and permanency planning—will integrate all of the work of the agency and provide needed direction to staff.
- **Culture of accountability.** Work in this area is multifaceted. DHS has demonstrated a willingness to hold staff accountable for egregious behavior. More work needs to be done to develop and use data strategically for staff and contractor agencies.
- **Planning for the local office.** DHS located a site for the first local office. This is a critical step in creating a more community-based system. Along with geographic assignment of cases, the office will better connect workers to the neighborhoods and to local resources. In addition, this will allow for the building of partnerships with communities and enhance their ability to protect children.
- **Family group decision making.** DHS has initiated and conducted family group conferencing, a practice strategy that facilitates the active engagement of families in solving the problems that place children at risk. This practice has the potential to ensure that placements are made only when safety problems cannot be solved. However, in order to realize the promise of this reform, DHS must significantly increase the participation of families, as well as the number of conferences completed.

The COB remains cautiously optimistic about the progress being made. DHS continues to take action on the CWRP recommendations. In most instances, the action is within the initially proposed timeline. Because of delays, some timelines have been renegotiated. In the process the COB has attempted to be both reasonable and ambitious.

At the same time, there is an urgent need for DHS to continue working to implement all the reforms recommended by the CWRP. There are several areas in particular to which DHS must pay even greater attention in the coming months. These areas are documented in the following sections.

Mission And Values

In keeping with the CWRP's recommendations, DHS has developed a new mission statement and set of core values, which embody the core goal of child safety. DHS also is planning revisions to its array of prevention programs to guarantee that they are consistent with ensuring child safety. Finally, DHS is moving forward with two new programs—In-Home Protective Services (IHPS) and the Alternative Response System (ARS)—both of which began in January 2009. IHPS carefully tailors the need for services for children living at home. ARS supports families with general needs where children are not at risk of abuse or neglect. The COB's recommendations in the area of Mission and Values are as follows:

- DHS should continue with its effort to retool its prevention programs, to ensure that they are targeted at those children and families at greatest risk of abuse and neglect.
- DHS should monitor the implementation of the IHPS and ARS programs using program data as well as the input from social workers, supervisors, and private agencies providing the services. As necessary, DHS should make modifications to the program to ensure that the right combination of services is being offered to the appropriate children and families.

Child Visitation

The COB has recommended that DHS implement a policy whereby all children in active cases are visited by a DHS social worker at least monthly. The department initiated this policy in July 2008 for all children ages birth to 5 years old in the five-county service area. Timelines called for the implementation of the same policy for all children ages birth to 5 years old living outside the five-county area in December 2008 and for all children, regardless of age, in January 2009. The COB makes the following recommendations:

- Given the challenges to DHS created by new visitation policies, a revised plan for implementation of monthly visits by DHS workers for all children in service should be submitted to the COB for discussion and approval.
- DHS should document the face-to-face visitation by all contract providers.
- The DHS Visitation Tracking System (VTS), which tracks all children whose cases originated in the five-county DHS service area, should generate reports on visitation compliance by the locations in which children are actually living.

Hotline Guided Decision Making

Hotline Guided Decision Making (HGDM) is a structured decision making tool DHS implemented in April 2008 that focuses the department's resources for children most at risk for abuse and neglect. HGDM has created a greater focus on the most serious cases referred to the agency and is intended to enhance and standardize the information obtained during the calls taken by Hotline staff, provide guidance and structure to the manner in which calls are taken, and ensure that the decisions made regarding the reports are according to agency policy and statutory requirements. While successful, there are several issues, particularly related to clarifying the tool for workers and integrating the manual paper-based HGDM process into an automated information system. Specific COB recommendations in this area include the following.

- Execute the planned implementation of FACTS2 as soon as possible to improve the efficiency of the call-taking process and to support the implementation of HGDM.
- Provide additional training and opportunities for peer consultation for workers who are not completely comfortable with the HGDM tool.
- Consider further refinements to HGDM to address areas of concern or confusion on the part of workers or supervisors.
- Continue community awareness efforts to address concerns raised by mandated reporters about the additional questions that HGDM requires workers to ask when taking referrals.

Expedited Response

DHS has fully implemented an Expedited Response (ER) program that provides a 0–2 hour response time for any report received at the Hotline that involves a child between the ages of 0 and 5. This is a critical success for DHS, as it has dramatically increased the responsiveness to Philadelphia’s most vulnerable children. However, we have several recommendations for further improvement of the ER program.

- Clarify the manner in which prioritization of ER reports is documented so that statistics reflect the actual response time based on ER rather than the HGDM priority result.
- Implement data collection and reporting related to ER cases handled by the Multidisciplinary Teams (MDT) and Intake units. This reporting should be consistent with the data available for the Hotline ER units in order to provide a complete perspective on the ER program.
- Conduct additional review of the ER system once data are available from the MDT, Intake units, and Intake Sexual Abuse units.

Child Fatalities Review

DHS has made incremental progress toward improving the child fatality review process. DHS has developed a new protocol for conducting and implementing recommendations from internal child fatality reviews, began entering data into a child fatality database, and implemented the practice of convening a “Strike Team” for child death reported to the Hotline for children active or known to DHS. However, DHS has yet to implement a strategy for using the findings from the Internal Child Fatality Reviews (ICFR) to understand child deaths in order to prevent future harm to children known to DHS. The COB believes that significant improvements to the death review process are urgently needed. The COB’s recommendations include the following:

- ICFRs and the lessons that may be learned from them need to be a priority for DHS. These reviews must include deaths of children active or known to DHS for which a General Protective Services (GPS) report is generated and those in which the child was in an out-of-home placement outside Philadelphia.
- Identify internal leadership and responsibility and necessary supports for the internal child fatality review process.
- Clarify and implement the process for conducting and strategically linking the DHS internal child fatality review (and near fatality) process with other child fatality review processes.
- Implement a process for conducting an analysis of the recommendations from the internal child fatality reviews and prioritizing and implementing appropriate recommendations.
- Continue to identify and implement effective strategies to address the most commonly known risk factors for deaths due to child abuse and neglect for children involved with DHS, particularly for children under the age of five, medically fragile children, children being cared for by parents or caregivers under the age of 20, and those with issues related to substance abuse. Many of these strategies will require collaboration and coordination with other agencies.

Criminal Background Checks

DHS policy issued in 2005 states that the department should obtain State police clearances on a regular basis in order to inform decision making regarding “placement resources and permanency for children, ongoing risk and safety assessments... and as part of investigations/assessments.” DHS has not instituted this practice due to concerns regarding its authority for asking for identifying information and its ability to enforce the requirement. In addition, DHS is struggling with the development of guidance on how social workers use this information that will ensure that they do not violate the civil rights of those providing the information. We strongly recommend that policy be developed expeditiously and the practice implemented in order to insure the safety of both children and the social work staff. The COB’s recommendations in the area of criminal background checks include:

- Develop policy regarding the process for conducting criminal background checks “on a regular basis to inform investigative and reunification decision making, and ongoing risk and safety assessments...as part of investigations/assessments” through the Pennsylvania State Police Central Registry; and

- Work with DPW to obtain direct “terminal access” to the National Crime Information Center database (NCIC); direct access would provide DHS’ immediate name-based criminal background information.

Outcomes And Accountability

DHS has made progress in developing strategies and procedures to measure and report on the internal performance of DHS and the performance of contract providers. DHS must now create report cards as recommended by the CWRP. While DHS current focus has been on identifying outcome measures related to permanency and child well-being, measures relating to child safety are of paramount importance. Efforts must be increased to incorporate safety-related measures into the monitoring and management of DHS and private agency performance. The COB’s recommendations in the area of outcomes and accountability include the following.

- Create and execute a plan to produce the annual report cards with the information already collected and analyzed. This plan should include a roll-out and distribution strategy for relevant DHS stakeholders, including providers.
- Create and publish an interim report card for both DHS and providers that focuses on the core measures of child safety that are not included in the January 2009 report cards.
- Develop a comprehensive plan for internal accountability that capitalizes on the information already available to DHS within its data systems, and develop the internal capacity to manage the plan over time.

Leadership And Infrastructure

DHS has made progress toward enhancing its internal effectiveness while also maintaining an increased degree of transparency to the public. Efforts such as paperwork reduction, implementation of new technologies and enhancements to existing information systems, and the stepped-up planning to implement a local area office are notable examples. The COB’s recommendations in the area of leadership include the following.

- Increase efforts to streamline the amount of required paperwork, which should include the implementation of the forms and document management processes already recommended by outside consultants.
- Significantly enhance new information systems to support workers, ensuring that the various information systems that are to be implemented act in as integrated a fashion as possible, thereby reducing burden on workers.
- Continue the planning efforts to open a local office.



CHAPTER 1

Report On Progress

The Community Oversight Board (COB) was created on June 14, 2007 by Mayor John F. Street and re-established by Mayor Michael Nutter in a new Executive Order in January 2008. The creation of the board was one of a series of recommendations to improve the performance of the Department of Human Services (DHS) made by the Child Welfare Review Panel (CWRP) in its report, Protecting Philadelphia's Children: The Call to Action (Call to Action) issued on May 31, 2007. The Executive Order charged the COB with monitoring the implementation of the recommendations by the CWRP in the Call to Action. The COB issued its first report, Assessment of Progress, on December 31, 2007, and issued a status letter to the Mayor on October 17, 2008.

The COB wishes to commend Mayor Michael Nutter for embracing the recommendations of the CWRP and his commitment to carry forward, without interruption, the important work of the COB. The near seamless transition between the Street and Nutter Administrations has reinforced for both DHS and the public at large that reform efforts will continue. Anne Marie Ambrose, J.D., has been appointed Commissioner and she is building a leadership team through strategic internal and external appointments. Dr. Arthur Evans and Dr. Joe Kuna also were instrumental in helping to ensure a smooth transition between the work of the CWRP and the COB.

As an oversight body, the COB must maintain a focused and critical review of DHS. The mandate of the COB extends to the operations of the entire department; however, the emphasis has been on the "front end" of child welfare, primarily intake and investigations. The COB recognizes that DHS is also implementing changes throughout the organization and wishes to draw attention to significant improvements in the area of adoptions and child placements. The department reports an 11 percent increase in the number of adoptions in 2008 compared to 2007. By the end of June 2008 there were 607 fewer children in placement than in June 2007 and 1,685 fewer children than in June 2003. The numbers indicate that the Department is working in a number of critical areas that are beyond the scope of the CWRP recommendations.

At the time of the original assessment by the CWRP, the random quality of practice was identified as a major problem. The COB wants to highlight that a new safety-focused model of practice is emerging in the department through the development and implementation of new practice tools and processes: Hotline Guided Decision Making (HGDM), expedited review, safety assessments and family group decision making. These tools provide more structure to practice and are designed to focus the service on safety and reduce the randomness of decision making that has been prevalent in the department.

Emerging Culture Of Accountability

DHS has recognized the importance of accountability. The Grand Jury investigation and indictments following the death of Daniael Kelly resulted in timely action against responsible staff. To shore up the City's capacity to manage illegal and unethical behavior, DHS is augmenting the Inspector General's staff. As employees have the experience of consistently being held accountable for standards of performance, the stigma that has characterized the agency based on a few poor performers can be reduced. In recent months, more effort has gone into recognition of exemplary performance. Clear standards coupled with fair accountability have the potential for shaping staff behavior and improving staff morale.

Also of significance is the creation of a Division of Performance Management and Accountability. This division will monitor internal performance and that of the contract agencies and work with leadership to improve the outcomes and quality of service. The division is in early development with key staff having been hired. Much work remains to be done to develop the strategies needed to effect change.

Although there is a beginning of a culture of accountability, the capacity to generate and utilize data in a more consistent manner is needed. Consistent use of data will inform the public and policy makers of progress and allow the shaping of service and management strategies based on information. These efforts have the potential for creating a learning organization that will be able to improve performance and respond to changes in the internal and external environment.

The COB notes DHS does not have the appropriate Information Technology (IT) and regular access to performance data to sustain true reform. The IT inadequacies inhibit social workers from performing at their most optimal level by requiring them to perform many manual tasks and by limiting access to timely and important information.

Organizational Trauma

The staff at DHS works daily with children and families that are suffering from the consequences of trauma. Repeated exposure to trauma weakens the ability of staff to serve families when there is no opportunity to address its impact on the work force. The Commissioner has recognized the impact of secondary trauma on staff and the need to reduce that stress in order to enhance performance.

For DHS, the organizational trauma associated with everyday practice has been exacerbated by the death of Daniael Kelly, the high level of public scrutiny, the firings of high ranking officials, the appointment of the Child Welfare Review Panel, the subsequent Grand Jury indictments, more firings, provisional licenses from the state, as well as the considerable changes in organizational leadership and practices. Commissioner Ambrose has recognized the severe impact all of this has had on DHS, and has engaged Dr. Sandra Bloom, internationally known expert on organizational trauma, to work with the DHS leadership and staff. Access to this training and consultation will help support a trauma-informed approach for system change.

External Relations

The current adoption and placement statistics are impressive indicators of improved relationships and communication with Family Court. A strong partnership with the Court is essential and the COB notes a marked change. At the same time, the relationship with the DHS provider community is strained. Providers have expressed concern about the deterioration in collaborative work with DHS. They specifically identified their lack of input on family service plans and their role in ongoing reform efforts. DHS's decision to implement new models of in-home services and reduce the number of providers, as well as its delays in payments and lack of consistency in monitoring performance standards, has contributed to the current situation. Since the vast majority of services are provided by private agencies, there is a need for ongoing communication and joint planning to better meet the needs of children served.

Fiscal Crisis

The City of Philadelphia, along with the nation, is in a severe economic crisis. The instability and unpredictability of the economy raises serious concerns about future demands and service capacity. The City is projecting a shortfall of over one billion dollars over the next 5 years. Although the DHS Prevention Division has sustained significant cuts, the core functions of DHS have been spared thus far. The COB expresses appreciation to the Nutter administration for recognizing that the economic crisis will impact even more harshly on vulnerable families in Philadelphia.

Information Systems

The COB has noted that within DHS, there is a lack of suitable information technology to support worker needs and system performance. In turn, the situation significantly impacts the department in virtually all areas of operations. This is most notable and pressing in the area of social work practice. The COB has looked at a number of areas of practice and found that the lack of a comprehensive and truly integrated information system to support workers has inhibited the ability of workers to care for children. Workers are performing too many administrative duties by hand. We also found that in many areas of DHS, a number of specialized databases are being used to track discrete activities, but are not linked, limiting their usefulness to the larger system. This is an area that DHS must reform moving forward.

Urgent Need For Continued Change

Finally, DHS has the most important of all government mandates—protecting children—and each and every task performed by the DHS workforce and provider agencies contributes to fulfilling this awesome mandate. The need for continued reform remains urgent. The COB recognizes that changes in policy and practice take time and the change process is stressful for staff. At the same time there is a need to continue to act aggressively and quickly to protect the children of Philadelphia.



CHAPTER 2

Assessment Of Progress

In this report, the Community Oversight Board (COB) provides an update on the implementation of each Child Welfare Review Panel (CWRP) recommendation. Not all areas are discussed at the same level of detail. As the COB transitions from reporting activities to the actual monitoring and verification of DHS progress, future reports will look at selected areas in more depth.

There were 37 separate recommendations, which are organized into five tables (Tables 3.1, 4.1, 4.2, 5.1, 6.1) that are located throughout this report. As a means of monitoring DHS progress toward planning and implementing recommendations of the CWRP, the COB developed the following classification system:

- Completed—DHS fully implemented a plan to address the recommendation to the satisfaction of the COB.
- Ongoing—DHS has fully implemented a plan to address the recommendation with activities ongoing (e.g., town hall meetings to increase community participation and DHS transparency).
- In progress—A plan to address the recommendation is in place with partial implementation.
- In planning—There is not yet an adequate plan for implementation.

In addition, the COB could classify any area of progress, including those that are completed or ongoing, as an area of concern.

- Area of concern—The COB has concerns about the plan to address a recommendation or its implementation.

Of CWRP’s original 37 recommendations, four from Phase 1 were superseded by recommendations in Phase 2. DHS has fully implemented 10 of the remaining 33 active recommendations; that is, 4 are completed and 6 are ongoing. Fifteen recommendations are in progress and seven are in planning. The COB has expressed concern about progress in seven recommendations—all in the area of child safety practices as seen in Table 2.1, Implementation Status of CWRP Recommendations. In Chapters 3 through 6 we explain the meaning of these findings.

Table 2.1. Implementation Status of CWRP Recommendations

Recommendations	Completed	Ongoing	Progress	Planning	Total	Concern
Mission and Values	2			2	4	
Child safety practices*		2	12	3	17	7
Outcomes/accountability	1		4	2	7	
Leadership/infrastructure	1	4			5	
Total	4	6	16	7	33	7

* Includes child fatalities review and new social work practice models.



CHAPTER 3

Mission & Values

The 2007 Child Welfare Review Panel's (CWRP) recommendations in the area of Mission and Values are intended to re-focus Department of Human Services (DHS) efforts on ensuring child safety, while maintaining a commitment to permanency and family well-being. There are four recommendations in this area: two each for Phases I and II. The DHS completed implementing the Phase I recommendations in 2007. Two items in Phase II are in planning and have due dates scheduled for 2009. Item 3 in Phase II contains two due dates: one for the completion of a work plan, and one for implementation. The Community Oversight Board (COB) did not identify any area of concern. Table 3.1, Status of Mission and Values Recommendations, summarizes the status of the COB's Mission and Values recommendations.

Table 3.1. Status of Mission and Values Recommendations

#	Recommendation	Panel Timeframe	Revised Timeframe	Status	Area of Concern
Phase 1					
1	Develop mission statement and core values that are centered on child safety.	12/2007	12/2007	Completed	No
2	Core values must embody specific principles. i. Creating a culture of respect, compassion, and professionalism ii. Enhancing communication and responsiveness to stakeholders iii. Instilling a greater sense of urgency among staff and providers iv. Providing services that are readily accessible v. Fostering a culture of collaboration vi. Providing culturally competent services vii. Creating a transparent agency	12/2007	12/2007	Completed	No
Phase 2					
3	Align prevention programs and resources with the mission and values developed in Phase 1, and also with the core principle of ensuring child safety.	11/2008	4/2009 Work plan 7/2009 Completion	In planning	No
4	Align more effectively in-home service programs and their utilization with DHS mission, values and with child safety.	1/ 2008	7/2009	In planning	No

DHS articulated a new mission and set of goals prior to the December 31, 2007, COB timeline:

The Philadelphia Department of Human Services is dedicated to providing and promoting safety for children and youth at risk of abuse, neglect and delinquency. Our goal is to strengthen and preserve families while empowering them to make choices that lead to stability and well being. We are committed to developing collaborative community partnerships and delivering culturally appropriate services in a respectful manner that are consistent with the needs of Philadelphia's diverse community.

