

**REPORT ON PROGRESS**  
from the  
**CITY OF PHILADELPHIA**  
**COMMUNITY OVERSIGHT BOARD**  
for the  
**DEPARTMENT OF HUMAN SERVICES**

**Presented to**  
**Mayor Michael Nutter and**  
**The Philadelphia Community**

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August 2009



## **ACKNOWLEDGEMENTS**

The Philadelphia Community Oversight Board (COB) is deeply indebted to many groups and individuals for their insight, support, and guidance over the past year. Without this assistance, neither this report nor the COB's ongoing work would be possible.

The COB wishes to commend Mayor Michael Nutter for embracing the recommendations of the Child Welfare Review Panel (CWRP) and his commitment to carry forward, without interruption, the important work of the COB. This commitment has reinforced for both DHS and the public at large that reform efforts will continue. We also wish to thank the Mayor's staff for its ongoing support.

The help of many Department of Human Services (DHS) staff members has been invaluable in helping the COB understand the nature, scope, status, and timeframes of the many reform efforts and activities currently underway. DHS staff have provided many hours of assistance helping us understand current reform efforts, providing us with data and reports for review, and answering our many questions. In particular, the COB wishes to thank Anne Marie Ambrose, DHS Commissioner, for her knowledge and insight into DHS as well as her unfailing commitment to the COB.

We are especially thankful to Carol Wilson Spigner, D.S.W., the original Chair of the COB who served from January 2008 to March 2009. Her leadership was an inspiration to all who served with her in the efforts to ensure the safety of the children of Philadelphia.

This report would not have been possible without the assistance of our consultants from Walter R. McDonald & Associates, Inc. and MFR Consultants, Inc. We also wish to extend our sincere gratitude to the Pew Charitable Trusts, the William Penn Foundation, the Annie E. Casey Foundation, and Casey Family Programs for their continuing support of the COB and DHS reform efforts.

Finally, we wish to express our sincere thanks to the many stakeholders representing the Philadelphia community who have taken time out of their schedules to attend meetings, provide input, and offer suggestions for moving forward.



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## EXECUTIVE SUMMARY

The Community Oversight Board (COB) recognizes the Department of Human Services' significant progress in organizational development, including the capacity to implement and sustain changes that will result in improved safety for the children and youth of Philadelphia. The COB attributes much of this progress to the strong, visionary leadership of Commissioner Anne Marie Ambrose.

In 2007 the Child Welfare Review Panel (CWRP) expressed concern about the Department's ability to implement and sustain change and that the Department was not fulfilling its fundamental mandate of ensuring safety for children. The CWRP report was intended, in part, to provide a roadmap for the Department to address these concerns with urgency and transparency.

The Department has made significant progress on the implementation of the panel recommendations and, perhaps more significantly, has begun to demonstrate an ability to make and sustain change beyond the CWRP recommendations. Specifically, the COB recognizes the significance of the creation and development of the Division of Performance Management and Accountability. This Division has the responsibility to measure and monitor outcomes for children served by the Department and the COB recognizes this as a foundational effort necessary to make and sustain change. The COB also recognizes the implementation of the Child Stat process. This process creates an accountability and feedback mechanism for staff and managers. Ultimately this process will allow the Department to quickly assess progress, target and correct impediments to progress, and continually improve performance of direct service staff, contract agencies, and managers.

These two developments are critical steps to ensure that the Department moves beyond compliance with the CWRP recommendations to demonstrating that the children of Philadelphia are safer as a result of the Department's reform efforts.

Further demonstration of the Department's progress is reflected in the status of the COB's seven areas of concern as identified in the last COB report on progress. During the past six months, the Department has demonstrated progress in four of these areas; including face-to-face visits, the implementation of child safety assessments, the enhanced child fatality review process, and expanding family group decision making. However, the COB believes that one of the seven areas of concern, the implementation of an evidence-based practice model, requires further definition and perhaps reconsideration as an area of concern. While more progress is needed in the implementation of some of the original recommendations, DHS has demonstrated a thoughtful and committed approach to their overall implementation of efforts.

Given the progress by the Department, it becomes more critical for the COB to begin to monitor whether the outcomes for children and families served by the Department are actually improving. The COB will continue to monitor DHS progress towards implementation of the CWRP recommendations, but will focus more directly on specific outcomes for children and families served by the agency. The COB is pleased that the Department has identified six key outcomes on which they will begin to report.

1. Repeat child maltreatment;
2. Child maltreatment rate in foster care;
3. Severity of repeat child maltreatment and length of time between incidents of child maltreatment;
4. Length of stay in out-of-home placement;
5. Changes in the level of care in placements and
6. Re-entry into out-of-home placements

The COB will focus on the following during the next six months:

1. Continue to monitor Department progress on all CWRP recommendations with a particular focus on identified areas of concern;
2. Monitor Department progress on the six child-related outcomes described above;
3. Concern that the Department ensures that all children in care, including those with their own families and in out-of-home placement, receive face-to-face visits that ensure their safety. The CWRP recommended monthly visits by a Department staff member. This recommendation has not been fully implemented and the COB will focus specifically on monitoring this recommendation during the next six months.
4. The COB will enhance its ability to monitor Department progress by increasing the frequency of interviews of staff, providers and constituents.

In summary, the COB recognizes the significant progress made by the Department and commends the strong leadership of Mayor Michael Nutter and Commissioner Anne Marie Ambrose in leading these efforts.

## SECTION 1. UPDATE AND FUTURE DIRECTIONS: FOCUS ON OUTCOMES

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*, issued on May 31, 2007. The Executive Order charged the COB with monitoring the implementation of the recommendations of the CWRP in the *Call to Action*, and with issuing twice yearly progress reports. The COB issued its first report, *Assessment of Progress*, on December, 31, 2007, issued a status letter to the Mayor on October 17, 2008, and produced its second full report on January 21, 2009.

The COB recognizes significant progress in organizational development under the leadership of Commissioner Anne Marie Ambrose. Especially significant is the creation of the Division of Performance Management and Accountability and its progress toward (1) identifying outcomes that demonstrate the safety of children in Philadelphia, and (2) the use of data in the development of internal quality improvement systems.

The COB is committed to the monitoring of the original CWRP recommendations and has established a small working group to revisit the timelines. Some of the timelines require an update and a re-negotiation with DHS on new timelines. The COB acknowledges that budgetary concerns may affect the timelines as well as the recommendations pertaining to establishing a local office and conducting criminal background checks.

For the next progress report the COB will focus on the monitoring of six outcome measures identified as key indicators of child safety.

### KEY OUTCOME MEASURES

The COB is particularly pleased with the work of DHS in developing a core set of outcome measures on which DHS will report on a regular basis to the COB. These include:

- Repeat child maltreatment;
- Child maltreatment rate while in foster care;
- Severity of repeat child maltreatment and length of time between incidents of child maltreatment;
- Length of stay in foster care and other placement types;
- Changes in the level of care in placements; and
- Re-entry into foster care and other placement types.

DHS has also agreed to provide the COB with regular reports of data normally required by state and federal agencies. The data include, but are not limited to, reports of child maltreatment, number of child maltreatment substantiations, entries into foster care, adoptions, and child fatalities.

The COB also looks forward to DHS identifying a core set of process measures that complement the outcome measures.

Following is a more thorough discussion of these outcome measures. For several of the measures, actual data is included as an example of how DHS can begin to establish baselines for monitoring trends. It should be emphasized that this data is extremely preliminary. The COB looks forward to working with DHS to continue to refine and monitor these outcomes over the next six months, and anticipates a more thorough presentation of them at the time of the next report.

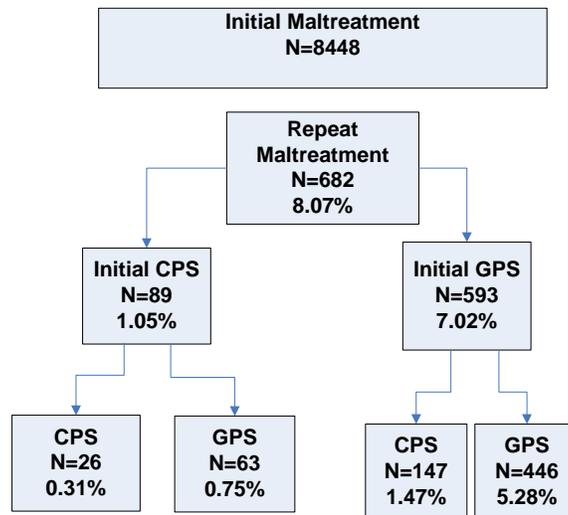
### Repeat Child Maltreatment

DHS considers repeat maltreatment a key indicator for child safety, for children in their homes, in foster care, congregate care, or in institutional settings. The table below shows the frequency of indicated or substantiated repeat maltreatment reports within six months from the initial indicated or substantiated maltreatment report (April 2007 through October 2008).

Of the 8,448 victims of maltreatment during that period, 1,480 warranted Child Protective Services (CPS) reports while 6,968 warranted General Protective Services (GPS) reports. Of all victims, 682 (8%) suffered a repeat incident of maltreatment.

GPS cases are generally considered to be less serious than CPS cases. Although CPS cases substantiated as GPS cases at repeat maltreatment may serve as a rough estimate of less severity, the COB would like to know why there are a disproportionate number of repeat maltreatments among the GPS cases.

**Table 1.1 Frequency of Indicated or Substantiated Repeat Maltreatment Reports Within Six Months from the Initial Indicated or Substantiated Maltreatment Report**



The COB would also like to know specifically about repeat maltreatment in placement and about the relationship between repeat maltreatment and child deaths.

### Child Maltreatment While in Foster Care

This outcome measure was added to the list of core measures at the request of the COB. DHS will prepare baseline data on this measure to present to the COB.

### Length of Time between Incidents of Maltreatment

DHS provided the following statistics on length of time between incidents of maltreatment broken down by CPS and GPS cases.

**Table 1.2 Length of Time Between Incidents of Maltreatment by CPS and GPS Cases**

Initial Maltreatment	Repeat Maltreatment	1-30 Days	31-60 Days	61-90 Days	91-120 Days	121-182 Days	Total
CPS	CPS	12	5	2	3	4	26
	GPS	28	12	9	5	9	63

Initial Maltreatment	Repeat Maltreatment	1-30 Days	31-60 Days	61-90 Days	91-120 Days	121-182 Days	Total
GPS	CPS	72	35	15	13	12	147
	GPS	139	117	61	65	64	446

Although it appears that most maltreatment occurs within the first 30 days, the numbers are misleading. Some of the reports in the first 30 days result from new information about prior abuse maltreatment surfacing while the case being under investigation. This generates a new report even though the maltreatment itself is not new. In the future DHS will report these numbers based on maltreatment reports generated after a determination of the initial report.

### Severity of Repeat Child Maltreatment and Length of Time Between Incidents

Although zero repeat maltreatment is the most desired outcome, the degree to which DHS can *reduce the severity* of maltreatment and *increase the time between* incidents of maltreatment will reflect positively on DHS practices.

DHS proposes to develop a repeat maltreatment severity index based on the following factors:

- CPS/GPS categorization;
- Types of allegations such as physical harm, neglect, sexual abuse, and others;
- Required response time (immediate, 2 hour, 24 hour);
- Age of the victim;
- Safety decision; and
- Service status such as court versus non-court involvement.

The COB requests that DHS continue to develop and test the utility of a severity index and further clarify the true incidence and timelines for repeat maltreatment.

### Length of Stay in Foster Care and Other Placement Types

Length of stay (LOS) indicates how successful DHS is in moving our children toward *permanency*. The secondary benefit is reducing the number of children in placement at any given

time. The following table shows that the percentages of children in care for less than 12 months, between 12 and 24 months, and longer than 24 months, have not changed substantially between FY08 and FY09.

**Table 1.3 Percentages of Children in Care for Less than 12 Months, Between 12 and 24 Months and Longer Than 24 Months**

	< 12 months	12 – 24 months	> 24 months	Total	Average LOS
FY 08	567 (31%)	443 (24%)	830 (45%)	1840	27 months
FY 09	512 (25%)	527 (26%)	986 (49%)	2025	28 months

### **Changes in the Level of Care in Placements**

Changes in the level of care in placements also serve as a measure of moving children toward *permanency*. The COB encourages DHS to continue developing a severity index that takes into account moving children from higher to lower levels of care and from the most restrictive to the least restrictive environments: for example, from group homes to supervised independent living.

### **Re-entry into Foster Care and other Placement Types**

DHS calculates re-entry based on all discharges for the following reasons:

1. Return to parents;
2. Placed with relative;
3. Adopted; and
4. Placed with permanent legal custodian.

## SECTION 2. THE DEPARTMENT OF HUMAN SERVICES (DHS) REPORT ON PROGRESS AND PRIORITIZATION

### INTRODUCTION

The Child Welfare Review Panel (CWRP) made a total of 37 distinct recommendations for DHS that were categorized into two implementation phases. Of these, four of the Phase 1 Practice-area recommendations were deemed to be encompassed within the Phase 2 recommendations. This leaves a total of 33 recommendations on which to report. As a means of monitoring DHS' progress toward planning and implementing the recommendations, the Community Oversight Board (COB) developed the following classification system:

***Completed and/or Ongoing***—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.

***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.

These classifications were used by the COB in its January 2009 report. At the COB's request, DHS has used the same classification system to track its progress in implementing the recommendations.

In June 2009, DHS submitted two summary tables to the COB providing:

1. A status report on each of the recommendations from the CWRP and their priority levels for implementing the recommendations that remain in planning (See Appendix A); and
2. The status of implementing recommendations that were identified by the COB as areas of concern in their report to the Mayor in January 2009 (See Appendix B).

This section provides a summary of progress made in the implementation of the CWRP. It highlights the status of the seven recommendations that were designated areas of concern by the COB in their January 2009 report. A more detailed analysis of the progress in these seven areas will be provided in Section 3 of this report, Update on Community Oversight Board Areas of Concern.

### IMPLEMENTATION OF CWRP RECOMMENDATIONS

In the CWRP report, recommendations were grouped into four areas:

1. Mission and Values;
2. Child Safety and a new Social Work Practice Model;
3. Outcomes and Accountability; and
4. Leadership and Infrastructure. The recommendations were also grouped into two phases to help DHS prioritize time frames for implementation. In order to remain consistent with

the CWRP's structure for the recommendations, Table 2.1, Status of CWRP Recommendations June 2009, presents a summary of the implementation status of the recommendations across the four areas and the two phases. It includes the original 37 CWRP recommendations.

**Table 2.1 Implementation Status of CWRP Recommendations, June 2009**

Recommendations	Completed	Ongoing	Progress	Planning	Total
<b>Phase 1</b>					
Mission and Values	2	0	0	0	2
Child safety practices	5	0	1	2	8
Outcomes/accountability	2	2	1	1	6
Leadership/infrastructure	2	0	0	0	2
<b>Phase 2</b>					
Mission and Values	1	0	1	0	2
Child safety practices	5	0	5	2	12
Outcomes/accountability	1	0	1	0	2
Leadership/infrastructure	1	0	2	0	3
<b>Total</b>	<b>19</b>	<b>2</b>	<b>11</b>	<b>5</b>	<b>37</b>

#### Comparison of Current Implementation Status with January 2009 Report

DHS has made significant progress implementing the CWRP's original recommendations, with ongoing effort in all four recommendation areas. Table 2.2 compares the status of implementation of the recommendations from January 2009 to July 2009.

**Table 2.2 Comparison of Implementation Status with January 2009 Report\***

Recommendations	Completed	Ongoing	Progress	Planning	Total
<b>Mission and Values</b>					
January 2009	2	-	-	2	4
July 2009	3	-	1	-	4
<b>Child safety practices</b>					
January 2009	-	2	15	3	20
July 2009	10		6	4	20
<b>Outcomes/accountability</b>					
January 2009	2	-	4	2	8
July 2009	3	2	2	1	8
<b>Leadership/infrastructure</b>					
January 2009	1	4	-	-	5
July 2009	3	0	2	0	5
<b>Totals as of July 2009</b>	<b>19</b>	<b>2</b>	<b>11</b>	<b>5</b>	<b>37</b>

\* Status for January 2009 taken from the January 2009 COB status report.

## Implementation Status by Area of Recommendation

A summary of the progress that DHS has made in each of the four areas is discussed below. For each of the four areas, recommendations for which DHS reported a change in status are highlighted.

In its status update, DHS designated each recommendation at one of three priority levels for implementation.

**High-Level**—Safety-related, targeted implementation is within 6 months; or Safety-related and requesting COB support.

**Moderate Level**—Safety-related or unrelated safety task and targeted implementation is within 6 month to 1 year; Implementation is underway, but DHS will monitor closely.

**Low-Level**— Unrelated safety task, target implementation is a year or more.<sup>1</sup>

For each of the four areas, recommendations DHS has categorized as high priority are also highlighted. All but one of the recommendations DHS has categorized as high-level priorities are presented in the area of child safety practices. The remaining recommendation that is listed as a high-level priority is in the area of outcomes and accountability. The status of each of these recommendations is presented below.

### Mission and Values

As of January 2009, DHS had completed both of the Phase 1 recommendations in the area of Mission and Values. This included developing a mission statement and a set of core values. Since that time, DHS has completed one of the Phase 2 recommendations. DHS has aligned its in-home service programs and their utilization with the mission and values and with child safety (1.b). DHS' efforts regarding this recommendation include successfully implementing the In-Home Protective Services Program in early 2009. The second Phase 2 recommendation – aligning prevention programs and resources with DHS' new mission and values and with child safety (1.a) is in progress, and has been assigned a medium-level priority for implementation by DHS.

