# COUNCIL OF THE CITY OF PHILADELPHIA

## COMMITTEE OF THE WHOLE

Room 400, City Hall
Philadelphia, Pennsylvania
Wednesday, April 17, 2013
10:30 a.m.

PRESENT:
COUNCIL PRESIDENT DARRELL L. CLARKE
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COUNCILWOMAN MARIAN B. TASCO

BILLS 130178, 130179, and 130180
RESOLUTION 130190

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COUNCILMAN GREENLEE: Good morning, everyone.

(Good morning.)

COUNCILMAN GREENLEE: Sorry for the delay. I know we're a little behind here, but I appreciate your patience.

This is the public hearing of the Committee of the Whole regarding Bill Nos. 130178, 130179, 130180, and Resolution No. 130190.

I would ask Ms. Lewis to please read the titles of the bills and resolution.

MS. LEWIS: Bill No. 130178, an ordinance to adopt a Capital Program for the six Fiscal Years 2014 to 2019 inclusive.

Bill No. 130179, an ordinance to adopt a Fiscal 2014 Capital Budget.

Bill No. 130180, an ordinance adopting the Operating Budget for Fiscal Year 2014.

And Resolution No. 130190, providing for the approval by the Council

of the City of Philadelphia of a Revised Five Year Financial Plan for the City of Philadelphia covering Fiscal Years 2014 through 2018, and incorporating proposed changes with respect to Fiscal Year 2013, which is to be submitted by the Mayor to the Pennsylvania Intergovernmental Cooperation Authority (the "Authority") pursuant to the Intergovernmental Cooperation Agreement authorized by an ordinance of this Council approved by the Mayor on January 3rd, 1992 (Bill No. 1563-A), by and between the City and the Authority.

COUNCILMAN GREENLEE: Thank you, Ms. Lewis. You're getting really good at that.

Our first department will be Department of Behavioral Health and Intellectual disAbility Services. If Dr. Evans could come forward.

And while he's coming up, I just want to make an announcement that tonight at 6 o'clock, 6:00 p.m., City

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Council will hold a neighborhood budget hearing at Penns Landing Caterers, better known as the Sheet Metal Workers Hall, as 1301 South Christopher Columbus Boulevard. That's at 6 o'clock tonight for public testimony.

(Witness approached witness table.)

COUNCILMAN GREENLEE: Good morning.

DR. EVANS: Good morning.

COUNCILMAN GREENLEE: Nice to see you. Dr. Evans, you have a fair long testimony here, so we would ask that you -- that will be made part of the record and that if you could --

DR. EVANS: I don't get to do the whole thing?

COUNCILMAN GREENLEE: No. I know we all like to hear it, but just in the interest of time, we would ask that you please summarize and then we'll have questions. Thank you.

DR. EVANS: And I have prepared

to summarize it.

COUNCILMAN GREENLEE: Thank you.

DR. EVANS: So good morning, Councilman Greenlee, members of Council. My name is Dr. Arthur C. Evans. I'm the Commissioner for the Philadelphia Department of Behavioral Health and Intellectual disAbility Services, and I'm here to present our testimony on our FY2014 budget.

The FY2014 budget requests $1.2 billion in the General Fund -- I'm sorry; $1.2 billion, 13.8 in the General Fund, 253 million in the Grants Revenue Fund, and 903 million in the HealthChoices Behavioral Health Fund.

Our major accomplishments over the past year include enhancing minority, women, and disabled-owned businesses and staff diversity. The Department continues to be committed to supporting the Administration's goals for minority, women, and disabled-owned businesses.

While our DBHIDS goals for participation was set at 8 percent for our for-profit participation, the Department was able to achieve 15 percent participation, and we've done this through a variety of ways, including continued support for the Office of Economic Opportunity's efforts to build supplier diversity programs within the not-for-profit sector by a variety of methods, including sending OEO requests for proposals for range setting, inviting OEO to participate in pre-bid meetings and RFP pre-proposal meetings and evaluation teams, as well as participating in OEO non-profit leadership team.

In terms of departmental diversity, the Department has 237 current full-time employees. This complement is comprised of 170 females and 67 males; 137 of the females are minority, 33 are Caucasian; in terms of males, 38 are minority, 29 are Caucasian.

In terms of other

accomplishments, I'll just quickly summarize some of the areas that we've been working on.

One of the things that I'm very proud of is the expansion of the availability of state-of-the-art treatments. We continued to employ and deploy evidence-based practices throughout our service system, and in this year, we are creating a center called the Evidence-Based Practice and Innovation Center, which will help to both systematically disseminate and implement evidence-based practices, as well as to help shape the scientific literature in this area.

We are continuing our efforts around health reform, a major issue for the Department. We're doing that through a variety of means, including trainings for providers, webinars and so forth.

Mental health first aid, as you probably know, is one of the cornerstones of the President's initiative around

mental health, and I'm really pleased to say that Philadelphia has already become a national leader in promoting mental health first aid. It is a groundbreaking, early intervention, public education program that teaches the community in terms of how to assist and identify people who might be experiencing mental health challenges and then to connect them to appropriate services. Our goal for the next two years is to train at least 10,000 individuals in Philadelphia over the next couple of years, and we're doing that through a variety of means.

We continue to do pay for performance. Our pay performance program is designed to improved clinical outcomes for children and adults receiving services. It's done by tying financial incentives to an array of important performance indicators. Over the last four years, our pay-for-performance program has greatly expanded and now

involved over 60 measures across ten levels of care, and at this point, we are covering about 90 percent of our service system in terms of using pay for performance as a way of generating additional revenue as opposed to the traditional method of giving cost of living allowances.

Our Intellectual disAbilities Unit manages our early intervention program. This program has continued to increase the number of children zero to three who are accessing that program and receiving those services. One of the things we're very proud of is that that program is very highly rated, and the staff, they do a really great job of managing that program, but more importantly, the children who receive those services often no longer need those services prior to entering school. So the program has been very important in terms of intervening early with children and changing their developmental

trajectory such that they no longer need those services in order to be successful in school.

Finally, I want to mention our efforts around trauma-informed services and trauma-informed community, which we're trying to create. We're doing that through a partnership with a variety of governmental and community-based organizations, including the Department of Human Services, the School District, our criminal justice system, and we've established a number of trauma-related services. As many of you know, trauma is, particularly in urban areas, is a very significant issue that has significant psychological impact on people, and we believe that if we can intervene early, we can change and reduce the impact of trauma, as well as to treat people who may have post traumatic stress or other kinds of stress-related disorders. Some of the examples of this are our community response teams where we

send out professionals after a community shooting or some kind of community traumatic event to educate the community and to provide information on how to access services if they are so needed.

We also recently received a grant for $1.6 million from the federal government to do a child traumatic stress program that will help to identify children who have experienced trauma and to intervene early with them in settings like pediatric settings.

And, finally, we are training a number of our providers in state-of-the-art trauma treatments, which will improve the kinds of clinical outcomes that we can give for people who have experienced trauma.

The last thing that I'll mention is that in terms of where I think we need to focus over the next year, one of the most important things I believe that we can focus on is the expansion of Medicaid, which will allow many more

people, we estimate somewhere in the range of 75,000 more individuals, who are uninsured to access healthcare services. That does two things. One is that it allows people to access the services, but it also frees up other dollars and resources that we're currently using for the uninsured. We will be able to shift those dollars to provide services that we currently cannot fund, programs like early intervention programs and prevention programs.

So with that, I'll conclude my summary comments, and we look forward to working with City Council, other stakeholders to continue to advocate for resources that will ensure that we are optimally and comprehensively responding to the behavioral health and intellectual disability needs of our citizens.

Thank you.

COUNCILMAN GREENLEE: Thank you, Dr. Evans.

Do you have anything yourself,

sir?

MR. COVONE: No.

COUNCILMAN GREENLEE: Just a couple quick questions to kind of follow up on one of your last points. On Page 7 of the testimony, you talk about the elimination of General Assistance payments and the major impact it would have, which we can imagine. Two-part question. Could you kind of quantify the amount of people who might be affected by this gap, and I guess the other part is, how much this could potentially cost the City.

DR. EVANS: Well, just to step back a moment. For General Assistance -- for the Medical Assistance program in Philadelphia, the City gets paid a capitation, which simply means we get paid a per member per month. Last year we had about 470,000 people in Philadelphia who had medical assistance. We got paid a per member per month capitation fee for each of those

individuals, and we were responsible for providing all of their behavioral healthcare.

The General Assistance population is a subset of that 470,000 people, and a couple of things have happened. One is that some of those people shifted to other categories, but the biggest change has been a reduction in the number of people in that particular category. So that means that less revenue has come into the City. Our numbers are about 37 percent of -- we've seen about a 37 percent reduction in people in that category of aid, and so our revenue has also been reduced by a comparable amount for that particular category.

The other complication with the General Assistance cut is that the cash benefit was cut, even though the category was not eliminated. What that did is a couple of things. One is that we believe that a lot of people who lost the cash

benefit believed that they were no longer eligible for General Assistance and then did not do the things that they needed to do to keep the entitlement. That is part of the impact. But we also think that for some people who lost the cash benefit, they no longer saw the importance of having the entitlement and no longer continued to do that.

So the cash benefit has been an issue, and the other challenge with that is that people use -- even though it was a very small amount, people use that cash benefit to access things like recovery houses. So we were able to get people into treatment. They could use the cash benefit to access a recovery house, which was not treatment, helped people to transition into the community. They no longer have that, and it's had a real impact on our ability to transition people out of residential care.

COUNCILMAN GREENLEE: Okay. Thank you. And before -- I know other

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Councilmembers have questions. Just one more for me. You talk about the Access to Recovery grant and grants expected to provide support to over 10,000 individuals by 2014. Can you briefly say what the plan is, what the strategy is to have the outreach to those individuals.

DR. EVANS: Sure. So the Access to Recovery grant is a federal grant that initially was used around the country to improve access to care for addictions treatment. In Philadelphia, we actually have pretty good access. We have a fairly well-developed network of services, and so the grant for us was not used to increase access to services, but to enhance the kinds of services that people were getting.

So we used the grant, put a lot of emphasis on things like recovery houses, other kinds of supports that people need to be successful in their recovery. And so what we've done is to -- as people came into our system, one

of the things that we've asked our providers to do is to make sure that those kinds of supports are in place for individuals. And so in terms of outreach, we've not had to use it to outreach to people. What we've done is to use it to supplement the services that people get. It's been enormously helpful in helping to ensure that people are going to be successful in their treatment.

COUNCILMAN GREENLEE: Certainly need it too obviously. All right. Thank you, sir.

Councilwoman Tasco.

COUNCILWOMAN TASCO: Well, you asked my question.

COUNCILMAN GREENLEE: Sorry about that. You should have warned me, see that.

COUNCILWOMAN TASCO: That's all right. Let me just -- good morning.

DR. EVANS: Good morning.

COUNCILWOMAN TASCO: I thank

you so much for the work that you do and your department does. I think you provide a lot of wonderful services to our citizens who have a need for the services you provide. So we're pleased with your outcomes.

DR. EVANS: Thank you.

COUNCILWOMAN TASCO: And the work that you do.

I just want to go back to the elimination of General Assistance, and you said it has an impact on individuals who are in -- are they in recovery houses but they can't get out to go -- just explain that to me.

DR. EVANS: Sure. So the way the treatment --

COUNCILWOMAN TASCO: They remain in the recovery -- are recovered while they're in recovery.

DR. EVANS: Right. So the way to understand the treatment system and how healthcare is financed, there are services that are treatment services that

are funded through Medicaid, and they have to be medically necessary, and those services tend to be either hospital based or licensed treatment provider based.

People also need a variety of other kinds of services. They need housing. They need vocational services. They need often peer services. Those things are outside of the treatment system and require different kinds of funding streams. We can't use Medicaid for those kinds of services.

So the way we've been able to help people -- because a person who is addicted, particularly person who has been in long-term addiction, has a number of issues, not just the treatment needs. And so what we've done is, for people who have those conditions, we're able to pay for their treatment through Medical Assistance or -- in this case, I'll just talk about Medical Assistance. And then use other funding streams for the other kinds of services.

In the cases of recovery houses, what people did who had the cash benefit is that they would use the cash benefit for recovery housing and other kinds of supports that they needed to live, and that was really important because that gave people who left treatment, formal treatment, an ability to step down to the community to go into recovery housing, and then they would receive outpatient services in recovery houses. So those services would be paid for by Medicaid. Their housing would be paid by their cash benefit.

Removing the cash benefit has made it really difficult for people to make that step down into the community, and we've had to use the Access to Recovery grant to -- in a way that we had not anticipated. So we have those resources available. We've just had to spend them at a much higher rate, and so over time, we'll probably be able to serve fewer people because we've had to

use much more of that grant to provide the backfill for the cash benefit that went away.

COUNCILWOMAN TASCO: Okay. Thank you very much.

Thank you.

COUNCILMAN GREENLEE: Thank you, Councilwoman.

Councilwoman Sanchez.

COUNCILWOMAN SANCHEZ: Good morning. Good morning, Dr. Evans.

DR. EVANS: Good morning, Councilwoman.

COUNCILWOMAN SANCHEZ: I first just want to thank you for all your work related to the recovery house situation and your office's willingness to go out into the community and with me suffer the brunt of the discussions and the concerns of the community. I appreciate that.