In late 2007, DHS adopted a set of core values that included safety, permanency, well-being, respect, competence, teamwork, accountability, transparency, communication, and trust. DHS developed these values by (1) examining the mission and values that were in place in other comparable municipalities, (2) extracting the core principles that were consistent within DHS' principles, and (3) drafting a new mission statement and set of values.

Alignment Of Prevention Programs

In response to the increased focus on child safety, the CWRP recommended that DHS examine the programs in the Division of Community Based Prevention Services (DCBPS). DCBPS has the responsibility for fostering increased family well-being among the general Philadelphia population deemed to be at risk for child abuse and neglect. The intent of the CWRP's recommendation was that DCBPS programs be aligned with DHS' renewed emphasis on child safety.

In response, DHS engaged the Center for the Support of Families (CSF) to analyze the current alignment of DCBPS and Children and Youth Division (CYD) programs and recommend ways to align DCBPS programs with the renewed focus on child safety.¹ Findings in the resulting CSF report were consistent with the CWRP's recommendations, stating that alignment of DCBPS and CYD programs is "extremely limited" and that "DCBPS and CYD have developed parallel case management and service-delivery systems with little collaboration and considerable redundancy of effort."² The report further articulated that, to effectively realign DCBPS programs with the increased focus on safety, there must be greater collaboration among DCBPS and CYD and that they must share a common mission, goal, values, and model of practice. The concept of an integrated practice model was noted as especially important, as it would foster an ongoing focus on child safety across all DHS programs.

DHS has completed a significant amount of planning work related to prevention realignment. In December 2008, DHS conducted a survey that sought to obtain staff input on the effectiveness of current prevention programs, the potential range of future prevention programs, and the characteristics of families receiving prevention services. DHS assembled a Prevention Services Alignment Advisory Group to gather input from external stakeholders about the ongoing need for, and effectiveness of, prevention services. DHS solicited feedback from other groups and researched best practices for prevention-based programs that are in practice in other large jurisdictions.

DHS plans to submit a formal Prevention Realignment Plan to the COB by April 2009, which will incorporate many of the recommendations in the Prevention Alignment Report. After the plan is finalized, the COB will work closely with DHS to review the strategies and recommendations so that DHS could implement the recommendations by July 2009.

In-home Protective Services Program

The CWRP's final recommendation in the area of Mission and Values was to align in-home protective services with the new mission and values, particularly the increased focus on child safety. As with the DCBPS programs, the CWRP felt that the department's current in-home services program—Services to Children in their Own Homes (SCOH)—deviated from protecting children at risk of abuse and neglect and moved toward a more multifaceted program that provides a greater array of services focused on improving overall family functioning and well-being. While these services are valuable and necessary, they are not consistent with national best practices for in-home services—which stress the need for a child to receive services while remaining in their home—and they should first and foremost ensure that the child remains safe.

DHS contracted with the Center for the Support of Children (CSC) to assess the current SCOH program and offer recommendations for moving forward based on the CWRP's recommendation. CSC found that, overall, there was a "significant lack of a clear and consistent understanding of the scope, target client and expectations for SCOH services." Further, the report recognized that program documentation for SCOH failed to express child safety as the program's first and foremost goal and that the majority of children receiving SCOH services were not

¹ Prevention Alignment Report—Analysis and Recommendations, developed by the Center for the Support of Families, delivered to DHS on 4/18/08.

² Ibid, p.2.

necessarily at risk for abuse or neglect. Rather, SCOH had morphed into a poverty-assistance program, with the majority of recipients receiving assistance to meet needs related to housing, food, utilities, and the improvement of household deficiencies. The report also found that many SCOH families were receiving assistance to improve a child's school attendance.

Recommendations

The COB recommends that DHS continue its efforts to assess and revise their array of prevention programs. The department has continued to move forward in its plans and continues to solicit an admirable degree of feedback from stakeholders. During the coming months, the COB wants to work closely with DHS to monitor the revisions that will be made to prevention programs.

Recommendations from the report focused on short-term, intermediate, and long-term steps that DHS could implement to reform SCOH into a program focused more acutely on child safety, and thereby reflect national best practices for in-home protective services. Short-term goals included developing an action plan for redesigning SCOH, increasing the focus on safety through the use of the safety assessment and safety plans for SCOH families, and increasing the frequency of visits for families receiving SCOH, particularly in cases with very young children (younger than 1 year old) or children who are deemed medically fragile.

The CWRP included one intermediate recommendation: the development of a new In-Home Protective Services (IHPS) Program specifically focused on children in need of protection. Long-term recommendations included modification of intake practices so that only the most at-risk children were accepted for services. Another long-term recommendation was that DHS should develop an Alternative Response System (ARS) that would serve families in which there was no risk of child abuse or neglect and needed more general types of assistance.

DHS has made significant progress with the realignment of in-home services programs to promote the core value of child safety, and has done so in a manner that is consistent with the findings in the SCOH assessment. DHS has completed a competitive procurement for two new programs—IHPS and an ARS. Contracts have been awarded to providers as a result of the competitive procurement. Services in both programs began in January 2009. The COB is encouraged that a competitive bidding process was used and that providers were selected based both on the proposed array of services they will provide, as well as the prior experience and history the providers have in serving children in the target risk group. The COB will monitor the initial and ongoing implementation of these programs to ensure that they remain focused on their core population and that child safety is maintained as a primary focus.



CHAPTER 4

Child Safety & A New Social Work Practice Model

This chapter is comprised of six sections:

- A New Social Work Practice Model
- Monthly Visitation Statistics
- Hotline Guided Decision Making
- Expedited Response
- Child Fatalities Review
- Criminal Background Checks

The Child Welfare Review Panel (CWRP) made 17 recommendations pertaining to child safety and a new social work practice model. The COB presents the original recommendations in Table 4.1, Phase 1 Status of Child Safety and Practice Recommendations, and Table 4.2, Phase 2 Status of Child Safety and Practice Recommendations. Four recommendations in Phase 1 are now redundant with Phase 2 (see Table 4.1, recommendations 8, 10, 11, and 12).

Table 4.1. Phase 1 Status of Child Safety and Practice Recommendations

#	Recommendation	Panel Timeframe	Revised Timeframe	Status	Area of Concern
5	Implement and use an adequate evidence-based safety assessment tool.	6/2007	12/2008	Ongoing	No
6	Conduct a safety assessment for every child within DHS' care—both children at home and children in out-of-home placements.	9/2007	3/2007	Completed (in-home)	No
			12/2008	In progress (out-of-home placements)	YES
7	Conduct immediate (within two 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 (Expedited Response).	6/2007	9/2007	Ongoing	No
8	Conduct monthly face-to-face contacts with all families receiving any service supported by CYD that have a child 5 years of age or younger.	5/2008	7/2008	See Table 4.2	
9	Establish a local office presence in at least one geographic location deemed highly at-risk.	5/2008	9/2009	In Planning	No
10	Implement a team decision making process to determine service plans for children 5 years of age or younger.	1/31/ 2008	1/2009	See Table 4.2	
11	Ensure that ongoing team case conferencing occurs routinely every 3 months (this is the Family Group Decision Making [FGDM] model)	11/2007	6/2009		
12	Clarify the roles and responsibilities of DHS workers relative to private agency workers, at both the supervisory and worker levels.	8/31/2007	6/2009		

Table 4.2. Phase 2 Status of Child Safety and Practice Recommendations

#	Recommendation	Panel Timeframe	Revised Timeframe	Status	Area of Concern
13	DHS must develop a more 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; allows for individualized services	5/2008	2/2009	In Progress	YES
14	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	5/2008	2/2009	In progress	YES
15	DHS must expand the use of Family Group Decision Making (FGDM) to all children and utilize specialized resources in the case-planning process.	12/2008	12/2008 Complete 70 meetings 1/2009 Additional families targeted 3/2009 Implement at intake	In progress	YES
16	DHS must revise policies for case openings and closures	12/2008	12/2008	In progress	No
17	DHS must conduct background checks on all members of child's household	12/2008	12/2008	In progress	YES
18	DHS must improve integration with physicians, nurses and behavioral health specialists	12/2008	12/2008	In progress	No
19	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	12/2008	8/2008	In planning	No
20	DHS must eliminate "boilerplate" referrals and ensure each child receives appropriate referrals specifically tailored for his/her unique needs	12/2008	12/2008	In progress	No
21	DHS must complete long-planned co-location of DHS, police, medical, and forensic interview personnel at community site to facilitate collaborative decision making in investigative phase of casework.	12/2008	5/2009	In planning	No
22	DHS must conduct a minimum of one face-to-face contact per month with each child in its care.	5/2008	7/2008 Children 0-5 initiated in five county area 12/2008 All children 0-5 initiated 1/2009 All children initiated	In progress	YES
23	DHS must clarify the role of supervisors.	3/2008	3/2009 Concept paper 6/2009 Roll-out via training	In progress	No
24	DHS must streamline its paperwork and records management practices.	3/2009	8/2008 Staff hired 3/2009 Completion	In progress	No
25	DHS must enhance the fatality review process.	12/2007	1/2009	In progress	YES

A New Social Work Practice Model

In this section the Community Oversight Board (COB) summarizes DHS progress in the development of a new social work practice model. The CWRP structured its recommendations so that DHS would develop a more rigorous and consistent approach to serving children and families who are receiving care from DHS. In its report, the CWRP noted that there was a great degree of variation in how DHS workers coordinated care for clients. The CWRP also noted that child safety was sometimes jeopardized as the result of the (1) infrequent and variable application of safety standards, (2) lack of a consistent approach to completing risk and safety assessments, (3) failure to incorporate all available information to assess a child's circumstance, and (4) inability of supervisory staff to monitor worker decision making.

DHS Progress in Phase 1

The COB is pleased with the progress that DHS has made in implementing the practice reforms. Of paramount importance, the new practice model should embody the new mission and values that DHS created, and we feel that the increased focus on safety serves to accomplish this. We recognize that DHS has taken the CWRP's practice recommendation very seriously and is committed to implementing reforms that will safeguard the safety of the children in care. The following areas present some key progress in the department's effort to implement safety-based practice reforms. (The items in parentheses refer to the recommendations found in Table 4.1.)

- **Implement and use an adequate evidence-based safety assessment tool (recommendation #5).** In August 2008, DHS completed training on the new safety practice model, including the use of the new safety assessment tool, with ongoing training being conducted as necessary. The COB is pleased that DHS developed a quality assurance protocol that includes reviews of approximately 100 safety assessments per month to ensure the appropriate use of the safety assessment tool and is guiding the development of appropriate services for at-risk children and families. Over the coming months, the COB encourages DHS to ensure that workers—both DHS and contracted agency workers—continue to ensure the safety of children at each visit, and that the safety assessment tool is used as appropriate.
- **Conduct a safety assessment for every child within DHS' care (recommendation #6).** DHS completed a safety assessment for all children receiving in-home and placement services in March 2008. From DHS' reports, we understand that the Department is still refining how it will use the safety assessment with regard to Family Service Plan (FSP) development. As child safety is a key factor in the overall well-being of all children, the COB recommends that DHS continue monitoring how findings from the safety assessments are integrated into each child's FSP.
- **Implement a team-based decision making process (recommendation #10).** DHS developed the FGDM model and implemented it in Ongoing Family Service Region I. The COB is encouraged that DHS went beyond the CWRP's recommendation of implementing such a model for children aged 5 years and younger, and has rolled out the model to all children who meet specific criteria.⁵ However, implementation has been slow to develop. The COB urges DHS to continue expanding FGDM to other Family Service Regions and ensuring that the information gathered during the process is used to guide development of service planning efforts for the family.

The COB is also concerned about DHS's progress in clarifying the roles and responsibilities of DHS workers relative to those of private agency workers (recommendation #23). DHS plans to deliver a concept paper regarding this topic in March 2009, with implementation (including necessary training for DHS and provider staff) beginning by June 2009. The COB believes that DHS must work more closely with the provider community as this effort moves forward. Based on input from leaders in the provider community, it is clear that significant frustration exists among providers regarding their current relationship with DHS. Moreover, consideration must be given to the roles and responsibilities with regard to any governing policies established through labor management agreements for DHS staff.

⁵The FGDM criteria are used to assess children who (1) are at risk of placement; (2) have a change in placement; (3) are at risk of placement disruption; (4) are being discharged from placement; (5) participate in older youth permanency meetings; and (6) have other critical issues (e.g., permanency decisions).

The clarification of supervisory roles is important. DHS has progressed in clarifying supervisory responsibilities in the context of the new initiatives and programs it has implemented (e.g., ARS, IHPS, FGDM). However, multiple layers of supervision that exist within DHS must be addressed. It is again worth noting that, as with the DHS social work staff, a labor union governs DHS supervisors.

DHS Progress in Phase 2

The CWRP centered its Phase 2 recommendations on the creation of a comprehensive model of 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; allows for individualized services.” The CWRP included a broad set of practices that DHS should adopt in order to move toward a more structured and comprehensive approach to service delivery including the following:

- Development of an evidence-based practice model that relies on analysis and evaluation to improve practice;
- Expanded use of team decision making;
- Increased frequency of face-to-face contacts with children of all ages;
- Clarity regarding the role of supervisory staff;
- Streamlined paperwork and records management; and
- Improvements to the fatality review process.

DHS has made progress—in some cases significant progress—in each of these areas. As stated previously, DHS has implemented the use of the safety assessment tool, implemented the FGDM model, made strides toward increasing the frequency of face-to-face visits between DHS staff and clients, and created an Emergency Response (ER) unit to respond immediately to reports of suspected abuse and neglect among children ages birth to 5 years old. These initiatives have helped to redouble DHS’ focus on ensuring child safety, and represent a positive change in direction in this regard.

Recommendations

The COB presents its recommendations in the following areas.

Ensuring child safety at each contact. DHS has completed the safety assessments of children in both in-home and out-of-home placements. We are pleased that this has happened as ensuring child safety is the overall objective of the CWRP’s report. However, it is essential to assess the safety of children at each contact with the child and his or her family, and that the safety assessment tool supports this assessment. Rather than completing the safety assessment tool at each visit, it should be used as necessary to document the child’s safety and ensure that all relevant factors have been considered. The critical issue is that each DHS and private agency worker ensures the safety of every child at each contact. The COB plans to work with DHS during the coming months to ensure that this ongoing assessment is happening at each contact with the child.

The COB is also concerned that the State has not yet finalized the safety assessment tool to be used for children in out-of-home placements. It is critical that social workers—in Philadelphia and elsewhere—have a finalized tool that covers all of the essential components of safety to ensure that workers are assessing safety according to accepted and agreed upon standards. The COB urges the State to finalize and publish the safety assessment as soon as possible.

Supporting families through the continuum of care. The CWRP recommended that the new practice model focus on child safety and bring together programs and practices that promote child permanency and well-being and embody the new mission and values (recommendation #13). The COB recognizes that DHS has made significant progress with regard to establishing a focus on child safety—the primary focus of the CWRP’s report. However, it is important that DHS address factors of child permanency and well-being and integrate programs and practices that embody these concepts into the new social work practice model. In doing so, the department will be able

⁶Philadelphia Child Welfare Review Panel. (5/31/07). Protecting Philadelphia’s Children: The Call To Action.

to more effectively address a child and family's entire service episode within DHS, from entry to exit. Practices such as case planning, FGDM, and stricter adherence to timeliness have been implemented with the goal of promoting permanency and well-being; yet, the COB urges DHS to expand these efforts to encompass more children and families.

More generally, the practice reforms need to guide DHS workers on aspects of casework, including ongoing services and resolution of problems. For instance, while DHS continues to focus on increasing frequency of face-to-face contacts, it is important that contacts focus on issues of permanency and well-being and not only on child safety. Risk assessments, safety assessments, and FGDM must become more closely integrated so that the information collected in each activity is considered in the development of service plans. Finally, as DHS continues to clarify the roles and responsibilities for DHS workers vis-à-vis private agency workers, it will be crucial that providers understand their role in fostering safety, permanency, and well-being, and do so within a community-based environment.

Collaboration with providers. As a result of the reform efforts underway, DHS has made significant changes in its relationships with providers. Recent competitive RFPs for the IHPS and ARS programs represent a shift in procuring services that force providers to more clearly articulate their service strategies, discuss their qualifications, and describe their monitoring and measurement strategies. In the procurement of services for these programs, DHS significantly reduced the number of providers, which will relieve the burden of monitoring contract compliance and allow DHS to spend more time measuring the effectiveness and outcomes that the providers produce.

The changes in how DHS is approaching provider relationships have resulted in some concern among providers. In a meeting with providers in December 2008, providers expressed concern that DHS workers are not always gaining the input of the private workers as service plans are developed and the family's progress is monitored. At the executive level, providers feel as though DHS is not as helpful as it should be, citing concerns such as late payments on contracts, poor monitoring and application of performance standards, lack of input from providers in development of the annual provider report cards, and failing to consult with providers regarding the clarification of roles and responsibilities that the CWRP recommended. In addition, providers noted concerns that children of color are overrepresented in the system and face disparate outcomes. Providers noted that there is a need for a more diverse base of providers to care for children.

Provider representatives expressed significant anxiety about the ongoing nature of the reforms and the role that providers will play in partnering with DHS to continue services. Several providers expressed concern about the implementation of the IHPS and ARS programs. Specifically, some provider representatives feel that DHS simply did not select enough providers for the programs. Others indicated that the set of providers selected may not have the skills and experience necessary to serve DHS' diverse client base. The COB is pleased that DHS has indicated its plans to closely monitor the implementation of these programs to ensure that the provider base is large and diverse enough to serve the intended program recipients. We will work closely with DHS during the initial implementation of these programs to assist with monitoring efforts.

Several providers also noted the lack of clarity regarding roles and responsibilities for DHS and private agency providers. This issue was discussed previously, and the COB reiterates that as DHS moves forward with the development of the concept paper on roles and responsibilities, it works more closely to obtain provider input.