### Child Safety Practices

Implementing and maintaining the recommendations in the area of child safety practices are critical to DHS' ability to ensure the safety of Philadelphia's most vulnerable children. This section summarizes DHS' reported progress in two ways. First, it presents progress DHS has made with respect to recommendations that the COB noted as areas of concern in the January 2009 report. Second, it provides a general summary of the remaining recommendations, noting those recommendations for which DHS reported significant progress.

### Areas of Concern

In the COB's January 2009 report, seven recommendations were highlighted as areas of concern. These seven recommendations were highlighted because sufficient progress in implementing

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<sup>1</sup> City of Philadelphia Department of Human Services (June 29, 2009). *Status Report on Child Welfare Review Panel Reform Recommendations with DHS' Reported Priority Levels*.

them had not been made. The seven recommendations—all of which were in the area of child safety practices—are presented in Table 2.3 below. The status of each recommendation in January 2009, and the more current status as reported to the COB by DHS in June 2009 are provided. In addition, the priority level assigned by DHS to the recommendation is also indicated.

**Table 2.3 Implementation Status for Areas of Concern Identified in January 2009 Report**

<b>Recommendations</b>	<b>Status, January 2009</b>	<b>Status, July 2009</b>	<b>Reported Priority Level, June 2009</b>
Conduct a safety assessment for every child within DHS' care, both for children at home and children in out-of-home placements (2.a.ii)	<ul style="list-style-type: none"> <li>• Completed (in-home)</li> <li>• In progress (placement)</li> </ul>	<ul style="list-style-type: none"> <li>• Ongoing (in-home and placement)</li> </ul>	<ul style="list-style-type: none"> <li>• Moderate<sup>2</sup></li> </ul>
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 (2.a.1).	<ul style="list-style-type: none"> <li>• In progress</li> </ul>	<ul style="list-style-type: none"> <li>• In progress</li> </ul>	<ul style="list-style-type: none"> <li>• Moderate</li> </ul>
Develop a comprehensive model for social work practice that is based on DHS' core mission and values; includes a stronger focus on child safety, permanency and well-being; is family-focused and community-based; and allows for individualized services (2.a).	<ul style="list-style-type: none"> <li>• In progress</li> </ul>	<ul style="list-style-type: none"> <li>• In progress</li> </ul>	<ul style="list-style-type: none"> <li>• Moderate</li> </ul>
Conduct a background check on each member in the child's household. If an adult household member has prior involvement with DHS or a criminal record that includes convictions for a felony that suggests danger for a child, then DHS must conduct an assessment to determine whether the household is safe and appropriate for the child (2.a.ii.2).	<ul style="list-style-type: none"> <li>• In progress</li> </ul>	<ul style="list-style-type: none"> <li>• In planning</li> </ul>	<ul style="list-style-type: none"> <li>• High</li> </ul>
Enhance the frequency of face-to face contacts with children of all ages (2.a.iii).	<ul style="list-style-type: none"> <li>• In progress</li> </ul>	<ul style="list-style-type: none"> <li>• Ongoing</li> </ul>	<ul style="list-style-type: none"> <li>• High</li> </ul>
Enhance the child fatality review process. DHS must ensure that the child fatality review is multidisciplinary and that there is a mechanism for implementing its recommendations (2.a.vi.1).	<ul style="list-style-type: none"> <li>• In progress</li> </ul>	<ul style="list-style-type: none"> <li>• Ongoing</li> </ul>	<ul style="list-style-type: none"> <li>• High</li> </ul>
Expand the use of Family Group Decision Making (FGDM) to all children and utilize specialized resources in the case-planning process (2.e.).	<ul style="list-style-type: none"> <li>• In progress</li> </ul>	<ul style="list-style-type: none"> <li>• Ongoing</li> </ul>	<ul style="list-style-type: none"> <li>• Moderate</li> </ul>

A more detailed assessment of DHS' progress on each of the recommendations included in Table 3.3 is provided in Section 3 of this report.

<sup>2</sup> A related recommendation for DHS to implement a placement safety assessment was categorized as high-level priority.

### ***Remaining Recommendations***

In addition to the areas of concern identified in the January 2009 COB report, DHS has made progress on other Phase 2 recommendations. In particular, the status of three recommendations has moved from “in progress” or “in planning” to “ongoing.” These are:

1. DHS must improve integration with physicians, nurses, and behavioral health specialists to ensure that each child’s medical and behavioral health is appropriately assessed. (2.a.ii.3)
2. 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. (2.a.ii.4)
3. DHS must eliminate “boilerplate” referrals and ensure that each child receives appropriate referrals that are specifically tailored for his or her unique needs. (2.a.ii.5)

### ***Outcomes & Accountability***

DHS has reported that two of the Phase 1 recommendations either have been completed or are ongoing: developing a comprehensive strategy for internal monitoring (3.a.ii) and validating that contracted agencies are making their required face-to-face contacts and performing safety assessments for the children in their care (3.b.ii). In addition, DHS has reported progress on the creation of an annual outcome report card for contracted agencies (3.b.i) which DHS reported as moving from “in planning” to “in progress.”

Of the remaining recommendations to implement in this area, DHS has identified the recommendation to “*expand the list of outcomes to be measured...to include permanency and well-being measures*” (3.a) as a high-level priority.

There are three recommendations not discussed elsewhere in this report to which DHS should devote greater attention. Regarding recommendation 3.a.ii, we recognize that DHS has increased its efforts and abilities to monitor its performance, specifically by adding senior-level staff to its Division of Performance Management and Accountability, and creating programs to review the quality of staff work—the inclusion of a formalized quality assurance review for safety assessments and Child Stat are notable examples. However, we hope to work with DHS in an ongoing manner to ensure that the results of its internal monitoring and evaluation efforts are focused on ensuring that there is a feedback mechanism to improve practice and enhance DHS’ ability to ensure child safety. Regarding 3.b.ii, the COB also intends to work with DHS to monitor contracted agencies, to ensure that they continue to make the required face-to-face visits and perform safety assessments.

Finally, while DHS has reported progress in creating the provider outcome report cards (3.b.i), the COB is concerned that progress has been slow on this recommendation, and that DHS has categorized this recommendation as low priority. The CWRP’s original deadline for the publication of the report cards was May 31, 2008, and as of this report no report card has been published and DHS has not established a date for producing them. We understand that DHS has made strides in specifying and obtaining the data necessary, and urge them to re-prioritize this recommendation and publish the provider report cards before the COB’s December report.

## Leadership & Infrastructure

DHS had made substantial progress on the leadership and infrastructure recommendations prior to the COB's January 2009 report. All of the Phase 1 and Phase 2 recommendations were either completed or ongoing. In the update DHS provided to the COB in June 2009, there were two changes. The recommendations for DHS to "*continue...its emphasis on making DHS a more transparent agency*" (4.a) and for "*DHS to take positive steps to enhance the healthiness of its infrastructure and staff morale*" (4.b) were moved from "ongoing" to "in progress." This change represents DHS' ongoing efforts to increase the transparency of the agency as well as improving overall staff morale. DHS did not identify any of the recommendations in this area as a high priority.

## SECTION 3. UPDATE ON COMMUNITY OVERSIGHT BOARD (COB) AREAS OF CONCERN

At the February 20, 2009 meeting, the Community Oversight Board (COB) decided to focus the July assessment of progress on seven of the original Philadelphia Child Welfare Reform Panel (CWRP) recommendations that the COB identified as areas of concern to date. The seven areas are:

1. A social work practice model;
2. Child monthly visitation;
3. Child safety assessments;
4. Evidence-based practice;
5. The child fatality review process;
6. Criminal background checks; and
7. Family group decision making (FGDM).

The COB created seven workgroups. Each group was led by a COB member and included representatives from DHS and COB consultants. See Table 3.1.

**Table 3.1 Community Oversight Board Workgroups**

	<b>COB Members</b>	<b>DHS Reps</b>
1. New model SW practice	Sandra Chipungu* Arthur Evans Fran Gutterman (CFP)	Dell Meriwether
2. Child visitation	Mark Cherna* Kathleen Noonan	Dell Meriwether
3. Child safety assessments	Kathleen Noonan* Carol Tracy	Brian Clapier
4. Evidenced-based practice	Sandra Chipungu*	Susan Kinnevy
5. Child fatalities	Cindy Christian* Howard Davidson	Jessica Shapiro
6. Criminal background checks	Howard Davidson* Kathleen Noonan	Anne Marie Ambrose Vanessa Garrett- Harley
7. Family group decision making	Sue Badeau* Mark Cherna	Pam Mayo

## A NEW SOCIAL WORK PRACTICE MODEL

In this section the COB summarizes the progress that the Philadelphia Department of Human Services (DHS) has made in the development of a new social work practice model (SWPM).

### Background

The CWRP recommended that DHS 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 social workers coordinated care for clients. The report also stated 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 social worker decision making.<sup>3</sup>

### Approach

When the workgroup first met, DHS had not produced any documents describing the development of a SWPM. The workgroup tasked itself with reviewing possible practice models in child welfare derived from the literature and expert opinions. The goal was to develop a statement that reflected what a DHS SWPM might look like.

### Findings

The CWRP had recommended that DHS create 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." When the COB reviewed relevant literature the workgroup found the CWRP recommendations to be consistent with current best practices in child welfare.<sup>4</sup>

### *Principles Common to a Social Work Practice Model in Child Welfare*

The COB found five essential principles that should guide policy and practices, staff training, resource development, service contract design, supervisory roles and accountability, quality assurance, and outcome evaluation in child welfare.

#### 1. General Principles

Children should live with their families. Exceptions should be made only when it is not possible through the provision of services (including intensive home-based services) to protect a child living with his/her family from harm, or to protect a child from harm upon reunification with his/her family.

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<sup>3</sup> Philadelphia Child Welfare Review Panel. (2007). *Protecting Philadelphia's Children: The Call To Action*.

<sup>4</sup> See, for example, School of Social Work University of Illinois at Urbana-Champaign (2004). *Elements of Best Practice in Family Centered Services*; Moore, J. (2007). *Connections Matter*. Children's Justice Initiative, Child Protection Conference; Hennepin County, Minnesota. (No date). *Child Protection*; McCroskey, J. & Meezan, W. (1998). *Family-Centered Services: Approaches and Effectiveness*, Protecting Children from Abuse and Neglect. 8; and Child Welfare Policy & Practice Group. (No date). *Adopting a Child Welfare Practice Framework*.

The system's efforts to assist children to achieve permanency should be conducted with the urgency appropriate to a child's sense of time. The response to children and families should not discriminate based on race, sex, religion, ethnicity, national origin, or sexual preference. Children should have freedom from excessive medication, unnecessary seclusion, and restraint.

2. Principles Related to Resource Allocation and Service Design

Neighborhood and community resources and institutions should be treated as key partners in serving children and families, both in planning for individual families and as a partner in system design and operations. Children and their families should have access to a comprehensive array of services, including intensive home-based services, designed to enable children to live with their families or to achieve timely permanency.

Services should be flexible and adapted to child and family needs. Children and families should not be expected to adapt to ineffective services. To enable children to live safely with their families, vigorous early intervention services should be offered to families-at-risk before the risk rises to a level necessitating involuntary intervention.

The system should be sensitive to cultural differences and the special needs of minority ethnic and racial groups. Services should be provided in a manner that respects these differences and attends to these special needs. These differences and special needs should not be used as an excuse for failing to provide services.

3. Principles Related to Assessment, Planning, and Intervention

Services to children and their families should be planned and delivered through an individualized service plan crafted by the child and family team. Children, their parents, the family's informal support network, caregivers, and foster parents should be full participants on this team. Involvement should include regular participation in family team meetings as a point for engagement, planning intervention, and assessment of progress.

Children, parents, and foster parents should be accurately informed in a timely manner, in language understandable to them, of their rights, the goal for the child/family, and their individualized service plans. Children and their families should receive individualized services based on their unique strengths and needs. Children and parents should be encouraged and assisted to articulate their own strengths and needs, the goals they are seeking for themselves, and what services they think are required to meet these goals.

The assessment process should address the underlying conditions creating the challenges experienced by the child and family, not just the symptoms of functioning. The system's assessment should be developed with the suggestions and contributions of the full family team. The mix of services provided should be responsive to the strengths and needs of the child and his/her family. Conceptualizing the needs-based plan should not be constrained by the availability of services. Where needed services are unavailable, appropriate services should be created. The system should ensure that the services identified in individualized service plans are timely, accessible, and responsive to children and families and delivered in a coordinated and therapeutic manner that integrates the efforts of the contributors.

The system should carefully monitor implementation of the individualized service plan and the progress being made toward the goal and objectives of the plan. The goal and the objectives of the individualized service plan should be updated as needed. Services identified in the plan should be modified as needed to meet the goal and objectives of the plan (for example, by adding new services or providing services in a different way).

4. Principles Related to Children Placed in Foster Care

When children cannot live safely with their families, the first considerations for placement should be with kinship connections capable of offering and demonstrating the resource of a safe, stable and appropriate home. Siblings should be placed together. The system should develop a policy identifying circumstances in which exceptions to this principle may be permitted. Children should be placed in their own communities, where they can maintain relationships with family and friends and continue to attend the same school they were in prior to placement.

Placements should be made in the least restrictive, most normalized setting responsive to the child's needs. The system should avoid temporary, interim placements. Children should be placed in settings that could reasonably be expected to deliver long-term care if necessary. To this end, the use of congregate shelter placements should be avoided in favor of family-based settings. The system should not place children six years of age or younger in congregate settings unless it is necessary to maintain connections with siblings placed in the same setting. When shelter is used, the placement should be short-term.

Children should receive prompt and appropriate attention to their health care needs. The system should vigorously seek to assure that children, when in foster care or custody, are integrated, to the maximum extent feasible, into normalized school settings and activities, and that they achieve success in school.

The matter of visiting, both between children in care and their parents and among siblings, should be addressed in the child's individualized service plan. The frequency and circumstances of visiting should depend on age and need. Visiting should be viewed as an essential ingredient of family reunification services. Hence, when the goal is for the child to return home or live with a family member, visiting should be actively encouraged. Visiting plans that require agency oversight or participation should take into account the work, education, and obligations on the part of the parents. After-hours and weekend visits should be options to permit parents to meet necessary obligations. Visiting may be arranged by the child, the child's parents or family, or the foster parents, as well as by staff and the staff of residential facilities, in accordance with the individualized service plan.

Supervision of visiting should be required only when there is a danger that the parent or family member with whom the child is visiting will harm the child unless the visit is supervised. The system should forbid summary discharges of children from placement.

The system should develop a policy that describes steps that should be taken prior to a child's discharge from a placement. The system should be based on the philosophy that the disruption of a placement is a failure of the system, not a failure of the child.

5. Principles Related to Transitions from Care to Reunification or Independence

Families whose children are reunified should receive ongoing supports that will enable them to safely sustain their children in their homes. Youth in custody who are expected to remain in care until adulthood should receive a full array of preparatory supports for independent living, addressing educational, emotional, relationship, and vocational development.

The system should promote smooth transitions for children to adult service. Planning for youth in custody who will reach adulthood without permanence should connect them with caring adults, both relatives and other resources, to whom they can turn for help after system supports are no longer available.

### Recommendations

The COB subsequently learned that DHS has made progress in this area. The agency distributed a draft of a DHS practice model to the COB in May 2009. In that draft DHS recognizes the need for a unified social work practice model that defines a practice framework and supports the mission of DHS and its initiatives. While DHS has made significant progress in the development and implementation of a safety model of practice, other elements of defining a SWPM remain a work in progress.

The DHS model will reflect the principles common to best practices in the field of child welfare and will include the following:

- Quality investigation and assessment;
- Working with family teams;
- Individualized planning and relevant services;
- Continuous review and adoption of best practices; and
- Safe and sustainable transitions from service to reunification or independence.

The COB is pleased that DHS has allocated the resources to this recommendation and looks forward to reviewing the final product.

### DHS Self Assessment

DHS indicated that significant progress has been made in the development of a new practice model that will help to address the COB's concerns around child safety, the incorporation of evidence into decision making, and supervisory support and monitoring. In addition, DHS outlined several other efforts and reforms already in operation that are helping to address the COB's practice-related concerns. Some of these efforts noted by DHS include:

- Ensuring that safety assessments are completed at each visit with the child, and conducting a quality review process on the safety assessments to validate that they are

being used by workers in a consistent and appropriate manner, such that the tool can accurately identify safety threats.

- Establishing non-placement support programs that help to address child needs across a continuum of care, including those children in need of services but for whom no safety threat exists. Programs for these children include the Alternative Response System (ARS), In-Home Protective Services (IHPS), Rapid Service Response, and Family Stabilization Services.
- Elements of the new practice model have been implemented with components such as Hotline Guided Decision Making and Family Group Decision Making.
- To more effectively incorporate the use of evidence into decision making, and ensure that a feedback loop exists to use collected data to improve practice, DHS has made significant efforts to increase its evaluation resources. A new Division for Performance Management and Accountability has been established and staffed with senior personnel. (See Appendix E.)