DR. EVANS: And we appreciate you.

COUNCILWOMAN SANCHEZ: Taking the heat with me, whenever possible.

That's a difficult situation.

Siting some of these locations are extremely hard. I noticed that in your budget while you hold them harmless, one of the programs we've been talking about needing to sort of expand and do some additional work is Prevention Point. So you hold them harmless. Is there going to be enough support that if we are able to site them somewhere else, we can get them some support to relocate them?

DR. EVANS: Yes. I think that's a two-part question. So I'll just make sure I understand it. So part of it is, is there support to help them relocate, and then the other part of the question is, is there support to help them expand.

I think the question -- I think the answer to that is yes on both instances.

COUNCILWOMAN SANCHEZ: Okay. In your CBH budget -- and this is something you and I have talked about

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before -- there's a $20 million allocation for Behavioral Health Initiatives under the New Reinvestment Plan. Can you tell me what some of those items are going to be?

DR. EVANS: If I think I understand the question, there is -- so for --

COUNCILWOMAN SANCHEZ: It's Section 46, Page 46 under the CBH budget, where you list out all in detail your healthy choices behavioral programs and your contractors. There's one labeled New Reinvestment Plan, Behavioral Health Initiatives at $20 million.

DR. EVANS: So what we're able to do, just to kind of give context, so with the HealthChoices program that the City manages, as I mentioned, we're paid on a capitation. We are responsible for all of the care that people have. If we have a surplus in any year, we're able to reinvest those dollars back into our service system.

So what we've done over the last several years is to use part of those savings to improve access to services, and the BHSI program is one of those. The BHSI program is a program for people who have substance abuse disorders but who are uninsured. So they don't have the Medicaid entitlement. They need access to care. Many of -- most of those people will convert to Medicaid, but initially when they show up for treatment, they don't have insurance, and so we've used that program to get people into care and then to convert them over to Medicaid.

So the kinds of services that we cover, essentially any kind of addiction services. It could range from residential services, outpatient services, intensive outpatient services. So it's a whole range of services that people would need.

COUNCILWOMAN SANCHEZ: So I know that there was a delay with the new

RFP for behavioral health, and I know you've been working really hard at setting high standards in the community. We've had the conversation about the quality of services stuff.

When do you expect the RFP to go out, and do you foresee expansions or some folks being realigned with the zip codes? I'm particularly interested -- my particular interest is as the community spreads out, particularly the language minority community, will that help us kind of expand some of those services, but at the same time, take out -- just like education, it's all about high performance slots.

DR. EVANS: That's right. Well, yeah. So we're -- because of healthcare reform, we're really trying to figure out what our needs are going to be. One of the things we don't want to do -- at the end of last year, we were contemplating an RFP that would allow us to expand our service system. When it

was clear that Medicaid was going to expand or at least nationally that Medicaid was going to expand, we made the decision that it didn't make sense at that point to put out an RFP at the end of last year when, if Medicaid expanded, we'd have to put out another RFP. It's a tremendous amount of work to do these kinds of things.

And so our position has been that we want to -- we continue to look at our data to figure out where high need areas are, but we really want to have a better sense of whether or not the state is going to expand Medicaid before we do an RFP.

The state would have to -- I think they have to have a decision or implementation by October, and in order to hit an October date, you're going to have to make the decision well in advance of that. So we're hoping that within the next couple of months, we're going to know better where the state is going to

end up on that, and then we'll be able to make a better decision about how to RFP.

COUNCILWOMAN SANCHEZ: In light of that fact that you're going to be doing these RFPs, what measures are you taking in the interim in terms of site visits? We've asked about the correlation between recovery houses and the behavioral health providers. What steps are you taking so that you can strengthen the requirements for the providers in the community so we don't have kind of the storefront stuff?

DR. EVANS: Around recovery housing or around treatment programs?

COUNCILWOMAN SANCHEZ: Around treatment programs that are strategically located in areas where there are high density of recovery houses.

DR. EVANS: Well, I'm not quite sure I understand the question, but let me see if I get it. I mean --

COUNCILWOMAN SANCHEZ: I want to know in light of the fact --

DR. EVANS: Recovery housing and treatment programs are very two different things and we approach them differently.

COUNCILWOMAN SANCHEZ: No, no. What I'm saying is, in light of the fact that you're going to come out with this new RFP under ObamaCare that's going to look different -- hopefully we'll be talking about that -- in light of that, what are some of the interim things that you guys are doing to increase the level of expectation around the providers and the siting of providers so that you don't have the density of the problem areas, because providers strategically locate where their work is easier.

DR. EVANS: I got it.

COUNCILWOMAN SANCHEZ: So some of those discussions is how we tie those two in.

DR. EVANS: Very good question. So I think as a department, we've gotten a lot more sophisticated about how we

think about siting programs. I think when I came to the Department, we did a little bit of geo-mapping. I think we rely on geo-mapping a lot more now. And I think to your point, if you look at a map of Philadelphia and look at where programs are, they are concentrated in certain parts of the City. They tend to be areas where real estate is less expensive and providers can afford to buy buildings. In areas where you have very high real estate, you see fewer programs.

And so I would agree with I think what's the underlying part of your question, which is that there are some communities that have a greater number of providers, and I think our responsibility, one, is to make sure that we have programs sited in the areas where people need them, but also that I think we want to be sensitive to communities not having to have more of their share of those programs. So that's one thing, is really use the geo-mapping. And the kind

of geo-mapping that we're doing now is not just looking at whether people are accessing care in a particular area or not, but we're looking at things like the suicide rates and the homicide rates and other kinds of things, because those are indicators of whether there are other behavioral health-related issues in those communities or needs.

The other part of your question, I think, though, is that we are doing a number of other things to try to raise the bar on our providers. I mentioned evidence-based practices. In healthcare in general, there's a big gap between what the science tells us and what people practice. That's in medicine and healthcare generally. We've been really trying to close that gap so that providers are practicing really at the state of the art and rebuilding a lot of infrastructure to do that. The Evidence-Based Practice and Innovation Center is an example of that.

The pay for performance strategies that we're using I think is another strategy, which is to give providers back empirical feedback on how they're doing relative to their peers, and then to measure people over time as a way of giving people feedback around things that we think are important.

We've put out practice guidelines that are based on the scientific literature, what the best practices are in the field, and on what the community and people tell us they need and they want, and we've basically said in order to provide a good service, here are the kinds of things that you should be doing. And so we have a variety of ways of reinforcing that.

So in a number of ways, we are saying to providers, articulating what we think the standard of practice should be and then building in ways of reinforcing that through financial incentives, through trainings, through other kinds of

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mechanisms.

COUNCILWOMAN SANCHEZ: Thank you. My time is up.

COUNCILMAN GREENLEE: Okay. You snuck that last question in. That was good. Thank you, Councilwoman.

Councilman Oh.

COUNCILMAN OH: Thank you very much, Mr. Chairman.

Good morning, Dr. Evans.

DR. EVANS: Good morning, Councilman.

COUNCILMAN OH: So pay for performance, which you were just talking about, how much money is that per year?

DR. EVANS: I think last year it was 17 million we paid out.

COUNCILMAN OH: 17 million?

DR. EVANS: Right.

COUNCILMAN OH: And pay for performance is basically kind of a reward system for the providers meeting the standards that have been set out by the Department.

DR. EVANS: That's correct.

COUNCILMAN OH: In various categories.

DR. EVANS: In various categories.

COUNCILMAN OH: So I am curious about pay for performance in that I'm not exactly clear on how it works.

DR. EVANS: Sure. I can explain how it works.

So I think the first thing is to recognize that when you're running a healthcare system, you have to figure out how you help providers keep up with inflation. If you look at healthcare inflation, it's usually about twice that of regular inflation. So healthcare providers, their costs are going up at a rate somewhere between probably 4 and 6 percent a year.

Historically the way funders like us would manage that is to simply give providers a cost-of-living increase so that they could keep up with

inflation. We took the position several years ago that we were no longer going to do that, that our position would be that the only way that you would get additional revenue is that it would be tied to performance and people meeting certain kinds of performance expectations.

COUNCILMAN OH: Could I stop you there for a second.

DR. EVANS: Sure.

COUNCILMAN OH: Because I do understand it. My question then is, if a provider is not meeting a minimum standard, whatever standard you set, would you not replace them or put them on probation or something? In other words, the financial incentives to get them to do or comply with the standards of the Department in order to get the results; in other words, without the financial incentives, they don't get the results, but with the financial incentives, they do get the results?

DR. EVANS: Well, I think there are two different issues. One is, if you think about anything, it's usually a bell-shaped distribution. You have people that are doing really well, you have people who are doing really poorly, and then you have most people are somewhere in the middle.

What we're trying to do is to get more people to be in the high performing part of the distribution, which is one issue. I think the issue of people who are poor performers is a different issue. We have a different way of dealing with people who are poor performers. Those people who are not meeting expectations ultimately will be kicked out of our network, and that's sort of a different process.

Most people are somewhere in the middle, and what we're trying to do is to move people who are providing an okay service to a point of providing an excellent service, and we're using a

variety of methods, as I mentioned to Councilwoman Sanchez, to try to move the bar up. Financial incentives are a very powerful way of getting providers to increase their performance, and if you look what's happening around the country, that is precisely what governments are doing. It's what private industry is doing. It's trying to figure out how do you use financial incentives to change provider behavior. And I can give you an example.

We've been talking about improving our follow-up rates after inpatient hospitalization. Last year I believe we went from 17 -- we had a 7 percent -- actually, it's more than 7. It's probably about a 40 percent increase in follow-up rates for kids leaving residential treatment, we think, in large part, because we measured it. We gave providers feedback on how they were doing, and providers understood that in the absence of performing at a certain

level, they were not going to be able to get that financial incentive.

COUNCILMAN OH: Right. So I do understand the government's move to paying for performance outcomes, which I think is a little unfair to healthcare providers because they just get the patients they get.

DR. EVANS: I'm sorry. Because?

COUNCILMAN OH: Healthcare providers get the patients that they get. They don't always recover the way government would like. It reminds me of my friend who joined Weight Watchers, and he could buy a pizza, and he started buying three or four of them, and then what happened is, the lady asked him to quit because he was messing up her stats, and that's how she got paid, right? Sorry to use him as an example.

DR. EVANS: I think I'm following him.

COUNCILMAN OH: So I like the

innovation of pay for performance. I'm not against it. I'm really very curious about how our government is moving to providing less money for healthcare and providing incentives for results that are -- they're not really related to the human condition that you must get these results.

I sit on the board of a hospital. We face the same type of issues.

So I think there's a lot of good in pay for performance. I wonder that the money for pay for performance, is it best used there? Does it artificially get certain results or is it best used in more accessibility of healthcare is --

DR. EVANS: Right. You're raising some very good questions, and I don't want to present this as we have a perfect system, because it's far from perfect. I think the issues that you raised around what we call in the field

case mix, if you have -- if you're a provider who has a particularly challenging population and someone else has a less challenging population, you're going to be potentially hurt by that. Those are all of the kinds of things that we try to factor into how we do that.

And so your points are very good. I think from a philosophical standpoint, I think where I come out on this is that ultimately we have to use the most powerful mechanisms that we have to get the kind of outcomes. We don't do pay for performance as much about -- ultimately what pay for performance is for us is how do we get the best kinds of outcomes. Your point about the human condition and how does this connect to the human condition I think is ultimately the question. And if you look at the kinds of things that we look at, if a child is in an inpatient hospital and is discharged and is not seen for 90 days, the likelihood of that child returning is

very, very high. And so we can talk until we're blue in the face about how it's important to connect those children to the next level of care, but when we change the financial incentives, all the sudden we got an increase in performance.

So ultimately I think it's to your point, how do we make sure that as we're doing this, it's ultimately connected to how people are doing. I think kids are much better off because we have done this than if we hadn't done it, and, secondly, we save money as a payer when we reduce that kind of unnecessary recidivism.

COUNCILMAN OH: Thank you very much for your answer. Let me just say that Dr. Evans has a lot of confidence from us, myself included. You're always on top of things and so reasonable and just well versed in things that I always give you the benefit of the doubt because --

DR. EVANS: I appreciate that.

I need it sometimes.

COUNCILMAN OH: I want to give you the encouragement having asked that question.

DR. EVANS: I heard the intent.

COUNCILMAN OH: I appreciate your hard work and your intelligence and everything else. Thank you.

DR. EVANS: Thank you.

COUNCILMAN GREENLEE: Thank you, Councilman. By the way, that pizza analogy, Councilman Jones would be jealous of that one. That sounds like something he would have.

Councilwoman Sanchez.

COUNCILWOMAN SANCHEZ: Just one more thing that I think is important, going back to the site locations and siting the different programs. There's a conversation I had with the Prison Commissioner, because he has such challenges doing the day reporting, and we're never going to get to a point to close a prison unless we do some of the

day reporting and some of the other things, and strongly encourage you to use some of your reinvestment dollars. I think co-locating services that are not so sexy with services that are more family oriented would make it more palatable for communities to accept this, to accept some of the programs that -- you know, my folks scream about anything. They don't want anything, because nobody is a drug addict in their neighborhood, their cousin, their uncle. They don't know anybody, but they know everybody.