More generally, providers felt that DHS had become less collaborative in nature since the dissemination of the CWRP's report and that, on a day-to-day basis, DHS staff does not sufficiently value the information, knowledge, and experiences that provider staff have gained in their regular interactions while coordinating services for DHS clients. Given that private agencies deliver the vast majority of direct services, the COB believes that greater focus on collaboration with providers is warranted. Further, this collaboration must be real and meaningful. The COB recommends that DHS develop a plan to work more effectively with providers during the coming months and that provider input and feedback regarding the reforms are considered.

Creation of an evidence-based practice model. An overarching principle with regard to the Phase 2 practice recommendations directed DHS to develop an evidence-based model of practice. This will require an approach to practice that integrates the new approaches (safety assessment, FGDM, family service plans, risk assessment and permanency decisions) and the ability to evaluate the impact of the model on client outcomes. At this stage,

a number of the elements are in place, though much more thought needs to be given to the connection of all of the components.

DHS has yet to implement a truly rigorous and integrated evaluation component to better understand its clients, its own performance, and the effectiveness of its services delivered to clients. As noted in other sections of this report, efforts are underway to create enhanced data and information about DHS services and clients, such as with the DHS internal and provider report cards. However, there is little evidence that DHS has developed a comprehensive plan for integrating the use of information into the management of daily activities. For instance, DHS has not developed the capacity to monitor the frequency of visits or track the timelines for ER.

The COB recognizes that an evaluation component requires significant resources, particularly to develop and implement the necessary information management systems to collect such information. While FACTS provides some useful information, the need for a new information system is clear. We understand that DHS has plans to implement FACTS2 for Hotline workers and that a new system called Libera is currently in development. However, FACTS2 has been in development for several years and has yet to be implemented. As well, the implementation timeline for Libera has recently been delayed. While creating these systems is resource intensive, the COB urges DHS to redouble its efforts and bring these systems to implementation as quickly as possible.

Create, enhance, and integrate DHS information systems to support social work staff. It was clear from virtually all aspects of our research into DHS' implementation of the reforms that there is a significant need for enhanced automation to support DHS' work. This is true in all areas, and perhaps most importantly in the area of social work practice, where the lack of automated supports is seriously inhibiting the ability of caseworkers to provide quality services. Workers reported that they currently do not have all available information on a family or the information that is available is out of date. Moreover, workers reported that they continually spend significant amounts of time completing paperwork manually, which limits their ability to meet with families, develop service plans, and understand the family dynamic within the larger community environment. While DHS continues to move forward with plans for FACTS2 for the Hotline, the COB has not heard of any plans for integrating these systems with the many other individuals systems that have been developed in response to a specific question or request for information. For example, the department has created a very useful database that maintains information on child fatalities, yet this database is completely isolated from other systems and has no ability to exchange data electronically.

The COB recognizes that implementing new information systems is a very difficult task. However, DHS has been planning FACTS2 for some time and the implementation date has repeatedly been pushed back. Further, the COB is not clear on how the recent planned addition of Libera will factor into the larger DHS IT portfolio. While we recognize that the Mayor's Office of Information Technology has recently reviewed both initiatives, the COB intends to work more carefully with DHS during the coming months to understand the larger context of DHS' information system and to understand DHS' plans to use these systems to facilitate better casework among social work staff.

Monthly Visitation Statistics

In this section, the COB will demonstrate that the implementation of the CWRP recommendation for monthly face-to-face visitation by DHS social workers to all children in service presents a tremendous challenge to the department. We begin this section with some descriptions of DHS statistical categories and then describe current DHS policy pertaining to monthly visits. We will then describe the Visitation Tracking System (VTS) and the numbers and percentages of children visited per DHS policy for a 6-month period (May–October 2008). Because the VTS began producing separate monthly statistics for children in service who were ages birth to 5 years old in summer 2008, we present statistics for a 4-month period (July–October 2008). Using October as an example, we present actual monthly visitation statistics for all children in service and by three general service categories.

Service Categories for Monthly Visitation

The following analysis applies only to cases receiving services. The VTS does not include cases that remain in investigation or assessment; there is a separate system for those cases called the Intake Statistics System (ISS). DHS refers to cases under investigation or assessment as open cases. Active cases are those that have been referred for service after workers complete an investigation or assessment.

Three VTS categories require explanation:

- In-Home Protective Services (IHPS), formerly Services to Children in their Own Homes (SCOH), are services children receive while living at home.
- Non-IHPS children are waiting for decisions by a court, receiving day care or day treatment services, in cases that involve sex abuse, or in families who refuse to cooperate with DHS service recommendations.
- Purchased placement refers to children living in residential care, group homes or foster care, kinship care, or independent living arrangements.

DHS Policy

As the result of a CWRP recommendation and COB follow-up, DHS plans to implement a policy whereby all children in active cases must be visited by a DHS social worker at least monthly. The department initiated this policy in July 2008 for all children ages birth to 5 years old in the five-county service area. In December 2008, COB mandated the implementation of the same policy for all children ages birth to 5 years old living outside the five-county area, and for all children—regardless of age—in January 2009. DHS workers are in compliance with face-to-face visitation requirements if the visits take place in the office, at home, outside the home, or in placement.

For all children 6 years old and older, visitation requirements vary depending on the service category. Table 4.3, DHS Visitation Policy, by Service and by Age, summarizes the VTS compliance rules as applied to DHS policy.

Table 4.3. DHS Visitation Policy, by Service and by Age

Children in Service		Age	DHS Visitation Policy
All children		Birth to 5 years	Monthly
All active cases		6+ years	Within 1 month of last intake visit
IHPS, formerly SCOH		6+ years	Quarterly
Family preservation/reunification		6+ years	Monthly
Non-IHPS	High risk	All children	Weekly
	Moderate risk	6+ years	Monthly
	Low risk	6+ years	Quarterly
Purchased care (in placement)		6+ years	Every 6 months
Finalized adoption		Does not apply	No visitation required

DHS must visit all children 6 years old and older in cases the department referred for services within 1 month of the last visit made by the investigation or assessment worker. A DHS worker must visit all children in IHPS quarterly, regardless of the number of visits made by providers. The policy states monthly visits must be made for all family preservation and reunification cases. The face-to-face visitation policies for non-IHPS cases vary by risk level, as described in Table 4.3. The department must visit all children in placement every 6 months, regardless of the number of visits made by providers. There are no visitation requirements for finalized adoptions.

The COB acknowledges that DHS visitation policies will change in 2009. Future progress reports will reflect those changes.

Visitation Tracking System

Once the data are hand entered by DHS supervisors, the VTS checks the date of the last required face-to-face visit for each child in the system, noting compliance or non-compliance for the month. VTS then divides the number of children visited by the number of required visits for the month for percentage compliance. By the 7th business day of each month, DHS calculates percentage compliance for each worker, supervisor, administrator, director, and deputy commissioner.

While VTS includes all children under the care of contract providers, only those visits conducted by DHS social workers are counted.

Findings

Table 4.4, Visitation Compliance, contains visitation statistics for a 6-month period (May–October 2008). The numbers represent required visits and children visited that month in accordance with DHS policies. Because the VTS adjusts compliance percentages per DHS policy, the numbers do not represent actual face-to-face contacts. Children may have been visited numerous times in any given month. Compliance ranged from 85 percent in July 2008, to 91 percent in October 2008. For example, the DHS caseload in October contained more than 11,000 children. Under current DHS policy, 7,163 children were scheduled for visits, and 6,521 children were visited at least once, for a compliance ratio of 91 percent.

Table 4.4. Visitation Compliance

Visitation of All Children in Service per DHS Policy						
	May	June	July	August	September	October
Required Visits	5,057	5,436	7,563	7,626	7,326	7,163
Compliance	4,409	4,673	6,493	6,793	6,620	6,521
Percentage	87%	85%	85%	89%	90%	91%
Visitation of All Children in Service, Ages Birth to 5 Years						
	May	June	July	August	September	October
Required Visits	DNA	DNA	4,100	4,074	4,056	4,013
Compliance	DNA	DNA	2,998	3,348	3,245	3,300
Percentage			73%	82%	80%	82%

As stated above, in July 2008 DHS implemented a new policy that required all children aged birth to 5 years old to have a monthly face-to-face visit from a DHS social worker. The VTS began tracking those visits that same month. DHS was in compliance with the new policy at 73 percent for that first month. Following the first month of implementation, completed visits ranged from 80 percent to 82 percent.

In Table 4.5, Visitation Tracking System Actual Monthly Visitation in October 2008, the numbers and percentages are not adjusted by DHS policies and reflect the actual number of children who received a face-to-face visit from a DHS social worker. Using October 2008 as an example, we present those numbers by VTS category. All numbers represent an unduplicated count of children visited.

Table 4.5. Visitation Tracking System Actual Monthly Visitation in October 2008

	IHPS (SCOH)	Non-IHPS	Placement	Total
Children in Service	1,536	4,190	5,521	11,247
Children Visited	937	2,840	2,725	6,502
Percentage	61%	68%	49%	58%

Of the 11,247 children in active cases in October 2008, 58 percent received a face-to-face visit from a DHS social worker. The percentages ranged from 49 percent of children in placement to 68 percent of all children in the category of non-IHPS. As mentioned earlier, this does not mean that the children were not visited; rather, it means they were not visited by DHS social workers.

In order to comply with a policy that all children in service must be visited face-to-face monthly by a DHS social worker, DHS would have had to make 4,745 more visits in October than the 6,502 visits recorded in the VTS.

Recommendations

The analysis of DHS visitation statistics has revealed a daunting challenge to the department. At the same time the COB is committed to frequent fact-to-face visiting by DHS social workers for all children receiving services. We will not forget that the creation of the CWRP and the continuing work of the COB resulted from the failed surveillance of one vulnerable child.

The COB makes four recommendations.

1. Given the challenges to DHS created by new visitation policies, a revised plan for implementation of monthly visits by DHS workers for all children in service should be submitted to the COB for discussion and approval.
2. DHS should document face-to-face visitation by all contract providers.
3. Investigate compliance with face-to-face visitation in cases under investigation or assessment as recorded in the Intake Statistics System.
4. The DHS VTS, which tracks all children whose cases originated in the five-county DHS service area, should generate reports on visitation compliance by where children are actually living.

Hotline Guided Decision Making

The COB review of the status of Hotline operations and the implementation of Hotline Guided Decision Making (HGDM) and Expedited Response (ER) was planned and conducted as a cooperative effort by the COB, DHS staff, and employee union representatives.

Approach

The review of HGDM included a 2-day visit to the Hotline. The visit included observation of workers during the call-taking process and interviews of staff. Statistical data were requested from DHS to augment the information gathered during the visit. To augment the site visit and observation, the observation team reviewed available statistics related to call activity, prioritization of calls, and Expedited Response. The observation team monitored 12 calls. In some cases, only part of a call was observed. The observer may have located the call after it was answered, or the worker may have continued processing the report (i.e., calling collaterals, performing data entry, completing the HGDM forms) after the observer left.

Findings

The Hotline is primarily responsible for receiving and screening referrals related to child welfare services, primarily child protection. Calls from the community are received and distributed through the Automated Call Distribution (ACD) system. Calls are placed in a queue and each is then answered by an available Hotline worker. Calls from the State child abuse hotline (ChildLine) are received and distributed through a priority queue to ensure that they are answered quickly. Hotline workers are assigned to one of three shifts: (1) 8 a.m.–4 p.m.; (2) 4

p.m.–12 a.m.; and (3) 12 a.m.–8 a.m. Some workers and supervisors work varied shifts and overtime staff is used to augment the regular Hotline staff when needed. There are two Hotline administrators; one oversees the daytime Hotline operations, and the other manages both after-hours shifts.

In addition to receiving and processing child abuse and related referrals, the Hotline’s specialized Screening Unit handles referrals of non-maltreatment-related service requests from other agencies, mental health issues, court referrals, and General Protective Services (GPS)-related walk-ins. The Screening Unit also receives referrals from Hotline workers when a family requires referral to the Community-Based Prevention (CBP) program.

The Child Abuse Prevention and Treatment Act (CAPTA) unit operates within the Hotline and is responsible for referrals from medical facilities when mothers give birth to a drug-affected baby.⁷ The CAPTA unit receives referrals from seven area hospitals on a dedicated phone line and has a 2-hour response time requirement; workers conduct the initial field screening of these reports and then refer the cases for services or to Intake for further assessment. The DHS CAPTA unit works closely with the CBP program and the DHS’s CAPTA team.

The Hotline operation also includes specialized units for responding to referrals that qualify for ER (children ages birth to 5 years old). The ER program is discussed in its own section later in this report.

After hours, the Hotline becomes the center of DHS operations, including the support for ongoing workers in the field. Hotline staff provide consultation to field staff, handle emergencies on new and open cases (including walk-ins), locate placements for emergency removals, and obtain restraining orders.

Call and Report Handling Process

The processing of a report after a call is taken appears cumbersome and overly time consuming. Workers spend a significant amount of time entering their handwritten notes into the FACTS system and completing the manual forms used for HGDM. Inefficiency in this process is due to a number of reasons.

- The FACTS system is based on very old technology and has severe limitations related to entry and edit capability. Correcting entries requires significant re-typing of narrative sections.
- FACTS does not include specific fields or edits for HGDM information.
- The system does not provide any guidance to the worker for the HGDM process.
- Reports and HGDM forms must be hand carried to supervisors and passed back and forth for corrections. No automated support exists for transferring the record to the supervisor or support for the supervisory review and approval processes.

HGDM Implementation

DHS implemented HGDM at the Hotline in April 2008 with the express purpose of narrowing the agency’s focus to child safety.⁸ HGDM targeted specific issues facing DHS, including the lack of protocols for Hotline workers, the effects of the high-profile attention DHS was experiencing, the perceived tendency to designate ER for referrals that did not require it, and the need to standardize decision making in general. Initial design of the HGDM occurred between July 2007 and January 2008. The department trained 199 Hotline staff during March and April 2008.

HGDM is currently composed of two separate forms—both identified as interim forms for use until FACTS2 is implemented. The first is the HGDM Tool and the second the HGDM Tool – (Six) 6 Domains. The first HGDM tool is completed for accepted reports only and workers complete this form manually or by typing into a Word template. The form is composed of five safety decisions:

- Safety Decision 1: Does the information constitute a report and if so what type (CPS, GPS, or General)?
- Safety Decision 2: Is there present danger (based on characteristics of the maltreatment, the child, and the parent/caretaker)?

⁷The CAPTA unit is named for its funding source, the Federal Child Abuse Prevention and Treatment Act.

⁸The design and implementation of HGDM, and the evaluation conducted in the first month, are described in the report, titled Hotline Guided Decision Making: Initial Front end Redesign for Philadelphia DHS (ACTION for Child Protection, 6/12/08).

- Safety Decision 3 (completed if Safety Decision 2 is no): Is there impending danger (based on five safety threshold items)? Safety Decision 3 also includes check boxes to denote special circumstances and a designation of whether or not the report qualifies as Expedited Response.
- Safety Decision 4: This is the section where the worker specifies the prioritization. Note: while the most recent version of the HGDM form includes a checkbox that allows a Hotline supervisor to override the response setting (to make it Immediate or 24-hour), there appears to be no requirement for documenting the reason for the override.
- Safety Decision 5: This is completed by the supervisor and designates the assignment of the report (ER, MDT, Family Service Region, Intake, or Intake [Sex Abuse]).

The form also includes a narrative section where the supervisor documents agreement or disagreement with the decisions of the worker.

The second form, the (Six) 6 Domain form, is completed manually for screened-out reports. These forms serve as the documentation of screened-out referrals. For an accepted report, the Six Domain information is entered into a text field in FACTS. There are six domains for which workers are to collect and document referral information.

- What is the extent of alleged maltreatment?
- What are the circumstances surrounding the maltreatment?
- What is the child's functioning?
- What is the adult functioning?
- What are the general parenting practices?
- What are the disciplinary practices?

The form contains two narrative boxes to add information from collateral sources and for the supervisor to enter comments.

Based on the interviews conducted during the COB observation visit, it appears that most Hotline workers and supervisors see both the benefits and challenges from HGDM. Most staff interviewed agreed that HGDM, as a whole, is a useful tool for the Hotline. Staff noted that the tool helps workers—especially newer workers—acquire more in-depth information, provides more consistency to the information collected during the calls, and provides a more objective basis for making decisions. DHS also reports that HGDM is having the intended effect of focusing the agency on the most critical cases. DHS reports that this improved focus on child safety is clearly reflected in a significant reduction in the SCOH caseloads.

HGDM has been in effect for less than 1 year and some staff indicated they still have some confusion related to the acceptance and prioritization of GPS referrals. Staff expressed particular confusion regarding when 24-hour response should be used for GPS cases. Various staff expressed concern regarding the elimination of “child endangerment” and “other” as types of GPS. Staff indicated that this prevents the acceptance of some reports, especially those where parent incapacity is the main concern (e.g., drug- or alcohol-impaired parents).

Workers expressed concern that referrals that do not qualify as Immediate or 24 hour, based on HGDM, must be designated as 7-day response (an issue also raised by ACTION for Child Protection in their recommendations following the implementation of HGDM). Staff indicated that some mandated reporters are frustrated by the additional questioning required by HGDM and indicated that more reports are made to the State's ChildLine to avoid dealing with the HGDM protocol. However, DHS Hotline staff members are still required to utilize the HGDM protocol when the call is subsequently referred to the Hotline. Staff also expressed the need for additional HGDM training.

The implementation of HGDM is a significant change for the agency and it is likely that some workers are having difficulty adapting to the more structured approach to evaluating and processing referrals. As mentioned above, the process has had the effect of focusing the agency's attention on the most serious cases, reducing ongoing caseloads, and bringing more consistency and depth to the process for gathering and documenting information from the initial referral calls.

HGDM Statistics

Call activity statistics for comparable pre-HGDM and post-HGDM periods were not available. Therefore, an analysis of the impact of HGDM on the time it takes to process calls could not be completed. DHS supplied data allowing an analysis of the possible impact of HGDM on calls abandoned before they are answered at the Hotline.⁹ Comparison of abandonment data for April–June 2007 and 2008 indicate an increase in abandoned calls since the implementation of HGDM (and the initiation of the collateral contact policy). Eight percent of calls were abandoned in 2007, compared to 11 percent in 2008. Abandoned calls increased even though there was an average of two more workers available for receiving calls in 2008 and there were more than 1,000 fewer calls during this period in 2008. Though the increase in abandoned calls may be related to longer call processing time, this cannot be stated with certainty without reviewing additional call activity data. It should be noted that the period covered by the data reported here includes only the first few months following the implementation of HGDM. During this period, the Hotline staff was just learning the new procedures and documentation requirements. The time per call, and the additional steps to document and process reports, are likely to decrease as workers become more familiar with the HGDM tool.¹⁰

Although statistics are not available to judge the impact of HGDM on acceptance and screen out decisions, data are available regarding the classification and prioritization decisions. Based on DHS statistics for April through September 2007 and 2008, there were substantially fewer reports accepted in 2008 as seen in Table 4.6, Comparison of 2007 and 2008 Accepted Reports: Classification and Prioritization (April–September).¹¹ General reports doubled as percentage of all accepted reports between 2007 and 2008 (from 8 percent in 2007 to 16 percent in 2008). This is significant since the General category is meant to be used for non-child maltreatment referrals (e.g. requests for home). However, some Hotline workers now use the General classification for neglect referrals that do not meet the agency’s current GPS definitions in order to accept a report they would otherwise be required to screen out.