## **CHILD MONTHLY VISITATION**

In this section the COB will describe progress made by DHS in the implementation of monthly child visitation, a critical activity for ensuring child safety. We begin this section with a review of the recommendations of the December 2008 Assessment of Progress and then describe the fact-finding activities of the COB Child Visitation Workgroup. We will review federal and state requirements for monthly visitation and then update DHS monthly visitation statistics.

### **Background**

The analysis of DHS visitation statistics in the December 2008 Assessment of Progress revealed a daunting challenge to the department. 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 DHS category the “non-IHPS.”<sup>5</sup> This did not mean children were not visited in any given month as DHS contracts with providers who also visit children in care.

In May 2007, the CWRP recommended that DHS alter its visitation policies 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 5 years of age or younger in the five-county service area. In December 2008, COB mandated the implementation of the same policy for all children 5 years of age or younger living outside the five-county area, and for all children, regardless of age, beginning in January 2009.

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<sup>5</sup> Non-IHPS children are waiting for decisions by a court or are receiving day care or day treatment services, whose cases that involve sexual abuse, or when families refuse to cooperate with DHS protocols.

## December 2008 Recommendations

Given the challenge to DHS for meeting the new COB requirements, the COB and DHS agreed to a set of next steps:

1. DHS will develop a revised plan for implementation of monthly visits by DHS social workers for all children in service;
2. DHS will work towards documenting face-to-face visitation by all contract providers;
3. DHS will investigate compliance with face-to-face visitation in cases under investigation or assessment as recorded in the Intake Statistics System; and
4. The DHS Visitation Tracking System, which tracks all children whose cases originated in the five-county DHS service area, should generate reports on visitation compliance according to where children are actually living.

## Approach

The workgroup met face-to-face followed by a meeting with the Deputy Commissioner for the Division of Performance Management and Accountability (DPMA), Dr. Susan Kinnevy. As a result, the group planned and participated in the following activities:

- Reviewed federal and state law pertaining to child visitation;
- Attended an orientation to FACTS2, LIBERA, and the newly developed Visitation Tracking Log (VTL). The VTL will allow for the documentation of child visits by contract providers;
- Met with DPMA staff on data integration, which consisted of the creation of an inventory of all data sets created by DHS staff;
- Met with Dell Meriwether and his staff to review and make recommendations pertaining to child visitation policy;
- Updated DHS visitation compliance statistics for all children in service per current DHS policy from November 2008 through April 2009;
- Updated DHS actual visitation statistics for all children in service from November 2008 through April 2009; and
- Updated DHS visitation compliance statistics for all children 5 years of age or younger in service from November 2008 through April 2009.

The group also attended several meetings with the Deputy Commissioner for CYD and his visitation policy group. The purpose of the meetings was to develop new visitation policies that meet DHS practice standards as well as the original CWRP recommendations.

## Federal and State Law

The Pennsylvania Office of Children, Youth and Families (OCYF) requires monthly caseworker visits to dependent and shared case management children under the care and responsibility of the county children and youth agency and the juvenile probation office.<sup>6</sup> Caseworkers must make at least one visit with a child each calendar month the child is in care, preferably at the child's residence. A child's residence is considered to be the home or facility where the child is living,

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<sup>6</sup> For a more complete description of federal and state law, see Appendix C: Federal and State Monthly Visitation Requirements for Children in DHS Care.

whether in-state or out-of-state. The residence may also be the home from which the child was removed, if the child is on a trial home visit, but still considered to be in foster care. Visits must be well planned and focused on issues pertinent to case planning and service delivery to ensure the safety, permanency, and well-being of children.

With guidance from the federal Administration for Children and Families (ACF), the OCYF defines monthly visits as face-to-face contacts by a qualifying caseworker. OCYF defines a qualifying caseworker as a person with case management or case visitation responsibilities for a particular case. Qualifying caseworkers include:

- The county children and youth worker;
- The juvenile probation officer;
- The private provider agency with which the county has an agreement to provide services, including visitation management;
- The foster care facility case manager with global case management responsibilities, including family visitation and service coordination; and/or
- In out-of-state cases, a counterpart of these same legal entities.

## Findings

The COB obtained data from DHS for the numbers and percentages of children visited per department policy for the 6-month period of October 2008 through March 2009. We present those statistics as well as monthly visitation statistics for children 5 years of age or younger in service, and monthly visitation statistics for all children in service, regardless of DHS policies.

### *The Visitation Tracking System*

DHS documents child visitation by DHS social workers using the Visitation Tracking System (VTS). Once the data are 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. The VTS then divides the number of children visited by the number of required visits for the month for percentage compliance. By the seventh business day of each month, DHS calculates percentage compliance for each worker, supervisor, administrator, director, and deputy commissioner.

### *Visitation Statistics*

Table 3.2 Visitation of All Children in Service per DHS Policy, shows visitation statistics for a 6-month period (October 2008 – March 2009). The numbers represent required visits and children visited that month in accordance with DHS policies. (Children may have been visited numerous times in any given month.) Compliance ranged from 90.2 percent in December 2008, to 92.3 percent in March 2009. For example, the DHS caseload in March contained more than 11,000 children. Under current DHS policy, 6,343 children were scheduled for visits while 5,853 children were visited at least once, for a compliance ratio of 92.3 percent.

**Table 3.2 Visitation of All Children in Service per DHS Policy**

Visitation of All Children in Service per DHS Policy						
	October	November	December	January	February	March
Required Visits	7,163	6,669	7,251	6,680	6,270	6,343
Compliance	6,521	6,066	6,543	6,082	5,695	5,853
Percentage	91.0	91.0	90.2	91.0	90.8	92.3

As stated above, in July 2008, DHS formulated a new policy that required all children 5 years of age or younger in the DHS five-county area to have a monthly face-to-face visit from a DHS social worker.<sup>7</sup> Compliance ranged from 80.2 percent to 83.7 percent for the period October 2008 through March 2009. See Table 3.3 Visitation of All Children in Service, 5 years of age or younger.

**Table 3.3 Visitation of All Children in Service, 5 Years of Age or Younger**

Visitation of All Children in Service, 5 Years of Age or Younger						
	October	November	December	January	February	March
Required Visits	4,013	4,041	3,939	3,848	3,644	3,534
Compliance	3,300	3,249	3,247	3,110	2,922	2,959
Percentage	82.2	80.4	82.4	80.8	80.2	83.7

In Table 3.4 Actual Visitation of All Children in Service, the numbers and percentages are not adjusted for DHS policies and reflect the actual number of children who received a face-to-face visit from a DHS social worker. The percentages ranged from 56.8 percent to 60.8 percent for the period of October 2008 through March 2009.

**Table 3.4 Actual Visitation of All Children in Service**

Actual Monthly Visitation of All Children in Service						
	October	November	December	January	February	March
Children in Service	11,247	10,893	10,764	10,610	10,018	9,948
Children Visited	6,502	6,066	6,543	6,082	5,695	5,853
Percentage	57.8	55.7	60.8	57.3	56.8	58.8

***Provider Visitation***

To date DHS has not been able to document the number and frequency of child visits by its contract providers. DHS is in the process of developing a new system called the Visitation

<sup>7</sup> The policy also included children in the process of family reunification, medically fragile children, and youth receiving services from DHS sex abuse units.

Tracking Log (VTL). The plan is for the VTL to reside on an Extranet so that providers can input worker activities directly into the system. DHS will include quality control through the use of structured case notes, which would be monitored by DHS staff.

### Recommendations

The COB and DHS will have to resolve the disparity between DHS visitation policies and the CWRP recommendation that all children are visited at least once per month by a DHS social worker. DHS policies are in line with federal and state law. The COB may accept DHS policy as adequate if the department can document contract provider visits through the implementation of the VTL.

### DHS Self Assessment

DHS recommends an alternative to CWRP and COB recommendations that establishes visitation frequency by a child's age and service need. For example, children in each of three specialty units will receive monthly visits – medically needy (in home), family reunification, and sex abuse (in home). DHS is also examining the relationship between service categories and maltreatment. If those relationships exist, DHS will modify its visitation frequency to ensure the safety of children in care. DHS is also in the process of developing web-based information system that will permit both contract providers and DHS workers to input and share information about the frequency and quality of child visits.

## CHILD SAFETY ASSESSMENTS

This section describes the efforts and progress that DHS has made in completing and conducting quality assurance reviews of the child safety assessments, which was a topic of concern in the CWRP report in June 2007. It includes a brief background on the scope of the Panel's recommendations, discusses the progress that DHS has made towards satisfying the recommendations, and details DHS' significant efforts in formalizing a program to conduct regular quality reviews of the safety assessments completed by DHS social workers and to use the quality review process to improve social work practice.

### Background

In the report issued by the CWRP on May 31, 2007, the CWRP recommended that DHS implement a new child safety assessment to monitor the current and ongoing safety of children placed in DHS' care, both for children remaining at home and children placed in substitute care settings. Specifically, the Panel recommended the following:

**DHS must implement and use an appropriate Safety Assessment tool.**

- i. DHS must implement an adequate evidence-based safety assessment tool. *Time frame: No later than June 30, 2007.*
- ii. DHS must conduct a safety assessment for every child within its care—both children at home and children in out-of-home placements. The safety assessment must be updated at each contact with the child. *Time frame: No later than September 30, 2007.*

As reported in the December 2008 report of the COB, DHS has made substantial progress in implementing these recommendations. Safety assessments were completed for all children in DHS' care in March 2008 using DHS' existing safety assessment tool. A new safety assessment for children receiving services in their own homes was implemented in August 2008. As noted in its December 2008 report, the COB was pleased with the progress that DHS had made in implementing these recommendations. The COB is also pleased the DHS continues to offer training on the safety assessment as necessary.

The only area of concern the COB had in its December 2008 report was that a new safety assessment tool for children in substitute care settings had not been implemented. The delay in implementing such a tool resulted in part because the Pennsylvania Department of Public Welfare (DPW) had not released a statewide safety assessment for children in out-of-home placements. While waiting for DPW to release the tool, DHS implemented an interim strategy to have its social workers complete a structured case note at a minimum of every 6 months using DHS-developed safety assessment guidelines and an interim placement safety assessment tool. DPW has approved the use of the DHS placement safety assessment tool until a statewide version is released.

### **Approach**

As part of its ongoing activities, the COB decided to observe the safety assessment quality review process that DHS had implemented, and understand how DHS uses the results from these reviews to ensure the safety of the children in its care. To conduct the reviews, COB members, along with a staff member from Walter R. McDonald & Associates (WRMA), reviewed the current safety assessment tools and review instruments, observed the review process, and interviewed quality assurance reviewers, supervisors, and staff responsible for analyzing trends in the review data.

### **Quality Assurance Reviews**

As noted previously, DHS completed the initial safety assessments in response to the CWRP recommendations in March 2008. Beginning in April 2008, DHS initiated a quality assurance review process to monitor the quality and completeness of the safety assessments DHS staff complete in the course of their daily activities. DHS' objectives in establishing these reviews included:

- Validating that DHS social workers are completing the assessment in a timely and appropriate fashion, thereby ensuring child safety;
- Promoting consistency in the completion of the assessments among DHS social workers; and,
- Providing feedback for DHS social workers to help them improve the completeness and quality of the safety assessments they complete, thereby promoting improved casework and child safety.

In April and May 2008, DHS conducted approximately 50 quality assurance reviews per month of cases where safety assessments had been completed. Beginning in June 2008, DHS increased the scope of reviews to approximately 150 cases per month. Of these 150 monthly reviews, approximately 125 reviews are conducted on each case's most recently completed safety

assessment. The additional 25 reviews include cases where the most recently completed safety assessment and the case's most recent Family Service Plan (FSP) are reviewed. When the reviews were initiated in April 2008, the review sample was pulled from cases in DHS' Intake Region. Reviews for cases in Ongoing Regions began in September 2008.

Most of the reviews are completed on cases where children are still residing at their homes, for which DHS is using the DPW safety assessment tool. However, as noted previously, the DPW has yet to publish a safety assessment tool for children placed in out-of-home care settings. In lieu of a state tool, DHS is using a structured case note, but based on discussions with QA review staff, there are few QA reviews of the structured case notes being completed at this time.

During the initial stages of the review process, DHS had two staff members that each conducted reviews a total of three days a week. In March 2009, DHS established a unit to conduct the reviews, which currently consists of one supervisor and five program analysts, all of whom have prior experience as DHS social workers.

Each review is focused on a specific DHS section.<sup>8</sup> The review unit sends a request for cases to the section administrator approximately one week before the review. Each section is responsible for assembling the necessary documents, including the most recently completed safety assessment, risk assessment, case notes, and (if the case is closing) the closing transfer summary. In addition, the entire physical case file is sent to the review unit so that the QA reviewers can refer to it for questions. The reviews generally take place on the floor where the DHS section is located, which facilitates consultation with the appropriate staff should questions arise during the review.

The reviews assess the completeness and accuracy of safety assessments across several categories:

- *Initial contact*, which measures whether the social worker completed the safety assessment within 24 hours of the visit with the children and whether it was completed at the child's home. This category also assesses whether there is sufficient proof of the facts recorded within the case record. (Typically, the reviewer will look at the dates attached to the social worker and supervisor's signatures to ascertain this).
- *Who was interviewed*, which assesses which family and household members were interviewed, whether all relevant individuals were interviewed, and whether they were each interviewed separately.
- *Was there sufficient information gathering in each of the domains*. Social workers are required to collect information in the domains of child functioning, adult functioning, general parenting, and parenting disciplinary practices.

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<sup>8</sup> At the time of the review, there were 26 sections in DHS. Each section is managed by an Administrator, who reports directly to one of the DHS Region Directors.

- *Assessment threats identified*, which measures whether the social worker has identified whether there are threats to the child’s safety, and if the narrative in the completed safety assessment justifies the identified threats.
- *Safety plan*. Social workers must indicate and justify that for all identified threats there is an established plan for mitigating danger to the child and that there is plan for ongoing monitoring of all required actions. This section also requires the reviewer to validate that the safety plan was signed by all responsible parties, including caregivers and providers.
- *Supervision and direction of care*, which assess whether the safety assessment was reviewed and signed by the supervisor in the required time frames, and also whether there is any evidence that the social worker and supervisor conferred on the case.

Data from each review are collected and then aggregated to provide results at the section level. Tabulated results are sent to a wider audience of the DHS Directors and Administrators so that comparative scores (across the sections) can be seen and areas of needed improvement can be identified.

## Findings

DHS staff have conducted an ongoing analysis of the data collected from the safety assessment, to better understand how social workers use the tools. Subsequently, they offer additional assistance and training to staff members in the use of the safety assessment tools. Generally, DHS staff has found that social workers are adapting well to the safety assessment protocols and are becoming more adept at completing the assessments. When the reviews began in April 2008, the quality assurance reviewers frequently found that social workers were not completing the assessments per DHS guidelines. Many of the errors were compliance-related in nature (e.g., social workers failed to complete the review within 24 hours or did not obtain a supervisor’s signature). However, in interviews with reviewers, it also was noted that, initially, some social workers failed to provide adequate narrative justification related to domains that measure child and adult functioning and general parenting capabilities. It also was noted that social workers would sometimes fail to provide justification as to why safety threats existed or what the safety plan was to address each identified threat.

While initial reviews have found errors in the completion of the safety assessment, the COB did not find that the safety of children in DHS’ care was compromised during the implementation of the tool. According to interviews with the review staff, errors found during the initial 6 months of reviews were largely related to incomplete documentation in the safety assessment narrative (as noted above). This is most likely reflective of the fact that social work staff required time to become accustomed to the new tool and the requirements for completing it.

DHS’ internal analysis of data from the reviews supports the notion that there was a learning curve for DHS social workers. Analysis of the safety assessment reviews completed of cases in the intake unit—which began in April 2008—found that, as social workers continued to use the safety assessments and feedback and additional training was provided, the quality of the reviews improved, particularly in the narrative portions of the assessment. In addition, this trend toward

standardization was seen in the safety assessments for cases in the ongoing regions, where reviews of the safety assessments began in September 2008. There was significant variability in quality initially, with a trend toward more standardized usage of the tool over time, particularly during the first 6 months.

### **Recommendations**

In general, the quality assurance reviews of the safety assessments are quite thorough and document that DHS social work staff are completing the assessment properly and ensuring the safety of children. The quality assurance reviews were not merely focused on compliance issues, such as whether the safety assessments were completed and required signatures were obtained within the required timeframes, but also on the quality of case and safety information collected and reported. During the observation of the review process, the COB saw evidence that the reviewers conducted detailed assessments of the quality of the safety assessment, with the objective of identifying whether DHS social workers were adequately identifying potential safety threats to the child and providing appropriate evidence.

While the COB is generally pleased with the progress that DHS has made on this recommendation, there are several areas in which DHS should focus in the future.