One of the things that I strongly encourage you to do before this new RFP goes out is that your staff and your team really look and do a site visit to all of the centers. I'm extremely concerned at some of these providers who locate in some of the neighborhoods that are challenged as it relates to public safety, but I'm seeing more and more glass preventing clients to feel welcome. As I told you, some of these storefront

places. If you're scared to be there, well, guess what, I don't need you to be there.

DR. EVANS: I absolutely agree with that.

COUNCILWOMAN SANCHEZ: So I have quite a few providers and I've visited them. They will not be surprised to hear me say this, because I've told them. You know, if it's not wheelchair accessible, if it's not friendly, if it's not family friendly, if it's not clean, you need to get out of the business. You run a billion-dollar corporation. You're serving some of the neediest communities, and they deserve treatment with dignity and respect, and we're not getting that. And I strongly encourage you to use this next process to raise that bar, the physical plant bar at least, clean, friendly. If you need a bulletproof thing, you don't need to be there.

DR. EVANS: I couldn't agree with you more, and I feel really strongly

about this issue. A few years ago we used some of our reinvestment dollars, because when I did go out -- and I do try to spend time out going to providers -- and you see some of those kinds of things, I think it's -- I just think it's unacceptable. I think when people come to a place, it's a healthcare facility. It should look like a healthcare facility. It should be clean. It should be well presented. And that's our expectation.

I agree with you. I think that there's some providers that take that on, and I think there's some places they're just immaculate. They're really nicely built and that kind of thing. But a few years ago because I had noticed that, we used some of our reinvestment. We gave providers sort of mini grants just to do painting and to replace carpets and those kinds of things. I think we may need to relook at that again. But if you look --

COUNCILWOMAN SANCHEZ: That

should be weighed in their proposal very heavily. It should really be weighed heavily.

DR. EVANS: I think that that's a great idea, and I'll ask --

COUNCILWOMAN SANCHEZ: Because that becomes the problem in the community when people say -- and I'll give you an example. I want to thank you, because I know you're supporting our expanded location for a Kensington Hospital Methadone Clinic. I live around the corner from a residential treatment center, from a methadone. Like it's -- I would not ask anybody to bear what I don't bear in my own backyard.

DR. EVANS: Absolutely.

COUNCILWOMAN SANCHEZ: But it has to be quality. So if we know we're doing methadone for 300 people, there needs to be space to accommodate those folks in a way that people are just not hanging out. We need to set that bar for folks, because then it's easier for us to

get community support when we're locating these places, because they say, Wow, this place is nice. If I'm uncomfortable coming here, I'm okay with the people coming through.

I think this particular RFP process, you need to set that bar. You need to go back and visit some of these places. You know I have no problem telling you the ones that I have concern, but if in fact we're ever going to get to a place where there's going to be equity in siting these locations throughout the City, that bar has to be raised.

DR. EVANS: I agree with you, and I think that's an excellent point. I think we can certainly look at how we can give that more weight in the RFP process. I think that's a great idea.

COUNCILWOMAN SANCHEZ: Okay. Thank you.

COUNCILMAN GREENLEE: Thank you, Councilwoman.

Councilwoman Reynolds Brown.

COUNCILWOMAN BROWN: Yes. Thank you. Good morning.

Good morning.

DR. EVANS: Good morning.

COUNCILWOMAN BROWN: Welcome back.

DR. EVANS: Thank you.

COUNCILWOMAN BROWN: It's been a year.

DR. EVANS: Yes, I know.

COUNCILWOMAN BROWN: On Page 4 of your testimony, you provide in great detail the, I would say, accomplishments, if you will, around MBE/WBE participation and you actually doubled your participation for the fiscal year. Speak to the factors that you believe significantly contributed to your ability to do just that, double the participation of women, minority, and disabled businesses.

DR. EVANS: Well, frankly, I think that Council's interest in this issue really, I think, has led to us

focusing much more and asking the question. I think the person who leads the effort in my department does a great job, Jim Hoefler, who is our CFO. We do a variety of things, and some I mentioned earlier, like whenever we do an RFP, we will have OEO participate in helping us to do range setting for that. We've done some things around minority suppliers, working not only with our suppliers but also working with our providers, taking the top providers within our system and asking them what they in turn are doing around this area.

We are encouraging -- we have a number of providers. Actually, the number that we have in our testimony is actually an underestimate of the true number of -- the true percentage of minority participation. We have about five providers who are in fact owned by a women, minority or disabled person, but they haven't gone through the process. So our numbers would actually look

better. And so one of the things we're doing is trying to encourage people to actually sign up.

But I think it's just sort of paying attention, asking the question, making sure that we have a broader range of people that are coming through the door, and then working with OEO to help us use strategies that they've seen other departments use.

COUNCILWOMAN BROWN: Yes, and use successfully.

DR. EVANS: Yes.

COUNCILWOMAN BROWN: Another area a number of us are paying more attention to is looking to hear and see how departments are doing when it comes to ensuring that the executive level of your department also looks like Philadelphia. So update us on where you are with that.

DR. EVANS: Sure. So we're actually doing really well in this area. We have two minority males on my

executive team, me being one of them. We have actually a third person. I should say that my Deputy, Mike Covone, this is his last time before City Council. He is in DROP and will be retiring May 17th, a huge, huge loss for the Department. He's been here for many years, and it's hard for me to imagine doing this job without him. But the person that we've been able to recruit from Maryland who will be taking Mike's position is an African American male as well.

So I think we've done a good job of -- if you look at my executive team, half are people of color. I think actually over half.

COUNCILWOMAN BROWN: And women?

DR. EVANS: And women, yes. Actually, the majority are women. The guys are in the minority in my house and in my work as well. I'm the only guy in my house. So same thing at work almost.

COUNCILWOMAN BROWN: That's important, and it matters to a number of

us in Council. It's been changed over the ten years, decade that I've been here. So it matters that that be acknowledged.

Discussion has already been given to the pay for performance. Speak to, if you will, the policy issue of Philadelphia residents being referred to suburban providers by CBH and the Philadelphia Crisis Response Centers, one of which I think might be in Councilwoman Blackwell's district. I'm not sure. Does your department reiterate the importance of using Philadelphia's Crisis Response Centers when it comes to referrals? So just, if you would, speak to that.

DR. EVANS: Right. I think there are a couple different issues. One is sort of the Crisis Response Centers and then the issue of using outside referral sources. Most of the -- the overwhelming majority of providers in our network are Philadelphia-based providers

and those services are provided within the City of Philadelphia. We only go outside of the City if there is a request or preference by someone or if a provider has a particular specialty or capacity that we don't have within the City.

COUNCILWOMAN BROWN: Is that a written policy?

DR. EVANS: Not necessarily a written policy. I think it's more or less the way the system actually operates. I mean, just as a practical matter, it's much easier to refer someone down the street than to some other community. And, again, the majority of providers in our network are Philadelphia-based providers.

COUNCILWOMAN BROWN: So what might be the percentage of those that are Philadelphia-based providers versus the other?

DR. EVANS: Let me look it up.

COUNCILWOMAN BROWN: And by others, I mean --

DR. EVANS: So 97 percent are Philadelphia based in terms of dollars that we're spending.

COUNCILWOMAN BROWN: Okay. And you say if there is a request or preference. That would be made by whom?

DR. EVANS: By the person. So, for example, sometimes you have people who have family members that might be high profile and for whatever reason they don't want to, you know, get services.

COUNCILWOMAN BROWN: Confidentiality.

DR. EVANS: Yeah, for confidentiality, those kinds of things.

COUNCILWOMAN BROWN: Well, the bell has rung, and we have to honor it. So I'll see you on the next round.

COUNCILMAN GREENLEE: Thank you, Councilwoman.

Councilwoman Blackwell.

COUNCILWOMAN BLACKWELL: Thank you very much.

Good afternoon.

DR. EVANS: Good afternoon.

COUNCILWOMAN BLACKWELL: Oh, no. It's still morning.

DR. EVANS: I'm just going with you.

COUNCILWOMAN BLACKWELL: Too much to do. I've been to too many things already.

Certainly we want to thank you for what you do, and as you know, we will get another bite at the apple with regard to homelessness. We thank you for the job you did to try to keep us together. I wondered how you would do that since we're so opposed, but we're looking forward to continuing the discussion. And I've got to call the Deputy Mayor and find out what they're doing with Love Park since they took all the benches out. And so we want to -- we look forward to continuing that discussion.

DR. EVANS: Sure.

COUNCILWOMAN BLACKWELL: Thank you. I hope the Administration heard me.

They took all the benches out of Love Park, and all the people who sit there just sit on the planters and sit on the ledge. People are still there. You know, it's a public place for everybody, people who visit our city, people who work downtown and have lunch, people who pass through, people who go to the venues in the area to buy lunch.

So anyhow, I know they're supposed to do some work there, but we sure need some details and how this relates to the whole issue of homelessness. Thank you.

And thank you.

DR. EVANS: Thank you.

COUNCILMAN GREENLEE: Thank you, Councilwoman.

Councilwoman Bass.

COUNCILWOMAN BASS: Thank you.

And I want to thank the Councilwoman, Councilwoman Blackwell, for mentioning the bench removal, because as the Chair of Parks and Recreation for

City Council, I think that would have been something nice if they had just dropped a note they were going to do. But anyway, good morning.

DR. EVANS: Good morning.

COUNCILWOMAN BASS: How are you?

DR. EVANS: I'm doing good.

COUNCILWOMAN BASS: Good.

So I just want to echo a couple of things. Number one, what Councilman Oh mentioned. It's always a pleasure to work with you. Whenever our offices have issues, concerns, questions, you are always available, and we really do appreciate that, because particularly with the urgency of the clientele that you serve. And so I just wanted to also go on record and say how much we do appreciate you always being available.

And I just had a couple of questions going back to Councilwoman Quinones-Sanchez's line of questions regarding the facilities, and I think the

condition of the facilities in our communities and in our district really does represent how people feel about not only the facility being there but the population that it serves.

DR. EVANS: Absolutely.

COUNCILWOMAN BASS: So it sends a really strong message in terms of if you've got this raggedy sort of dump of a building that may or may not be providing the quality and level of service that we need it to provide, it goes a long way in terms of if we are able to help more people who are going through these very difficult circumstances. And so I just wanted to touch on that briefly, because it's obviously very much of a great concern in my district as well.

DR. EVANS: Yeah. Again, I feel very strongly about this. I think that the way you present your program tells people what you think about them when they come through the door.

COUNCILWOMAN BASS: Absolutely.

DR. EVANS: And I want to use another example of the ways that we're trying to impress upon this with our providers. If you look at our practice guidelines, for example, we specifically talk about the physical environment. A year and a half ago, we did a project called OTIP, which stands for Outpatient Treatment Improvement Program. We basically created an incentive program, put some resources on the table, and one of the things that we asked providers to do is to really look at how their program interfaced with the community, what was it like for a person to actually walk through the door, what was the physical environment. So people actually used the dollars to change -- and we actually have before and after pictures where people -- they painted, they added artwork, they did those kinds of things to get it exactly what you're saying, which is when people walk there, they should feel welcomed.

So we have put a lot of emphasis on that. I think that there is still probably too much variability in that area, and I think the recommendations that we've heard today, I think we'll go back and look at that issue and further push our providers in that area.

COUNCILWOMAN BASS: Okay. And it should be seamless in terms of the fit into the community if it's going to be something that's going to be embraced by the folks who live in the neighborhood.

And as you know, some providers do a really great job, an excellent job of providing service, and then there are some providers who maybe not as much and even some who may be considered by people in the neighborhood even predatory. And so you've got a wide range there. But I wanted to really touch upon those that provide service who maybe may not be meeting the benchmarks, and can you talk a little bit about how your office

handles that. Are there sanctions? Are they removed after warnings? How does that work?

DR. EVANS: Sure. That's a good question. So we do that through a variety of ways. So as I mentioned to Councilman Oh, you have the pay for performance for the top part of the distribution. For the bottom part of the distribution, we have a number of ways of getting at that. One is that we have a monitoring process where we go out and do a comprehensive monitoring of providers. We look at their charts. We talk to people who are receiving services in those programs. We interview the staff. We take data. We look at what we call quality improvement reports. So if over the course of the year an issue comes up, the provider is required to submit what's called a quality improvement plan, and we use that plan to make sure that whatever the issue is is corrected over the course of the year. But during that

comprehensive visit, all of that information is used and we make a determination about whether that provider should stay in the network, how long we should credential the provider to continue to be in the network. And in the last year, we've had at least two providers who have consistently not met the standard and we have made the decision to terminate them from the network.

So while we believe in incentivizing providers, we also take very seriously our fiduciary responsibility to make sure that providers who are providing services are doing it in a way that meets standards.

So both of those providers over -- so our first obligation is to make sure that the people in those programs get connected to services, but we think it's sending a very strong message to our providers, is that we're not playing around. There are certain

standards that you have to meet.

COUNCILWOMAN BASS: Okay. Very good. Thank you.

COUNCILMAN GREENLEE: Thank you, Councilwoman.

Councilman O'Brien.

COUNCILMAN O'BRIEN: Thank you, Mr. Chairman.