Prioritization of accepted reports does not appear to have changed significantly since the implementation of HGDM, except for the prioritization of General reports. Only 3 percent of General reports were given an Immediate priority in 2007 compared to 6 percent in 2008. In 2008, 35 percent of General reports were rated as 24-hour or P 24-hour compared with only 10 percent in 2007.

Table 4.6. Comparison of 2007 and 2008 Accepted Reports: Classification and Prioritization (April–September)

Accepted Reports	2007			2008		
	8,307			6,902		
	CPS	GPS	General	CPS	GPS	General
Reports by Classification	1,925 (23%)	5,735 (69%)	647 (8%)	1,908 (28%)	3,913 (57%)	1,081 (16%)
Prioritization (% within classification)						
Immediate	18%	13%	3%	17%	14%	6%
P 24-Hours	NA	NA	NA	10%	22%	14%
24-Hours	82%	63%	10%	73%	43%	21%
Other (7-Day)	0%	25%	87%	0%	21%	59%

Note: The DHS statistics in this table include ER reports. ER reports are prioritized based on HGDM, even though the reports ultimately are responded to with an Immediate priority (0–2 hours). Therefore, some of the reports that are shown as response times of P-24, 24-hour, or other (i.e., 7-day), subsequently become an Immediate response based on their assignment to ER.

⁹Abandoned calls are any calls where the caller hangs up before the call is answered by a hotline worker.

¹⁰DHS supplied statistics after the original draft of this report indicating that abandoned calls, although still somewhat higher than in 2007, have decreased.

¹¹Based on interviews, most workers and supervisors interviewed believe that HGDM has led to more referrals being screened out. Some consider the increased screen outs to be appropriate; others had concerns that some of these referrals should have received further assessment. For example, circumstances where a parent’s capacity to care the child is in question but no maltreatment is alleged do not typically fit the current GPS definition.

The HGDM observation team also made the following observations:

- Although data are not available for screened-out calls, it appears that HGDM, a lower overall call volume, or a combination of both, have led to fewer accepted reports.
- Social workers are using the General category to make up for the fact that DHS eliminated two of the catch-all GPS categories and to allow them to accept these reports.
- Now that workers are using the General classification for more neglect reports, they are giving a higher priority status to the General reports than they were prior to HGDM.
- The increase in the percentage of CPS reports, relative to GPS reports, does suggest a greater focus on the more serious CPS referrals. DHS also reports that caseloads for SCOH have been reduced through the improved screening. This sharper focus on the more serious referrals was an intended objective of the HGDM implementation.
- DHS has begun “transfer of learning” (TOL) training for HGDM and the other procedures involved in taking and processing reports at the Hotline. Implementation of these ongoing training efforts will provide additional guidance and will assist workers to adapt to the changes created by the implementation of structured decision making at the Hotline.

Recommendations

The observation team recommends that DHS improve the implementation of HGDM as follows:

- Implement the planned Hotline module of FACTS2 (or an alternative system) to expedite the entry of reports and to provide automation to guide workers in the HGDM process.¹²
- Refine the HGDM tool so that workers are clear about the definition of GPS and so that the definition is sufficiently broad to accommodate valid neglect reports that are now being accepted as General reports.
 - » Clarify the priority setting for GPS reports and consider implementing a shorter response time than 7 days for reports without present or impending danger. Although supervisors are now allowed to override the prioritization decision, overriding rules in a structured decision making process only serves to undermine the model.
 - » Review the five threshold items of HGDM, as some are confusing to staff (e.g., the definition of a vulnerable child). Some staff members believe that requiring all five threshold items to identify a report as impending danger misses some cases that they believe should be considered for more immediate response.
 - » Although DHS indicates that it is rare that supervisors override the prioritization that results from HGDM, it would be useful to clarify the conditions under which the response time can be overridden (Safety Decision 4) so that supervisors consistently apply this option and provide clear documentation of the reason for the override.
- Clarify the policy regarding contact of collateral sources so that staff use this activity consistently. Some of the workers believe that collateral contacts are expected to be initiated whenever available; others understand the policy as only calling collaterals if needed for the decision whether or not to accept the report. The policy should also take into account the time of day, the appropriateness of contacting non-family members, and the potential delay that these calls could create for the processing the report.
- Continue the community awareness efforts with the mandated reporter community regarding the purpose and use of HGDM at the Hotline to reduce the inclination of some reporters to bypass the DHS Hotline and report directly to ChildLine.

¹²DHS informed the COB that the implementation of FACTS2 at the Hotline will begin early in 2009. The FACTS2 application has been developed and tested and implementation will begin with the training of Hotline workers.

¹³The implementation of Alternative Response in January 2009 should help clarify some of the prioritization issue since non-safety related GPS will be assigned to ARS with a response time of 72 hours.

- Create additional opportunities for peer consultation, which along with the TOL training mentioned above, will help clarify definitions and procedures for workers who have expressed confusion related to HGDM and the acceptance, categorization, and prioritization of GPS reports.
- Continue efforts to work with the State in regard to the issues that are created by the differentiation between CPS and GPS and the State's narrow definitions of these report classifications.

Expedited Response

Expedited Response (ER) requires a 0–2 hour response for referrals involving children ages birth through 5 years old. ER was implemented a few months prior to HGDM. DHS has implemented ER through a combination of response units—specialized ER units (and some overtime staff), Multidisciplinary Teams (MDT), and Intake units (regular and sexual abuse units).

All GPS reports that qualify for an ER response are assigned to the specialized Hotline ER units. ER is performed for referrals received between 8 a.m. and 7 p.m. (with the last ER contact before 9 p.m.). The Hotline currently has two ER units—five workers and one supervisor for each—and is adding another unit to reduce the number of ER cases currently handled by overtime staff.

CPS reports that qualify for ER are handled by the MDTs (active cases) or the Intake units (new cases). The observation team did not have an opportunity to observe the non-Hotline units involved in ER.

Based on the observations of the Hotline ER team, workers who respond to an ER referral always call the supervisor upon their arrival at the home. The worker also calls for confirmation from a supervisor after conducting their initial assessment and before returning to the office. The supervisor approves all screen out decisions. The ER units utilize the Community-Based Prevention (DCBPS) services extensively. The CBP is required to respond to an ER referral from DHS within 24 hours.

ER staff occasionally is unable to make direct contact with the child within two hours. The child and/or family may be unavailable or unable to be located during the first attempted contact. When this occurs, DHS policy requires that another attempt be made within 24 hours of the initial attempt. If the second attempt also fails, the report is transferred to the Intake Unit or to the ongoing worker. The intake worker or ongoing worker must make a third attempt within 24 hours following the second attempted contact.

Staff interviewed during the Hotline visit mostly agreed that the prioritization of referrals involving children aged birth to 5 years old is appropriate. However, there are some cases where prioritizing based solely on age may overrate the required response. The example was given of a child who had not received regular medical checkups for a 6-month period. The supervisor felt that an under-2-hour response in such circumstances was extreme. On balance, it appears that such cases are rare and that the ER procedure provides an important focus on young children who are considered vulnerable. As importantly, the implementation of ER, especially for reports received on active cases, provides assessment of the child's safety by a second worker. Review of the family's circumstances, and the child's safety, by a worker not currently involved with the family directly addresses some of the concerns raised by Daniela Kelley case. The ER system has also had the positive effect of reducing caseloads for the intake and field units.

Since the ER program is handled by a variety of units and personnel, comprehensive statistics are required to assess the overall functioning of ER. However, statistics are currently available only for the hours ER units are available at the Hotline. DHS reports that the MDT and Intake units are planning to develop statistical reports based on the framework used by the Hotline ER units. Table 4.7, Expedited Response Referrals and Dispositions 1st Quarter FY 2009, presents data from the first quarter of FY 2009. Contact could not be made in 32 percent of the ER referrals. A Safety Plan, or an Order of Protection, was needed in fewer than 10 percent of the ER reports.

Table 4.7. Expedited Response Referrals and Dispositions 1st Quarter FY 2009

Total referrals received	N=562
Arrived at location within 2 hours of the report	491 (87%)
Unable to make contact	180 (32%)
Child determined safe	166 (30%)
Referred to Special Assessment unit	83 (15%)
Closed with no further involvement	56 (10%)
Child determined safe with Plan	44 (8%)
Referred to Community Based Prevention	7 (1%)
Order of Protection required	4 (1%)
Other	22 (4%)

Findings

The COB reached the following conclusions.

1. DHS has successfully implemented the CWRP recommendation for ER to respond to all reports involving children ages birth to 5 years old.
2. The ER process for GPS referrals involving children ages birth to 5 years old is implemented through specialized units and overtime staff at the Hotline. CPS referrals that qualify for the ER response, based on the age(s) of children involved, are handled by MDT and Intake units.
3. Implementation of ER has not significantly affected the process for taking calls. The prioritization of referrals, based on age alone, is considered appropriate by the Hotline staff.
4. ER has heightened the priority for child safety of the youngest children referred to the agency and additionally provides the benefit of an assessment of the case by a second worker for reports received on active cases.

Recommendations

DHS should consider the following refinements to the ER policies and procedures.

1. Clarify the manner in which prioritization of ER reports is documented so that statistics reflect the actual response time based on ER rather than the HGDM priority result.
2. Implement data collection and reporting related to ER cases handled by the MDT and Intake units. This reporting should be consistent with the data available for the Hotline ER units in order to provide a complete perspective on the ER program.
3. Conduct additional review of the ER system once data are available from the MDT, Intake units, and Intake Sexual Abuse units.

Child Fatalities Review

The CWRP recommended that DHS enhance the child fatality review process and ensure that a mechanism exists for implementing the resulting recommendations. The overall purpose of the internal child death reviews (convened and organized by DHS) is twofold:

1. To examine the circumstances of a child death as a result of suspected child abuse from a systems perspective; and
2. To make recommendations for change to reduce the likelihood that future child fatalities will result from child abuse and neglect.

In particular, these reviews are to “provide for an introspective system review by the county agency to gather facts regarding the agency’s involvement with the family while determining compliance with local and State policy,

procedure and regulation...and determine whether an appropriate level of service was provided to the child and family by public and private agencies.”

In general, the COB has noted that DHS has begun to make progress in this area, and in particular DHS has recently increased efforts to implement the requirements of Act 33 and develop a process for more effectively integrating the death review recommendations into DHS’ practice framework.

The COB did not undertake an in-depth analysis of the administrative data regarding all the child fatalities that were active or known to DHS in the past 2 years. This analysis will be conducted for the next COB report. The purpose of the analysis will be to gain a better understanding of the characteristics of the children who died in 2007 and 2008 and were active or known to DHS regardless of whether a GPS or CPS report was generated at the time of their death; how many of these children were receiving services from DHS as the time of their death; the circumstances surrounding their death; and the manner and cause of death.

Approach

In order to gain an understanding of the DHS’ current internal child fatality review process, the COB reviewed current policy documents that outline the process. The COB also conducted an analysis of DHS’ child fatality review process as it relates to best practice. The COB also analyzed the process that DHS currently uses for reviewing Internal Child Fatality Review Team (ICFRT) recommendations, identifying needed changes in practice and policy, and implementing these changes into DHS’ practice model.

The COB also conducted an analysis of aggregate data from 2007 and 2008 and the Internal Child Death Reports of child deaths reported to the Hotline. Data were requested from DHS on the child fatalities that were reported to the Hotline starting from the date of the last child fatalities review conducted by the CWRP. Specifically, data were requested for three time periods:

- August 5, 2006–December 31, 2006
- January 1, 2007–December 31, 2007
- January 1, 2008–October 31, 2008

DHS provided data reports for child fatalities that occurred during the following time periods:

- November 1, 2006–February 28, 2007
- February 27, 2007–November 30, 2007
- January 1, 2008–October 31, 2008

DHS also provided ICDR reports for 10 cases in which the death occurred in 2007, and for six cases in which the death occurred in 2008. Data for 2008 were easily accessible from the new Child Fatality Tracking database. The data for 2007 were put together through an analysis of the data reports, the ICDR, and DHS staff confirmation through FACTS.

Findings

DHS has made incremental progress toward improving the child fatality review process and implementing changes in practice and policy based on the information gained through the child fatality reviews conducted by the ICFRT. Following are some of the actions that DHS has taken to improve the child fatality review process:

- Expanded the ICFRT to include more external partners, including two pediatricians and a child psychiatrist; additional standing members including a child psychiatrist, two pediatricians, and the chief medical examiner;
- Created and began implementing a child fatality database in December 2007. The database facilitates rapid reporting of both aggregate and case-specific information about child fatalities. While the database has no connection with FACTS, or any other DHS information system, QA staff members manually enter most of the information from the Child Fatality Data Collection Form. The DHS QA staff began entering data on child fatalities in early 2008, and at the time of this report had information on all fatalities reported to DHS in 2008;
- Implemented the practice of convening a “Strike Team” that meets within 24 hours of notification of the death of a child known to DHS. The Team assembles information and assess DHS’ role with the family;

- Hired a full-time staff person responsible for coordinating internal child fatality reviews; however, the person left the position in August 2008 and it has not been filled since that time; and
- Developed new guidance for conducting and implementing recommendations from internal child fatality reviews in June 2008.

In addition, the COB has been informed that DHS has:

- Increased its support to the Maternity Care Coalition’s Kids for Cribs program, which provides cribs to families who cannot afford them and educates families about the dangers of co-sleeping, the safest way to put a child to sleep, and other unsafe sleeping practices.
- Developed a public education campaign in collaboration with the Department of Health on co-sleeping; and
- Implemented a Safety Alert highlighting common risk factors for child fatalities that is distributed to all staff.

The COB, however, believes that significant improvements to the death review process are still needed and, most importantly, that DHS must implement a strategy for using the findings from internal child fatality reviews to improve the health and safety of the children in DHS’ care. DHS is now at a turning point due to the requirements of the implementation of Act 33 of 2008¹⁴ that became effective on January 4, 2009. Act 33 requires DHS to establish a team to review child “near fatalities” in addition to child fatalities.

Child Fatality Review Process

In December 2007, the responsibility for overseeing and managing fatality reviews was moved within the Quality Assurance (QA) Support Center. A full-time project manager was designated to coordinate all activities, including quality assurance and practice improvement pertaining to child fatalities. Since August 4, 2008 this position has been vacant. The responsibilities of this position have been performed by another staff person in the interim. On August 15, 2008, DHS requested, as part of their Needs-Based Plan and Budget for FY09/10, two full-time Social Service Program Analysts and one Support Staff to support the work that needs to be done with regard to child fatality reviews and near fatality reviews.¹⁵ These positions have not been funded. In addition, the roles and responsibilities of the internal child fatality review Project Manager have not been determined although DHS drafted a working paper to provide guidance regarding the roles and responsibilities of the Project Manager.

Current State policy requires that the ICFRT, at a minimum, include (1) an administrative staff person; (2) a supervisory staff person; (3) a casework staff person; and (4) an advisory board committee member. Participation of other county agency staff multidisciplinary team members, independent consultants, neighboring county agency staff, law enforcement, and Office of Children, Youth and Families (OCYF) is suggested, as appropriate.¹⁶ Act 33 of 2008 requires that the ICFRT have no fewer than six members “broadly representative” of the City’s experts in prevention and treatment of child abuse. The team’s members may change based upon the circumstances of a case and a suggested list of possible team members is included in the law.

In December 2007, DHS expanded its external representatives of the ICFRT to include two pediatricians and a child psychiatrist. Additional external representatives that serve as standing members also include a Child Welfare Advisory Board representative, OCYF Regional Office representative, the Chief Medical Examiner, community representative, and a provider representative (as appropriate). At this time, a representative from law enforcement is not included on the ICFRT, even though having such representation is considered a best practice. DHS has neither identified a person to chair the ICFRT who is not in the employ of DHS nor defined the role and responsibilities of the chairperson as required by Act 33 of 2008. Further, training and preparation for conducting child fatality reviews for the ICFRT have not been developed or established.

Protocol

On June 16, 2008, DHS developed a new protocol for holding internal child fatality reviews and implementing the resulting recommendations.¹⁷ The protocol requires that the Project Manager send a copy of the report to the

¹⁴ Act 33 of 2008.

¹⁵ City of Philadelphia, Department of Human Services (DHS). (8/15/08). Children and Youth Needs-Based Plan & Budget Fiscal Year 2009–2010.

¹⁶ Commonwealth of Pennsylvania, Department of Public Welfare. (10/10/00). Child Death Review and Report Protocols, Bulletin 3490-00-01.

¹⁷ City of Philadelphia, DHS. (6/16/08). Internal Child Fatality Review Process.

Commissioner, Deputy Commissioner and Operations Director for review and approval. In addition, in a separate document, it requires that the project managers develop a memorandum outlining the report's recommendations with suggestions as to who within DHS is responsible for implementing each recommendation. This document, along with the recommendations, must be reviewed and approved by the Commissioner. The project manager is also responsible for notifying the DHS staff member(s) responsible for implementing each approved recommendation and then monitoring and tracking the implementation. Finally, the project manager is responsible for reporting quarterly to the Commissioner and the fatality review team on the implementation status of each approved recommendations. To date, DHS has not conducted the process it outlined in policy. Therefore, at this time, DHS has not used the internal child fatality review process for making improvements in practice and policy.

A review of other DPW and DHS policies regarding the conduct of child fatality reviews conducted by the COB also revealed several other possible required reviews when a child's death is reported to the Hotline. Private providers are required to conduct their own internal review of each case where a child dies as a result of suspected child abuse or neglect and the agency was currently providing services or had provided services during the past 16 months. As required by DPW, DHS contracts include language requiring the private agencies to conduct their own internal fatality reviews. DHS has provided private agencies a template for documenting the findings of their review¹⁸ and private agencies participate on a relevant ICFRT, as appropriate.