1. *Increase reviews of safety assessments for children in placement.* As noted previously, most of the quality assurance reviews conducted are for children residing at home, with fewer reviews of the safety assessments for children placed in substitute care settings. Regardless of the instrument used to conduct the safety assessment, the COB encourages DHS to increase the number of reviews of the safety assessments completed for those children in placement settings.
2. *Ongoing feedback and learning for DHS social workers.* It was clear from the COB's observations that individual social workers receive appropriate feedback on their safety assessments when a review is conducted. The COB believes that this is appropriate and is useful in helping social workers understand how to complete the safety assessments more effectively. However, it was not clear whether there is a structured feedback mechanism in place where aggregated results from the reviews were used to identify opportunities for feedback to all DHS social workers either through additional training or written guidance to staff. DHS should consider adding a more structured feedback mechanism as an output of the review process.
3. *Improved documentation.* One of the major areas where reviewers noted room for ongoing improvement was in the documentation provided on the safety assessments. It was observed that reviewers often have difficulty assessing whether the safety assessment was completed properly based on the social worker's documentation. Two such areas stand out in particular—understanding whether the social worker accurately assessed the domains of child functioning, adult functioning, and general parenting capabilities, and determining whether the social worker interviewed each member of the case separately, as required. DHS did note that its own internal review of review findings over the last

year has indicated that social workers have made significant improvement in documentation. However, a more formalized program to provide guidance to social workers would likely provide even greater returns in the quality of the safety assessments reviewed.

4. *Integration with provider social workers.* While the safety assessment completed by DHS social workers provides a valuable insight into the safety of the children in care, it would be useful to conduct similar reviews of the safety assessments completed by the providers with whom DHS contracts. Contracted social workers also are required to conduct assessments of child safety and currently there is no independent review of those safety assessments. This would provide a more comprehensive picture of child safety, and is especially important given that the private agency social workers often have more frequent contact with children than do DHS social workers

### **DHS Self Assessment**

DHS reiterated the significant efforts it has made over the last two years to conduct safety assessments for children residing at home and in placement settings. Initial safety assessments visits for all children receiving in-home services were completed in February 2007. DHS has an in-home safety assessment tool currently in use, and for which ongoing training is available to staff.

DHS also reported that all children in placement had a safety assessment conducted within the past six months as part of DHS' ongoing practice. DHS is implementing a structured case notes tool as the safety assessment for children in placement, and reviewed this tool with the COB in March 2009. This tool will serve as an interim placement safety assessment until the DPW publishes a statewide tool. DHS also noted that it will confer with labor management, DHS line staff, and providers to obtain additional feedback on the tool. Finally, DHS noted the significant strides it has made with the implementation of a quality assessment review of the completed safety assessment – a process that reviews more than 150 safety assessments every month to validate their completeness and provide a mechanism for providing line staff with feedback.

### **EVIDENCE-BASED PRACTICE**

In this section the Community Oversight Board (COB) provides background information on, and a definition of, evidence-based practice, and provides an exemplary model from the field of child welfare. The COB recommends that further clarification be provided by the COB, in discussion with the Philadelphia Department of Human Services (DHS), on how an EBP model correlates with the practice initiatives already being implemented by DHS.

#### **Background**

Areas such as medicine, mental health, and youth violence prevention are increasingly relying on the identification and delivery of practices that are supported by strong scientific research. They are also relying on the active integration of research evidence into day-to-day service provision.

While some fields have embraced this movement toward evidence-based practice for decades, there is reason to believe that it still takes years to integrate scientifically proven practices into everyday practice.<sup>9</sup>

### Approach

When the workgroup first met, DHS had not conceptualized an EBP model. In reviewing possible practice models in child welfare derived from the literature and expert opinions, the group developed a statement that reflects what a DHS definition of evidence-based practice might look like.

### Findings

EBP uses the best *available* research. Many areas in the child welfare field have not been systematically researched. In the absence of research based on scientific methods, other forms of evidence such as community consensus and local experience are often used. The COB learned that evidence-based practice:

- Provides guidance for child welfare social workers in their work with families;
- Structures services so that every family receives the same interventions regardless of where services are provided or who is providing the services;
- Provides assurances that child welfare social workers are trained to provide, and refer families to, services that are empirically based;
- Diminishes liability for child welfare agencies when child welfare social workers are providing, and referring to, services based on proven models of practice;
- Minimizes personal preferences and biases of staff; and
- Provides the ability to evaluate practices to ensure they meet the federal and state targets for the outcomes of safety, permanency and child/family well-being.

The identification of efficacious practices has become easier, thanks to the Internet. However, the knowledge to implementation process can be very difficult. Practice may be incompatible with organizational structures and cultures. The implementation effort may be under funded. New practices may lack passionate champions. Unfortunately, a failed implementation effort may result in the belief that the practice itself was ineffective, resulting into a decreased willingness to consider other innovations.

The Chadwick Center for Children and Families has created the California Evidence-based Clearinghouse for Child Welfare (CEBC).<sup>10</sup> This project's stated goal is to "identify and disseminate information regarding evidence-based practices relevant to child welfare." To overcome the challenges of implementation, the CEBC offers guidance and materials to help with these efforts. For example, the DEMOS project in Texas helped county child welfare departments create searchable databases of the services their clients received, caseworker's

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<sup>9</sup> Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academy Press.

<sup>10</sup> The California Evidence-Based Clearinghouse for Child Welfare, Chadwick Center for Children and Families. <http://www.cachildwelfareclearinghouse.org/>

decisions, and outcomes.<sup>11</sup> This allowed the agencies to accumulate their own evidence as to what practices worked, and for whom. This localized approach may offer a resolution to the problems encountered when fitting an intervention protocol developed for one population into the unique needs of other communities.

### **The Child Stat Process**

The COB is particularly pleased with the implementation of the Child Stat process as it represents a concerted effort on the part of DHS at data-driven practice. The Child Stat process began in February 2009. Since that time Child Stat meetings focusing on the Ongoing Service Regions have occurred on a monthly basis. Since there are three Ongoing Service Regions, each region has experienced Child Stat on two occasions. In July 2009, the Department also held its first Child Stat meeting for the Investigation Sections.

Each Child Stat meeting lasts for approximately two hours and is organized into four parts. The first portion of a Child Stat meeting consists of a presentation of data that is collected through the quality improvement case review process. This case review process includes information concerning the quality and consistency of safety assessment, safety planning, and service planning. Data specific to outcomes and work performance is also gathered by a Quality Improvement team. Some examples include timeliness to permanency, monthly visits, ability to move cases to the Adoption Region, ability to complete investigations in a timely manner, and case load size. (See Appendix D.)

### **Recommendations**

The COB recognizes that there is a need for more clarification from the COB regarding this recommendation. While the prior discussion of the efficacy of evidence-based practice is still germane, the discussion of what it means to implement an EBP model needs further exploration. The COB recognizes that DHS is, indeed, relying on child welfare research and evaluation in the implementation of many of its current practice initiatives.

Therefore, the COB proposes further clarification of this recommendation in conversation with DHS, and reconsideration of this recommendation as an area of concern. The COB also encourages DHS to continue the Child Stat process and to keep the COB informed as to its use and further development in the department.

### **DHS Self Assessment**

DHS asks the COB for further guidance in the implementation of an evidence-based practice model. Previous discussions with DHS and the COB have not clarified the direction this recommendation should take. In the meantime, DHS continues to rely on research and evaluation in child welfare to inform the development programs and practices. Examples of include Hotline Guided Decision Making, a Safety Model of Practice/In-Home Protective Services, an Alternative Response System, and Family Group Decision Making.

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<sup>11</sup> Schoech, D., Basham, R., & Fluke, J. (2006). A technology enhanced EBP model. *Journal of Evidence-Based Social Work*, 3(3/4), 55-72.

## **CHILD FATALITY REVIEW PROCESS**

In the December 2008 progress report, the COB indicated that it was concerned that DHS had not fully implemented its policy on the conduct of child fatality reviews. Since that time DHS has made significant progress. DHS established a leadership team in the area of child fatalities, established an Act 33 Review Team, and conducted a number of fatality and near fatality reviews. However, concerns remain.

DHS was required by Act 33 to implement, by January 2009, a new process for reviewing both fatalities and near fatalities.<sup>12</sup> At the end of last year, DHS had not yet issued guidance on how these reviews would be conducted. The COB was also concerned that a mechanism for implementing the recommendations from previous years' child fatality reviews had not been established. The COB also raised concerns regarding the CPS/GPS classification and its impact on the lessons that might be learned through the child fatality review process. The COB strongly recommended that DHS conduct reviews of child fatalities and near fatalities in which a GPS or General report was generated in a case in which the family had been active with, or known to, DHS in the past 16 months.

### **Approach**

On March 27, 2009, members of COB met with DHS staff to discuss the status of the implementation of DHS' progress regarding:

- The implementation of the child fatality and near fatality review process;
- The review and implementation of previous findings and recommendations from the Internal Child Fatality Review Team; and
- The policy and practice regarding reviews of child fatalities that generate GPS or General reports rather than CPS reports.

COB members also conducted a review of data on 2007 and 2008 child fatalities that generated a GPS or General report by the Hotline. The purpose of the review was to determine the types of deaths that generated GPS or General reports and how they differed from child fatalities that generated CPS reports.

In addition, a follow-up meeting with the new Child Fatality Program Administrator and a representative from the Law Department was held on July 21, 2009. The purpose of this meeting was to discuss the process that has been established for implementing recommendations from the Act 33 Review Team. Prior to the meeting, the COB was provided with a document outlining the process titled Act 33 Recommendation Tracking Process. In addition, the COB was provided with an Excel chart outlining the recommendations from the child fatality reviews conducted by the Internal Child Fatality Review Team (ICFRT) that preceded the Act 33 Review Team.

### **Status**

Following is a summary of the status of the implementation of the recommendations made by the COB in December 2008.

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<sup>12</sup> 23 Pa.C.S. §6365.

### ***Child Fatality and Near Fatality Review Process***

On March 25, 2009, DHS developed a Policy and Procedure Guide on the legal requirements for the interdisciplinary review of child fatalities and near fatalities; the responsibilities for social work staff regarding preparation for, and participation in, these reviews; and the protocol for the newly established child fatality/near fatality review team, known as the Act 33 Review Team.<sup>13</sup> The guide has not been officially released. Amendments are being drafted to the guide that will include an internal review process of child fatalities and near fatalities that are generated by GPS or General reports.

A review of the Policy and Procedure Guide was conducted by the COB and discussed at the March 27, 2009 meeting with DHS staff. The new process, as outlined and discussed, provides a clear process for implementing a new child fatality/near fatality review process. Following is an overview of the process.

1. When a Child Protective Services (CPS) report is received by the DHS Hotline alleging a child fatality or near fatality, the hotline staff immediately notifies the Hotline Priority Alert list.
2. The DHS Child Fatality Program Administrator will schedule a review of the case and notify the members of the Act 33 Review Team that a review has been scheduled. DHS will proceed to investigate the report according to existing policy and procedure.
3. Within 72 hours of a report alleging a fatality or near fatality, the Chief Medical Examiner, as the chair of the Act 33 Review Team, convenes the Coordination and Immediate Review Team (CIRT). The CIRT includes representatives from the Medical Examiner's office, DHS, and the Law Department. The purpose of the team is to coordinate communication and gather information regarding the child's history from various City agencies (including DHS, the Health Department, Police Department, and the Medical Examiner's Office) in preparation for the formal review by the Act 33 Review Team.
4. The Law Department representative reviews DHS file and prepares a summary for review if the case was active with, or had a history with DHS. This summary will be reviewed and discussed by the CIRT team.
5. The Act 33 Review Team will be scheduled to meet to review cases on the first and third Friday of every month to ensure that the requirement that the team be convened within 31 days from the receipt of the report is met.
6. A final report will be submitted to the Department of Public Welfare (DPW) and the Mayor of the City of Philadelphia (per the law) within 90 days of convening the Act 33 Review Team.

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<sup>13</sup> The Philadelphia Department of Human Services, Policy and Procedure Guide, *Act 33 Review Team Protocol for Fatalities and Near Fatalities* (March 25, 2009).

The COB commends the broad membership that has been identified for the Act 33 Review Team. The core members of the team now include representatives from the agencies or professions that are necessary to ensure that the team is effective and is in compliance with Act 33. It is “broadly representative” of the City’s experts in prevention and treatment of child abuse. The membership includes the following people or representatives.

- Chief Medical Examiner
- DHS Deputy Commissioner and/or DHS Operations Director
- DHS Division of Performance Management and Accountability
- City of Philadelphia Law Department
- District Attorney’s Office
- Philadelphia Police Department
- Department of Public Welfare
- School District of Philadelphia
- Physician from St. Christopher’s Hospital
- Physician from Children’s Hospital of Philadelphia
- Social Work Educator
- Early Childhood Representative
- Representative from a Domestic Violence Agency

The COB believes that it was a prudent decision to have the City of Philadelphia’s Chief Medical Examiner, Dr. Sam Gulino, chair the Act 33 Review Team. As the Medical Examiner for the City of Philadelphia, Dr. Gulino is aware of every unexpected child death that occurs in the City. Additionally, he has extensive medical knowledge and experience in identifying suspicious child fatalities.

The new Policy and Procedure Guide also makes clear the obligations of the Act 33 Review Team. The team must produce a report which identifies any deficiencies and strengths in compliance with statutes and regulations and services to children and families. It must also make recommendations for changes at the State and local level for:

- Reducing the likelihood of future child fatalities and near fatalities directly related to child abuse and neglect;
- Monitoring and inspection of county agencies; and
- Collaboration of community agencies and service providers to prevent child abuse and neglect.<sup>14</sup>

As indicated in the December report, an effective internal child fatality/near fatality review process requires someone to lead the planning and coordination of all that needs to take place. DHS has determined that the Division of Performance Management and Accountability (DPMA) will be responsible for leading the planning and coordination of the reviews and ensuring the distribution and implementation of the recommendations. A full-time Child Fatality Program Administrator was hired on May 18, 2009, to coordinate meetings, prepare presentations, and write the formal report. The new Program Administrator is also responsible for summarizing the case file and creating a PowerPoint presentation of the case for the Act 33 Review Team. The social worker and his/her entire chain of command involved in the case are also expected to be present at the Act 33 Review Team meeting to participate in the open discussion of the case.

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<sup>14</sup> The Philadelphia Department of Human Services, Policy and Procedure Guide, *Act 33 Review Team Protocol for Fatalities and Near Fatalities* (March 25, 2009).

The COB was also informed that DHS plans to administer a staff questionnaire to those involved in the Act 33 Review Team. DHS wants to ensure that social workers are comfortable with the process. They want to make it clear that the review process is meant to be a learning process not a punitive process.

### ***Implementation of Recommendations***

The COB understands that the process for reviewing and implementing recommendations from the internal child fatality/near fatality process has been revised. The new protocol requires that the DHS Commissioner review the recommendations made by the Act 33 Review Team. Approved recommendations are sent back to the Act 33 Administrator. The recommendations are then entered into the Act 33 database and distributed to the appropriate Division/Department Heads. Division/Department Heads are responsible for reviewing and determining the feasibility of the recommendations within one month, implementing recommendations, reporting implementation status to the Act 33 Administrator, and providing a “completion report” two weeks prior to each quarterly update. The Commissioner, Act 33 Review Team, and DHS staff will be informed of the progress of implementation on a quarterly basis.<sup>15</sup>

The COB continues to be very concerned, however, that it has not been provided any material from DHS indicating what DHS has learned from, and is now doing differently based upon, recommendations made in past child fatality reviews over the last two years. DHS staff has indicated that they have a plan to provide this information but as of this date it has not been provided to the COB. It is critical that DHS review these earlier recommendations, determine what steps, if any, need to be taken, and develop an action plan for the implementation of any needed policy and/or practice improvements. In particular, the COB is troubled by the lack of material from DHS on any policy and practice changes related to past deaths of medically fragile children and children who died in co-sleeping situations.

As indicated above, DHS provided the COB with a matrix of recommendations from the Internal Child Fatality Review Team (ICFRT). The COB understands that recommendations that were determined to be feasible, concrete, and measurable from the ICFRT were identified for implementation. Each recommendation was submitted to the appropriate Division/Department Head on May 3, 2009. At this time, the status of responses to these recommendations is not clear. DHS is planning to submit a status report to the COB on July 31, 2009.

Case specific recommendations are to be implemented immediately. Further, DHS staff are consulting with DHS nurses in cases of near fatalities to assist in understanding the medical issues and assist in hospital discharge planning. Nurses are also participating in the Act 33 Review Team process.

The COB was also informed that In-Home Protective Services (IHPS) established a specific unit that specifically works with cases involving medically fragile children. This specialty unit was established in March 2009.

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<sup>15</sup> *Department of Human Services (ND)*. Act 33 Recommendation Tracking Process.

### ***Review of 2007 and 2008 Child Fatalities Generating GPS/General Reports***

As indicated in the December report, a majority of fatalities that were reported to the Hotline in 2007 and 2008 did not generate CPS reports. That is, the allegations regarding the child's death, if true, would *not* constitute child abuse as statutorily defined. The COB conducted a review of data provided by DHS of 2007 and 2008 child fatalities that generated GPS or General reports that were active or known to DHS within the last 16 months.

The more in-depth review of the data supports the COB's recommendation that consideration should be strongly given to the conduct of Act 33 Team Reviews for all child fatalities that were active or known to DHS within the past 16 months at the time of death, regardless if they were labeled a GPS or General report. There is significant overlap in the manner of death in the cases that generate CPS reports and those that generate GPS or General reports. This is most evident in deaths of medically fragile children and cases involving very young children (under the age of one) with the manner of death related to unsafe sleeping. It was not clear what distinguished these cases from many of the deaths related to unsafe sleeping that generated CPS reports.

To address this concern, DHS is amending the draft Policy and Procedure Guide on the review of child fatalities and near fatalities to include an internal review team that will include Dr. Sam Gulino. The internal review team will review the cases and determine if further review is required by the Act 33 Review Team.