I just have a statement and I'd like to echo the sentiments of you, Arthur Evans. I'd like to give a shout-out to Mike Covone and Kathy Sykes. They brought our citizens, our community from the shadows of institutional living. They gave us a core value system in recognizing these people are part of our community. They taught us how to see them and to serve them in a more significant way. It was not an easy job because of the prejudice and the pushback. But you are real heroes, and I can't overstate the importance of the infrastructure that you represent over these many years in serving a population

that was invisible, and you always remind us to see those people in the shadows and the people that are invisible to most of us policymakers like myself. So thank you.

(Applause.)

COUNCILMAN GREENLEE: Thank you, Councilman.

Councilwoman Sanchez.

COUNCILWOMAN SANCHEZ: One last thing around language access, and I noticed you reported your numbers out. What is it that your department is doing to improve language access, both in your department, in your executive team, and the service providers?

DR. EVANS: From a service standpoint, we do it multiple ways. One is that we make sure that we have providers from various linguistic backgrounds within the network. In terms of Spanish speaking, we have very good access, and in fact, if you look at our penetration numbers, our utilization

numbers, Hispanics/Latinos have the highest penetration rate of any of the racial ethnic groups. So we feel really good about that. And I was at the Latino conference a few months ago and I shared some of the data from our system around that. Not only do we have really good access to services for the Latino, Spanish-speaking population, but we also have -- those providers, I should say, are doing a really good job of connecting people and keeping people engaged in care. The modal number of sessions in outpatient treatment, "modal" meaning the most frequent number of sessions in outpatient treatment, across the country is about one. In our system it's about one, with the exception of the Latino providers. So people are coming back and engaging in treatment at a much higher rate in those programs, and we feel very good about that.

In addition to that, we have other services, in particular

translational services, which are not the ideal. It's much better to have people who not only speak the language but understand the culture to work with the people. So in some of the other groups, Asian groups in particular, we have some Asian services and providers from those communities. We need more, and there are some things that we're doing to try to increase that, but the primary way that we address those kinds of concerns when we don't have a provider is through translational services.

COUNCILWOMAN SANCHEZ: How about with your team and your executive team? I noticed your numbers are like 3, 4 percent?

DR. EVANS: Very low, yeah. I would say two things about that. One is that because we have such a large number -- we have over 19 Latino programs in our system, which is just phenomenal. I came from Connecticut that has a population twice this, very large

Hispanic population. We had maybe three or four. In the City of Philadelphia, we have 19. So we've done a really good job, but what that means is that for the Latino, Spanish-speaking professionals, they have entree into the private sector. They pay better. They have -- I don't know if they have better working conditions, but they certainly pay better than we do in government. And so we don't have a lot of Latinos who actually apply to be in the Civil Service system. As you know, we're sort of constrained around that. Where we do have more Latino, Spanish-speaking staff are within CBH and within BHSI. Again, they're more sort of private, but within the Civil Service system, we just don't get a lot of people that actually seem to want to work within government. But, you know, what I would say about that is if -- I think it's really important to have a variety of viewpoints at the decision-making table, and there are a

lot of ways that we try to do that. So I think if there are people that you can identify or people that you can put us in contact who might help us do recruitment in that area when we have key positions, that would certainly be welcomed.

COUNCILWOMAN SANCHEZ: I think it would be helpful to have someone in your executive team. I think part of -- it's great to have a robust system, but also when you're increasing the standards, they are some folks that are not going to survive, hopefully some of the new standards, and having someone at the executive team that serves as the face of this is not discriminatory, this is about good practices, I think as we move forward and we really do try to professionalize this in all languages -- I represent a lot of Portuguese community. I represent a Russian-speaking community -- is people feeling like there's someone at the table, because if you're going to do the

next couple of years right, there's going to be some pain.

DR. EVANS: Yeah.

COUNCILWOMAN SANCHEZ: So I don't want to be the face that has to be the bad guy all the time. I think there should be some spread -- some shared pain on this.

DR. EVANS: We'll try to share the love, Councilwoman, yes.

COUNCILWOMAN SANCHEZ: Thank you, Dr. Evans.

DR. EVANS: Thank you.

COUNCILMAN GREENLEE: Thank you, Councilwoman.

Councilman Johnson.

COUNCILMAN JOHNSON: Thank you. Thank you, Mr. Chair.

I want to first and foremost thank Dr. Evans for his service to the City of Philadelphia, primarily in the area of behavioral health. It's often one of those areas that's overlooked if you don't make it a priority in terms of

addressing and making sure that particular population of individuals receive the type of support that they need. And so I'm well aware of the work that you have been doing and just want to just commend you on your work.

Just a couple questions regarding behavioral health issues and the issue of crime and violence amongst young people. Give me an idea in terms of your overall programming of services maybe the percentage of work that's done with young people that are perceived to have behavioral health issues and the types of services and programs that you have addressing it.

And the reason why I want to put that out there is, myself and my former House Speaker, Denny O'Brien, we're working on a balanced prevention initiative that begins to look at why young people commit acts of crime and violence, specifically looking at it from a behavioral health standpoint, looking

at the psychological mind state of a young person who had witnessed a friend being murdered, had a close friend who was being murdered and how do they process those feelings. Do they go out and seek revenge? Do you act out in the classroom? And I think that's an area that's not really talked about. I know we have people that go away in our armed services and they serve our country, and they come back shellshocked, post traumatic stress syndrome.

But we're working with a bunch of doctors, Drexel, Temple. We had a roundtable discussion to begin looking at this issue of crime and violence from a health standpoint. And if you can just elaborate from your perspective, and also how we can be supportive in Council to make sure that rather it's from a policy standpoint or resource standpoint, we could be helpful to address that issue.

DR. EVANS: Sure. We as a department, as a city provide a really

wide array of services, a comprehensive array services, and I think what the City has done before I got here has been to develop, I think, a pretty extensive array of services and probably would rival that of any place in the country. And those services range from obviously emergency services. We have a Crisis Response Center that is specifically dedicated to children. So children who are having psychiatric crisis don't have to go to an adult crisis center. They can go to a crisis center that specializes with children.

We have a very extensive amount of school-based services. We spend about $70 million each year in the Philadelphia schools. That's in the schools. That's not counting services that are provided for children outside of schools. So we have a very extensive set of school-based services for those -- for children in that setting, which is really important.

One of the things we're really

pleased about is that those services are designed and the way Medicaid is designed is to work with a particular child who gets a diagnosis, but what we've done is when we have those professionals, behavioral health professionals in schools, they're also working with teachers and administration on how to both identify and work better. And so they're actually changing the school climate. And so we've been able to leverage those programs to actually have a much broader impact, not just dealing with the specific children but really trying to deal with the overall school environment. And in those schools where we've been able to do that, the principles and staff really, really appreciate having that kind of support.

We have a variety of outpatient services for children, but I think the point that you're making is that a lot of the children in Philadelphia have experienced trauma. Our field, the

mental health field, I think over the last, I would say, 10, 15 years has had an increasing understanding and recognition of the importance of treating trauma. Most people who are trained as clinicians, whether psychiatrists, psychologists, social workers, nurses, are not trained as a part of their training to work with people who have been traumatized. And so what we've had to do then is to develop -- not to develop, but to implement specialized trauma treatments, and we've done that by bringing in people who have created evidence-based programs.

We've trained ten providers within our city to provide specialized trauma treatments for children. We think that's going to be a really important enhancement to our service system, because you're exactly right. When kids experience those kinds of traumas, they're not treated. It leads to other problems. As they say in more colloquial

term, hurt people hurt people. And if we can intervene when people are hurt, it's going to make it less likely that they then in turn are people who are committing violence against other people.

We have a new federal grant that we're very excited about, because what it does is -- I mean, the issue with trauma is this, that kids are often traumatized. It goes unnoticed, unrecognized. It comes out in their behavior. People deal with them around their behavior, don't deal with the trauma. For many, many people, they don't acknowledge that they've had abuse, neglect, those kinds of things until they're into their adulthood, and what we're trying to do is to intervene much earlier. So the grant will allow us to screen kids in pediatric settings, primary care health settings, working with other healthcare professionals, and them connect those children to services.

So I guess what I'm saying is

that we have a really broad range of things. The work that we're doing around trauma I think is really important.

You asked a question about what can City Council do. I think the most important thing that we're doing right now is something called mental health first aid, which is similar to physical first aid. People know -- if someone has a heart attack, people know to do CPR. Someone begins to show signs and symptoms of psychosis, most people don't know what to do, or if someone is depressed or saying I'm suicidal, most people don't know what to do. And so what mental health first aid does is to try to equip the general public to be able to respond in a similar way to those individuals in the same way that we respond to a person who might be having a heart attack.

It's a one-day course. We have some state legislators who have already done it. So they've kind of set the bar. I would encourage not only your staffs

and people in your community to be trained in mental health first aid, but I will encourage you to be trained. I've been trained. The Prison Commissioner has been trained. We've had judges that have been trained.

And I think in terms of trying to get the message out that being able to recognize these kinds of issues early and then knowing how to connect people I think is probably one of the most important things we can do as a community.

COUNCILMAN GREENLEE: Thank you. If you have another question, you have to go back around, because I have a couple people waiting. Thank you, Councilman.

Councilman Jones.

COUNCILMAN JOHNSON: Thank you, Mr. Chair.

Thank you, Dr. Evans.

DR. EVANS: I'm sorry. I wanted to give you --

COUNCILMAN JOHNSON: No. That was a very well-responded statement to my question. So thank you very much. I'll follow up on the second round.

DR. EVANS: All right.

COUNCILMAN GREENLEE: Thank you.

Councilman Jones.

COUNCILMAN JONES: Thank you so much, Mr. Chair.

First of all, thank you for recently spending some time with me to explain to a novice your side of government for me. There are certain things in my wheelhouse and there are certain things that are not. Mental health, not. And you took the time to come over and explain some of the general areas and challenges and even silos that exist within that side of things. So I thank you for that.

DR. EVANS: Sure.

COUNCILMAN JONES: On the line of Councilman Johnson's question, the

mental health issue that I deal with most often is post traumatic stress syndrome that comes in a number of forms. It comes in the form of Mr. Scott, Bernard Scott, who was murdered and his family who are traumatized, the young man that served as the good samaritan who actually drove the young man to the hospital when he expired. All of these things come into a community and, quite frankly, again, as an elected official, I feel almost helpless to deal with.

DR. EVANS: Exactly.

COUNCILMAN JONES: So you're dealing with young people who are becoming desensitized to the situation, that teddy bear memorials are, you know, nothing to worry about because it's going to come again, it's just a part of their life.

How do we create trauma units that come into an area to try to deal with the grief, the impulse for revenge, which is another one. It's almost a

Hatfield and McCoy, "Imma hit you back" kind of thing that kind of creates a catastrophic series of events in a community. Are we prepared for that kind of thing?

DR. EVANS: Yeah. So we're doing a number of things. So the issue that you talked about where you have a community traumatic event. Often there are community rituals -- or vigils afterwards. So one of the things that we're doing is really trying to take a more public health approach, which means that rather than people being traumatized and then waiting for them to come to treatment, we're trying to get into the community where people are immediately after those events. So we have developed community response teams. We have about 70 people that we've trained in psychological first aid. It's the intervention that's used by FEMA when there is a natural disaster and you send in mental health professionals to work

with people after a flood or a hurricane, those kinds of things. It's the same kind of training. We have those networks that cover the entire city.

We have RSAN and we have connections with the Police Department so that when we know about these kinds of things, we will send a community response team into the community. They give information. They provide psychological first aid for people who might be attending those kinds of events. So we think that's a really important intervention and strategy for dealing with that.

You mentioned the need for retaliation. So one of the programs that we support is a program called Healing Hurt People, and it is a program that is led by Drs. John Rich and Ted Corbin at Drexel University. We have one that is connected to Hahnemann Hospital, a Level 1 trauma center, and St. Christopher's Hospital. And what it does is -- what

typically happens when people are shot, intentionally injured, if they survive, they are patched up physically and then they are sent out, and often their mental health needs are not dealt with. And just what you said, so people are now dealing with the trauma, sometimes there's anger, there's revenge.

So what they do in their program is, when these people come in -- and most of them are young men of color -- they have a program where they intervene with them. They provide them counseling. They provide case management. But they try to do two things. One is to try to deal with the psychological trauma that they've dealt with, and a lot of times these are young guys who themselves are just innocent bystanders and they have a lot of guilt associated with being -- and stigma associated with being shot. They will tell you, I was shot, but people treat me as if I did something wrong. So they

have a lot going on with them and a lot of stigma associated with being shot. And so they try to deal with the psychological trauma that they've experienced, but then they also try to intervene with them in a way that makes it much less likely for them to retaliate.

And the programs around the country that have been most successful are programs that have used that sort of methodology. They understand that violence is like a contagion, and so the people that are most likely to be violent are people who themselves have had violence committed against them. So if you can intervene early, you're not only helping the person, but you're also reducing the likelihood that those people are then going to commit other acts of violence.

COUNCILMAN JONES: The first time I heard gun violence as a mental health issue, I heard it in a seminar

Councilman Johnson put together, and one of the most frightening things in the world was the desensitization of one of the young men as to this is the way it is and this is how we do it and this is the rules we live by, kind of gloomy prospect of life.