A Multidisciplinary Team (MDT) Review is also required when the family was or should have been receiving services from multiple agencies to address cross-system issues that are identified within the internal or OCYF reviews.¹⁹ In addition, the county agency or appropriate community agency must convene a Community Review to examine those child deaths that occurred as a result of substantiated child abuse that were not known to the county agency within 60 days of the date of the oral report to ChildLine. The COB was also provided a draft Protocol for Child Fatality Reviews developed in February 2008. The draft protocol called for additional fatality review teams including a Neglect Assessment Fatality Review Team (NAFRT) and an Other Assessment Fatality Review Team (OAFRT). The COB is not clear whether DHS intends to implement these additional review teams.

Additional legislation passed in 2007 requires the implementation of local public health child death review teams. These teams are required to review all child deaths in order to identify factors which cause risk of injury and death, recommend improvements to health and safety policies and the coordination of services and investigations by child welfare agencies, medical officials, law enforcement and other agencies. The legislation requires that the director of the children and youth agency or a designee serve on the team.²⁰

As discussed previously, Act 33 of 2008 requires DHS (with help from the DPW and the local District Attorney) to establish a protocol for both child death and "near fatality" reviews. Act 33 also seeks to implement a condition of Federal funding to the State under the Child Abuse Prevention and Treatment Act (CAPTA) by requiring the statewide establishment of a minimum of three citizen review panels, one of which may be the child fatality or near fatality review team. It is not known whether DPW intends to designate any current or new child fatality/near-fatality review team as a citizen review panel.

It is not clear to the COB how these many separate legislatively required review processes are coordinated or linked and how the information learned and recommendations developed from these processes are shared and implemented. In fact, it is not clear that DHS is currently conducting MDT or Community Reviews. There is also great overlap in the purposes and goals of the multiple fatality review teams. All have similar purposes, are required to be multidisciplinary, and require the participation of DHS.

Child Fatality Data and Internal Child Death Reports

Prior to late 2007, DHS did not have any reliable way to track and provide reports on child fatalities reported to the Hotline. The capacity of DHS to track child fatality data was complicated by the limitations in the FACTS system. In late 2007, DHS designed and developed a Fatality Tracking Database to enable the Department to more effectively track and report information reported about fatalities of Philadelphia children who are reported to the DHS Hotline. Information in the database includes basic information such as child and family demographics,

¹⁸Department of Human Services. (7/28/03). Child Death Internal Review Report—Provider Agency.

¹⁹Commonwealth of Pennsylvania, Department of Public Welfare. (10/10/00). Child Death Review and Report Protocols, Bulletin 3490-00-01.

²⁰Act 87 of 2007.

circumstances regarding each child’s death (including the cause and manner of death), and the child’s service history with DHS. The database also includes selected parental risk factors, such as substance abuse involvement, mental health history, criminal history, and prior involvement with DHS. Finally, the database has the ability to track information regarding the internal DHS reviews—including the ICFR, the rapid Response Team review, the Infant Death Review, the Neglect Assessment Fatality Review, and any other reviews that may be required. The database is used primarily by the DHS Quality Assurance (QA) staff that has responsibility for maintaining this information and, as required, managing the required internal reviews of selected fatality cases.

A review of the child fatality data for 2007 and 2008 shows that the number of child fatalities reported to the Hotline in each year was close to 50. A majority of these fatalities did not generate CPS reports. That is, the allegations regarding the child’s death, if true, would not constitute child abuse as statutorily defined. Of the 111 reports to the Hotline, 21 (18.9 percent) generated CPS reports, and 54 (48.6 percent) generated GPS reports. See Table 4.8, Fatalities Reported to the Hotline.

Table 4.8. Fatalities Reported to the Hotline

Year	Children Who Died Reported to the Hotline	CPS Reports Generated	GPS Reports Generated	General Reports Generated	Report Not Generated
2007	51	11	33	1	6
2008	60	10	21	12	17
Total	111	21	54	13	23

Internal Child Fatality Reviews (ICFR) must only be conducted for child deaths that result in the generation of a CPS report when the child or family was known, for any reason, to the county agency regardless of the final CPS investigation status determination. This includes cases that are currently active and those that were active during the past 16 months. Table 4.9, presents the number of child fatalities for which a CPS report was generated and whether the child was active with DHS or known to DHS during the past 16 months. Of these child fatalities, 6 out of 11 (54.5 percent) were active or known to DHS in 2007, and 5 out of 10 (50 percent) were active or known to DHS in 2008.

Table 4.9. Fatalities for Which CPS Reports Were Generated/DHS Involvement

Year	CPS Reports Generated	Active	Inactive	Unknown
2007	11	2	4	5
2008	10	2	3*	5
Total	21	4	7	10

* One case was reported as a near fatality; though case was inactive, the child was known to DHS more than 16 months prior to the death.

A review of the child fatality data and the internal child death reports for 2007 and 2008 suggests that many of the same risk factors were present in the child fatality cases active or known to DHS that were identified by the CWRP’s review of fatalities from 2001 to 2006. Very young children, especially children younger than 5 years old and who are medically fragile, continue to be at great risk. Issues related to parents or caregivers younger than 20 years old, substance abuse among caregivers, and parents and caregivers with unrealistic expectations of child development and behavior also continue to be factors in these cases. Issues presented by the parents included drug and alcohol abuse, lack of parenting skills, lack of knowledge regarding the care of infants including medical care, safe sleeping and bathing and need for physical and mental health assessment and services. Environmental factors present for the families were unsuitable housing, lack of adequate daycare, and domestic violence. Child factors that were predominant were significant health issues.

Further, it became clear that the distinction between a child death in which a CPS report was generated and a child death in which a GPS report was generated is not clear. Therefore, DHS does not have a full understanding of the spectrum of factors that lead to child deaths, nor does it have a complete understanding of possible practices and policies that may help prevent deaths. In fact, DHS indicated that it planned to conduct internal child fatality reviews for cases that generate a GPS report that were active or known to DHS in its Needs-Based Plan & Budget, Fiscal Year 2010.

It also is not clear that DHS has developed a plan to prioritize and implement the many recommendations from the ICFRT. The recommendations from the review of the internal child fatality reviews conducted in 2007 and 2008 are similar to those outlined by the CWRP from their review of the internal child fatality reviews conducted between 2001 and 2006. The ICFRT continues to include similar recommendations for improvements in training, systems development and systems change, practice and collaboration. Appendix B provides a summary of the recommendations.

The review of the internal child death reports also shows the Pennsylvania Department of Public Welfare (DPW) format for what should be addressed is being followed. However, it was very difficult to distinguish the systemic recommendations from the case-specific recommendations. Findings regarding whether the death was preventable also were not clearly identified in many of the reports. In addition, the race/ethnicity of the child and the child's age at death are not included as part of the demographic information.

Recommendations

DHS has not fully implemented its current policy and now must amend its practice to include the review of near fatalities as required by Act 33 of 2008. Overall, internal child fatality reviews and the lessons that may be learned from them have not been a priority for DHS. While we understand that DHS is implementing many system reforms to ensure the safety, permanency and well-being of the children for which it is responsible, internal child fatality reviews (and now near-fatality reviews) are an important process for identifying how to continually improve practice and policies to help prevent future child deaths and near fatalities.

Scarce resources require that DHS' internal child fatality and near fatality review process is strategic and linked with other child fatality review processes. It is critical that the information and recommendations from these processes be shared and implemented. DHS must work with DPW to determine if the number of reviews could be streamlined in order to facilitate a more effective and efficient use of time and resources. Moreover, DHS and DPW must work together to ensure that the process itself does not hinder the purpose of understanding child deaths in order to identify ways that may prevent future deaths.

An effective internal child fatality review process requires someone to lead the planning and coordination of all that needs to take place. DHS needs sustained leadership for coordinating these reviews and ensuring distribution and implementation of the recommendations. Adequate staffing is critical to implement the expanded comprehensive and multidisciplinary process required by Act 33 of 2008. The position of Project Manager for Fatality Reviews must be filled immediately and support for this position identified. DHS must also quickly identify both "core" team members and others who may be asked to serve on the ICFRT team. DHS also must identify the additional ad hoc representatives that should be included for specific types of cases, with consideration of the list provided in Act 33. DHS must also identify a person to serve as the chair of the ICFRT who is not in the employ of DHS and define the role and responsibilities of the chairperson.

As DHS develops a new protocol to come into compliance with Act 33 of 2008, the COB strongly recommends that DHS include the conduct of child fatality reviews for child deaths (and near fatalities) in which a GPS report was generated where the family is active or was known to DHS during the past 16 months. The protocol should also address: the need to review all services provided to the child and family, by any relevant agency (not just DHS or its providers); the need to obtain and review all relevant court records and documents; and how the ICFRT will address whether or not DHS "complied" with the laws, regulations, policies, and procedures that were relevant to the case. The protocol also needs to address how DHS will ensure that Act 33's requirement of a final report to DPW, within 90 days of the team first convening, will be completed. In addition, DHS must validate that every report addresses: deficiencies and strengths in law, policy, and practice compliance; deficiencies and strengths in the services that were (and are generally) provided to the child and family; and recommendations for changes

—at both the State and local levels—for reducing similar fatalities or near fatalities, for improved monitoring of agency functions, and for better collaboration among community agencies and service providers. The COB is very concerned that one month prior to the required implementation date DHS has not produced guidance on how Act 33 local team requirements will be implemented.

As discussed, many of the recommendations for improving practice and policy from the ICFRT reports are similar to those identified in the reports reviewed by the CWRP. DHS must review these recommendations, identify what steps they are taking to prioritize them, develop a plan for implementation, and report back to the COB at the February 2009 meeting.

Further, in the course of identifying the status of the implementation of the CWRP’s recommendations regarding child fatality reviews, we identified some issues that will require consultation with, and action by, the Department of Public Welfare (DPW):

1. **GPS/CPS Classification:** Pennsylvania’s unique and idiosyncratic way of classifying reports of possible maltreatment and the requirement of local reviews of only child deaths for which a CPS report is generated diminishes the value of internal child fatality reviews. Reviews are only required on child death reports for which a CPS report is generated. DPW should consider implementing a requirement to require internal child fatality reviews for child deaths in which GPS reports are generated. Though DHS has indicated that it wants to review child deaths that then generate GPS reports, it does not currently have the resources to expand the reviews.
2. **Number of Separate Child Fatality Review Processes:** There are more than 4 disparate child fatality reviews that are being required by the State, which DHS actively participates in or facilitates. DPW should provide guidance on how to streamline and link these reviews in order to ensure the effective and efficient use of resources while ensuring that the processes are identifying ways to prevent future deaths and serious harm to children.

Criminal Background Checks

DHS policy issued in 2005 stated that the department should obtain State police clearances on a regular basis in order to inform decision making regarding “placement resources and permanency for children, ongoing risk and safety assessments... and as part of investigations/assessments.” DHS has not instituted this practice for a number of reasons we will discuss below. However, the COB believes that these issues can be resolved. We strongly recommend that policy be developed expeditiously and the practice implemented in order to insure the safety of both children and the social work staff.

Findings

In May 2007 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 the department 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.²¹ CWRP recommended this policy as one component in a comprehensive model of social work practice. The intent was for DHS to develop policy and practice regarding the conduct of criminal background checks during the investigation/assessment process as well as prior to reunification. These criminal checks would be conducted in addition to their current practice of conducting criminal background checks on out-of-home placement resources.

Criminal Background Screening

Criminal background checks on an alleged abuser(s) and other adults are conducted for several reasons. They provide CPS workers with important information that could guide their decisions regarding preparations prior to visiting or interviewing an alleged abuser(s) (e.g., seeking assistance of a law enforcement officer to ensure safety during an initial home visit). They also allow CPS workers to identify potentially hazardous situations before coming face-to-face with the family. The information could also be especially useful in assessing or reducing the level of risk to the alleged child victim. Criminal background checks conducted on adults in the household prior to reunification will likewise assist in evaluating risk factors in returning the child home.

²¹Philadelphia Child Welfare Review Panel. (5/31/07). Protecting Philadelphia’s Children: The Call to Action, p. 12.

There are several methods of criminal background screening. These include:

- A Federal (FBI) record check, based upon submission of fingerprints, giving nationwide criminal information (required for prospective foster and adoptive parents by the Federal Adam Walsh Act);
- An FBI record check through a name-based check of the National Crime Information Center database (NCIC) (specific authority for child welfare agencies to directly access the NCIC is provided in the Adam Walsh Act); and
- A State records check (this has been done for the agency through the State Police for some time).

As a matter of policy, DHS is not currently conducting criminal background checks during an investigation/assessment or prior to reunification of a child with his/her biological parents. DHS regularly conducts criminal background checks for prospective kinship, foster, Permanent and Legal Custodianship (PLC) providers, and adoptive parent applicants, and these substitute caretakers' adult household members or household members between the ages of 16 and 18 years old who the social worker has reason to suspect has committed a crime.

These "alternative care provider" background checks may include:

- Philadelphia Police Records check;
- State Police Records check;
- ChildLine Clearance;
- Out-of-State Child Abuse and Neglect Registry Checks; and
- An FBI criminal background check.²²

The COB conducted a review of current DPW, DHS and Federal policies regarding criminal background checks. In addition, we held a meeting with DHS staff from the Law Department and DHS Policy and Practice on November 25, 2008 to determine the status of the development of policy and practice.

In the time since the May 2007 CWRP report, DHS has not developed any policy for conducting the criminal background checks specified by the CWRP, a task that was supposed to be completed by December 31, 2008. However, we understand that there is a commitment by both the Law Department and DHS Policy and Planning leadership to begin discussions regarding the concerns raised regarding expanding the conducting of criminal background checks beyond out-of-home placement resources.

The Law Department and DHS Policy and Planning leadership will research examples of policies and practices from other jurisdictions to provide guidance to their policy development. It was agreed that at the February 2009 meeting, representatives from the Law Department and Policy and Planning will provide the COB with an update on their progress.

Following is an overview of the current policy and practice regarding criminal background checks in Philadelphia related to expanding criminal background checks and some of the concerns discussed with DHS that need to be addressed, and COB recommendations.

Policy

On October 1, 1997, the Department of Public Welfare (DPW), Office of Children, Youth and Families (OCYF) issued a bulletin regarding access to the Pennsylvania State Police Records.²³ As of now, DHS is provided complete access to criminal history record information through the Pennsylvania State Police Central Registry (PSPCR). In addition to information on convictions, information on the following can also be accessed:

1. The number of times a person was arrested and the charges brought as the result of the arrests(s);
2. The number of arrests where there were no convictions; and
3. The number of arrests pending disposition.

²²Department of Human Services, Children and Youth Division. (5/30/08). Policy and Procedure Guide, Interim Policy for FBI and Out of State Child Abuse Clearances for Prospective Kinship, Foster and Adoptive Parent Applicants.

²³Commonwealth of Pennsylvania, Department of Public Welfare, Office of Children, Youth and Families. (10/1/97). Access to Pennsylvania Police Records, Bulletin # 00-97-09.

The 1997 DPW bulletin indicated that “county child and youth agencies should develop written policies regarding when it will query the PSPCR.” County agencies should query the PSPCR:

- When investigating and assessing reports of suspected child abuse and neglect to determine whether or not the alleged perpetrator or caretaker’s name is on file;
- When returning a child from out-of-home care to determine whether or not any household member’s name is on file; and
- When the best interests of a child indicate the need to determine whether the name of the person who will be responsible for the child’s’ welfare is on file.

DHS issued its policy regarding the use of the PSPCR, effective April 1, 2005.²⁴ Through this policy, DHS staff is required to query the PSPCR:

- Prior to placing a DHS-committed child with a kinship caregiver; and
- When completing an Interstate or out-of-county request for a home study.

The DHS policy also stated that when “fully implemented, DHS was going to obtain State police clearances on a regular basis to inform decision making regarding “placement resources and permanency for children, ongoing risk and safety assessments... and as part of investigations/assessments.” DHS never implemented this policy into practice.

The most recent issuance on the conducting of criminal background checks by DHS was on May 30, 2008.²⁵ In conformance with the passage of Act 73 of 2007²⁶ and the Federal Adam Walsh Child Protection and Safety Act of 2006,²⁷ the policy requires that all prospective foster, kinship and adoptive parent applicants and household members 18 years old and older complete a fingerprint-based criminal record check through the FBI. These individuals are also required to submit child abuse history record checks from other States in which they resided within the previous 5-year period. However, the May 30, 2008, issuance was completely silent on the issue of conducting criminal record checks through the FBI for adults in the child’s home, either for investigative, safety, or reunification decision, and no mention was made of the opportunity DHS has to have a current State Police data terminal, now physically located within DHS, expanded to include access to the FBI NCIC database.

Practice

As mentioned, DHS now has direct access to obtaining criminal background information from the Pennsylvania State Police Central Registry (PSPCR). The query requires a name, date of birth, and/or a social security number. Requests are submitted to the Liaison Unit that processes the request. Because of the presence of a data access terminal, this process could be concluded in a matter of minutes. For prospective foster and adoptive parents, DPW contracts with Cogent Systems to obtain FBI criminal background checks. DHS does not receive the reports directly. Rather, the information is sent to DPW and then ChildLine forwards a letter with the results to DHS.

Issues Raised

A number of serious concerns were raised that will need to be addressed in the development of the DHS policy on conducting criminal record checks on parents and other adults in the child’s home. These concerns include

- DHS’ ability/authority for asking identifying information (e.g., Social Security Numbers) from parents or other household members during an investigation/assessment;
- How and when to enforce the actual obtaining of this information from reluctant parents and household members;
- Identifying situations in which such background checks should be conducted (e.g., in every investigation/assessment, or just those cases involving serious injury, sexual abuse, etc.); and

²⁴City of Philadelphia, Department of Human Services (DHS), Children and Youth Division (CYD). (4/1/05). On-line Access to Pennsylvania State Police Criminal Record Information.

²⁵City of Philadelphia, DHS, CYD. (5/30/08) Interim Policy for FBI and Out of State Child Abuse Clearances for Prospective Kinship, Foster and Adoptive Parent Applicants.

²⁶Act 73 of 2007.

²⁷P.L. 109-248.

- Developing clear guidance for social workers, supervisors, and others on how to make use of such criminal history information obtained as part of the investigation/assessment or as part of reunification decision making, to ensure that the use of information is directly related to suitability of those in the home to provide safe care to a child, and so as to not create civil rights violations arising from a misuse of the information.