### **Recommendations**

Following are recommendations regarding next steps as they relate to child fatality and near-fatality reviews.

1. Given that the Act 33 Review Team process has just recently been implemented, it is too early to conduct any evaluation of that process. The COB recommends that an evaluation of the child fatality and near fatality review process should be built into the overall review process. The evaluation should include, at a minimum, a process evaluation that examines how well the team is functioning and whether its membership is consistently participating in team meetings. The evaluation should also examine whether the team is effecting change. That is, has the team helped DHS identify and implement system improvements through agency, program, or policy change that could help prevent child fatalities and near-fatalities?
2. In the review of the administrative data on child fatalities, it was noted that extracts received by the COB at different points in time resulted in different numbers of child fatalities that generated GPS or General reports. We understand that DHS has been in the process of improving how they collect, record, and report child fatality data through the Fatality Tracking Database implemented in January 2008. Since that time, the data has improved. The COB, however, recommends that an evaluation of the data being collected be conducted and that a determination be made as to whether all necessary data fields are being provided. In addition, the COB recommends that all cases involving near fatalities be included in the Child Fatality Tracking Database. This is especially important so that DHS can determine if additional steps need be taken to help assure that hospitals and

other sources of near-fatality reports are aware of the importance of these cases being reviewed by the Act 33 team, and there is a process for making such referrals are made for team review.

### **DHS Self Assessment**

In its assessment of progress submitted to the COB, DHS describes the creation of the Act 33 review team, and notes the significant commitment of the City's Chief Medical Examiner as a member in the new fatality-review process. DHS did not include any information on how it intends to incorporate information learned from the reviews into its ongoing social work practice model. DHS also failed to include any information regarding whether it intends to review all GPS fatality and near-fatality cases in an ongoing fashion.

### **CRIMINAL BACKGROUND CHECKS**

In May 2007, the CWRP recommended that the DHS conduct a criminal background check on each adult member in the child's household during the investigation/assessment process and prior to any reunification. In December 2008, the Community Oversight Board (COB) strongly recommended that policy be developed and the practice be implemented expeditiously. The COB felt strongly that this was necessary in order to ensure the safety of both children and the social work staff. Specifically, the COB recommended that DHS should immediately:

1. Begin research on other State and County agency practices and policy regarding conducting criminal background checks in these cases;
2. Develop policy regarding the process and procedures for conducting the criminal background checks; and
3. Identify how they will get access to the National Crime Information Center's (NCIC) database so that these checks can be done expeditiously.

### **Approach**

On March 27, 2009, COB members met with DHS staff to discuss the status of the development of a policy regarding the conduct of criminal background checks. A follow-up memorandum was submitted to the COB providing additional information on the status of the process on June 19, 2009. On July 21, 2009, COB members met with DHS staff again to discuss recent progress and next steps in implementing the conduct of criminal background checks. In addition, the COB was provided an update of the progress at the July 24, 2009 meeting.

### **Findings**

DHS has worked diligently to move forward in implementing the recommendation from the CWRP that they institute the practice of conducting criminal background checks on a regular basis to inform decision making regarding the safety of children during the investigation/assessment process and prior to reunification.

At the March 27, 2009 meeting, the COB was informed that DHS had put together a workgroup to assist in the continuing process of researching practice and policies of other jurisdictions. The workgroup planned to meet with staff from Allegheny County, Pennsylvania and New York City

to learn how they have implemented the process of conducting criminal background checks in investigation and reunification cases. In addition, the COB was informed that the workgroup was to explore which computer system would be used to conduct the criminal background checks.

The follow-up memorandum submitted to the COB on June 19, 2009, indicates that DHS is continuing to move forward with the necessary steps that will allow them to conduct timely criminal background checks in these cases. DHS has determined that they will use the Pennsylvania Justice Network (JNET) to conduct criminal background checks. They are in the process of securing JNET access for supervisors, administrators, and directors. For this to be achieved, FBI fingerprints must be obtained for all potential data terminal users, sponsors, and registrars. In addition, all users must be trained; user agreements executed; and appropriate precautions taken to ensure confidentiality of the information at each users workspace.

DHS has also drafted a Policy and Procedure Guide, *Criminal History Clearances for Investigations and Reunifications*. It addresses for whom clearances must be obtained, the time frame for obtaining the clearances, documenting the information, and how long the information is to be considered valid. In addition, instructions for interpreting the results of the criminal history record check and ensuring confidentiality is also provided.

DHS has also indicated that its action plan for implementing the practice of conducting criminal background checks for investigation and reunifications includes the following steps.

1. Continue to explore obtaining access to Protection from Abuse Orders via the Banner Database from Family Court. Access to that Database is viewed as critical to child safety decision making, as it provides important information on perpetrators of domestic violence who may present a danger to children.
2. Develop form(s) for requesting and responding to criminal history searches.
3. Develop and implement training for DHS social work staff regarding the use of information from criminal background checks for investigations and reunification including a special curriculum on confidentiality issues. DHS hopes to get assistance in this training by professionals from the Philadelphia law enforcement agencies regarding interpreting and using results from criminal background checks.
4. Meet with providers, stakeholders, and Family Court judges to inform them of DHS' new policy on conducting criminal background checks to aid in investigation and reunification safety decision making.
5. Implement a pilot program for conducting criminal history checks prior to home reunification.

At the July 21, 2009 meeting, the COB learned that Mr. Oswald Smalls has been named as the DHS Chair of the Criminal Clearance Workgroup/ Project. Mr. Smalls will work with the Law Department in finalizing and implementing the plan for the conduct of criminal background checks.

The COB was also informed that DHS has very limited access to the Family Court's computer system that houses information on Protection from Abuse (PFA) orders. DHS' access would have to be tremendously expanded for DHS to be able to obtain this information when doing clearances for investigations and reunifications, particularly given the volume of reports that DHS receives. Vanessa Garret Harley has spoken with Judge Dougherty, Administrative Judge for Family Court about gaining access to the Court's database that contains information on Protection from Abuse (PFA) orders. Judge Dougherty is supportive of DHS gaining access to the database and has requested that DHS work with Judge Murphy, Supervising Judge for the Domestic Relations Branch.

DHS hopes to begin piloting the conduct of criminal background checks for reunification cases within the next six months. DHS had approximately 2,000 reunifications in 2008. The COB members working on this issue suggested that DHS consider beginning the pilot with reunifications involving children less than five years of age as they are the most vulnerable for repeat abuse or neglect. If the pilot needs to be a narrower group of children, these COB members suggested children less than 5 years of age in which the allegation that resulted in a child going into care involved a crime of violence, including but not limited to alleged sexual abuse.

The issue of keeping good data on the results of these criminal background checks was also discussed. DHS agreed that it will be critical to keep good data so that they can, at a minimum, determine the percentage of cases in which there was a match and how the information was used. Lastly, it was noted that ensuring that the results from the criminal background checks are understood and used appropriately in the safety assessment by social workers will require training. DHS has talked with the District Attorney's office and they are willing to train social work staff on interpreting results and understanding the coding used.

In the December report, the COB also indicated that these criminal background checks were important for ensuring the safety of social workers. The COB was very pleased to learn that there are other measures already in place to ensure social worker safety. For all night responses, we were informed that social workers always go out in teams to conduct the investigation. In addition, social workers are uniformly informed that they can request that a member of the police department accompany them on any investigation if they are worried at all about their safety.

### **Recommendations**

The COB strongly believes that implementing the process of conducting criminal background checks for investigation and reunification case decision making is a critical piece in ensuring the safety of Philadelphia's children who have reported to be, or have been confirmed as, victims of child abuse or neglect. We recognize that DHS has continued to work towards achieving this. We recommend the following to ensure that the process continues to move forward expeditiously and that it is one that will be in concert with best practice.

1. DHS should clarify the timeline for completing each step of its action plan for conducting criminal background checks; identify the responsible parties and specify any workload or funding issues that may be barriers to full implementation and how they will be addressed.

2. DHS should make sure that they have access to Protection from Abuse Orders via the Banner Database from Family Court. The COB strongly believes that this information is as critical to ensuring the safety of children as criminal background checks.
3. The draft Policy and Procedure Guide, *Criminal History Clearances for Investigations and Reunifications* is comprehensive. However, there are unique issues that may need to be addressed in reunification cases. The COB suggests that a guide be developed specifically addressing these reunification issues, as this is the area where this record checking will first be utilized for child safety decision making.
4. As part of the plan, DHS should develop a mechanism for tracking data on the findings from the criminal background checks and actions taken by DHS social workers in response thereto. This information will support DHS in its efforts to become a “Learning Organization” as well as in continuing to refine its policies and practices in this area.

### **DHS Self Assessment**

DHS’ assessment of progress is consistent with what the COB has observed and included in this report. Within the DHS assessment submitted to the COB, the Department noted it has and continues to “*consistently conduct background checks as required by law and regulation*” and also notes its plans for a 6-month phased implementation of the initiative to conduct criminal history clearances for investigations and reunifications. DHS also reported that it has assigned a senior, experienced staff member to oversee this effort.

### **FAMILY GROUP DECISION MAKING (FGDM)**

In this section, the COB will describe the progress that DHS has made in the implementation of Family Group Decision Making (FGDM). The section includes background on FGDM in Pennsylvania and DHS’ implementation of the program. This is followed by a description of the COB review methodology, a description of the program and the agency’s implementation strategy and status. Program statistics are provided that detail the number of referrals to FGDM and the results of these referrals. Conclusions reached during the FGDM review, as well as recommendations for future action, are included at the end of this section.

#### **Background**

DHS is implementing FGDM in response to specific recommendations of the Child Welfare Reform Panel (CWRP) recommendations. The implementation of FGDM was addressed in both the Phase 1 and Phase 2 CWRP recommendations.

The Phase 1 panel recommendation stated:

*Ensure that ongoing team case conferencing occurs routinely every 3 months (this is the Family Group Decision Making [FGDM] model).* In response to this recommendation, FGDM was initially scheduled for implementation in November 2007. The timeframe for the implementation of this recommendation has since been revised to June 2009.

The Phase 2 CWRP recommendation stated:

***DHS must expand the use of Family Group Decision Making (FGDM) to all children and utilize specialized resources in the case-planning process.*** A goal of 70 completed family conference meetings by the end of December 2008 was associated with the Phase 2 recommendation. Based on available data, this expectation was not met by DHS due to the early delays in the implementation of the program.

FGDM is a method by which families and extended family members become directly involved in the planning and decision making processes in child welfare cases. Family members in FGDM become responsible not only for participation in the service planning process, but also for executing, supporting, and monitoring components of the plan. Depending upon an agency's implementation strategy, FGDM can be offered to families at any juncture in the case from the onset of agency services to later specific junctures in the case where particular risks are imminent. Typical events during a case when FGDM might be used are: when a child is at risk of placement, when a child is at risk of placement disruption, or when a child requires reunification or discharge planning. DHS is currently employing FGDM at specific event stages of the case. (DHS' specific event criteria for FGDM are presented later in this report.)

There are a few major models of FGDM and one of the most widely implemented is the Family Group Conferencing model, originally developed in New Zealand. Pennsylvania's model for FGDM includes two of the significant tenets of the Family Group Conferencing approach:

1. Family meetings, which are the core activity of FGDM, are facilitated by a neutral party who is not otherwise involved in the case; and
2. Families have private time during the family meeting, without the presence of professionals, to formulate and propose their own plan for reaching case objectives. Families also use this time to identify the responsibilities of family members and friends who have agreed to participate in the family's case plan.

Pennsylvania began the statewide effort to implement FGDM approximately ten years ago. Allegheny County was the first to implement FGDM in 1999. The DPW provides counties with funding assistance to implement FGDM, assuming that a county adheres to the basic principles of the adopted FGDM model. DHS' program qualifies and receives such funding. The state also provides support for county implementation of FGDM through the state's training programs. The statewide effort is also supported through periodic regional implementation meetings to allow counties to share experiences and strategies related to their FGDM programs.

DHS' implementation of FGDM began in Spring 2008 with a pilot program in Region 1. The first family conference took place on May 28, 2008. The pilot program saw a relatively low volume of referrals for FGDM services. However, FGDM began to be implemented agency-wide on March 23, 2009, and referrals have increased steadily since that time. Interviews with DHS staff involved in managing the FGDM program, as well as perspective gained from interviews with the FGDM service provider, indicate a strong commitment to FGDM. The DHS managers

involved in the FGDM program express the hope that the philosophy of family involvement in the decision making process will begin to permeate the agency culture and will not only impact the families involved in the FGDM program, but all families receiving services from DHS. As any change in the paradigm of service provision in a large organization, deep changes such as this are likely to take considerable time.

### **Approach**

The COB review of the implementation of FGDM included the following activities:

- Interviews with DHS' FGDM program managers;
- Review of DHS' procedure and program documents;
- Site visit to A Second Chance, Inc. (ASCI), the single FGDM provider agency chosen through a competitive bid process at the initiation of DHS' FGDM implementation. The site visit to ASCI included the following:
  - Interviews with program managers (2—program director and program supervisor)
  - Interviews with FGDM case coordinators (2)
  - Interviews with family meeting facilitators (2)
  - Interview with the ASCI FGDM trainer (1)
  - Review of available statistics
  - Review of case record documentation
  - Review of completed FGDM plans (10 plans); and
- Consultation with staff at the Jerry Lee Center of the University of Pennsylvania. The Jerry Lee Center is in the process of evaluating DHS' FGDM program.

### **Findings**

The process of implementing FGDM and statistics regarding the FGDM program are discussed below.

#### ***Family Group Decision Making Process***

Since the agency-wide implementation of FGDM on March 23, 2009, social workers are now required to offer FGDM to families when one or more children in the family:

- Is at risk of placement;
- Has a change in placement level;
- Is at risk of placement disruption;
- As being discharged from placement;
- Participates in older youth permanency meetings; and/or
- Has other critical issues, e.g. permanency decisions.<sup>16</sup>

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<sup>16</sup> Philadelphia DHS/CYD Policy and Procedure Guide, Issue Date March 23, 2009.

Under the above conditions, the DHS social worker is to offer FGDM services to the family (parents, caregivers, and youth 14 years of age and older). FGDM is voluntary on the part of the family.<sup>17</sup> Only DHS social workers can refer cases for FGDM services. When offered, the family is to sign the “FGDM Meeting Intent Form” indicating acceptance or rejection of FGDM services. Upon acceptance by the family, all referrals are entered into DHS’ FGDM database and reviewed and approved by the social worker’s supervisor.

By policy, referrals for FGDM services are not offered to families “When there are issues, such as domestic violence, sexual abuse, or criminal history, which may endanger FGDM participants during a meeting...”<sup>18</sup>

Once approved internally at DHS, all FGDM referrals are submitted to ASCI for coordination and facilitation services. DHS’ FGDM database system automatically notifies ASCI of the referral and ASCI staff accesses the information from the same data system (via web access).

ASCI has been involved in the program since the inception of the pilot program. The referral volume was light during the pilot period that extended from May 2008 to March 2009. ASCI is in the process of adding new staff to handle the recent increase in referrals, now that the program is agency-wide at DHS. A new class of coordinators (5) and facilitators (5) has been trained. In addition, ASCI has hired a dedicated program director for the FGDM program. With the addition of these new staff, ASCI expects to be able to handle 120 referrals per month, which is the ongoing target referral level for the program.

Upon receipt of a referral, ASCI’s FGDM supervisor sends a letter to the family and an email to the DHS social worker indicating the initiation of the ASCI coordination process. The case is assigned to an ASCI FGDM coordinator. The coordinator first contacts the DHS social worker to obtain background and to begin exploring timing and dates for the family conference. ASCI follows all phone contacts to DHS with confirmation emails. The DHS and ASCI FGDM managers have worked closely together to expedite the process for the initial contact with DHS workers, as ASCI cannot begin the coordination phase until conferring with the DHS social worker.

Once contact with DHS occurs, the ASCI coordinator begins to work with the family to identify potential family members, friends, and support people to include in the family conference. A major focus of the coordination effort is to identify all potential associates of the family who may be useful in developing and executing the family plan. This is a key element of the program as often these are individuals who would not otherwise be recognized as contributors to the successful completion of the case plan. The FGDM coordinator also works with the involved agencies and professionals, including the DHS social worker and supervisor, and the caseworker from the assigned provider agency for the family.

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<sup>17</sup> There are instances in which the Court has ordered FGDM for the family. However, it is preferred that the Court restricts its order to the offer of FGDM to the family, as the voluntary nature of the process is deemed critical to its success.

<sup>18</sup> Ibid

After identifying participants and obtaining the necessary background information, the family meeting is scheduled. A pre-conference meeting is also convened, with professionals only, to discuss the details of the case and to determine the objectives from the perspective of DHS and other agencies. The pre-conference is always held within the week prior to the family conference.

Family meetings are facilitated by a neutral facilitator from ASCI. The facilitator's first involvement in the case is attendance at the pre-conference meeting. The family meeting itself is almost always held at night or on weekends to accommodate the schedules of the family members. This poses some challenges for the professionals involved. ASCI reports that DHS social workers have accommodated the schedule (their attendance is mandatory), but that provider agency staff often do not attend the family conference.