And so is there a single point of contact that we as Councilpersons and maybe an orientation might be in order in the high incident areas that you could put together, but if there was one place that our staff whenever something happens, is there an automatic kick-in when there's a homicide or is it triggered by a call? How do we connect?

DR. EVANS: So we have -- what I will do -- what we will send back to you is that contact information. We have a gentleman named Phil DeMara, who runs our disaster -- mental health response system and runs the Crisis Response Teams for us. What we can do is put you in contact, give you that contact

information so that if these kinds of issues come up, you have a single point of contact, we had a shooting, we had a suicide, whatever, we have people that are traumatized, and then we will deploy people to those events.

COUNCILMAN JONES: I just would offer that to all of us who have high incidences. Councilman Johnson and I watch the news differently and it probably would be a trifecta with Jannie involved, because when I hear a crime incident, it's almost the geography of it. And not that I say, Oh, thank God, but I do that it wasn't in my area. But we need to kind of be oriented on how this kicks in, what the methodology is, because I know we'd get a lot of use out of it.

So thank you, Mr. Chairman.

COUNCILMAN GREENLEE: Thank you. Thank you, Councilman.

Councilman Johnson.

COUNCILMAN JOHNSON: Thank you.

I just want to follow up, Dr. Evans, with just a couple other questions. Do you partner with DHS, Family Court regarding the mental health issue as it relates to the issue of crime and violence?

And then, two, the other component in terms of self-medicating, I know y'all do contracts with Northeast Treatment Centers and various other behavioral health organizations. A lot of times another issue that's swept under the rug is the high level of drug use amongst juvenile, not adults. Some of these crimes take place where young men who smoke wet. Some of these crimes take place with young men that snort heroin. Some of these crimes take place with young people who smoke weed. And what I've encountered is also a population of young people who are self-medicating to not only just deal with the post traumatic stress as it relates to the gun violence, but to be quite frank with you,

living in the inner City of Philadelphia, just thinking that there is not any hope and opportunity for them to do anything with their lives. And so I come from an environment where, quite frankly, Friday night, Saturday night, Sunday, and all throughout the week you find a population of young people just self-medicating to get by but primarily some of the acts of crime and violence based upon young men smoking wet.

And so I just wanted to also if you can like maybe shed some light on -- because some things I'm quite sure we could be doing to be supportive of your efforts, but we want to get an idea of those issues.

DR. EVANS: Well, first of all, in terms of DHS, we have a very strong partnership, myself with Commissioner Ambrose, in terms of looking at the overlap between behavioral health and child welfare. And we have a contract for mental health services within the

Youth Study Center. We have Behavioral Health staff that actually staff -- that are in the courts so that as judges are making decisions about how to -- what the plan is for a child, there are behavioral health professionals there in the court that help them come up with a plan that's going to make sense for those children.

We created a special evaluation center specifically for Family Court and for Child Welfare, because what was happening was that some of the evaluations that kids in the child welfare system were getting were not, we believe, in the best interest of kids. So we raised the bar, brought in new evaluators, psychiatrists and psychologists. We're get much better evaluations, and I think we're getting much better treatment plans for youth who are in that system.

So there are a whole host of ways that we -- those are just some examples of how we try to interface and

work together around these issues. We're working together around some trauma stuff as well.

In terms of adolescents, young people who are using substances, I think that of all the areas in our system, that is one area where I think, frankly, we need to do much more. We have some services, but I don't think that they are -- there are enough services for that population. We are looking at an RFP for services specifically for that population. I don't want to say more, because I don't want to give anyone an unfair advantage, but just to say that we are looking specifically at that particular population.

But I think -- I mean, I think you're raising another issue that I think we need to go back and think about, which is what we know is that generic services generally don't work as well as services that are targeted to a specific population. So you're talking about wet

and what kids in the inner city might be using. Well, that probably is going to take a different way of thinking about how we build those programs. So I think as we go back and look at that RFP, I think one of the things we may want to do is think about sort of the cultural framework that we want to see that program built in. And so if you have ideas -- this was a great opportunity for if you have ideas or particular things that you're seeing where you think that Behavioral Health services could be helpful, it would be helpful to hear that sooner than later.

COUNCILMAN JOHNSON: Thank you.

DR. EVANS: Sure.

COUNCILMAN GREENLEE: Thank you, Councilman.

Councilwoman Reynolds Brown.

COUNCILWOMAN BROWN: Yes. Thank you.

I'd like to go back and get some clarity regarding the Crisis

Response Centers. So help me understand their purpose, separate from outside referrals to suburban providers.

DR. EVANS: So the Crisis Response Centers were set up about -- so usually if you go to most communities, if you go to Chicago, New York, whatever, when people have a psychiatric emergency, they end up in a hospital emergency department, and those are really almost the worst place for people to go, because if you're having psychotic symptoms, the last place you want to be is a place where you're being overstimulating. And then hospital emergency departments will tell you -- and I don't agree with this, but they will tell you often that people who have psychiatric illness are not appropriate or they're, quote, getting in the way of people who have more life-threatening conditions, although having a psychiatric illness can be life threatening because of the high rates of suicide. So I don't necessarily agree

with that, but I do believe that people can be better served in settings that are specifically tailored for psychiatric emergencies.

And so what the City did about 20 years ago was to build a -- or contract for a network of five -- right now we have five different Crisis Response Centers.

COUNCILWOMAN BROWN: All in Philadelphia?

DR. EVANS: All in Philadelphia. And those centers are connected to hospitals for the most part, but they're separate from them in terms of how they operate. If a person is 302'd or involuntarily committed, that's where they are sent to be evaluated, and then a determination is made as to whether that person should be admitted to a hospital or whether the person could be released and referred to another kind of program.

COUNCILWOMAN BROWN: Okay. And

so now -- so I better understand their role, their purpose, and function. And so the 3 percent of the persons that you send to suburban --

DR. EVANS: Most of those people are not coming through a Crisis Response Center. I mean, the Crisis Response Centers are primarily for individuals who are having a psychiatric crisis. Most of those people are going to be admitted to an inpatient unit and an inpatient unit that's in the City of Philadelphia almost -- most time, the vast majority of times. And, in fact, most of the Crisis Response Centers are connected to a hospital. So most likely the person is going to be admitted to their hospital as opposed to another facility.

COUNCILWOMAN BROWN: Okay. So then in terms of additional detail, can you provide to the Chair the total budget for -- you said 97 percent are in Philadelphia?

DR. EVANS: Of the dollars that we spend are for Philadelphia-based providers.

COUNCILWOMAN BROWN: Yes, yes, yes, yes. And for the total amount and then the 3 percent that goes outside of Philadelphia, who they are.

DR. EVANS: Sure.

COUNCILWOMAN BROWN: Okay. What is the linkage with the Philadelphia Corporation of Aging? Example, lady returns to Philadelphia, threatens suicide, family is anguished about how best to help. What would be the case management of that individual?

DR. EVANS: So in that case -- and actually I've been personally involved in some of those types of cases. We would just do outreach to the Philadelphia Corporation of Aging. Usually for the most part, we're just going to manage the situation from a behavioral health standpoint, but if we think that it's a situation that really

would benefit from having them involved, we have staff that will just make that outreach and they'll coordinate with them directly.

COUNCILWOMAN BROWN: With the Corporation of Aging?

DR. EVANS: Yes.

COUNCILWOMAN BROWN: So a case like that that's still, quite frankly, unresolved in my office should be referred to?

DR. EVANS: Sure. If we get the information and there needs to be coordination with them, we'll do that. We'll do that outreach.

COUNCILWOMAN BROWN: In the wake of now I'm told 22 schools closing, what will be the -- had there been conversation with the School District of Philadelphia to capture those young people normally served by your agency in those schools that are closing?

DR. EVANS: Sure. And I should say that we have a really excellent

relationship with this administration, the School District. They've been excellent in understanding sort of the overlay and working with us, and one of the things that we've done relative to that issue is to look at every single school. We've looked at the services that we provide in those schools. We've looked at the children that are in those schools, and for 100 percent of those children who are receiving services in schools, we have a plan for how they will continue those services when they transition.

COUNCILWOMAN BROWN: Very good.

DR. EVANS: The other piece of that is, we're looking at the -- and part of the conversation with the School District has been the schools that are the receiving schools may need additional behavioral health supports that they had not had historically. So we're working with them to make those determinations, and we may be enhancing the behavioral

health services in those schools.

COUNCILWOMAN BROWN: Very good. So no gap -- that eliminates any possible gap.

DR. EVANS: We are planning down to the level of the child.

COUNCILWOMAN BROWN: Very, very good. Very encouraging. Okay.

Mr. Chairman.

COUNCILMAN GREENLEE: Thank you, Councilwoman.

Councilman Jones.

COUNCILMAN JONES: Thank you again, Mr. Chairman.

On that line of questioning, which was what I wanted to know, that there is synchronization between services at School A that will now be available at --

DR. EVANS: School B.

COUNCILMAN JONES: -- School B.

DR. EVANS: Absolutely.

COUNCILMAN JONES: So no school that is closing will a decrease in mental

health services; it will remain the same or get better.

DR. EVANS: Yeah. In most likelihood, there'll be more capacity.

COUNCILMAN JONES: The other thing is, on your -- and I don't know the acronym you used on recognizing mental health issues. Are we working within the school system to train personnel for that kind of situation as well?

DR. EVANS: So as I mentioned, we have, I think, the best relationship --

COUNCILMAN JONES: Could you for the record tell me the acronym.

DR. EVANS: Mental health first aid, MHFA. Mental health first aid. So it's just like physical first aid, except it's for psychiatric.

So we've had a number of conversations with the School District. We are making sure that we're doing joint planning. I'll give you a quick example, then I'll answer your question.

When Sandy Hook happened, when that shooting happened, we immediately started talking to the School District about how they were going to handle that situation. We actually crafted a letter that we felt could help them in terms of explaining what happened and how to access services and so forth, and then they actually used that letter in terms of communicating with their system about the mental health issues.

Since then, we've had conversations about how we can build capacity. The School District actually has pretty good capacity already. They have some staff that are behavioral health trained, but the conversations that we've had are what are the things that should be handled by the School District and then at what point do we bring in our system. And one of the areas where we think we should build capacity is around getting mental health first aid training across a variety of

their staff. And so they've agreed. They're going to train people who will be instructors. Those instructors will then in turn train teachers, administrators, other staff within the School District so that they can build that capacity.

COUNCILMAN JONES: Just as a practical matter, there's always from our vantage point and probably from yours, there's a 50,000-foot-in-the-air view and then there's right boots-on-the-ground view. From this point of view and how it translates to us is, I'll get a call from someone who says, My child is getting bullied. And then we'll go into cases and say, Well, who is the individual doing the bullying. And then we'll find out -- and this is an actual case, and I'll try not to violate anybody's personal confidentiality. But the young person, whether it is related or not, is in foster care. She had some issues related to foster care, and therefore, I'm not a professional. The belief is

she's acting out because of some of that.

So how do you balance, how do we balance the need for the individual that has been traumatized by the bullying and the individual who, over a period of time, probably had some cause and effect about being in a system and whatever events happened within that system, and then managing the balance to have an education?

So intervention at points is critical, because I don't want to -- we don't want to victimize the young person in foster care twice, but the person being bullied, that's not their issue. And the parent is really intolerant about the fact that whatever your issues are, you're taking it out on my child.

DR. EVANS: Right. Well, what I would say is two things. One is that I think when you have those kinds of situations and you think it would be helpful to have a consultation with us, we're certainly willing to do that. As I

mentioned, we work really well with DHS in terms of kids who are in both systems, and often those kids have -- kids who are in the child welfare system do have mental health issues and challenges, and we have services that can help address that.

So I would say certainly reach out to us. That situation, unfortunately, is not unique, and so we have developed over time ways of dealing with kids who are in that situation.

COUNCILMAN JONES: So, again, I'm going to lean on you to set up for Council a briefing on how we can connect our constituent service issues that we identify and then pass them off to individuals who are better trained than us to address and intervene.

DR. EVANS: Sure. Absolutely.

COUNCILMAN JONES: Thank you, Mr. Chairman.

COUNCILMAN GREENLEE: Thank you.

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If I could remind the members, we are already an hour behind and we have a full schedule of departments today, plus a hearing this evening. Thank you.

Councilwoman Reynolds Brown.

COUNCILWOMAN BROWN: My last question around the partnership with Mural Arts, the funding stream for that, and has a location been chosen for the mural?

DR. EVANS: We have a great partnership with the Mural Arts Program. It's part of our strategy to try to reduce stigma around mental health issues, because, as you know, probably know, when a mural is done, it is a community engagement activity. And so what we've done is, we've had projects on suicide prevention. And I'll use that as an example. Suicide is a really big issue. The suicide rates in Philadelphia nationally for African Americans, Latinos, and Asians is higher than the national average. It may not be known.

And even though it's lower than that of majority of individuals, it's still higher than it is nationally when compared to other groups. African Americans, for example.

So we believe that a big part of our strategy has to be not just treatment but also how do we help educate the community. And the suicide prevention mural that we did, we had over a thousand people to participate. We had really great participation from the Fire Department, which during the year preceding that, we had, I think, three or four firefighters who had died as a result of suicide, and so that department was sort of dealing with this issue. I think it would have been difficult to have a forum to have people come and talk about it, but when we did the mural and embedded in the mural were some of their former colleagues, people came out to pay tribute to support the families.