Recommendations

The COB recommends that DHS begin immediately to develop policy and practice procedures for taking advantage of the information that could be gained from the PSPCR and the National Crime Information Center’s (NCIC) database for case investigations, home safety determinations, and family reunification decisions. It is clear from both State and DHS policy, and the authority provided since late 2006 by the Federal Adam Walsh Act’s Sections 151 and 153, that conducting criminal background checks in these circumstances is considered best practice. That was even prior to CWRP specific recommendation on this issue. The COB now recommends that the following steps be taken. The status of the implementation of these steps should be reported to the COB at the February 2009 meeting.

- DHS should immediately begin research on other State and County agency practice and policy regarding the conducting of criminal background checks on parents, caretakers, and others in the home where abuse or neglect has been alleged to occur—during the investigation/safety assessment process and for guiding decision making on removals and reunifications.
- DHS should immediately develop policy regarding the process for conducting criminal background checks “on a regular basis to inform investigative and reunification decision making, and ongoing risk and safety assessments...” as part of investigations/assessments” through the PSPCR. DHS already has direct access to the PSPCR and it is in concert with DHS policy issued in April 2005. DHS also should develop clear guidance for workers to establish how to use the information obtained from the background checks.
- DHS should engage in discussions with DPW regarding DHS obtaining direct “terminal access” to the NCIC. Direct access would allow them immediate name-based criminal background information. These checks are critical as people are very mobile and move from State to State, and adults in a child’s home may have extremely relevant criminal histories from States other than Pennsylvania.
- DHS should develop an annual report regarding the conduct and findings from the criminal background checks.



CHAPTER 5

Outcomes & Accountability

The Child Welfare Review Panel's (CWRP) recommendations in the area of Outcomes and Accountability require that the Department of Human Services (DHS) assume a greater degree of accountability for its performance as well as for the performance of the private agencies with which it contracts for services. Table 5.1 summarizes the status of the Outcomes and Accountability recommendations. There are no changes in status since the October 2008 status letter. The COB did not designate any area of concern.

Table 5.1. Status of Outcomes and Accountability Recommendations

#	Recommendation	Panel Timeframe	Revised Timeframe	Status	Area of Concern
Phase 1					
26	Develop an annual report card that measures and communicates DHS' performance.	5/2008	3/2009	In progress	No
27	Develop a comprehensive strategy for internal monitoring of DHS' performance.	5/2008	6/2009	In planning	No
28	Create an annual outcome report card for contracted agencies.	5/2008	1/2009	In progress	No
29	Validate that private agencies are making face-to-face contact with children, performing safety assessments, and that contacts are sufficient to determine the child's safety.	6/2007	12/2008 Plan developed 1/2009 Roll-out	In planning	No
30	Establish a Commissioner's Action Line.	8/2007	4/2007	Completed	No
Phase 2					
31	Revisit and expand the list of outcomes to be measured.	6/2008	2/2009	In progress	No
32	Link DHS and private agency performance to outcomes of accountability, including financial incentives.	6/2008	12/2008	In progress	No

Findings

DHS has made significant progress in developing strategies and procedures to measure and report on the internal performance of DHS and the performance of contract providers. DHS completed the strategy documents per the timelines in the CWRP report. The strategy pertaining to the broader internal accountability system that DHS must implement includes measures for many of the DHS reforms such as Expedited Response (ER), Family Group Decision Making (FGDM), In-home Protective Services (IHPS), and Alternative Response (ARS). The timeframes for the development and publication of the DHS and provider report cards have been modified since the original report card. As of the December COB meeting, the deadline for the development of both the internal DHS and provider report cards has been postponed.

Progress on DHS and Provider Report Cards

Through funding made available by Casey Family Programs, DHS is working with the Chapin Hall Center for Children to develop the methodology for measuring DHS internal and private agency performance. The measures will be based on administrative data currently collected by DHS information systems.

Per the agreement with DHS, Chapin Hall has the responsibility to:

- Clean and standardize the raw administrative data received from DHS;
- Assemble the raw administrative data into a format that could support the development and analysis of the performance outcomes; and
- Tabulate key outcome data and assist DHS in interpreting the results.

DHS has the responsibility to:

- Create the extracts from administrative data and send them electronically to Chapin Hall;
- Receive and evaluate the tabulated data from Chapin Hall;
- Decide on the measures to use for the DHS internal and provider report cards;
- Create and publish the report cards; and
- Maintain the history of administrative data extracts and tabulated results.

Within DHS, these responsibilities rest the Quality Improvement (QI) unit, which is part of the newly created Division of Performance Management and Accountability.

Data

Source data used for the analysis originate from the DHS Family and Child Tracking System (FACTS). Since its initial implementation in 1993, FACTS has served as DHS' primary information system for managing and reporting on the children and families receiving services from the Department. The initial export of FACTS data was generated in the spring of 2008; a subsequent extract was created and sent to Chapin Hall in August 2008. The August extract contains the data that were used to create the preliminary indicators, which Chapin Hall presented to DHS in November 2008. The original data extracts from FACTS covered a time period that began in the early 1990s. However, DHS and Chapin Hall decided to use data only from 2000 forward, as it was agreed that data prior to that time would not provide useful information about the types of services and casework practices currently employed at DHS.

The analysis used to generate the outcomes is based on what is referred to as "agency spell data." An agency spell is defined as a continuous length of time a child spends in the care of an agency until the child either leaves that agency as the result of a permanent setting or through a nonpermanent exit, such as a transfer to another agency."²⁸ The use of spell data is a commonly accepted method used to analyze child welfare caseload characteristics and dynamics. It enables DHS to understand the dynamics of how children receive services over time, and evaluate how various types of services impact a child's permanency.

Outcomes of Interest

The specific outcome measures that will be used in the report cards for DHS and its providers have not yet been chosen. However, the measures will focus primarily on child permanency and recurrence of entry to care. Data are structured to provide information on key child welfare indicators such as:

- Types of settings where children are placed into care;
- Entry to and exit from care;
- Placement stability;
- Placement durations; and
- Re-entry to care following discharge.

The data could be broken down by demographic information such as child age, gender, and race/ethnicity. More specific breakdowns could be made depending upon the outcome of interest. For example, when examining placement stability, which tracks the number of different placement settings a child experiences during an out-

²⁸Analysis of Agency Performance in Achieving Permanency in Philadelphia. Internal confidential report to DHS from Chapin Hall (10/2/2008).

of-home care spell, the data could be organized to show the placement stability within specific time periods (e.g., the child's first 6 months of care, second 6 months of care, or other periods as appropriate).

The attributes of the children in care (e.g., sex, age, and race/ethnicity) will vary across providers based on the types of services offered by providers, provider specialties, and potentially the provider's location. This is understandable and appropriate given the number of children in care and the diversity of their needs. As a result, it is likely that provider performance will vary—perhaps significantly—across a standard set of outcome measures. The analysis of outcomes must account for this to ensure that providers are not penalized simply because they work with a needier clientele where permanency is a more difficult objective to attain. Therefore, the analysis provides controls for various characteristics of each provider's caseload, such as:

- Entry cohort year;
- Gender;
- Age at beginning of an agency spell;
- Race/ethnicity;
- Reason for placement in care;
- Type of first placement setting;
- Sibling ever in care; and
- Number of agency spells a child has experienced.²⁹

While controlling for caseload characteristics, the data are structured to support multiple views of DHS and private provider performance, thereby enabling DHS to examine the same outcome data across various geographical entities and across individual providers. Outcomes can be viewed citywide, by provider, and by geographical unit, such as police districts or family service regions. This will enable DHS to identify performance outcomes and patterns within the context of where the services are provided. This ability is particularly important when comparing the performance of various entities (e.g., providers, family service regions, etc.) to one another. For example, comparing an individual provider's performance on selected outcome measures against a citywide average could suggest that the provider is performing below average. Understanding that provider's performance relative to factors such as geography (for example, the police district where the provider administers services) could show that the provider is actually performing above average relative to its location.

In addition to assessing internal DHS and provider performance for a given period of time, it is important that DHS continue to assess performance of providers and of the agency itself over time. This will enable DHS to understand how it is improving on the various outcomes of interest over time, and to assess how providers are succeeding over time. In turn, it is important that the initial set of measures used for the report card are fixed, so that the same measures are used over time.

Outstanding Issues Related to the Report Cards

There are still a number of decisions that must be made prior to the release of the report cards. Perhaps the most significant issue is that DHS has not yet finalized what specific outcome measures will be included in the report card. These issues are highlighted in this section.

Creating the Report Cards

While progress has been made in generating the core data that will be used to generate the report cards, there has not been significant progress in defining the content or release schedule for the DHS and provider report cards. DHS now has a robust set of data that could support analysis of caseload dynamics, spell durations, and internal and external performance. However, the information in the core data set, as well as the initial analysis of the data, is somewhat technical in nature and may be neither understandable nor accessible to many of DHS' stakeholders. DHS must translate the available information into outcome measures that are meaningful, understandable, and

²⁹Analysis of Agency Performance in Achieving Permanency in Philadelphia. Internal confidential report to DHS from Chapin Hall, 10/2/2008.

reflect the performance of DHS and its providers in the context of their individual clients. Rating providers on a series of outcome measures must be done in a way that accounts for the child-level variations in each provider's caseload.

Impact on Providers

At the time of this report, DHS has not developed a strategy for presenting the outcome report cards to the provider community. Providers have an obvious interest in the outcomes used to measure their performance. The report cards will be a publically available and highly visible document that will be scrutinized by many of DHS' stakeholders, many of whom may use the report cards as the principal method for assessing how well providers are serving the families and children in their care. Moreover, the CWRP's Phase 2 recommendations include linking provider performance to the outcome measures and incorporating the use of financial incentives based on the measures. This will certainly be of high interest to the providers contracted with DHS. It is possible that the release of the report cards will generate significant concern among the providers, and potentially animosity toward DHS.

The COB recommends that DHS develop a strategy for working with providers as the report cards are generated. This should including soliciting provider input on the content and format of the report cards, obtaining input on how the reports should be distributed, and developing a mechanism for provider feedback, assuming that any provider faring poorly may wish to defend its performance.

Frequency

One outstanding question regarding the internal DHS and provider report cards is the frequency with which they will be produced and reported to entities outside of DHS. The COB recognizes the importance of maintaining the data extracts routinely so that ongoing monitoring of outcomes is a viable option for DHS and its stakeholders. However, the COB reaffirms the CWRP's original recommendations that the DHS internal and provider report cards be produced annually. We believe that DHS and its providers need ample time to implement the changes and reforms currently underway and in planning, and that it is not reasonable to expect results to occur immediately. Therefore, generating the report card indicators too often is unwise and may cause unnecessary alarm that changes are not occurring as speedily as expected.

Information Systems

Data extracts are currently generated from FACTS, although DHS has indicated plans to migrate to a new system known as Libera in the near future. While the COB does not view this as a concern, it is important that DHS consider the implications that a new information system will have for producing the data extracts used to generate the outcomes. Specifically, DHS must ensure that all data elements currently used to generate the outcomes and report cards are collected through whatever new information systems are implemented.

More generally, as expressed in Chapter 4, the COB feels that DHS does not have an integrated plan for the creation, enhancement, and use of information systems. As noted previously, this is most alarming in the area of social work practice, as the lack of systems inhibits good casework. There are implications in the management of information as well. Because DHS has numerous information systems—both planned and in operation—that do not work in an integrated fashion. As stated in the prior section on social work practice, the COB intends to work more closely with DHS during the coming months to review its plans for information systems. Part of this review will include an assessment of DHS' IT capability with regarding reporting, data and information management, and creation of outcome measures to support efforts to increase DHS accountability.

Inclusion of Additional Measures

The CWRP's original recommendation stated that the initial iteration of the report cards include outcomes related to safety, including maltreatment rate, likelihood of maltreatment, and likelihood of recurrence of maltreatment. DHS has chosen to focus the initial round of report cards on permanency measures, with the exception of some safety-related measures that will report rates of repeated maltreatment for children in placement. Therefore, a robust set of safety measures will not be included in the report cards, and potentially from the broader internal DHS measurement strategy. While DHS has stated its intent to include safety measures in subsequent iterations, the COB fears that omitting the core measures of safety from the initial report cards may divert attention away from the critical need to protect children. In addition, the COB feels that DHS needs to increase its efforts for obtaining

data that support development of performance measures on additional reform efforts, including prevention, ARS, and IHPS.

Ongoing Use of Information

The COB acknowledges the progress DHS has made toward both the report cards and obtaining the information necessary to create a broader set of internal measures needed to enhance accountability. The ability to implement a more intensive internal accountability structure is significantly enhanced by the information DHS has received from Chapin Hall. This new source of information has the ability to serve as a useful evaluative tool for DHS and support a more detailed understanding about the effectiveness of DHS' program and service delivery strategies. In turn, this should help DHS move forward with the CWRP's recommendation to implement a more rigorous approach to internal monitoring and measurement of DHS performance.

The COB feels that DHS' true challenge ahead is developing the capacity to use the information it now has at its disposal. The Department has demonstrated an ability to collect and maintain data on the children and families in its care; however, it has not proven that it could transform the raw data into meaningful information that informs policy and program decision making efforts. Through the partnership with Chapin Hall, DHS now has a useful source of meaningful information. However, DHS must become proficient in using information and applying it to the array of programs and services it offers. Information analysis does not, at present, appear to be a core DHS competency. The creation of the Division of Performance Management and Accountability and the recent appointment of a Deputy Commissioner for this division are steps in the right direction. However, DHS appears to have made only moderate progress in developing information analysis as a core competency.

Ongoing Role for External Consultants

Because DHS lacked the time, capacity, and expertise to create an administrative dataset suitable for use in creating the performance measures, an external consultant—Chapin Hall—was contracted. Funding for this consultant was provided by Casey Family Programs. As of this report, the ongoing role for external consultants in the data evaluation, report card development, and ongoing performance monitoring and measurement strategy has not yet been determined.

The COB strongly believes that ongoing support for an external consultant is necessary, regardless of what entity provides that support. As discussed above, though DHS has the ability to collect vast amount of raw data, it does not have the ability to transform the data into useful information for analysis and evaluation purposes. However, transformation of human services administrative is something that many consulting organizations have as a core competency. The ongoing involvement of such an entity will increase the quality of the analysis and the speed at which it could be completed. Moreover, it will provide validation of the performance monitoring and reports cards from a respected external organization that is a national leader in this area. We feel that this independent validation is crucial given the ongoing public scrutiny of DHS.

Recommendations

Based on the current status of DHS in developing the reports, as well as the many outstanding issues noted above, the COB has the following recommendations related to the area of Outcomes and Accountability.

- The focus on the report cards is largely on child permanency. While permanency is of great importance, it does not provide insight into how well DHS and contracted providers are ensuring the safety of children. Therefore, the COB recommends that DHS increase its effort to include safety measures as part of the report card. We recommend that DHS include safety measures related to recurrence of maltreatment on the public report cards, and that these report cards be produced no later than May 2009. We further recommend that DHS produce an interim internal report for the COB no later than March 30, 2009 that includes measures of child safety that are developed in collaboration with the COB.
- For the January 2010 report cards, the COB recommends that DHS continue to report on the measures of safety and permanency, and add performance measures related to new DHS reforms and programs, including IHPS, ARS, FGDM, and other measures of interest identified in collaboration with the COB.
- DHS must develop a strategy for working with providers to roll out the report cards and account for provider-specific differences that may be represented in the performance measures. As noted, when the outcomes for

providers working with specific child populations (e.g., medically needed, infants) are compared with the overall provider population, contextual differences must be considered.

- DHS must develop a stronger in-house capability to use the administrative data and outcome data provided by Chapin Hall (or any other external consulting firm used in the future). Such data provide a valuable source of information for understanding DHS performance, and identifying where program or other changes are warranted. The COB recommends that the new Deputy Commissioner of Performance Management and Accountability be assigned to develop a plan for developing this capability within DHS.
- DHS should continue to fund external consultants to assist with the development of the administrative data sets and tabulated information that will provide the basis for the report cards. The COB feels this is appropriate because an external entity—particularly one that is regarded as an expert in the use of administrative data for development of performance indicators—will lend credibility to DHS’ report cards and performance monitoring efforts.



CHAPTER 6

Leadership & Infrastructure

This is an area that the Community Oversight Board (COB) will pursue in more detail in the June 2009 report. At the present time we can comment only on paperwork reduction, the establishment of Department of Human Services (DHS) local offices, and recent experiences with town hall meetings. There are no changes in status since the October 2008 status letter. As seen in Table 6.1, Status of Leadership and Infrastructure Recommendations, the COB did not designate any of the seven recommendations as an area of concern.

Table 6.1. Status of Leadership and Infrastructure Recommendations

#	Recommendation	Panel Timeframe	Revised Timeframe	Status	Area of Concern
Phase 1					
33	Establish a mechanism and process to ensure ongoing community oversight, including the establishment of a Community Oversight Board.	6/2007	6/2007	Completed	No
34	Ensure ongoing community participation and input into DHS improvements.	7/2007	9/2007	Ongoing	No
Phase 2					
35	Expand the emphasis to make DHS a more transparent agency.	8/2008	8/2008	Ongoing	No
36	Enhance the healthiness of DHS infrastructure and staff morale.	3/2008	3/2008	Ongoing	No
37	Enhance DHS' ability to actively and transparently manage crisis, including strengthening processes related to child death reviews and increasing public access to information.	3/2008	3/2008	Ongoing	No

Paperwork Reduction

The Child Welfare Review Panel (CWRP) recommended that DHS streamline its paperwork and records management practices as part of an overall approach to improving social work practice. The CWRP further recommended, as part of DHS' approach to leadership and infrastructure, that DHS "take positive steps to enhance the healthiness of its infrastructure and staff morale." Based on interviews with DHS social work staff and supervisors, the CWRP recognized that many paperwork requirements represented a significant burden for DHS staff. Therefore, the CWRP felt that streamlining DHS paperwork would be an important step in improving staff morale.

DHS engaged a professional consulting firm to analyze existing paperwork requirements for DHS social workers and supervisors and offer recommendations for reducing paperwork requirements. The consultant offered numerous recommendations for consolidating DHS forms, letters, and notices in most of DHS major program areas in order to reduce the paperwork burden. The consultant also made a series recommendations aimed at improving document management processes and the use of automated technology.