Conduct of the meeting includes:

1. Exercises to facilitate open discussion and to ascertain everyone's goals and objectives;
2. Discussion of issues and objectives to be addressed in the FGDM plan;
3. Break (that includes the participants sharing a meal);
4. Private family time—where the family members meet alone to develop the plan for addressing each objective of the plan. The tasks and monitoring responsibilities are specified during this time;
5. Facilitator then presents the family's plan to the DHS social worker. If approved, the group comes together for conclusion of the meeting. If any part of the plan is not accepted by DHS, the facilitator returns to the family and the family works on the plan until an acceptable plan is reached; and
6. ASCI's FGDM coordinator types up the plan while everyone is present and prints copies for signature at the meeting

Family meetings are quite long, usually ranging from three to five hours. It appears that the process does usually reach the intended goal of an agreed-upon family plan.

### ***FGDM Statistics***

During the site visit to ASCI on May 20, 2009, ASCI provided current statistics from the FGDM information system (data through May 19, 2009). A follow-up request to ASCI resulted in the receipt of monthly referral statistics up to May 29, 2009. Since the information pertains only to those cases actually referred to ASCI, it does not include the number of families to whom FGDM had been offered, the number of families declining FGDM, or information related to the FGDM activity across the DHS regions.

A total of 209 referrals were received by ASCI since the program's inception (up to May 29, 2009). ASCI received 38 referrals from May 2008 through February 2009, the period of the Region 1 pilot (average 3.8 per month). DHS issued policy and procedures for agency-wide implementation on March 23, 2009. Since that time, the referrals per month have increased significantly. ASCI received 35 referrals in March, 52 in April, and 55 in May (up to May 29). Referrals are growing substantially each month as staff becomes more familiar with the program.

The table below shows program statistics up to May 19, 2009.

**Table 3.5 Family Group Decision Making Statistics As Provided by A Second Chance, Inc., Data as of 5/19/09**

Family Group Decision Making Statistics		
	#	%
Referrals to FGDM thru 5/19/09	187	
Pending FGDM Conference	86	46%
Terminated Prior to Family Meeting	52	28%
Family Meetings Completed	49	26%
Meetings Resulting in Agreed Upon FGDM Plan	46	94%
Cases Completed 90 Day Follow-up Phase	18	
Plans Meeting Outcomes (at 90 days)	16	89%
Plans Not Meeting Outcomes	2	11%

The 187 FGDM referrals include referrals received during the pilot phase and those referred since the program became agency-wide on March 23, 2009. As of May 19, 2009, there were 86 cases pending a family conference. All of these cases are in the pre-conference, coordination process where ASCI is working with families and professionals to prepare for the family meeting. Assuming that a family does not decline participation during this coordination phase, ASCI will schedule the family meeting once coordination services are completed and will hold a professionals only pre-conference meeting within one week of the family meeting.

Up to May 19, 2009, 52 families had dropped out of the FGDM process after the referral to ASCI and prior to the scheduling of the family meeting. Terminations during the coordination phase can occur when a family declines to participate after the referral or when a referral is withdrawn by DHS (e.g. a safety issue or the existence of sexual abuse is discovered during the coordination phase).

Of the 49 family conferences that had been held up to May 19, 2009, only three ended without an agreed-upon FGDM plan. Such a high rate of agreement between the families and DHS, at least at this early point of implementation, appears to validate the process as an effective approach for involving families in the case planning process. Although only 18 cases have completed the full 90-day follow-up period after the family meeting, initial results are promising in those 16 cases have met the desired outcomes (e.g. avoiding placement, avoiding a change in placement, or successful reunification). Additional follow-up after the 90-day period would be useful in determining the permanency of these outcomes.

As stated earlier, the above statistics represent a very early view of the FGDM program. Shortly before drafting the COB report, it was learned that the University of Pennsylvania's Jerry Lee Center was continuing to conduct a formal evaluation of DHS' FGDM program. The Jerry Lee Center has issued a preliminary report that includes data up through June 2009. Currently DHS and the Jerry Lee Center are discussing the direction for future program evaluation. Since the program became agency-wide only recently, it is important that DHS continue to evaluate the program, either through its own Division of Performance Management and Accountability or through its contract with the Jerry Lee Center.

### **Recommendations**

At this stage of FGDM implementation in Philadelphia, there are typical startup issues. FGDM is a major change, not only in program and procedure, but also in the philosophy of working with families. Bringing all staff on board—not only complying with the process but understanding how to work with families and providers in the context of FGDM—is a major undertaking and one that will take time before it becomes the accepted approach to working with families. Referrals are only recently beginning to approach the level anticipated for the program in its full operation. Additional time is needed to determine if FGDM will reach the intended level of utilization and to assess whether or not the outcomes continue to be as positive as they have been over the first few months of implementation.

DHS' FGDM program managers appear very committed to the program and most importantly to the concept of shared responsibility with the family and using the family's own support network to address issues of child safety. The provider chosen for the coordination and facilitation of FGDM (ASCI) also appears very committed to the program and has reacted quickly to build capacity to handle the recent increases in referrals. Both agencies are maintaining effective communication to identify and address issues as they arise. The FGDM program is benefiting from the use of an automated system, which begins tracking each case from the initial referral through the follow-up period after the conference. The system provides an efficient method for initiating referrals, obtaining supervisory approval, and transmitting the referrals to ASCI. Because cases are tracked from the beginning of the FGDM process, the system provides critical case management data to identify issues quickly and to resolve any "log jams" that prevent families from receiving FGDM services when they are needed and most effective.

This report is being written at a very early stage of the agency-wide implementation of FGDM. Even so, indications based on the early results suggest that FGDM will be an asset to the agency and can have a true impact on the safety and well-being of the children and families served by DHS.

The following recommendations are offered in recognition of some of the challenges noted at this early stage of implementation.

1. Assuming that this has not occurred at the time of publication of this report, DHS should complete the training of all staff as soon as possible. Although the agency has issued the agency-wide directive for use of FGDM, how well a family is prepared, and in fact how receptive a family will be, is often dependent on the initial approach of the social worker.

2. Any mechanisms that encourage maximum “buy-in” from social workers and supervisors will increase the utilization and effectiveness of FGDM and may reduce the number of families who drop out of the program during the coordination phase.
3. Since DHS contracts ongoing services to provider agencies, the involvement of provider agency staff in the process, especially their attendance at family meetings, is critical. Although involvement in the FGDM process is a contract expectation of these agencies, their involvement to date does not appear to be satisfactory and is a factor that limits effectiveness in some cases. It is likely that some provider agencies do not have the means to accommodate the staff scheduling that is required by FGDM, since most meetings occur at night or on weekends. DHS should work with provider agencies to address this issue. Continuing education efforts with the provider agencies is critical. Consideration should be given to enlisting the support of ASCI in this effort.
4. DHS and ASCI should continue to monitor FGDM cases closely through the automated system and should focus on:
  - a. Any stages of the process where cases do not progress according to expected time frames (e.g. initiation of referrals, supervisory approval, first contacts with families or professionals, scheduling of the family conference);
  - b. The impact that the rapid increase in referral volume has on the ability of ASCI and DHS staff to continue to provide competent and timely FGDM services to all families referred; and
  - c. Any evidence that specific regions or agency units are not fully utilizing the resource of the FGDM program.
5. It is recommended that DHS develop a plan for long-term evaluation of FGDM since the program has only recently been implemented on an agency-wide basis. Longer-term evaluation should include the assessment of the utilization of FGDM across DHS offices and should include a comparison of the number of families that meet the criteria for FGDM and the number to whom FGDM is offered. The evaluation should continue to look at what happens to a case after the referral to ASCI (e.g. the number of families who decline during the process and the reasons these families drop out, the length of time between referral and the actual family conference, and the outcomes of the FGDM plans as judged at the end of the 90-day follow up period). If possible, the agency should consider a longer follow-up period in order to assess the permanency of the initial case outcomes.

### **DHS Self Assessment**

DHS has moved the FGDM initiative forward in the past 4 months with the issuance of the Family Group Decision Making policy. While there have been some growing pains that hindered implementation, DHS continuously monitors staffing challenges, communications between DHS and its contract providers, as well as the number of cases referred and serviced.



**APPENDIX A. STATUS REPORT ON CHILD WELFARE REVIEW  
PANEL REFORM RECOMMENDATIONS WITH DHS' REPORTED  
PRIORITY LEVELS (JUNE 29, 2009)**

Panel Implementation	Timeframe	Status	Priority Level
<b>PHASE ONE</b>			
<b>Mission and Values</b>			
<b>Recommendation 1.a.</b> (Page iv) DHS must develop a mission statement and core values that are centered on child safety	Recommended by panel: December 31, 2007	Completed	Completed
<b>Recommendation 1.b.</b> (Page iv) DHS core values must embody at a minimum the following principles: <ul style="list-style-type: none"> <li>i. Creating a culture of respect, compassion and professionalism;</li> <li>ii. Enhancing communication with, and responsiveness to, stakeholders;</li> <li>iii. Instilling a greater sense of urgency among DHS staff and providers;</li> <li>iv. Providing services that readily accessible;</li> <li>v. Fostering a culture of collaboration;</li> <li>vi. Providing culturally competent services; and</li> <li>vii. Creating a transparent agency.</li> </ul>	Recommended by panel: December 31, 2007	Completed	Completed
<b>Practice</b>			
<b>**Recommendation 2.a.i.</b> (Page iv) DHS must implement an adequate evidence-based safety assessment tool	Recommended by panel: June 30, 2007	<b>Investigation and In-home protection safety assessment tool:</b> Completed  <b>Placement safety assessment tool:</b> In progress	<b>Investigation and in-home protection safety assessment tool:</b> Completed  <b>Placement safety assessment tool:</b> High-Level
<b>**Recommendation 2.a.ii.</b> (Page iv) DHS must conduct a safety assessment for every child within its care – both children at home and children in out-of-home placements. The safety assessment must be updated at each contact with the child.	Recommended by Panel: September 30, 2007	<b>In home safety visits:</b> Completed & On-Going  <b>Placement safety visits:</b> Completed & On-Going	Moderate-Level (DHS Division of Performance Management & Accountability will monitor)

Panel Implementation	Timeframe	Status	Priority Level
<p><b>**Recommendation 2.b.i. (Page iv)</b></p> <p>DHS must conduct immediate (within 2 hours) face-to-face visits for every children 5 years of age or younger for whom a report of suspected abuse or neglect is received by the Hotline. This face-to-face contact must be made regardless of whether the Hotline classifies the case as General Protective Services (GPS) or Child Protective Services (CPS).</p>	<p>Recommended by Panel: June 30, 2007</p>	<p>Completed</p>	<p>Completed</p>
<p><b>Recommendation 2.b.ii. (Page v)</b></p> <p>DHS staff must – on at least a monthly basis –conduct face-to-face contacts with all families receiving any service supported through the Children and Youth Division (CYD) that have a child 5 years of age or younger and physically observe the condition, safety and behavior of any such child, as well as parental capacity.</p> <p><b>Please note: DHS presented an alternative plan it implemented re frequency of visits based on age of child and service category provided. The alternative has been adopted by DHS.</b></p>	<p>Recommended by Panel: June 30, 2007</p>	<p>Completed and on-going</p>	
<p><b>Recommendation 2.c. (Page v)</b></p> <p>DHS must establish a local office presence in a least one geographic location deemed highly at-risk.</p>	<p>Recommended by Panel: May 31, 2008</p>	<p>In planning</p>	<p>Moderate-Level</p>
<p><b>**Recommendation 2.d. (Page v)</b></p> <p>DHS must implement a team decision making process to determine service plans for all children 5 years of age or younger. A pre-placement conference must be held for all non-emergency cases where a child 5 years of age or younger may need to be placed into a substitute care setting. The pre-placement conference must include the child's family, including potential kinship placement resources; the DHS worker; the provider agency worker</p>	<p>Recommended by Panel: August 31, 2007</p>	<p>In progress</p>	<p>Moderate-Level</p>

Panel Implementation	Timeframe	Status	Priority Level
<p>(where applicable); a physician or nurse; and individuals representing mental health, substance abuse, and domestic violence services, as needed, who have the authority to commit resources of their respective agencies; and individuals requested by the family representing their social support network. When feasible, the supervisors of both the DHS and provider agency workers should participate in the team decision making conference. The initial Family Service Plan (FSP) must be developed during this process.</p> <p><b>Please note that DHS has implemented Family Group Decision Making and there are no age limitations on eligibility for the service</b></p>			
<p><b>Recommendation 2.e. (Page v)</b>  DHS must ensure that ongoing team case conferencing occurs routinely every three months, for cases involving children age 5 years or younger, after the initial pre-placement conference, and the child's family, the DHS worker, the provider agency worker, and other interdisciplinary resources must be included as appropriate. Monitoring of service provided, progress, and revisions to the FSP must be made as part of this process.  <b>Please note the FGDM Model does not include case conferencing every three months for children age 5 years or younger. The case progress is reviewed within 90 days, but does not necessarily result in a group meeting.</b></p>	<p>Recommended by Panel: November 30, 2007</p>	<p><b>FGDM Implementation – Completed &amp; On-Going</b></p>	<p>Moderate-Level</p>
<p><b>Recommendation 2.f. (Page v)</b></p> <p>DHS must clarify the roles and responsibilities for DHS workers relative to private agency workers, at both the supervisory and worker level.</p>	<p>Recommended by Panel: August 31, 2007</p>	<p>In planning</p>	<p>Low-Level</p>

Panel Implementation	Timeframe	Status	Priority Level
<b>Outcomes and Accountability</b>			
<p><b>Recommendations 3.a.i. (Page vi)</b></p> <p>DHS must develop an annual report card that measures and communicates its performance on outcomes of interest, including at a minimum, those outcomes specified in Chapter 4 of the Report.</p>	<p>Recommended by Panel: Strategy developed by November 30, 2007 and report card delivered by May 31, 2008</p>	<p>In progress</p>	<p>Low-level</p>
<p><b>Recommendation 3.a.ii. (Page vi)</b></p> <p>DHS must develop a comprehensive strategy for internal monitoring of its performance. DHS must be able to monitor the performance of regions, units and workers, and must use performance information to identify weaknesses and areas for improvement.</p>	<p>Recommended by Panel: Strategy developed by November 30, 2007 and Tracking to begin May 31, 2008</p>	<p>Completed</p>	<p>Moderate-Level</p>
<p><b>Recommendations 3.b. (Page vi)</b></p> <p>DHS must enhance oversight of contracted agencies</p>	<p>Recommended by Panel: No overall timeframe given</p>	<p>Completed &amp; On-Going</p>	<p>Moderate-Level</p>
<p><b>Recommendation 3.b.i. (Page vi)</b></p> <p>DHS must create an annual outcome report card for contracted agencies. At a minimum, the report card will focus on measures of child safety, which are detailed in Chapter 4 of the Report.</p>	<p>Recommended by Panel: May 31, 2008</p>	<p>In Planning</p>	<p>Low-Level</p>
<p><b>Recommendation 3.b.ii (Page vi)</b></p> <p>DHS must validate that contracted agencies are making face-to-face contact with children, that they are performing safety assessments at each contact, and that the contacts are sufficiently frequent and adequate to determine the safety of the child.</p>	<p>Recommended by Panel: June 30, 2007</p>	<p>Completed &amp; On-Going</p>	<p>Moderate-level</p>
<p><b>Recommendation 3.c. (Page vi)</b></p> <p>DHS must establish Commissioner's Action Line (CAL).</p>	<p>Recommended by Panel: August 31, 2007</p>	<p>Completed Note: DHS established the Commissioner's Action Response Office (CARO)</p>	<p>Completed</p>

Panel Implementation	Timeframe	Status	Priority Level
<b>Leadership</b>			
<p><b>Recommendation 4.a.</b> (Page vi)</p> <p>DHS must establish a mechanism and process to establish ongoing community oversight. At a minimum, the City must establish a Community Oversight Board.</p>	<p>Recommended by Panel: The Board must be appointed no later than June 30, 2007</p>	<p>Completed</p>	<p>Completed</p>
<p><b>Recommendation 4.b.</b> (Page vii)</p> <p>DHS must ensure ongoing community participation and input into the improvements undertaken by DHS. This participation shall include, at a minimum, a series of ongoing town hall meetings, focus groups, and other events that facilitate the input of community members, private provider agencies, parents, clients, and other stakeholders.</p>	<p>Recommended by Panel: Plan of action must be in place by July 31, 2007</p>	<p>Completed &amp; On-Going</p>	<p>Moderate-Level</p>
<b>PHASE TWO Mission and Values</b>			
<p><b>**Recommendation 1.a.</b> (Page vii)</p> <p>DHS must align prevention programs and resources with mission and values developed in Phase One, and also with the core principle of ensuring child safety.</p>	<p>Recommended by Panel: Analysis to begin by November 30, 2007 and alignment to begin by November 30, 2008</p>	<p>In progress</p>	<p>Moderate-Level</p>
<p><b>**Recommendation 1.b.</b> (Page vii)</p> <p>DHS must align more effectively in-home service programs and their utilization with the mission and values of DHS and with child safety.</p>	<p>Recommended by Panel: Analysis to begin by July 31, 2007 and alignment and revisions to SCOH by March 31, 2008</p>	<p>Completed.</p>	<p>Moderate-Level</p>
<b>Practice</b>			
<p><b>**Recommendation 2.a.</b> (Page vii)</p> <p>DHS must develop a comprehensive model for social work practice that is based on DHS' core mission and values; includes a stronger focus on child safety, permanency and well-being; is family-focused and community-based; and allows for individualized services.</p>	<p>Recommended by Panel: May 31, 2008</p>	<p>In progress</p>	<p>Moderate-Level</p>