So I think that it's a really

innovative way of talking about these issues. It's getting really great reviews nationally as an innovative strategy. We used a small amount of reinvestment money to start the project and then we got funding through the Robert Wood Johnson Foundation. We have funding through William Penn, through the Scattergood. We have probably at this point five or six foundations that have supported this work, because they think it's a very innovative strategy for having a conversation about mental health issues.

COUNCILWOMAN BROWN: Indeed. And there would be those on the arts/cultural ledger who would know that it is innovative from a social science perspective, but from an art perspective, it's just another level, another paradigm of communicating a sensitive issue. So I commend your organization for being willing to think outside the lines and work with the department in government

that has exceeded all of our expectations when it comes to handling sensitive, sensitive issues.

Thank you for your work.

DR. EVANS: Thank you.

COUNCILMAN GREENLEE: Thank you, Councilwoman.

Councilman Jones.

COUNCILMAN JONES: Yes. Very briefly, Mr. Chairman. I'm going to ask the Chair of Health and Human Services, Councilwoman Tasco and her committee, to -- we'll submit in writing a list of issues that we have for you, not so much -- but designed to educate us that aren't on that Committee, and if the Chairwoman would convene a briefing for us so that we can know where to plug in by way of these types of services that may be helpful in situations where we have high instances of traumatic violence. And if she would take that charge on, I will have no further questions. That's my -- otherwise, I'm

going to keep pushing the button.

Thank you.

DR. EVANS: Say yes, please.

COUNCILMAN GREENLEE: Thank you, Councilman.

Being no further questions, Doctor, thank you very much.

DR. EVANS: Thank you very much.

COUNCILMAN GREENLEE: Michael, good luck in your retirement. Thank you.

Our next department is the Health Department.

You have a welcoming committee here, Dr. Schwarz.

(Witnesses approached witness table.)

COUNCILMAN GREENLEE: If I could ask those who are leaving to please do it quietly so we can proceed as quickly as possible.

Doctor, welcome.

DR. SCHWARZ: Thank you.

COUNCILMAN GREENLEE: Welcome

to you all here.

We have your testimony. If I could ask you to maybe have a summary. And if I could ask obviously by the signs -- and you know I always ask the question anyway. If you could talk about District 10 and the new health center in your opening remarks. That way we could address that right away.

DR. SCHWARZ: I'd be happy to.

COUNCILMAN GREENLEE: Thank you very much, sir. Please proceed.

DR. SCHWARZ: Thank you.

Good afternoon, Councilman Greenlee, members --

COUNCILMAN GREENLEE: Please, please. If everybody could take the conversation outside, we'd appreciate it. Thank you.

I'm sorry, Doctor. Go ahead.

DR. SCHWARZ: I'm Donald Schwarz, Health Commissioner. With me today are Tara Mohr, Deputy Commissioner for Finance --

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COUNCILMAN GREENLEE: Doctor, could I ask you to speak a little bit more in the microphone.

DR. SCHWARZ: Better?

COUNCILMAN GREENLEE: Got ya.

DR. SCHWARZ: -- (continued) Kevin Vaughan, Deputy Commissioner for Administration, and we really appreciate the opportunity to present the Department of Public Health's Operating Budget request for Fiscal Year 2014.

The Fiscal Year '14 budget will continue to support services basic to the Department of Public Health's core mission, to protect and promote the health of all Philadelphians and provide a healthcare safety net for those most at risk. The Department's Fiscal Year '14 budget request totals $338 million, of which 114 million is in the General Fund, 79 million in the Grants Fund, and 145 million is from the Acute Care Hospital Assessment Fund. The proposed Fiscal Year '14 General Fund budget represents

an increase of approximately $1.8 million from Fiscal Year '13's estimated obligations to bring physician salaries in line with market rates in order to prevent future and fill current physician vacancies in our health centers.

The budget will support 992 full-time positions, 762 in the General fund, 216 in Grants, 14 in the Acute Care Hospital Assessment Fund. As of April, a little over 12 million -- excuse me; 1,213 -- excuse me; as of April of this year, 208 full- or part-time employees, or approximately 21 percent, are bilingual or trilingual with fluency in 44 different languages, ranging from Spanish to Hmong to Gujarati.

The Department's workforce is 71.5 percent minority and 70.8 percent female. Our executive staff are 43 percent minority and about 62 percent female. Staff hired within the last 12 months are 67 percent minority and 82 percent female.

The Department is committed to contracting with minority, disabled, and women-owned businesses. For Fiscal Year '12, the most recent year with complete data, 95 percent of the Department's contracted dollars supported non-profit providers. Of the non-profit entities, 95 percent have diversity in their workforce, 81 percent in their executive staff, and 68 percent in their boards through either race or gender.

In Fiscal Year '13, the Department of Public Health's budget supports 158 contracts with 82 distinct entities, of which 35 percent are for-profit and 65 percent are non-profit entities. As of today, for Fiscal Year '13 our M/W/DSBE participation rate is 12.4 percent, which exceeds our goal of 3 percent set for Fiscal Year '13 by the Office of Economic Opportunity. Our participation goal for Fiscal Year '14 is 10 percent.

Our written testimony provides

detail on many of the Department's accomplishments in the last year. Let me highlight a couple of these, and at the end of that, I will talk about Health Center 10.

COUNCILMAN GREENLEE: Thank you.

DR. SCHWARZ: First, the Department continues work on building and deploying our electronic health record, which will improve clinical outcomes for our patients, integrate health services across the eight health centers, and provide a knowledge base for public health policy. And I want to add, it's required by the federal government that we have such a health record.

We're now -- we have now completed rewiring our health centers and successfully launched the appointment scheduling, patient registration, and billing modules as of January 31. This included building electronic connections with the City's public health laboratory

systems so that patient demographic information and billing functions are now linked between the two systems. We will continue to install these practice management pieces at each health center, and in the next 60 days, we'll begin to deploying the clinical modules which will create a more complete electronic health record.

Progress continues on our joint venture between the City and the Children's Hospital of Philadelphia to provide healthcare to South Philadelphia adults and children in a unique arrangement that will include a new South Philadelphia regional branch library and a new DiSilvestro Playground and recreation building. The plan brings two busy existing clinics into one pediatric primary care practice in South Philadelphia and allows the City to continue its adult health services and other health services in one building that would be constructed by the Hospital

on City land and outfitted by both the City and the Hospital. The new health center will allow the City to expand its provision of dental care, mammography, prenatal care, and a wide range of other children's and adult services. We hope to open the health center library and recreation center in late 2015.

The Fiscal Year '13 budget included a $2 million increase in our appropriation for chronic disease prevention through the Get Healthy Philly initiative. The Department leveraged these dollars with federal and state support and partnered with agencies across the City to promote healthy eating, active living, and smoke-free communities. From 2006 through 2010, childhood obesity rates dropped by 5 percent among Philadelphia school children. In 2012, levels of adult obesity declined for the first time in eight years. I believe we're the first city to report such a decline.

From 2008 through 2012, smoking among adults in Philadelphia decreased by 15 percent, from 27.3 percent to 23.3 percent, resulting in 42,000 fewer smokers and 21,000 averted tobacco-related deaths. We continue to work hard to make Philadelphians healthier.

In April 2011, in response to the rising number of sexually transmitted diseases, or STDs, among the youth of Philadelphia, the Department undertook a campaign for adolescents' reproductive health. In the campaign, the Department promoted a custom-labeled Philadelphia condom called the Freedom Condom; expanded the number, location, and type of places providing free condoms to teens; implemented a mail order mail for condoms; and developed a social media presence for the campaign. Since April 2011, the Department has distributed over 4 million free condoms through local community centers, health centers, barber

shops, retail stores, clinics, and the mail.

Occasionally condom dispensers -- additionally, condom dispensers have been installed in 12 Philadelphia high schools as a pilot initiative. These schools were selected because they have high STD prevention priority and have infrastructure in place to support the program. The STDs occur across the entire City of Philadelphia and are not isolated to certain schools, neighborhoods or zip codes. If this program is considered successful in the pilot schools, the plan is to expand this program to the many more high schools within the School District of Philadelphia and to charter schools. To date, approximately 37,000 condoms have been distributed by the dispensers and another 42,000 provided directly to students by the Health Department staff working on site at the schools.

As a result of the

multi-faceted adolescent STD prevention campaign, our epidemic appears to be waning. Cases of chlamydia in teens, which had been steadily increasing since 2007, showed a decline of 5 percent over the last year. Gonorrhea, which had shown a 52 percent increase in adolescent case counts from 2009 to 2011, declined by 6 percent in 2012. Moving forward, the Department plans to continue to work on obtaining support and involvement for this initiative from individuals and organizations that frequently interact with adolescents such as parents, schools, community organizations, and retailers, and now to work hard to reduce the rate of STDs in adults.

Let me talk a little bit about the Northeast. As this Council knows, we have been concerned jointly about the need for expanded access to healthcare in Northeastern Philadelphia. The good news I have is that the waiting time for a new adult patient appointment at our Health

Center 10 in the Northeast, which is the only federally qualified health center in that part of Philadelphia, the waiting time for a new adult patient appointment is down by about 15 days compared to last year, which may not seem like a lot, but it's --

COUNCILMAN GREENLEE: I'm sorry. And that goes from what to what now?

DR. SCHWARZ: That goes from about 266 days down to about 251 days.

COUNCILMAN GREENLEE: You're right, that doesn't sound like a lot. I'm not criticizing, but I'm saying you're right, it doesn't sound like a lot.

DR. SCHWARZ: It's going in the right direction for the first time in a long time.

COUNCILMAN GREENLEE: I understand.

DR. SCHWARZ: However, we've also talked over time about efforts by

the Department to try to figure out structurally how to either partner with other agencies or for the City itself to improve access to care in the Northeast.

We, a year ago, a little over a year ago, received an award from the federal government, a small grant, to do planning and look at what the issues would be to create a federally qualified health center in the Northeast. That work was completed in the fall and a report was generated for the Health Resources and Services Administration.

In essence, what it said was there were a number of things that the City could do such as identify parts of the Northeast that would qualify as medically underserved. A requirement for federally qualified health center status is that patients come to a federally qualified health center from medically underserved areas. Work had not been done in Philadelphia to do what is a fairly onerous task of evaluating federal

criteria and state criteria for medical under-service. We did that and have applied for the designation within neighborhoods in the Northeast of medical under-service. That will provide a new incentive and help enable other providers, not just the City but others, to be able to create federally qualified health centers in the Northeast and is an important step.

In addition, we looked at the feasibility, economic feasibility, of creating a new health center in the Northeast. The biggest issue in creating a health center, surprisingly enough, isn't building the health center, which is a substantial obstacle. It's operating the health center. And in looking at the cost of operations, what is clear is, for any provider, even with federal qualification designation, there would be an operating loss of more than a million dollars and, in fact, probably several million dollars, depending on

what happens in Pennsylvania with the expansion of Medicaid.

With that kind of gap in funding, it's difficult to imagine a private provider stepping in to open a new health center in the Northeast. And so we are seriously looking at what we can do in the City to figure out how to expand service. However, we can't, I don't think, think about that kind of expansion given the budget constraints that we have and have had until we know what happens with healthcare reform.

So what I am willing to promise to the Council and to those who are here is, as we look at the fiscal impact on our health centers, if our revenue goes up, we will certainly propose to the Budget Bureau, to the Mayor, and to Council changing the structure of dollars and reallocating them so that we could help support additional healthcare services in the Northeast. I think the City should and needs to do that. That's

a little time off from now, a ways off. In addition, planning for a new health center, no matter how it's done, is a distance off.

So in the interim, the City has designed and we're going to execute a rebuild of part of Health Center No. 10 to increase the number of examination rooms, and you see in our current budget a request to increase the salary of physicians. We know that the City's physician salary structure has fallen behind the salary structure for physicians in Philadelphia. We also know that healthcare reform is coming very soon, and what healthcare reform will likely do is increase the demand for physicians. So that if the City is as far behind as we currently are, we will never be able to staff up and, in fact, we likely won't be able to keep physicians on our payroll.

So we have put in this request. We worked with the Office of Human

Resources for the City to come up with a reasonable increase that is based on the market what the salary structure should be. It's taken us a while to go through all of the processes in the City getting to this point. Lots of people had to review our numbers. But we believe that increasing salaries for physicians is going to be a critical part of staffing up, so that even with an increase, although it's a modest increase in the number of examination rooms, we will have a better chance of recruiting and retaining.

COUNCILMAN GREENLEE: Doctor, if I could ask you one quick question. I know there's other members that want to ask. On that salary variance, on average what are we talking about between a City physician and a private, someone in the private, roughly?

DR. SCHWARZ: So the City salary at the end of this will still be somewhat lower than the market rate. To

get us up -- the increase that's in the budget is about a 25 to 28 percent increase. It's huge. We've not increased physician salaries in a long time.

COUNCILMAN GREENLEE: Okay. All right. Thank you. I have a lot of questions here.

Councilwoman Reynolds Brown, please.

COUNCILWOMAN BROWN: Thank you very much, Mr. Chairman. Good morning.

Good morning, Commissioner.

DR. SCHWARZ: Good morning -- good afternoon.