DHS has moved forward slowly in implementing many of the recommendations. The responsibility for the effort is located with the Division of Quality Improvement. A new staff member has been hired who is dedicated specifically to the paperwork reduction effort.

In addition to the efforts to reduce the amount of paperwork required, DHS plans to implement the Libera information system, which is consistent with the recommendations regarding the use of information technology. The new system should—if implemented as envisioned—enable DHS staff to use their computers to pre-fill many DHS forms and have instant access to information about families and clients. It should allow for information sharing and collaboration in the completion of service planning forms.

The COB acknowledges DHS efforts in the area, and urges the department to accelerate the timeframes for implementing the consultant's recommendations. The COB will prepare a detailed progress report on the status of the paperwork reduction effort in the next progress report.

Establishment of Local Offices

The COB approved the department's revised implementation date of August 2009. At the time of this report, DHS has tentatively selected a site for the office and begun initial preparations regarding facility build out and transition activities. Given the ample time needed to complete the project, as well as to realign DHS practices to support the provision of services in a newly created local office, the COB questions whether August 2009 is still realistic. While the COB will work with DHS to set a more appropriate timeframe, we believe that DHS must increase its effort to select a site and secure the facility necessary to ensure that the CWRP's recommendation is carried out as quickly as possible.

Town Hall Meetings

While the COB consultants did not attend the Town Hall meetings in 2008, they recognize that DHS has made efforts to facilitate community involvement and make the department more transparent to the public. Town Hall meetings began shortly after the release of the CWRP report and continued through November 2008. DHS also made strides toward instituting a focus on community outreach, with enhancements to the DHS Web site, increased meetings with child advocates, and the hiring of a communications director. During the next reporting period, the COB will provide additional opportunities for the community to express its concerns and comment on DHS progress.



Appendix A

Hotline Observation & Site Visit Report

December 23, 2008

Executive Summary

The Hotline observation visit and data analysis is described in detail in this report. Excerpts of this report are included in the December 2008 Community Oversight Board (COB) Progress Report. The COB review of the status of Hotline operations and the implementation of Hotline Guided Decision Making (HGDM) and Expedited Response (ER) was planned and conducted as a cooperative effort of the COB members, Department of Human Services (DHS) staff, and supervisor and employee union representatives. The review of Hotline included a 2-day visit to the Hotline and an accompanying data analysis. Several major findings are discussed in this report.

1. The delay in implementing FACTS2 is a significant hindrance to the efficient implementation of HGDM. Specific automation functionality that is important for Hotline operations is described later in this report.³⁰
2. Since its implementation in April 2008, HGDM has undergone a number of modifications. The structured decision making tool has led to greater consistency in the collection of information and decisions regarding acceptance and prioritization of referrals. DHS credits HGDM with improving the focus of the agency on the most serious cases and with reducing the SCOH caseloads. The HGDM tool needs additional refinement and staff training to help staff to become comfortable with the new process, especially related to classification and prioritization of General Protective Services (GPS) referrals.
3. Even though DHS conducted community awareness efforts with the mandated reporter community, some mandated reporters have reacted negatively to the additional questioning that HGDM requires. Some of these reporters are now calling ChildLine (State hotline) rather than reporting to DHS directly.
4. DHS has implemented the ER program as recommended by the CWRP. The ER process for GPS referrals involving children ages birth to 5 years old is implemented through specialized units and overtime staff at the Hotline. CPS referrals that qualify for the ER response, based on the age(s) of children involved, are handled by Multidisciplinary Teams (MDT) and Intake units.
5. Implementation of ER has not significantly affected the process for taking calls at the Hotline. The prioritization of referrals, based on age alone, is considered an appropriate criterion for prioritizing calls by the Hotline staff.
6. Quality assurance (QA) on a case-by-case basis is performed by supervisors who review every referral received at the Hotline. However, QA performed at the administrator level was not implemented until recently. Until data are available from the administrator review process, it is difficult to assess the quality of decisions made by workers and supervisors and the impact of HGDM on the handling of referrals at the Hotline.

Key recommendations based on the COB review are:

1. Continue to refine the HGDM tool, and associated training, policy and procedure documents, to address identified issues related to GPS definitions and prioritization decisions. Inclusion of staff in this process is critical to the full acceptance of structured decision making at the Hotline.
2. Management should make provisions for staff to participate in peer consultation sessions to review cases where definitions and decision making are unclear.
3. Conduct additional community awareness efforts to address the concerns of mandated reporters regarding the more extensive questioning required by HGDM.
4. Implement FACTS2, or a suitable alternative, at the Hotline as soon as possible.
5. Collect and analyze data related to screened out referrals.
6. Upon implementation of the administrator QA process, analyze the results of these reviews to evaluate the appropriateness of acceptance, classification, and prioritization decisions at the Hotline.
7. Implement data collection and reporting related to ER cases handled by the MDT and Intake units. This reporting should be consistent with the data available for the Hotline ER units in order to provide a complete perspective on the ER program.

³⁰Recently DHS has informed the COB that the implementation of FACTS2 at the Hotline will begin within the next month. The FACTS2 application has been developed and tested and implementation will begin with the training of Hotline workers.

8. Engage in peer consultation with other Hotlines to identify improvements in operations and methods for program evaluation. The COB recommends contacting New Jersey, which due to its proximity to Philadelphia and its recent automation of the Hotline, can provide some useful input for DHS.³¹

The observation team suggests follow-up review by the COB should occur in the following areas:

- Evaluation of reports that are not accepted (screened out). DHS will be entering this information into an interim database in the near future;
- Review of the progress on revising and finalizing the HGDM tool;
- Evaluation of the results of the Quality Assurance process recently implemented at the Hotline and for which data will be available in the near future;
- Monitoring the progress regarding the implementation of FACTS2 at the Hotline;
- Conduct additional review of the ER system once data are available from the MDT, Intake units, and Intake Sexual Abuse units.

Hotline Observation And Review Method

Members of the COB conducted an on-site observation of the DHS Hotline on November 12 and 13, 2008. Five people comprised the observation team:

- Kathleen Noonan
- Carol Tracy
- Susan Badeau
- Margarita Davis-Boyer
- James Kennedy (Walter R. McDonald & Associates, Inc. [WRMA], consultant support)

The purpose of the visit was to evaluate the changes at the Hotline since the implementation of HGDM and ER—two safety reform priorities of DHS. The visit included observation of workers during the call-taking process and interviews of staff. Statistical data were requested from DHS to augment the information gathered during the visit.

The specific objectives of the Hotline observation were to:

- Assess HGDM impact on acceptance and screen out decisions;
- Assess HGDM impact on prioritization and determination of response times;
- Assess HGDM impact on call handling, call times, and the overall capacity of the Hotline unit to manage call volumes;
- Assess procedures used for classifying, processing, and assigning ER reports;
- Assess solicitation of impressions and input from staff (at all levels) related to the status and results of HGDM and ER; and
- Identify any outstanding issues related to the implementation of HGDM and ER at the Hotline.

The COB observation team conducted conference calls with DHS staff and representatives of the unions prior to the site visit to plan logistics, review objectives, and identify staff to be interviewed. The COB distributed a final schedule as well as potential interview questions prior to the visit. DHS staff received a one-page description of the observation visit, containing the objectives, planned activities, and assurances related to the handling of confidential information and the intent not to disclose staff names in the final report. These assurances sought to provide a comfort level for staff and to encourage the sharing of information with the observation team.

The observation team observed calls on a random basis during the evening shift on November 12, and the day shift on November 13. Due to the manner in which calls are distributed at the Hotline, observers walked around the floor and identified workers who were taking calls for observation. Since the team also conducted a number of

³¹Members of the COB are available to provide introduction and staff contacts to engage this process.

interviews with supervisors and administrators during the visit, time for call observation was limited. Twelve calls were observed, in whole or in part. Observers listened only to the social worker's side of the call, as the Hotline does not have the capability to listen to calls while in progress.

Interviews were conducted with management, administrators, supervisors, social workers, and representatives of the social workers' union. Several interviews were performed during the Hotline observation:

- Hotline Management (2)
- Administrators (3) (day and after-hours shifts, and ER)
- Supervisors (8) (included Screening Unit and CAPTA)
- Social workers (9)
- Union representative (1)

To augment the site visit and observation, the observation team reviewed available statistics related to call activity, prioritization of calls, and ER. (As discussed later in this section, DHS cannot at this time supply statistics for referrals screened out.) The focus of this review was to evaluate the changes since the implementation of HGDM and ER at the Hotline. Key findings of the observation visit and the statistical review are presented in the next section.

Status And Findings

The findings from the Hotline visit and statistical reports are separated into the following areas:

- Hotline Organization
- Hotline Guided Decision Making
- ER Implementation
- Quality Assurance

Hotline Organization

The Hotline is primarily responsible for receiving and screening referrals related to child welfare services, primarily child protection. Calls from the community are received and distributed through the Automated Call Distribution (ACD) system. Calls are placed in a queue and each is then answered by an available Hotline worker. Calls from the State child abuse hotline (ChildLine) are received and distributed through a priority queue to ensure that they are answered quickly. The Hotline workers are assigned to one of three shifts—8 a.m.–4 p.m., 4 p.m.–12 a.m., and 12 a.m.–8 a.m. Some workers and supervisors work varied shifts and overtime staff is used to augment the regular Hotline staff when needed. There are two Hotline administrators—one oversees the daytime Hotline operations, the other manages both after-hours shifts.

In addition to receipt and processing of child abuse and related referrals, the Hotline has a specialized Screening unit to handle referrals of non-maltreatment related service requests from other agencies, mental health issues, court referrals, and GPS related walk-ins. The Screening unit also receives referrals from Hotline workers when a family requires referral to the Community-Based Prevention (CBP) program.

The CAPTA unit operates within the Hotline and is responsible for referrals from medical facilities when mothers give birth to a drug affected infant.³² The CAPTA unit's phone line receives referrals from seven area hospitals. The CAPTA unit has a 2 hour response time requirement. CAPTA workers do the initial field screening of these reports and then refer cases for services or to Intake for further assessment. The DHS CAPTA unit works closely with the CBP program and the DHS's CAPTA team. Table A.1, CAPTA Referrals and Dispositions 1st Quarter FY 2009, shows the dispositions of CAPTA referrals for the first quarters of FY 2008 and FY 2009. The comparison of these two periods shows a marked increase in the number of cases referred to Intake and a decrease in referrals to CBP and DHS's CAPTA program.

³²The CAPTA Unit is named for its funding source—the Child Abuse Prevention and Treatment Act.

Table A.1. CAPTA Referrals and Dispositions 1st Quarter FY 2009

#	Recommendation	Panel Timeframe	Revised Timeframe	Status	Area of Concern
Phase 1					
33	Establish a mechanism and process to ensure ongoing community oversight, including the establishment of a Community Oversight Board.	6/2007	6/2007	Completed	No
34	Ensure ongoing community participation and input into DHS improvements.	7/2007	9/2007	Ongoing	No
Phase 2					
35	Expand the emphasis to make DHS a more transparent agency.	8/2008	8/2008	Ongoing	No
36	Enhance the healthiness of DHS infrastructure and staff morale.	3/2008	3/2008	Ongoing	No
37	Enhance DHS' ability to actively and transparently manage crisis, including strengthening processes related to child death reviews and increasing public access to information.	3/2008	3/2008	Ongoing	No

The Hotline operation also includes the specialized units for responding to referrals that qualify for ER (children between the ages of 0 and 5 years old). The ER program is discussed in its own section later in this report.

After hours, the Hotline becomes the center of DHS operations, including the support for ongoing workers in the field. Hotline staff provides consultation to field staff, handles emergencies on new and open cases (including walk-ins), locates placements for emergency removals, and obtains restraining orders. As mentioned, one administrator is responsible to oversee both the 4 p.m.–12 a.m. and 12 a.m.–8 a.m. shifts. The administrator works varied hours during these periods and is accessible offsite via a Blackberry.

Call and Report Handling Process

As noted above the observation team listened in on 12 calls. In some cases, only part of the call was observed. The observer may have located the call after it was answered or the worker may have continued processing the report (calling collaterals, performing data entry, or completing the HGDM forms) after the observer left. The typical process for handling reports, as observed during the visit, was as follows:

- Social Worker answers call, acquires information, and records notes manually;
- Worker initiates the “work status” (by pressing a button on the phone) to show they are not available to take new calls and complete the processing of the report;
- Social worker performs a search of the FACTS system (DHS information system) for prior involvement with the family (some workers do this during the call; others after the call);
- Social worker makes collateral contacts and records information manually;
- If the social worker decides to accept the report, the worker enters the report information into FACTS;
- Social worker completes the HGDM forms (either handwritten or typed);
 - » If the worker intends to screen out the report, the HGDM (Six) 6 Domains tool is completed; and
 - » If the worker intends to accept the report, the HGDM Decision Making Tool is completed.

- Social worker adds call to their log sheet (manually or typed);
- Social worker prints the FACTS report and submits the FACTS report and completed HGDM forms to the supervisor (hand carries to the supervisor);
- Supervisor reviews the report. If the supervisor agrees with the report decision and deems the report documentation acceptable, the supervisor signs off on the report form. If corrections or consultation is needed, the supervisor and worker discuss and may seek administrator guidance;
- Social worker makes any corrections needed in FACTS and resubmits the completed forms to the supervisor; and
- Worker cancels the work status and is again ready to receive calls.

If a report is accepted, the supervisor assigns the report to one of the following:

- CYD—If the referral is a GPS with no present danger, the safety threshold is not met³³, and the referral does not qualify for ER response;
- ER—All GPS referrals if a child 5 years old or younger is involved;
- MDT—If the referral is a CPS involving repeat abuse;
- Intake (investigation/assessment)—If the referral is a new CPS; and
- Intake (new sex abuse investigation/assessment)—If the referral is a new CPS and involves sex abuse.

Screened out reports are not entered into FACTS and the forms are placed in a box for later filing. According to Hotline management, a database is being created for the entry of screened out report information prior to the implementation of a new information system. Since these calls are not entered into FACTS, and the interim database has not been implemented, statistics related to screened out reports are not currently available. This is unfortunate since a key question is whether or not HGDM has significantly affected the acceptance of referrals at the Hotline.

The processing of a report after the call is taken appears cumbersome and overly time consuming. Workers spend a significant amount of time entering their handwritten notes into the FACTS system and completing the manual forms used for HGDM. Inefficiency in this process is due to a number of reasons.

- The FACTS system is based on very old technology and has severe limitations related to entry and edit capability. Correcting entries requires significant re-typing of narrative sections.
- FACTS does not include specific fields or edits for HGDM information.
- The system does not provide any guidance to the worker for the HGDM process.
- Reports and HGDM forms must be hand carried to supervisors and passed back and forth for corrections. There is no automated support for transferring the record to the supervisor or support for the supervisory review and approval processes.

Staff at all levels expressed frustration regarding the delays in implementing the FACTS2 system. Hotline staff was under the impression that FACTS2 would not be implemented and that the agency is planning to implement a new system (Libera). However, the COB learned in the December meeting that FACTS2 is still the intended solution for the Hotline (and possibly other DHS programs). Implementation of Hotline automation should be a priority and the new system should include the following features:

- Expedited worker entry of calls and include tools for editing and spell checking entries;
- Automated guidance provided for gathering, entering, and assessing information for the reports, including the full incorporation of the final HGDM tools;
- Inclusion of documentation of screened out reports;

³³Once Alternative Response (AR) is implemented, these referrals will be assigned to one of the AR units. AR is expected to be implemented in January 2009.

- Provision of automated transfer of reports between social workers and supervisors with clear designation of who is responsible for the report at each phase and controls to ensure that reports are processed on a timely basis;
- Provision of automated processes for approval and correction of reports; and
- Provision of statistical reports that allow analysis of worker productivity, processing, and disposition of all calls coming into the Hotline (including those screened out and those received by the Screening and CAPTA units).

The observation team listened in on calls only from the social workers side of the call. This was adequate for observing the call-taking process. However, administrators and supervisors should have the capability to listen into calls while the social worker is on the phone in order to monitor the process and to assist if needed. The COB team encourages the implementation of this functionality for the Hotline.

The team wished to review statistics to ascertain the impact of HGDM on the time required to process a report at the Hotline. As of the writing of this report, detailed call activity statistics for comparable pre-HGDM and post-HGDM periods were not available. DHS did supply data allowing an analysis of the possible impact of HGDM on calls abandoned before they are answered at the Hotline.³⁴ Comparison of abandonment data for April 2007 through June 2007 and 2008 indicates there has been an increase in abandoned calls since the implementation of HGDM (and the initiation of the collateral contact policy). Eight percent of calls were abandoned in 2007, compared with 11 percent in 2008. Abandoned calls increased despite that was an average of two more workers available for receiving calls in 2008 and there were more than 1,000 fewer calls during this period in 2008. It should be noted that the period covered by the data reported here includes only the first few months following the implementation of HGDM. During this period, the Hotline staff were just learning the new procedures and documentation requirements. The time per call, and the additional steps to document and process reports, are likely to decrease as workers become more familiar with the HGDM tool.³⁵

Hotline Guided Decision Making

DHS implemented HGDM at the Hotline in April 2008. DHS worked with ACTION for Child Protection to develop the structured decision making tool. The design and implementation of HGDM, and the evaluation conducted during the first month, are described in the report *Hotline Guided Decision Making: Initial Front end Redesign for Philadelphia DHS* (ACTION for Child Protection, June 12, 2008). HGDM was implemented with the express purpose of narrowing the agency’s focus to child safety from the broader focus of serving families seeking any social intervention. HGDM targeted specific issues facing DHS including the lack of protocols for Hotline workers, the effects of the high profile attention DHS was experiencing, the perceived tendency to designate immediate response for referrals that did not require this, and the need to standardize decision making in general. Initial design of the HGDM occurred between July 2007 and January 2008. Training of 199 Hotline staff was performed during March and April 2008.

During the first 30 days of HGDM implementation, 1,089 accepted and non-accepted reports were reviewed for the purpose of evaluating the program and determining any needed changes. Some of the most significant findings of the initial 30-day assessment performed by ACTION for Child Protection are noted below.

1. There were 342 fewer reports accepted for investigation/assessment in April 2008 than in April 2007. (It is not clear whether or not this means a higher percentage were screened out in April 2008 compared to the prior year);
2. There was a small increase in the number of reports designated as 0–2 hour response times;
3. There was no significant change in the percentage of reports that received 24-hour/Priority 24-hour response times;
4. Information collection by Hotline workers improved with the use of the HGDM tool, based on an evaluation of the information collected in the six HGDM domains (discussed in more detail later in this section); and

³⁴It should be noted that abandoned calls are not necessarily calls related to reports. In some cases, callers may hang up after realizing that they have reached the wrong department or office.