Panel Implementation	Timeframe	Status	Priority Level
<p><b>Recommendation 2.a.i</b> DHS must move toward an evidence-based practice model and take active steps to determine the effectiveness of its practice with an evaluation process that it open and informs good practice</p>	<p>Recommended by Panel: May 31, 2008</p>	<p>In progress</p>	<p>Moderate</p>
<p><b>Recommendation 2.a.ii.1</b> DHS must revise polices for case openings and closures – DHS must enhance the focus on team decision making to include team decision making for reviewing case closures. DHS must develop guidance for staff, and train them to work with cases where parents are uncooperative</p>	<p>Recommended by Panel: December 31, 2008</p>	<p>Completed &amp; In progress</p>	<p>High-Level</p>
<p><b>Recommendation 2.a.ii.2. (Page viii)</b> DHS must conduct a background check on each member in the child's household. If an adult household member has prior involvement with DHS or a criminal record that includes convictions for a felony that suggests danger for a child, then DHS must conduct an assessment to determine whether the household is safe and appropriate for the child.</p>	<p>Recommended by Panel: December 31, 2008</p>	<p>In planning</p>	<p>High-Level</p>
<p><b>Recommendation 2.a.ii.3 (Page viii)</b>  DHS must improve integration with physicians, nurses, and behavioral health specialists to ensure that each child's medical and behavioral health is appropriately assessed.</p>	<p>Recommended by Panel: December 31, 2008</p>	<p>Completed and On-going</p>	<p>Moderate-Level</p>
<p><b>**Recommendation 2.a.ii.4 (Page viii)</b>  DHS must reexamine the risk assessment in the context of the new safety assessment and integrate it into the new team decision making model for placement and services.</p>	<p>Recommended by Panel: December 31, 2008</p>	<p>Completed and On-going</p>	<p>Moderate-Level</p>
<p><b>**Recommendation 2.a.ii.5 (Page ix)</b>  DHS must eliminate "boilerplate" referrals and ensure that each child receives appropriate referrals that are specifically tailored for his or her unique needs. DHS will follow-up and act to ensure that the services are actually obtained.</p>	<p>Recommended by Panel: December 31, 2008</p>	<p>Completed and On-going</p>	<p>Moderate-Level</p>

Panel Implementation	Timeframe	Status	Priority Level
<p><b>Recommendation 2.a.ii.6</b> (Page ix)</p> <p>DHS must complete the long-planned co-location of DHS, police, medical and forensic interview personnel at a community site to facilitate collaborative decision making in the investigative phase of casework.</p>	<p>Recommended by Panel: December 31, 2008</p>	<p>In planning.</p>	<p>Low-level</p>
<p><b>Recommendation 2.a.iii.</b> (Page ix)</p> <p>DHS must enhance the frequency of face-to face contacts with children of all ages.</p> <p>Since face-to face contacts are the most important actions to ensure child safety, DHS staff must conduct a minimum of one face-to-face contact per month with each child in its care. More frequent contact may be warranted depending on the specific safety and risk factors in each case.</p> <p><b>Please note that DHS developed an alternative to this recommendation that conceptually identifies visitation frequency based on age and service category</b></p>	<p>Recommended by Panel: May 31, 2008</p>	<p>Completed and On-going</p>	<p>High-Level</p>
<p><b>Recommendation 2.a.iv.</b> (Page ix)</p> <p>DHS must clarify the role of supervisors to support the DHS practice model being implemented.</p>	<p>Recommended by Panel: March 31, 2008</p>	<p>In progress</p>	<p>Moderate-Level</p>
<p><b>Recommendation 2.a.v.</b> (Page ix)</p> <p>DHS must streamline its paperwork and records management practices.</p>	<p>Recommended by Panel: August 31, 2008</p>	<p>In progress</p>	<p>Moderate-Level</p>
<p><b>Recommendation 2.a.vi. and 2.a.vi.1.</b> (Page x)</p> <p>DHS must enhance the child fatality review process. DHS must ensure that the child fatality review is multidisciplinary and that there is a mechanism for implementing its recommendations</p>	<p>Recommended by Panel: December 31, 2007</p>	<p>Completed and On-going</p>	<p>High-Level</p>

Panel Implementation	Timeframe	Status	Priority Level
<b>Outcomes and Accountability</b>			
<p><b>Recommendation 3.a</b> (Page x)</p> <p>DHS must revisit and expand the list of outcomes to be measured- whereas Phase One was largely focused on child safety, Phase Two will expand the focus to include permanency and well-being measures.  <b>DHS articulated 5 practice areas/measures (repeat maltreatment, severity of repeat maltreatment and time between incidents of maltreatment, length of stay, changes in levels of care, and reentry)</b></p>	<p>Recommended by Panel: Beginning June 1, 2008, following the development of the first DHS annual report card</p>	<p>Completed</p>	<p>High-Level</p>
<p><b>Recommendation 3.b</b> (Page x)</p> <p>DHS must link its performance and the performance of its contracted providers to outcomes of accountability, including financial incentives.</p>	<p>Recommended by Panel: June 1, 2008</p>	<p>In progress</p>	<p>Moderate-Level</p>
<b>Leadership</b>			
<p><b>Recommendation 4.a.</b> (Page x)</p> <p>DHS must continue to expand its emphasis on making DHS a more transparent agency.</p>	<p>Recommended by Panel: Develop plan by June 30, 2008 and implementation to begin by August 1, 2008</p>	<p>In progress</p>	<p>Low-level</p>
<p><b>Recommendation 4.b.</b> (Page x)</p> <p>DHS must take positive steps to enhance the healthiness of infrastructure and staff morale</p>	<p>Panel recommended: March 31, 2008</p>	<p>In progress</p>	<p>Low-level</p>
<p><b>Recommendation 4.c.</b> (Page xi)</p> <p>DHS must enhance its ability to proactively and transparently manage crisis, including strengthening process related to child death reviews and increasing public access to information.</p>	<p>Recommended by Panel: March 31, 2008</p>	<p>Completed and On-going</p>	<p>Low-level</p>

**APPENDIX B. REPORT ON PROGRESS AREAS OF CONCERN CITED  
IN THE COMMUNITY OVERSIGHT BOARD'S JANUARY 2009  
REPORT TO MAYOR NUTTER (JUNE 24, 2009)**

COB Cited Area of Concern (CWRP Recommendation #)	Panel Timeframe	Status	Accomplishments/Updates/ Next Steps
<b>PHASE ONE RECOMMENDATIONS</b>			
DHS must implement and use an adequate evidence-based safety assessment tool <sup>19</sup> . (2.a.i) Please note that this involves the development of two different tools. One for investigations and in home safety assessments and another for evaluating safety of children in placement.	June 30, 2007	Investigation and in-home protection safety assessment: Through 2007-2008, DHS completed the development and implementation of a safety assessment process and tool for investigations and ongoing in-home services.  Placement safety assessment tool: Fall 2009	Investigation and In-home protection safety assessment tool: <ul style="list-style-type: none"> <li>• Safety assessment training is on-going and is often facilitated through DHS' Transfer of Learning (TOL) sessions for all social work staff. TOL sessions are offered on an on-going basis with each unit within DHS experiencing TOL a minimum of every nine weeks.</li> <li>• On May 6, 2009, DHS and the Law Department conducted a joint training for court staff and attorneys on the safety model of practice and the safety assessment tool.</li> <li>• DHS' Quality Assessment team reviews over 150 safety assessments monthly and provides individual feedback to the chain of command. This process is on-going.</li> </ul> Placement safety assessment tool: <ul style="list-style-type: none"> <li>• DHS is in the process of finalizing an interim safety assessment tool for placement until the Department of Public Welfare (DPW)/Office of Children, Youth and Families (OCYF) issues a tool.</li> <li>• DHS consulted with Casey Family Programs Breakthrough Series Collaborative</li> <li>• DHS developed a tool called "structured case notes" which documents the quality visitation</li> </ul>

<sup>19</sup> Even though CWRP Recommendation #2.a.i. is not cited as an area of concern in the COB's January 2009 Report, the development of a tool to assess safety of children in placement is still being developed.

COB Cited Area of Concern (CWRP Recommendation #)	Panel Timeframe	Status	Accomplishments/Updates/ Next Steps
			<p>reflecting safety and well-being for youth in placement. This was presented to COB on May 22, 2009</p> <ul style="list-style-type: none"> <li>• DHS revised the tool based on COB feedback. Our next steps include: <ul style="list-style-type: none"> <li>○ Getting feedback from Labor Management, DHS line staff, and provider workers</li> <li>○ Automating the form and making it web-based so that the data from the form can be incorporated in our computerized case management system</li> </ul> </li> </ul>
<p>DHS must conduct a safety assessment for every child within its care – both children at home and children in out-of-home placements. The safety assessment must be updated at each contact with the child (2.a.ii.)</p>	<p>September 30, 2007</p>	<p><b>In home safety visits:</b> Initially completed: February 2007. However, this is an on-going initiative for the Department.</p> <p><b>Placement safety visits:</b> Initial push was for children 5 and under in placement in the 5 county area to be seen immediately. This was completed.</p> <p>Placement safety visits is on-going initiative for the DHS.</p>	<p><b>In home safety visits:</b> DHS completed safety visits for all children receiving in home services as of February 2007.</p> <p><b>Placement safety visits:</b></p> <ul style="list-style-type: none"> <li>• All children in placement had their safety assessed within the past six months as part of DHS' current practice.</li> <li>• In addition, DHS will use its own safety visit guidelines to do a more structured safety visit with all children in placement. DPW has approved DHS' use of their own safety visit guidelines for placement while DPW is developing their own tool. (see above section for comments on tool development)</li> </ul>
<p><b>PHASE TWO Mission and Values</b></p>			
<p>DHS must develop a comprehensive model for social work practice that is based on DHS' core mission and values; includes a stronger focus on child safety, permanency and well-being; is family-focused and community-based; and allows for individualized services. (2.a.)</p>	<p>Recommended by Panel: May 31, 2008</p>	<p><b>Safety Model of Practice Developed and Implemented:</b> 2007-2008</p> <p><b>Development and implementation of a comprehensive model for social work practice:</b> TBD</p>	<p><b>Safety Model of Practice:</b></p> <ul style="list-style-type: none"> <li>• DHS has implemented a comprehensive approach to incorporating safety assessment into all aspects of decision making through the life of a family's interaction with DHS.</li> <li>• Decision making is driven by the assessment of active safety threats, degree of severity, vulnerability of child, imminence of the anticipated event and the protective capacities of the primary</li> </ul>

COB Cited Area of Concern (CWRP Recommendation #)	Panel Timeframe	Status	Accomplishments/Updates/ Next Steps
			<p>caregiver.</p> <ul style="list-style-type: none"> <li>• Children who are not experiencing active safety threats but have other risk or well-being needs are referred for less intrusive community based services. Consequently, DHS has developed a continuum of services that correlates with threats of safety. These services include (listed from least intrusive to most): <ul style="list-style-type: none"> <li>○ Community Based Prevention Services – provides supportive services for any family in the City of Philadelphia</li> <li>○ Alternative Response System – provides up to 90 days of supportive services who become known to the Department through the hotline but where the allegations do not rise to the level of having an “active safety threat”</li> <li>○ Rapid Service Response – provides up to 60 days of immediate supportive and safety services for families who become known to DHS through the hotline and where the allegations rise to the level of a possible safety threat.</li> <li>○ Family Stabilization Services – provides supportive services for families who become known to DHS through the hotline and who at the close of the investigation are found to be “safe” by DHS but are court ordered to be monitored by DHS.</li> <li>○ Teen Diversion – provides supportive service families with adolescents at-risk of placement</li> <li>○ In Home Protective Services – provides up to 180 days of intensive safety services for families experiencing active safety threats.</li> </ul> </li> </ul>

COB Cited Area of Concern (CWRP Recommendation #)	Panel Timeframe	Status	Accomplishments/Updates/ Next Steps
			<p><b>Development and implementation of a comprehensive model for social work practice:</b></p> <ul style="list-style-type: none"> <li>• DHS has implemented many components, such as Hotline Guided Decision Making, Family Group Decision Making, Safety Assessments, the development of an Educational Support Center, of an effective model for social work practice. However, DHS has yet to articulate a unified model of practice.</li> <li>• DHS' next steps include: <ul style="list-style-type: none"> <li>○ Finalizing model draft for staff and COB Work Group review</li> <li>○ Presenting model at next COB meeting</li> <li>○ Develop implementation plan which will include: <ul style="list-style-type: none"> <li>▪ Incorporating the model into training for on-going staff, new staff with On-the-Job-Training, and supervisors' training</li> </ul> </li> </ul> </li> </ul> <p><b>DHS' Newly Formed Division of Performance Management and Accountability (PMA)</b></p> <ul style="list-style-type: none"> <li>• Susan Kinnevy, Ph.D. was named Deputy Commissioner of PMA on January 20, 2009. It consists of 4 units (Performance Management, Quality Improvement, Provider Relations and Evaluation of Programs, and Data, Information and Management).</li> <li>• The Division's Mission is to: <ul style="list-style-type: none"> <li>○ Track the efficiency and effectiveness of our services (internal and external)</li> <li>○ Ensure the alignment of all agency initiatives, mandates and programs with the core values and goals: safety, permanency and well-being</li> <li>○ Utilize a data driven and evidence-based approach in guiding a best practice model of service delivery; and</li> <li>○ Ensure data collection and dissemination is streamlined to</li> </ul> </li> </ul>

COB Cited Area of Concern (CWRP Recommendation #)	Panel Timeframe	Status	Accomplishments/Updates/ Next Steps
			<p>support strategic development of the agency</p> <ul style="list-style-type: none"> <li>• Some of the Division's major initiatives include: <ul style="list-style-type: none"> <li>○ Development of a performance management system</li> <li>○ Development of random case file review process</li> <li>○ Streamlining and integration of agency databases</li> <li>○ Development of electronic case management system</li> <li>○ Review and reform of provider evaluation instruments and standards</li> <li>○ On-going development and refinement of ChildStat program</li> <li>○ Collaboration with Family Court and the City's Department of Technology with data integration</li> </ul> </li> </ul>
<p>DHS must conduct a background check on each member in the child's household. If an adult household member has prior involvement with DHS or a criminal record that includes convictions for a felony that suggests danger for a child, then DHS must conduct an assessment to determine whether the household is safe and appropriate for the child. 2.a.ii.2.</p>	<p>Recommended by Panel: December 31, 2008</p>	<p>December 31, 2009</p>	<ul style="list-style-type: none"> <li>• DHS has consistently conducted background checks as required by law and regulation.</li> <li>• DHS will continue to use the procedures currently in place for searches on potential foster/kinship caregivers and household members, and potential adoptive parents and household members.</li> <li>• At the May 22, 2009 COB Meeting, DHS presented a draft policy and procedure guide for "Criminal History Clearances for Investigations and Reunifications" and a corresponding implementation plan.</li> <li>• DHS is recommending that this initiative be phased in by beginning with reunification cases to ensure access to all relevant information to conduct the clearances as a prerequisite to returning the child.</li> <li>• DHS has assigned Oswald Smalls, Director of Focused Services, to oversee this initiative.</li> <li>• Target timeline for implementation is 6 months</li> </ul>

COB Cited Area of Concern (CWRP Recommendation #)	Panel Timeframe	Status	Accomplishments/Updates/ Next Steps
<p>DHS must enhance the frequency of face-to face contacts with children of all ages. Since face-to face contacts are the most important actions to ensure child safety, DHS staff must conduct a minimum of one face-to-face contact per month with each child in its care. More frequent contact may be warranted depending on the specific safety and risk factors in each case. 2.a.iii.</p>	<p>Recommended by Panel: May 31, 2008</p>	<p>DHS Timeframe: On-going</p>	<ul style="list-style-type: none"> <li>• The Department has over time created a number of visitation mandates through policy, contracts, and practice. DHS understands that visitation provides the ability to assess safety, permanency, well-being; to judge progress; and to address the concerns of the youth.</li> <li>• Three specialty units within DHS require monthly visitation: <ul style="list-style-type: none"> <li>o Medically needy – in home</li> <li>o Family reunification</li> <li>o Sex abuse – in home</li> </ul> </li> <li>• DHS has developed an alternative to the COB’s recommendations for monthly visits by DHS staff for all placement cases. It was presented at the May 22, 2009. Conceptually it identifies visitation frequency based on age of youth and service category.</li> <li>• DHS intends to consider the correlation between service level and maltreatment in determining visitation frequency and will modify its proposed visitation standards based on its findings.</li> <li>• DHS is also finalizing structured case notes to capture information during visits and developing a web-based system for providers and DHS to input the structured case notes</li> </ul>
<p>DHS must enhance the child fatality review process. DHS must ensure that the child fatality review is multidisciplinary and that there is a mechanism for implementing its recommendations. 2.a.vi.1.</p>	<p>Recommended by Panel: December 31, 2007</p>	<p>April 2007 DHS created a “Rapid Response Fatality Review Team” to respond immediately to notices of fatalities and to gather critical information.</p> <p>April 2009 DHS implemented the Act 33 Review Team</p>	<ul style="list-style-type: none"> <li>• On May 18, 2009, DHS Commissioner issued a Policy on Near Fatalities and Fatalities, an Act 33 Review Team Protocol, and uniform letters to Hospital Administrator to assist them in reporting “near fatalities”.</li> <li>• DHS assigned Benita Jones, Administrator to be the DHS operational champion for these reviews. She will work with Dana S. Wilson, Director of Performance Management to manage and facilitate the child fatality and near fatality review process.</li> <li>• Act 33 Review Teams convene on the first and third Fridays of every</li> </ul>

COB Cited Area of Concern (CWRP Recommendation #)	Panel Timeframe	Status	Accomplishments/Updates/ Next Steps
			<p>month. It is an opportunity to share information between DHS, medical providers, law enforcement and other social service agencies. The fact that the reviews are held so close in time to the report being made (within 31 days) it is helpful for implementing service suggestions for families as well as providing guidance to DHS with their investigations. It will also allow for the timely implementation of recommendations.</p>
<p>DHS must expand the use of Family Group Decision Making (FGDM) to all children and utilize specialized resources in the case-planning process.</p>	<p>12/08</p>	<p>June 30, 2009 – the target is the capacity for 120 referrals</p>	<ul style="list-style-type: none"> <li>• DHS has completed 41 FGDM since its inception. For the month of April 2009, there were a total of 14 completed reports.</li> <li>• DHS experienced an increase of 38% in referrals during the month of April 2009.</li> <li>• Our capacity development plan has been successful with capacity at 20/month in February, 45/month in March, 75/month in April, and 120/month by June 30, 2009.</li> <li>• DHS will encourage and require staff to make referrals. Leadership recognizes that it is a cultural shift for the agency, but is committed to the model.</li> <li>• The Jerry Lee Center will conduct the program evaluation.</li> </ul>



## **APPENDIX C. FEDERAL AND STATE MONTHLY VISITATION REQUIREMENTS FOR CHILDREN IN DHS CARE**

### **FEDERAL AND STATE MONTHLY VISITATION REQUIREMENTS FOR CHILDREN IN DHS CARE**

The team based the following summary on a review of the Pennsylvania Office of Children, Youth, and Families (OCYF), PA Department of Public Welfare Bulletin #: 3490-08-03, issued May 1, 2008, Subject: Frequency and Tracking of Caseworker Visits to Children in Federally Defined Foster Care, By: Richard J. Gold, Deputy Secretary of Children, Youth and Families. Types of child placements subject to the following visitation requirements include: non-relative foster family homes; kinship foster homes; group homes; emergency shelters; pre-adoptive homes, including non-subsidized; residential facilities (non-JCAHO, non-COA, or CARF accredited); and child care institutions, public or private, with no more than 25 beds.