COUNCILWOMAN BROWN: Oh, it is that.

COUNCILMAN GREENLEE: Already afternoon.

COUNCILWOMAN BROWN: To your and your team of professionals.

So I'm going to ask a question and I have to run to an engagement, and I'm going to ask Councilwoman Maria

Quinones-Sanchez to pick up this ball for me on her round.

So I first need to say a huge thank you to you and the members of your team for the work we did for a mighty long time on lead poisoning. It was -- what do you call that effort, when you got --

DR. SCHWARZ: Elevating? Improving?

COUNCILWOMAN BROWN: Heavy lift.

DR. SCHWARZ: Heavy lift.

COUNCILWOMAN BROWN: For those who we had to bring around, if you will. But my office would be badly remiss if we didn't salute and say thank you to Nan -- pronounce her last name so I don't get it wrong.

DR. SCHWARZ: Nine Feyler.

COUNCILWOMAN BROWN: Who was a real leader, not only with members of this body but with the real estate community, who had very legitimate

concerns, and collectively, coupled with input from a number of my colleagues who helped with this ball, we were able to make a small movement of the needle. So we're better than where we were and in no ways where we want to get to.

DR. SCHWARZ: We appreciate your leadership on this issue.

COUNCILWOMAN BROWN: We know that the dollars continue to be targeted for cut, so we have to do the best with what we have.

And I'll leave it there and circle back, Mr. Chairman. Thank you.

COUNCILMAN GREENLEE: Thank you, Councilwoman.

Councilwoman Sanchez.

COUNCILWOMAN SANCHEZ: Good afternoon.

DR. SCHWARZ: Afternoon.

COUNCILWOMAN SANCHEZ: I want to talk a little bit about this health center. Earlier I was talking to Dr. Evans around the siting of services,

and in light of what you said with the report and the challenges between operationalizing this health center, this is one of those perfect opportunities for the silos to come down and for us to figure out how do we use behavioral health services that are needed in that geography and pair it up with a health center. This is --

(Applause.)

COUNCILWOMAN SANCHEZ: -- a perfect example. And I really want to challenge the Administration. We've talked about the co-location of services over and over and over again. We cannot continue to wait. And that was part of -- just for the record, Councilwoman Tasco had a series of questions related to that. In light of the reinvestment dollars that are available in Behavioral Health, the need of Dr. Evans to provide some services -- we've talked about some of the behavioral services; we've talked about some of the methadone situation

with the large number of folks on methadone in the Northeast. This is an opportunity for us to demonstrate to the community, who has been very resistant around all of these services, can we pool all of this together in a very unique situation, very safe so that they can accept it. I think that's the only way we're going to do it. And whether we do it as a city or we do it with one of our many great federally certified partners that we have -- my district could not survive without the partners that I have.

Can we get this done? Can we really look at challenging ourselves and say in a year -- because the issue is going to be the location. I mean, those are the issues I already begin, as I transition into my new district, I begin to hear. So unless we're able to pool a multitude of family services, we're not going to be able to site it. I mean, it's just challenging.

Can we get a commitment from

the Administration to maybe set up a work group -- and we could do it -- obviously Councilwoman Tasco represents some part of that Northeast with us -- through the Committee on Health Services in Council to begin to address that? I think if we can find a location, if we could look at the co-location, I think this is a perfect opportunity to do it.

DR. SCHWARZ: I very much appreciate your statement and your thoughts on that. I would add that on the Behavioral Health side, Dr. Evans and I have talked about the co-location of health services in Behavioral Health sites and thinking about the community benefit for mental health service providers and methadone providers of providing community healthcare services, particularly in Northeast Philadelphia but in other neighborhoods where there may be need.

So, yes, I think the concept is an important concept. We believe in a

wholistic concept, that people who have any sort of health need often have other sorts of health needs, and to look at the whole person as opposed to just part is very important.

Our health centers, I should say, in a couple of cases have Behavioral Health sites with them, and in other health centers, we've worked with Behavioral Health to pay for primary care providers to do the kind of behavioral healthcare that a primary care provider -- do depression treatment, for instance, and improve the care and the ability of providers, for instance, to identify domestic violence, to work on trauma and identification of trauma.

So we're working in that direction. I think the spirit that you're talking about is one that we share and is a very important thing for us to look at as we move forward. Thank you for that.

COUNCILWOMAN SANCHEZ: I think

it's is important, except setting up that work group so that we're moving and challenging ourselves is going to be important. And I'm going to do what Councilman Jones did to Tasco, charge her as Chair of that committee to really pull it together.

I think her and I have talked about within our boundary lines that we share, and because this is an important issue to both of us, being able to talk through this whole process with the community and really break down some of those barriers. We're ready for that. We just need it. I mean -- and I think this is -- if we have this kind of co-location and we have the resources, we could really address all of the public safety issue concerns, the transportation concerns that that community would have, but we need to be able to go there with some tangibles.

So thank you. I'll make sure we follow up with the Councilwoman.

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Councilwoman Tasco had some questions around the realignment of resources related to AIDS services and AIDS program services in the Ryan White money. Can you speak to -- there's an elimination of Class 200 dollars in the tune of $600,000 and then the realignment of the AIDS programs in Ryan White.

DR. SCHWARZ: I can start, and if you have other questions, we'll invite Jane Baker, who is the head of the AIDS Activities Coordinating Office, up.

So the story in large part is federal realignment. So we received an expansion in dollars around prevention in particular. The federal government made a determination that prevention of HIV as a science had moved forward, but the federal guidance to localities, cities, states hadn't kept up. And they put out some money to ask jurisdictions -- we were one of them -- to do planning based on the most recent data for prevention. We did that. Those were one-time

dollars. And we're waiting to see, given the sequestration in Washington, whether those dollars will come out to continue some of that work, but one of the things that they did was, they said we're going to continue to give you some dollars for prevention as we have, substantial dollars, and we want you now to take what was done in that planning and put it into practice.

So nationally, for instance, we know that prevention work with people who have HIV is incredibly important, work to make sure that people with HIV get connected to care so they get treated and their HIV level comes down, which means they're much less likely to transmit the virus. Those are two areas of prevention, one of which overlaps with Ryan White CARE obviously, getting people into care and making sure they're treated. And our dollars, from the federal government's point of view, are required to be redirected into those

areas. So in part, you see a reduction in Class 200 because our federal dollars have been reduced, and in part you see a change in direction because the federal government is changing direction.

The final thing related to Ryan White is, with healthcare reform, the Ryan White funding line, which funded independently of other payment sources, has increasingly said we will pay last dollar in. So all providers of Ryan White CARE must first bill insurers, particularly Medicaid.

So we have been required both by the state, since there are two parts of Ryan White, both by the state and the federal government to assure that our providers are registered and licensed to bill Medicaid and that they do bill Medicaid first and that we don't pay for any services that could have been billed to Medicaid. That will stretch the dollars ultimately, but that's what you're seeing in the budget.

COUNCILWOMAN SANCHEZ: Okay. The bell has rung.

COUNCILMAN GREENLEE: Thank you, Councilwoman.

Councilman Jones.

COUNCILMAN JONES: Thank you, Mr. Chairman, and I will attempt to be brief, no matter how long it takes.

COUNCILMAN GREENLEE: We're looking forward to it.

COUNCILMAN JONES: So I'm going to ask three quick questions, and you can answer them.

We will be sending a letter to all department heads about the DROP issue and its succession planning requirements. So I'll skip that. I'd like you to speak to -- Senator Hughes brought to the attention of Medicaid and the lack of responsiveness on behalf of the Governor to take advantage of some of those opportunities and your perspective on that, and touch on telemedicine as a use of technology as a multiplier effect to

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deliver services.

How was that, Mr. Chairman? Was that all right?

COUNCILMAN GREENLEE: Very good, sir.

DR. SCHWARZ: Let me go in reverse order. Telemedicine. So you brought up to us the issue of telemedicine, now I think it may even be four years ago, and I'm happy to report that the Department, despite some bumps in the road, has embraced that in two particular areas. So telemedicine has most often been used in areas where there's large geography to cover. So the State of Alaska, for instance, has invested heavily in telemedicine, because they don't have doctors in a lot of places. We have lots of doctors.

Where we are not so good as a jurisdiction is, there are specialists in certain locations, often with long waiting times, and patients, particularly patients in our health centers, who can't

always afford care at those institutions. So we have partnered, for instance, with the University of Pennsylvania dermatology folks.

If you look at concerns that people have, dermatology concerns are high on the list. They're urgent. If you woke up with a rash all over, you'd want somebody to see you and fix it. So dermatology issues are fairly urgent. They often are the only evidence we have of a whole body systematic problem, so they're important.

University of Pennsylvania School of Medicine's Dermatology Department and all of our health centers now partner on telemedicine. We can take pictures, send them over the Internet, and get direction from the dermatologists on how best to handle someone with a skin condition. It's a wonderful partnership.

The other is in radiology. So we have x-ray machines and mammography machines in our health centers. And what

in the distant past had happened was, we would take a picture on a hard piece of film and somebody would have to come in and read it. That meant that people didn't get an answer on their x-ray or their mammogram until the doctor arrived, which often took a long time, because we don't have a full time.

So we now partner with a radiology office, and you can see in our Class 200 dollars, that we send everything electronically. We've had to change our equipment so that now we have electronic equipment that can, through the Internet, send images, someone can interpret them and send back a response quickly. So we can identify issues for our patients more quickly. So we think telemedicine is very important.

COUNCILMAN JONES: Is that in conjunction with the stimulus money that electronic files, physical files, were downloaded into electronic form?

DR. SCHWARZ: So in part it is.

That act, the sort of part of the stimulus that had to do with electronic records, has meant that we're moving toward electronic health records in all of our health centers. The wiring for that is a real boon to being able to do telemedicine in the way that we are.

Your second question.

COUNCILMAN JONES: Was Vincent Hughes and the --

DR. SCHWARZ: Medicaid.

COUNCILMAN JONES: Medicaid.

DR. SCHWARZ: Yes. And I have talked pretty broadly, and there are others who are here in the audience who have been very concerned. The Affordable Care Act anticipated that Medicaid would be expanded in every state. When the Supreme Court ruled that the Affordable Care Act was constitutional, they also said that part of it, the one part of it where the federal government commanded states to expand the Medicaid program to all poor adults, that command wasn't

constitutional, that the federal government had to offer it to states, and states had to have an opportunity to say yes or no.

Pennsylvania so far has said no. That means that probably a hundred thousand Philadelphians who, under the vision of the Affordable Care Act, would have had Medicaid coverage won't have that coverage and, in fact, won't be eligible for any insurance. So that's a real problem for us.

In addition, the Affordable Care Act expected that the dollars to pay for that Medicaid expansion, which are entirely federal dollars for the first three years -- a hundred percent of those dollars come from the federal government, not from the state. The most the state will pay in six years is 10 percent of the total bill for that expanded number of adults. So it's a good deal. But to pay for that, they took dollars, the federal government, took dollars that are

called disproportionate share dollars, these are dollars that go to hospitals to care for the uninsured nationwide, and they're based on how much Medicaid business or Medicare business that hospital does. Well, the Medicaid dollars that were going to the uninsured were shifted over to go to the newly insured under Medicaid. Those dollars in Pennsylvania are still going away. If the Governor doesn't expand Medicaid, we won't get the benefit of that. So we will have hospitals who no longer have support to care for the uninsured and don't have new payments for people who are newly insured. It's going to create a crisis in Philadelphia for care for the uninsured.

COUNCILMAN JONES:

Mr. Chairman, your longstanding interest in sick leave brings me to that point. I'd like, along with Councilwoman Sanchez, like to have this department do an in-depth briefing to us, and maybe

we'll all get together and submit the questions in advance, thus allowing us an opportunity to work with your staff to give us answers to some of these things and, in a thoughtful way, be able to arm us so that as we get these questions, you can help us out with that.

So thank you, Mr. Chairman.

COUNCILMAN GREENLEE: Thank you. Thank you, Councilman.

Councilman Oh.

COUNCILMAN OH: Thank you very much, Mr. Chairman.

My questions are really very much along the same lines that was just articulated by Majority Leader Jones, and, that is, your role as the Health Commissioner, which I envision beyond being the head of the Public Health Department is also the chief representative of the public health interest in the City of Philadelphia. And our state as well as our city is not doing very well in the healthcare

provider area in that we had many challenges for our hospitals, our doctors, and practices that have closed for a number of reasons.

What is the current situation in Philadelphia in terms of accessibility to healthcare?

DR. SCHWARZ: I'm trying to think how best and quickly to answer that question. So if someone today needed healthcare, they would likely have to go to an emergency room. The safety net of safety nets in the City really is the City's health centers. They could go to a federally qualified health center that isn't one of the City's if they weren't a patient of ours, but the waiting times even for federally qualified health centers, depending on where they go, might be such that they wouldn't get in today. So if someone were uninsured and had a healthcare need, they would likely need to go to the emergency room.

COUNCILMAN OH: How many

emergency rooms have closed in the last five, ten years?

DR. SCHWARZ: I would need to go back and refresh my memory, but I think it's -- the one that I know of isn't a closure. It's just sort of a turning off the lights and not being overly accessible, but it's only one. I'm trying to think which other hospitals have completely closed.