³⁵DHS supplied statistics after the original draft of this report indicating that abandoned calls, although still somewhat higher than in 2007, have decreased.

5.5. HGDM included a policy change to instruct workers to make collateral contacts, when available, to obtain more information. During the first month, Hotline workers contacted collaterals in 43 percent of the cases where collaterals were available.

An important aspect of the initial post-HGDM evaluation involved assessing the quality of decisions made by the Hotline staff using the HGDM tool. This was done by comparing the Hotline worker judgments with the judgments of selected reviewers. The following are the major findings:

- Reviewers determined that only seven cases were not accepted even though they met the statutory criteria for CPS or GPS (3 percent);
- Reviewers found that 59 reports were accepted that did not meet the statutory criteria (7 percent); and
- Reviewers agreed with the “present danger” decision 81 percent of the time; with the “impending danger” decision (safety threshold questions) 77 percent of the time; and with the response time decision 70 percent of the time.

The ACTION for Child Protection report includes a number of anecdotal comments from workers collected through focus groups held at the end of the evaluation period. These comments are similar to those received by the observation team during the visit. These issues are addressed later in this section.

The conclusions of the evaluation by ACTION indicated that improvements were needed in:

- Increasing the use of collateral contacts when available;
- Assisting workers in differentiating “present danger” and “impending danger;” and
- Changing the response time categories so that workers have an option shorter than 7 days for referrals that are not present or impending danger.

HGDM is currently composed of two separate forms; both identified as interim forms for use until FACTS2 is implemented. The forms are the HGDM and the HGDM Tool – (Six) 6 Domains. The first HGDM tool is completed for accepted reports only and workers complete this form manually or by typing into a Word template. The form is composed of five safety decisions:

- Safety Decision 1: Does the information constitute a report and if so what type (CPS, GPS, or General)?
- Safety Decision 2: Is there present danger (based on characteristics of the maltreatment, the child, and the parent/caretaker)?
- Safety Decision 3 (completed if Safety Decision 2 is no): Is there impending danger (based on five safety threshold items)? Safety Decision 3 also includes check boxes to denote special circumstances and a designation of whether or not the report qualifies as ER.
- Safety Decision 4: This is the section where the worker specifies the prioritization. Note: while the most recent version of the HGDM form includes a checkbox that allows a Hotline supervisor to override the response setting (to make it Immediate or 24-hour), there appears to be no requirement for documenting the reason for the override.
- Safety Decision 5: This is completed by the supervisor and designates the assignment of the report (ER, MDT, Family Service Region, Intake, or Intake (Sex Abuse).

The form also includes a narrative section where the supervisor documents agreement or disagreement with the decisions of the worker.

The second form, the (Six) 6 Domain form, is completed manually for screened out reports. These forms serve as the documentation of screened out referrals. For an accepted report, the Six Domain information is entered into a text field in FACTS.

Workers collect document referral information from six domains:

- What is the extent of alleged maltreatment?
- What are the circumstances surrounding the maltreatment?

- What is the child’s functioning?
- What is the adult functioning?
- What are the general parenting practices?
- What are the disciplinary practices?

The form also has two narrative boxes to add information from collateral sources and for the supervisor to enter comments.

According to staff at the Hotline, the tool has undergone a number of the changes since its implementation in April 2008. Since the forms do not contain version numbers or effective dates there appeared to be some confusion about the latest version of the HGDM forms. (Hotline management indicated that all current forms are available online for staff to print as needed.)

The observation team’s interviews indicated that most Hotline staff members see both benefits and challenges from HGDM. Most staff interviewed agreed that HGDM, as a whole, is a useful tool for the Hotline. Staff noted that the tool helps workers acquire more in-depth information (especially newer workers), provides more consistency to the information collected during the calls, and provides a more objective basis for decisions. DHS also reports that HGDM is having the intended affect on focusing the agency on the most critical cases. DHS reports that this improved focus on child safety is clearly reflected in a significant reduction in the SCOH caseloads.

HGDM has been in effect for less than 1 year and some staff indicated they still have some confusion related to acceptance and prioritization of GPS referrals. Staff expressed particular confusion regarding when a 24-hour response should be used for GPS cases. Various staff expressed concern regarding the elimination of “child endangerment” and “other” as types of GPS. Staff indicated that this prevents the acceptance of some reports, especially those where parent incapacity is the main concern (e.g., drug or alcohol impaired parents). Concern was expressed regarding the fact that referrals that do not qualify as Immediate or 24-hours, based on HGDM, must be designated as 7-day response (an issue also raised by ACTION for Child Protection in their recommendations following the implementation of HGDM). Staff indicated that some mandated reporters are frustrated by the additional questioning required by HGDM and indicated that more reports are made to the State’s ChildLine to avoid direct contact with DHS. Staff also expressed the need for additional HGDM training.

The implementation of HGDM is a significant change for the agency and it is likely that some workers are having difficulty adapting to the more structured approach to evaluating and processing referrals. As mentioned above, the process has had the effect of focusing the agency’s attention on the most serious cases, reducing ongoing caseloads, and bringing more consistency and depth to the process for gathering and documenting information from the initial referral calls.

The observation team was most interested in how HGDM has affected decisions made in regard to referrals received at the Hotline. Although statistics are not available to clearly judge the impact of HGDM on acceptance and screen out decisions, data are available regarding the classification and prioritization of reports.³⁶ Based on DHS statistics for April–September 2007 and 2008, there were substantially fewer reports accepted in 2008 (see Table A.2, Comparison of 2007 and 2008 Accepted Reports: Classification and Prioritization [April–September]). General reports doubled as percentage of all accepted reports between 2007 and 2008 (from 8 percent in 2007 to 16 percent in 2008). This is significant since the General category is meant to be used for non-child maltreatment referrals (e.g., requests for home evaluations from other counties or States). However, some Hotline workers now use the General classification for neglect referrals that do not meet the agency’s current GPS definitions in order to accept a report they would otherwise be required to screen out.

Prioritization of accepted reports does not appear to be significantly different since the implementation of HGDM, except for the prioritization of General reports. Three percent of General reports were given an Immediate priority in 2007 compared with 6 percent in 2008. In 2008, 35 percent of General reports were rated as 24-hour or P 24-hour compared with only 10 percent rated as 24-hour in 2007.

³⁶Based on interviews, most workers and supervisors interviewed believe that HGDM has led to more referrals being screened out. Some consider the increased screen outs to be appropriate; others had concerns that some of these referrals should have received further assessment. For example, circumstances where a parent’s capacity to care for the child is in question but no maltreatment is alleged do not typically fit the current GPS definition.

Table A.2. Comparison of 2007 and 2008 Accepted Reports:
Classification and Prioritization (April–September)³⁷

Accepted Reports	2007			2008		
	N=8,307			N=6,902		
	CPS	GPS	General	CPS	GPS	General
Reports by Classification	1,925 (23%)	5,735 (69%)	647 (8%)	1,908 (28%)	3,913 (57%)	1,081 (16%)
Prioritization (% within classification)						
Immediate	18%	13%	3%	17%	14%	6%
P 24-Hours	NA	NA	NA	10%	22%	14%
24-Hours	82%	63%	10%	73%	43%	21%
Other (7-Day)	0%	25%	87%	0%	21%	59%

These data are consistent with the following findings:

- Although data are not available for screened out calls, it appears that HGDM, a lower overall call volume, or a combination of both, have led to fewer accepted reports.
- Social workers are using the General category to make up for the fact that DHS eliminated two of the catch-all GPS categories and to allow them to accept these reports.
- Now that workers are using the General classification for more neglect reports, they are giving a higher priority status to the General reports than they were prior to HGDM.
- The increase in the percentage of CPS reports, relative to GPS reports, does suggest a greater focus on the more serious CPS referrals. DHS also reports that caseloads for SCOH have been reduced through the improved screening. This sharper focus on the more serious referrals was an intended objective of the HGDM implementation.

The findings of the observation team suggest that DHS should consider the following to improve HGDM implementation.

- Implement the Hotline module FACTS2 (or an alternative system) to expedite the entry of reports and to provide automation to guide workers in the HGDM process.
- Refine the HGDM tool so that workers are clear about the definition of GPS and so that the definition is sufficiently broad to accommodate valid neglect reports that are now being accepted as General reports. Also:
 - » Clarify the priority setting for GPS reports and consider implementing a shorter response time than 7 days for reports without present or impending danger. (Although supervisors are now allowed to override the prioritization decision, overriding rules in a structured decision making process only serves to undermine the model.)³⁸
 - » Review the five threshold items, as some are confusing to staff (e.g., the definition of a vulnerable child). Also, some staff members believe that requiring all five threshold items misses some cases that they believe should be considered impending danger cases.
 - » Clarify the conditions under which the response time can be overridden (Safety Decision 4) so that supervisors consistently apply this option and provide clear documentation of the reason for the override.

³⁷The DHS statistics in this table include ER reports. ER reports are given a priority based on HGDM even though they will ultimately be responded to as Immediate priority (0–2 hours). Therefore, some of the reports that are shown as response times of P-24, 24-hour, or other (i.e., 7-day), subsequently become a 0–2-hour response based on their assignment to ER.

³⁸The implementation of Alternative Response in January 2009 should help clarify some of the prioritization issue since non-safety related GPS will be assigned to ARS with a response time of 72 hours.

- Create additional opportunities for peer consultation, which along with the TOL training mentioned above, will help clarify definitions and procedures for workers who have expressed confusion related to HGDM and the acceptance, categorization, and prioritization of GPS reports.
- Although DHS indicates that it is rare that supervisors override the prioritization that results from HGDM, it would be useful to clarify the policy regarding contact of collateral sources so that staff use this activity consistently. Some of the workers believe that collateral contacts are expected to be initiated whenever available; others understand the policy as only calling collaterals if needed to determine that the referral should be accepted or screened out. The policy should also take into account the time of day, the appropriateness of contacting non-family members, and the potential delay that these calls can create for the processing the report.
- Continue the community awareness efforts with the mandated reporter community regarding the purpose and use of HGDM at the Hotline to reduce the inclination of some reporters to bypass the DHS Hotline and report directly to ChildLine.
- Continue efforts to work with the State in regard to the issues that are created by the differentiation between CPS and GPS and the State's narrow definitions of these report classifications.

Expedited Response Implementation

Implementation of the ER system was a direct recommendation of the Child Welfare Review Panel. ER requires a 0–2-hour response for referrals involving children from birth through age 5. ER was implemented a few months prior to the implementation of HGDM. DHS has implemented ER through a combination of response units—specialized ER units (and some overtime staff), Multidisciplinary Teams (MDT), and Intake units (regular and sexual abuse units).

All GPS reports that qualify for an ER response are assigned to the specialized Hotline ER units. ER is performed for referrals received between 8 a.m. and 7 p.m. (with the last ER contact before 9 p.m.). The Hotline currently has two ER units (five workers/one supervisor for each); another unit will be added to reduce the number of ER cases currently handled by overtime staff.

CPS reports that qualify for ER are handled by the MDTs (active cases) or the Intake units (new cases). The observation team did not have an opportunity to observe the non-Hotline units involved in ER.

Based on the observations of the Hotline ER team, workers who respond to an ER referral always call the supervisor upon arrival at the home. The worker also calls for confirmation from a supervisor after conducting their initial assessment and before returning to the office. The supervisor approves all screen out decisions. The ER units utilize the Community Based Prevention (CBP) services extensively. The CBP is required to respond to an ER referral from DHS within 24 hours.

At times, ER staff are unable to make direct contact with the child within two hours. The child and/or family may be unavailable or unable to be located during the first attempted contact. When this occurs, DHS policy requires that another attempt be made within 24 hours of the initial attempt. If the second attempt also fails, the report is transferred to to the Intake Unit or to the ongoing worker. The intake worker or ongoing worker must make a third attempt within 24 hours of the second attempted contact.

Staff interviewed during the visit indicated that, for the most part, prioritization of referrals involving children ages birth to 5 years old is appropriate. However, there are some cases where prioritizing based on age alone may overrate the required response. The example was given of a child who had not received regular medical checkups for a 6-month period. The supervisor felt that an under-2-hour response in such circumstances was extreme. On balance, it appears that such cases are rare and that the ER procedure provides an important focus on young children who are considered vulnerable. As importantly, the implementation of ER, especially for reports received on active cases, provides assessment of the child's safety by a second worker. Review of the family's circumstances, and the child's safety, by a worker not currently involved with the family directly addresses some of the concerns raised by Daniela Kelley case. The ER system has also had the positive effect of reducing caseloads for intake and field units.

Since the ER program is handled by a variety of units and personnel, comprehensive statistics are required to assess the overall functioning of ER. However, statistics are currently available only for the normal hours ER units at the Hotline. DHS reports that the MDT and Intake units are planning to develop statistical reports based on the

framework used by the Hotline ER units. Table A.3, Expedited Response Referrals and Dispositions 1st Quarter FY 2009, presents data from the first quarter FY 2009 ER report for the Hotline ER normal hours units. As seen in Table A.3, contact could not be made in 32 percent of the ER referrals. A Safety Plan, or an Order of Protection, was needed in fewer than 10 percent of the ER reports.

Table A.3. Expedited Response Referrals and Dispositions 1st Quarter FY 2009

Expedited Response Referrals and Dispositions	N=562
Arrived at location within 2 hours of the report	491 (87%)
Unable to make contact	180 (32%)
Child determined safe	166 (30%)
Referred to Special Assessment unit	83 (15%)
Closed with no further involvement	56 (10%)
Child determined safe with Plan	44 (8%)
Referred to Community Based Prevention	7 (1%)
Order of Protection required	4 (1%)
Other	22 (4%)

DHS may want to consider the following refinements to the ER policies and procedures.

- Clarify the manner in which prioritization of ER reports is documented so that statistics reflect the actual response time based on ER rather than the HGDM priority result.
- Collect ER data from all units that perform the ER response so that the ER system as a whole can be evaluated.

Quality Assurance

The first stage of quality assurance is the oversight performed by supervisors on a case-by-case basis. Based on the observations during the visit, extensive consultation occurs between workers and supervisors on many of the calls received. By policy, supervisors review all reports (accepted and screened out). It was noted that a backlog of supervisor review can occur and that reports may be reviewed by the next shift or reviewed on the following day. Data related to supervisory review of reports, such as the level of agreement between supervisors and workers, are not currently available. Certain technical enhancements (the new information system and capability to monitor calls directly) could make the supervisory review process more efficient and would allow DHS to more effectively assess the decision making of workers and supervisors.

DHS recently implemented a formal quality review process in December 2008. The new quality review process for the Hotline, as described to the observation team by Hotline management is as follows:

- Hotline administrators (day and after-hours shifts) will review a minimum of 10 percent of all Hotline reports.
- Administrators will review reports on a random basis, although they can focus on specific types of reports if special concerns have been raised.
- The administrator will complete the HGDM Review Tool, which contains ratings of the information collected and documents the agreement/disagreement between the reviewer and the worker.
- Data from the HGDM Review Tool will be entered into the QA database for analysis.
- Analysis of the results of the QA reviews will be used to tailor the Transfer of Learning (TOL) training and the policies and procedures related to HGDM.

The QA process will be useful only to the extent that Hotline managers utilize the data for evaluation and planning purposes. This report identifies a number of recommendations that related to data collection and reporting. It is also important that DHS managers obtain and use data more effectively to evaluate the impact of changes in policy and procedure, to identify problems, and to effectively allocate and deploy the agency's resources.



Appendix B

Summary Of Recommendations From Internal Child Fatatlity Review Team

The Internal Child Fatality Review Team (ICFRT) reviewing the 2007 and 2008 cases had some similar recommendations to those presented in the CWRP's report regarding training, systems development and systems change, practice, and collaboration. These recommendations, as well as those of the COB based on their review of the cases, are summarized by each of these areas below.

Training

- Education and training for biological and foster parents on the two highest risk situations for child deaths: co-sleeping and bathing/water-based deaths. Need to develop tip sheet that spells out safe practices. Anyone that DHS or its providers know is caring for a child younger than 4 years old must be personally given safe sleeping and bathing instructions (in fact, a child should not be placed in that home until the caregiver has signed the information was received);
- Training regarding the use of allegations of drug use or client disclosure of drug use as a “red flag” and how to do safety planning and evaluate child risk in such homes;
- Training for working with uncooperative families; and
- Providing supervisory staff with training and guidelines on how to present family history and behavior patterns to the Law Department when preparing to seek legal action on a case.

System Development And System Change

- Enforce existing policies for SCOH case closure decisions when a new baby enters the family, with attention paid to the impact of a new baby on the family and the safety of the baby, even if all previous goals have been achieved;
- Guidelines are needed for ensuring that children receive an appropriate standard of medical care (including immunizations) for families receiving SCOH services;
- Develop policy and practice of reviewing families with multiple reports even if unfounded and cases that have multiple episodes of SCOH services in order to fully assess the families' needs and determine the appropriate level of intervention;
- General Protective Services (GPS) allegations that would be substantiated but are embedded in unfounded CPS reports need to be identified so that GPS issues can remain and receive appropriate attention and intervention;
- Develop guidelines to assist staff in determining when Parental Capacity Evaluations should be done and how to access them;
- Clarify practice and policy regarding mother/baby joint placements and determine if more resources are needed;
- Enforce existing policies for discharge of in-home cases when a new baby enters the family with attention paid to impact of a new baby on the family and the safety of the baby.
- Develop practice by which social workers regularly consult with supervisors for medically challenging children and determine need for consultation with physicians in those cases; and
- Develop clear expectations in writing regarding CAPTA referrals (referrals to DHS when child is born drug exposed). The agency's first involvement with mom may be a result of a CAPTA referral. In the cases of drug-exposed newborns, the hospital expects something to happen to protect the child. Practice and policy regarding the federal policy requires that a safe care plan gets written for the children and effectively implemented. The COB wants assurance that these “safe care plans” are being done in each CAPTA referral case.

Collaboration

- Work with other appropriate agencies to address the impact of the lack of financial resources on accessing quality daycare;
- Consider invoking, on an as-needed basis, roundtable teams made up of system partners to address coordination of services and to solve problems for complex cases; and
- Work with the medical community to develop formal protocols for all DHS cases involving medically fragile children to better ensure that there is constant oversight of care by an M.D.



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