#### **Summary of Child Visitation Requirements**

The OCYF requires monthly case worker visits to dependent and shared case management children under the care and responsibility of the county children and youth agency and juvenile probation office. Case workers must make at least one visit with a child for each calendar month the child is in care, preferably at the child's residence. A child's residence is considered to be the home or facility where the child is living, whether in-state or out-of-state. The residence may also be the home from which the child was removed, if the child is on a trial home visit, but still considered to be in foster care. Visits must be well planned and focused on issues pertinent to case planning and service delivery to ensure the safety, permanency, and well-being of children.

With guidance from the federal Administration for Children and Families (ACF), the OCYF defines monthly visits as face-to-face contacts by a qualifying worker. OCYF defines a qualifying case worker as a person with case management or case visitation responsibilities for a particular case. Qualifying case workers include:

- The county children and youth worker;
- The juvenile probation officer;
- The private provider agency with which the county has an agreement to provide services, including visitation management;
- The foster care facility case manager with global case management responsibilities, including family visitation and service coordination; and/or
- In out-of-state cases, a counterpart of these same legal entities.

For children under shared case management of children and youth and juvenile probation, the worker responsible for case planning and visitation is the worker responsible for the monthly visit. Each county must determine which agency carries those responsibilities.

For children placed out-of-state, the agency in the other state engaged through the Interstate Compact Office to provide supervision and visitation, can fulfill the monthly visiting requirement. To ensure that visits are timely, the case worker of the state agency of the State in

which the home of the parents of the child is located, or the case worker of the state in which the child has been placed, may visit the child in the home or institution and submit a report on the visit to the state agency of the state in which the home of the parents is located.

If the county agency contracts with a private provider to conduct monthly visitations for children placed out-of-state, the county children and youth agency must also visit the child once every six months in accordance with the federal fiscal year (October 1<sup>st</sup> – September 30<sup>th</sup>). This means that one visit must be made between October 1<sup>st</sup> and March 31<sup>st</sup>, and a second visit must be made between April 1<sup>st</sup> and September 30<sup>th</sup>. The qualifying worker may be the child's primary worker, or another agency worker who has a child placement in the placement setting, as well as a worker from the state in which the child has been placed.

Likewise, if the county agency contracts with a private provider to conduct monthly visitations for children placed in-state, the worker from the county children and youth agency or juvenile probation agency with care responsibility for the child must visit the child at least every six months.

To promote service continuity and make optimum use of agency staff and fiscal resources, OCFY recommends that county agencies consider the following:

- Assign one worker to multiple children placed in homes or facilities, whether in-state or out-of-state, that are located 50 or more miles from the county agency, and for whom there is no private agency worker involved; and
- Delegate one worker to fulfill the monthly visitation responsibility in cases that meet all of the following criteria: 1) There are several same county agency children, with different case workers; 2) The children are placed at the same home or facility; and 3) The home or facility is located more than 50 miles, one way, from the agency.

OCFY caveats to these suggestions include:

- Each worker must see the child on his/her caseload at least once every six months, but should consider quarterly visits to provide contact continuity for the child.
- In months when visits are delegated to another worker, each worker must call the child on his/her caseload to alert the child, give the name of the worker who will visit, and ask the child what is needed or wanted from him/her.
- Each worker should provide to the visiting worker an agenda to cover during the face-to-face visit with the child;
- The child should be assured that any concerns raised during the visit will be reported to his/her own worker; and
- "Group" visits are not acceptable; each child must be seen for an individual "face-to-face" visit for some portion of the home/facility visit.

## **APPENDIX D. THE CHILD STAT PROCESS**

### The Purpose of the Child Stat Process

The Child Stat process was developed to be used as part of a larger Continual Quality Improvement process surrounding practice at the Department of Human Services. Through this process data is collected from various parts of the system and performance is measured. The Child Stat meeting serves as a forum for participants to review this data and to ask questions about what needs to occur in order for the Department to be more effective.

The Child Stat meeting also serves as a process to break down silos and to increase communication and accountability across the agency. Through this process representatives from each division and service area in the agency are provided an opportunity to focus on how their work affects others' work and contributes to the larger success of the organization.

### The Process

Each month one DHS Region participates in the Child Stat process. The Director, each of the Administrators, and the Supervisor and Social Worker team connected to a case presentation, are expected to attend. In addition to the members of the DHS Region, the Commissioner, Deputy Commissioners, and Directors from each area of the Department are also in attendance. Other outside stakeholders, such as representatives from the state, school district and the behavioral health system also participate.

### The Welcome Statement

Each Child Stat meeting begins with a welcome statement which includes a review of the Department's mission statement and the purpose for the Child Stat meeting. The purpose of the welcome statement is to begin each meeting by helping participants focus on the role that they play in improving outcomes for children and families and how this role fits into the larger context.

“We would like to welcome everyone to Child Stat. We are here because it is our mission to provide and promote safety and permanent homes 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 safety, stability, and well-being. We partner with families, communities, providers, advocates, and each other to develop and deliver preventive and culturally appropriate services that are consistent with the needs of Philadelphia's children. Child Stat is specifically designed so that we can each be accountable for our portion of this important work, know how our individual work fits in the larger context, and to support us in working together for better outcomes for children and families.”

### Data Presentation

Each Child Stat meeting lasts for approximately two hours and is organized into four parts. The first portion of a Child Stat meeting consists of a presentation of data that is collected through the quality improvement case review process. This case review process includes information concerning the quality and consistency of safety assessments, safety planning, and service planning. Data specific to outcomes and work performance are also gathered by the Quality Improvement (QI) team. Some examples of this data include timeliness to permanency, monthly visits, ability to move cases to the Adoption Region, ability to complete investigations in a timely manner, and case load size.

### Support in Being More Effective

During the second portion of the Child Stat meeting the moderator specifically asks the DHS Region staff what supports they feel are needed in order for them to be more effective in their work. Although many of these issues are raised during the data presentation, this portion of the meeting is included to further encourage collaboration between the various areas of the Department and to encourage a supportive atmosphere for the front line staff.

### Case Presentation

The work completed on a specific case is presented by the Director of the DHS Region during the third portion of the Child Stat meeting. Because this case is selected and reviewed by the Quality Improvement team two weeks previous to the Child Stat meeting, participants at the Child Stat meeting are provided access to the quality of the safety assessment, safety plan, and the family service plan for this specific family. Other support centers, such as mental health and medical, are also able to provide documentation regarding their interactions with the family.

### Recognizing Outstanding Performance

During the final portion of the Child Stat meeting, the group takes the time to acknowledge outstanding work done by line staff. The outstanding work does not need to be tied to the case that was presented but should have occurred since the time of the last Child Stat meeting. One to three staff are selected by the Director of the region and are presented with a certificate by the Deputy Commissioner of Children and Youth.

### The Experience So Far

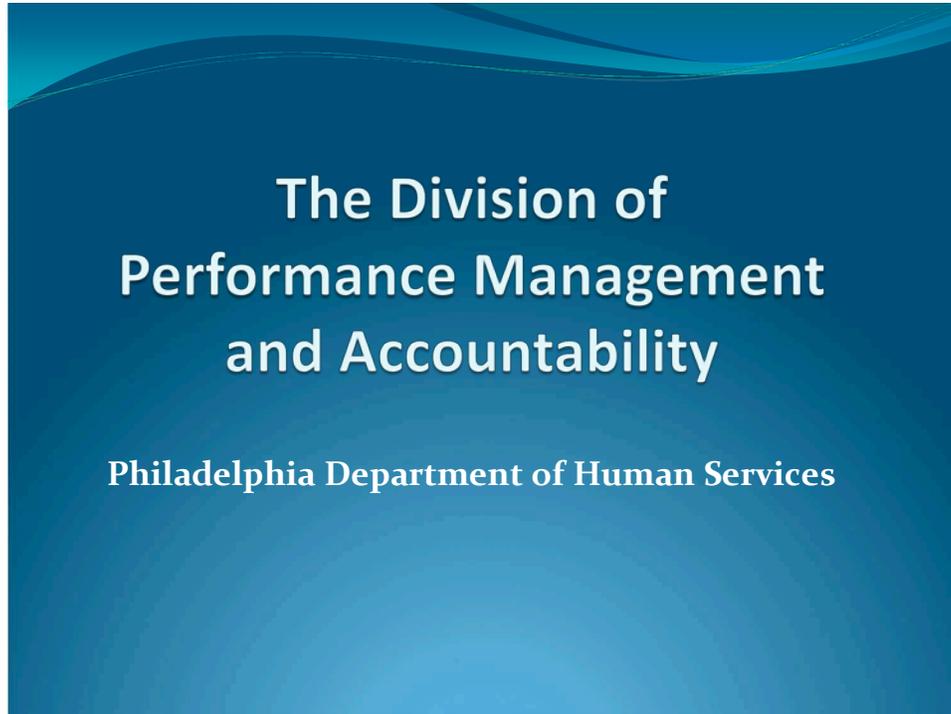
The Child Stat process at the Department of Human Services (DHS) began in February 2009. Since that time Child Stat meetings focusing on the Ongoing Service Regions have occurred on a monthly basis. Since there are three Ongoing Service Regions, each region has experienced Child Stat on two occasions. In July 2009, the Department also held its first Child Stat meeting for the Investigation Sections. DHS anticipates conducting this process for the Investigation Sections every other month.

DHS has found that there is certainly an increased level of accountability present for the DHS Region staff asked to participate in the Child Stat process. Data for each section is compared to each other and the data for the region is compared to overall agency performance. The work on a specific case is also reviewed. Both over performing and under performing sections become apparent through this process.

There is also an increased level of accountability present for the other participants in the room. When issues that affect the line workers' ability to be effective are brought to light, it is the expectation that the right people are in the room to make improvements to the overall process. Without the participants in attendance who have the power and ability in the organization to make decisions and positive change in there area of influence, the process would be unbalanced. Their presence allows the agency to make this a supportive process for the staff who then can translate this work into concrete interactions with children and families.



## APPENDIX E. THE DIVISION OF PERFORMANCE MANAGEMENT AND ACCOUNTABILITY



## Division Leadership



## RESPONSIBILITIES

### Director of Performance Management

- Develop, implement, and monitor agency-wide performance management system
- Identify and facilitate continuous improvement of the overall processes across the entire agency
- Manage and facilitate child near fatality and fatality review process
- Consult with Provider Relations and Program Evaluation Unit (PREP) on streamlining evaluation tools and revising standards

## RESPONSIBILITIES

### Director of Performance Management

- Consult with DHS Reform Team and track progress via the PhillyStat process
- Consult with new Education Support Center to develop outcome measures on child well-being with regard to educational attainment
- Represent the Division on the Leadership Advisory Council

## RESPONSIBILITIES:

### Director of Provider Relations and Program Evaluations (PREP)

- Provide oversight for Central Referral Unit (CRU) and CANS assessment process
- Monitor compliance and quality of our contracted provider community and support improvement effort
- Investigate complaints pertaining to provider performance and develop plans of correction
- Facilitate Provider Accountability Forum

## RESPONSIBILITIES:

### Director of Provider Relations and Program Evaluations (PREP)

- Review and update existing contract standards; develop standards for new contracted programs, e.g. expansion of PBC programs
- Collaborate on the RFP, proposal review and grant award process
- Conduct consumer satisfaction reviews
- Support the upcoming random case file review process

## RESPONSIBILITIES

### Director of Quality Improvement

- Monitor the agency's safety model of practice to ensure fidelity to the principles of the model
- Monitor internal staff's ability to interpret data collected through safety and risk assessments and use it to inform practice decisions
- Conduct case reviews around practice issues internal to the department and provide clear feedback to CYD, CBPS, and JJS staff
- Organize and facilitate workgroups in identified areas aimed at improving the quality of practice

## RESPONSIBILITIES

### Director of Quality Improvement

- Assist in the development and implementation of our new electronic case management system
- Co-facilitate ChildStat and lead the upcoming random case file review process
- Ensure that results of case file reviews are shared appropriately and used to improve quality of practice
- Supervise MSW interns and part-time social work staff

## RESPONSIBILITIES:

### Director of Data Information and Management

- Collaborate with Systems to develop and maintain databases
  - Data extraction; data monitoring; technical assistance
- Data integration and data warehouse
  - Integrate data from independent agency databases and external sources
  - Strengthen the capacity of the warehouse to provide systematic and timely reports for use inside and outside the Agency

## RESPONSIBILITIES:

### Director of Data Information and Management

- Data analysis and support
  - Support the work of the division and the agency as a whole
  - Work closely with the MIS staff to improve data quality and to create a culture in which data is used to improve performance at all levels of the organization
  - Ongoing analysis of performance and outcome measures agency-wide
  - Creation, maintenance and dissemination of ongoing data reports

## RESPONSIBILITIES: Special Advisor

- Work closely with Deputy Commissioner to facilitate relationships and interactions with outside stakeholder groups and cross-divisional collaborative projects
  - OCYF
  - NGA
  - PIP
- Lead State and Federal monitoring, evaluation, and program improvement activities
  - Annual State Inspection
  - Plan of Correction/LIS
  - CFSR
- Serve on Homeless Fatality Review Team
- Serve on Youth Advisory Board
- Special Initiatives (TBD)

## RESPONSIBILITIES

### Deputy Commissioner

- Oversee all functions of the the Division of PM&A
- Member of Commissioner's Executive Staff
- Member of Fatality Review Team
- Member of Planning Committee for the Family Court Data Project
- Member of the Planning Committee for the Education Support Center
- Strategic Planning for growth of the Division within the Agency
- Strategic Planning with the Department of Technology for enhancement of the Agency's technological profile

## RESPONSIBILITIES

### Deputy Commissioner

- Lead in the development of appropriate outcome measures related to safety, permanency and well-being
- Lead in the development of data reports appropriate for internal and external dissemination
- Ongoing review of Agency's data needs and upgrading of Agency's data proficiency
- Ongoing review of Agency performance
- Ongoing review of Provider performance
- Ongoing collaboration with OCYF
- Participation in state-wide activities through PIP

## MAJOR DIVISION INITIATIVES

- Development of a performance management system
- Development of random case file review process
- Streamlining and integration of agency databases
- Development of electronic case management system
- Review and reform of provider evaluation instruments and standards

## RANDOM CASE FILE REVIEWS: Phase I

- Adapted from Utah's quality service reviews which double score the cases: one score for the system and one for the child/family
- Will use a team approach: 1 administrator from CYD, 1 supervisor from PREP, 1 supervisor from Quality Improvement, and 1 representative from the provider community
- Review instrument will combine elements of our current internal case file reviews on the safety model with CFSR measures and some of the measures used in Utah



## RANDOM CASE FILE REVIEWS: Phase I

- Verification with the family
- Pilot project being developed for implementation in the fall – will use IHPS cases because provider base is small
- Will learn through the pilot how long the process takes, how many cases we can reasonably expect to complete each month, whether the process should be quarterly, etc.