COUNCILMAN OH: I'll have to check my notes, but I thought three or four.

DR. SCHWARZ: Yeah, for maternity care.

COUNCILMAN OH: Maternity care for sure, but also a lot of the smaller neighborhood hospitals, just the affordability of it is very challenging.

DR. SCHWARZ: I'll go back and look as well. I'm happy to give you a list.

COUNCILMAN OH: Which is a problem, if that's the case -- I have to

check my own notes, but the fact is that people in neighborhoods far away from Center City do not have the availability of that healthcare services that they believe is in proximity to where they live. They'd have to come all the way down to Center City.

DR. SCHWARZ: So Northeastern Hospital, for instance, is one that I think of, and Councilwoman Sanchez knows it well. We were very worried during the recession and, in fact, worked with the Department of Public Welfare to monitor the fiscal health of hospitals in town and to look at where they were in terms of their operating budgets, where they were in terms of their endowment. And endowment for hospitals went down substantially. It's unclear if Northeastern closed because of the recession. I think people could argue that a long time. But the hospitals that were really on the edge, the one that I can think of that came closest was

probably Roxborough, which reorganized and has been bought, and it's the one where for a long time their emergency room was sort of minimally operating. But otherwise, during the recession, we made it through, and part of that was working with the state to make sure if hospitals needed prompt payment so their cash flow would work and they could make their payroll, they would.

But I agree with you. I saw that as an important role for the City and the Public Health Department and the Mayor's Office. So we worked as hard as we could. St. Agnes Hospital became a chronic care facility. That happened before the recession, as did the Graduate Hospital conversion.

COUNCILMAN OH: Yes. Before the recession, but still the rate of insurance premiums in the state and other things have seen a lot of the practices close and move out, particularly in the areas where there's large legal suits

and --

DR. SCHWARZ: Yeah, malpractice is a substantial issue.

COUNCILMAN OH: So your comment was that under healthcare reform, we're going to need a lot more doctors. That is a way of saying the doctors would be leaving the City.

DR. SCHWARZ: In primary care.

COUNCILMAN OH: In primary care.

What does the City need to do to prepare for that? Because as the bell is ringing, I will say that I believe that the less robust economy, the less there is funds that are there for services, there are poor services, less investment in technology and methodology, and there seems to be a corresponding increase in unfunded mandates from the Legislature, as well as other types of requirements to achieve certain goals. And we're going towards a system of goal-oriented funding with less money

available. I think that's particularly a problem for our city, and as we are looking at less docs, less services, less funding, it seems that we need a lot more money or that there may be something legislatively that our city or administratively has to do to keep our healthcare services on par with the needs of the residents of the City.

DR. SCHWARZ: So I would say a couple of things. One is, the Affordable Care Act, as it was written, actually is a workable piece of legislation, and Medicaid expansion and what was called the Public Health Fund together would have seen us through. The Public Health Fund has been whittled away by Congress, particularly the House, and the Medicaid expansion isn't being accepted by the Governor.

COUNCILMAN OH: Right.

DR. SCHWARZ: If Medicaid expansion doesn't occur, many of the benefits to Philadelphia of the

affordable -- there are many benefits. So simply having exchanges -- and that piece of it, incredibly important for us. But Medicaid expansion is really important. One reason is beyond simply insuring people, the Affordable Care Act increases the rate for payment for primary care under Medicaid.

Now, federally qualified health centers like the City's health centers won't get an additional benefit from that because of the way we're already paid, which is different. But hospital-based providers and community-based providers who see Medicaid-insured individuals will actually be paid at a higher rate.

COUNCILMAN OH: Right, but right now it's not on the table.

DR. SCHWARZ: The higher rate will exist for anyone who is currently in Medicaid, but the expansion of Medicaid would mean that many of the people who are -- many people who are poor and uninsured at the moment would be able to

benefit from that as well.

COUNCILMAN OH: The fact that --

COUNCILMAN GREENLEE: Councilman, I'm going to have to call you on time.

COUNCILMAN OH: Okay. I'll come back to it.

COUNCILMAN GREENLEE: Thank you.

DR. SCHWARZ: Happy to chat.

COUNCILMAN GREENLEE: Councilwoman Sanchez.

COUNCILWOMAN SANCHEZ: Okay. I was given questions from both Councilwoman Tasco and Councilwoman Blondell Reynolds Brown. I think in order to avoid a potential callback for you, I am going to state some of the questions, and then you can submit them for the record, because they want them, and that way I don't bog you down, because they're very good questions.

If I had read Councilwoman

Tasco's as she gave it to me, I first was supposed to thank you for coming to our hearings on Medicaid Affordable Act piece.

One of her issues around the questioning with realignment of AIDS dollars, she is particularly concerned about the HIV infections in communities of color. So she'd like to get some data. Too many times when we get cuts, we poorly fund programs as opposed to efficiently funding the ones that work. So she wants to make sure that as those realignments happen, that we have that. So if you could provide that for her, she will be thankful.

DR. SCHWARZ: We'll provide it, but reassure her that we share her concern.

COUNCILWOMAN SANCHEZ: So he's concerned about groups like Bebashi and others. You know who her concerns are.

For Councilwoman Blondell Reynolds Brown, she's asking for a report

out based on the implementation of her lead bill, particularly looking at has the number of requests increased, the number of staff within your department, the technicians who are able to perform the lead abatements, and when the next lead abatement service RFP is going to be going out. So she really is kind of -- just a report out where we are, are there higher requests because of the children component, those types of things.

DR. SCHWARZ: Sure. And the one thing that she knows, but I'll reiterate, and I think she would want me to, is that the dollars for abatement, which have come from the federal --

COUNCILWOMAN SANCHEZ: She recognizes --

DR. SCHWARZ: -- have been decimated.

COUNCILWOMAN SANCHEZ: Right. So the issue is, what are we doing to kind of address it and if there's a big request for it.

The other question -- just for the record, I'm asking my colleagues' questions for the record so we can avoid a callback, okay, and then that way we can respond to it.

COUNCIL PRESIDENT CLARKE: Thank you.

COUNCILWOMAN SANCHEZ: The health centers waiting line, you mentioned this briefly. She's gone back and she said in 2001, the average wait was 66 days and now you're reporting 83 days. I know you reported out that the Northeast one is better. So she'd like to get trending of -- a correlation between bringing the per diem doctors online, what is the goal. And we often said if it ain't measured, it's not done.

DR. SCHWARZ: We won't -- even by increasing physician salaries, we won't completely eliminate, unfortunately, waiting times. But we know that the increase in waiting times has correlated with loss of physicians,

which relates to our salary structure.

COUNCILWOMAN SANCHEZ: Right. So the issue for her is how do you set your goals --

DR. SCHWARZ: Understood.

COUNCILWOMAN SANCHEZ: -- to try to make sure as we bring people online.

And then as it relates to MBE/WBE/DBE, she wants an explanation. Your goals continue to be -- while you're trending up, your goal for next year is 10 percent, and so she'd like a little discussion about why is it still low and what other steps you've taken to increase that for the record.

DR. SCHWARZ: Happy to.

COUNCILWOMAN SANCHEZ: And as it relates to the benefits counselors, you talked about over 4,000 patients getting enrolled. She wanted to know is there a benefits counselor in each health center.

DR. SCHWARZ: Yes.

COUNCILWOMAN SANCHEZ: And then are we measuring where there's high enrollment, low enrollment and where there's a gap?

DR. SCHWARZ: Yes.

COUNCILWOMAN SANCHEZ: She'd like to get that for the record. She's particularly interested in senior enrollment. And then she has -- a lot of good questions here. She's going to keep you busy.

And she was speaking to the issue of the collection rate for some of the fee for services, particularly the ambulatory health services. I know we got a new provider in that, so she'd like to see for the record the collection rate and what's the new goal for the new company. Because, again, it's an issue of we recognize it was an area where we had very low collection rates. So what's the goal with the new company.

And then the other modest fees that the Department collects. We

instituted -- I think two years ago was the fee. So how are we doing on those collection rates.

And then the last one is on succession planning for the Department, the large number of staff who are in DROP, and what is the Department's plan to staff up and, at the same time, provide training to fill those.

So those were Councilwoman Blondell Reynolds' question. If you forward them for the Chair, hopefully we will not have to do a callback.

And that is it.

DR. SCHWARZ: Thank you.

COUNCILWOMAN SANCHEZ: Thank you.

Thank you, Mr. Chair.

COUNCIL PRESIDENT CLARKE: Thank you, Councilwoman.

The Chair recognizes Councilman Oh.

COUNCILMAN OH: Thank you very much, Mr. President.

So up till now, the Governor had said no to the Medicaid.

DR. SCHWARZ: That is correct.

COUNCILMAN OH: So that represents a lot of money not in our city.

DR. SCHWARZ: That's correct.

COUNCILMAN OH: So from the budget process, which is my only interest in this line of questioning, is, how much money do we appropriate for Health and as we move into the future, what are we expected to put into Health? You've identified that doctor salaries have to increase in order to keep physicians in Philadelphia. That may take dollars out of buildings or equipment. I'm not sure. Or we may have to move some other dollars, but in my kind of understanding what's happening, it doesn't end with just increasing by 28 percent physician salaries. There is continuing cost increase, more doctors leaving, other types of issues, and I want to understand

from your expertise what are we looking at in the future, what kind of money do we have to prepare for.

DR. SCHWARZ: I think the unfortunate answer to that is, we're not entirely sure, but we have increased the projection on revenue for the Health Department, because there's a funding line around electronic health records that we will be eligible to draw on beginning in the upcoming fiscal year, and it's those dollars that we've proposed to use for the increase in physician salaries. So it's budget neutral from the point of view from revenue and expenses for our health centers.

COUNCILMAN OH: Well, so dollars in for electronic --

DR. SCHWARZ: Health records.

COUNCILMAN OH: -- health records will be used for physician salaries.

DR. SCHWARZ: Because the

physicians will be the users heavily of, in a certain sense.

COUNCILMAN OH: There are other legislated mandates coming down about what you're supposed to do. I understand there's a bill in Harrisburg that mandates how many nurses per patient. It doesn't provide any money for the nurses, but it requires hospitals to have certain number of -- so there's a lot of mandates coming down in the healthcare area but no money.

DR. SCHWARZ: Many of the mandates that are coming down don't relate to us. They're related to either hospitals or larger healthcare providers.

COUNCILMAN OH: True, and this is my point: The hospitals will not be able to appropriately deal with this. They will close certain sections, reduce services, make services not available, and what will happen is, those who cannot afford or will not be serviced must go to the City's health services that I hope

we'll be able to provide for them.

DR. SCHWARZ: Yeah. I think the best answer I can give is, we're going through a year of change. So the Affordable Care Act will really come into play between January and April of 2014, and no one knows what that will do specifically to City health services and what that will do to other providers of care. There are substantial incentives for hospital-based providers to step up from the federal side, and there are substantial incentives for federally qualified, other federally qualified, health centers to increase their service provision. How that happens, you're right, depends in part on what the state does and in part on what the federal government does and what providers do and what consumers do.

So we have put into this budget our best approximation of what service will look like while we implement an electronic health record, see what

happens with health reform, try very hard to meet increased demand or decreased demand, depending on what happens. I believe our budget for '15, for next year, we'll be much better informed because of what happens. But since the Affordable Care Act impact will occur over really less than half a year, I think we'll be okay for '14. I am worried about '15, and we're going to need to carefully observe in the first few months of '14 what happens. And the budget, remember, gets moved forward in November. We have this conversation in the spring. So there may need to be some revision during that time based on the reality of what we're seeing. I also think even the '15 budget will be a transition budget, and it won't be until '16 or '17 that we hit steady state with the Affordable Care Act.

So I share your concern. I think we don't know enough about the future, and what you see in the budget is

our best approximation of what we need to carry through in '14. We're going to have to come back and talk again about '15.

COUNCILMAN OH: Thank you very much, Doctor. I would like to just echo Councilman Jones' request that you brief us with all of these important issues and what you see happening.

DR. SCHWARZ: I'm delighted to do so. Thank you.

COUNCILMAN OH: Thank you.

COUNCIL PRESIDENT CLARKE: Thank you, Councilman.

The Chair recognizes Councilman Jones.

COUNCILMAN JONES: I will be absolutely brief.

A part of the questioning about DROP is would you add to it a question about how many of your employees are contract employees versus full-time employees. There's a trend that says that a lot of departments are doing that,

and I would wonder is there a cost evaluation to hiring versus contracting out that makes sense. And this is not just directed at you but all departments that are doing that, because at the end of the day, privatization doesn't always save. Sometimes it puts us in a position where we are locked into vendors and/or contractors in a way that is not as frugal as we once thought.

DR. SCHWARZ: So what I will say to you is, the Health Department historically has had a substantial number of employees who have been hired through contract, and we've had conversations here in this Council about that. We have been committed to trying to rationally look at that and figure out how to not increase the number of individuals. In the last contract that was signed with District Council 47, a paragraph was agreed to between the City and the District Council related to a pilot program to create something called a

Civil Service exempt group for grants-funded people. One of the reasons that the Health Department has had such a large number of contracted positions is because so much of our funding is soft money or comes from grants, so we don't know over time what the workforce demand will be.

But we have grants that have been around for a long time, and if those positions are contracted out, sometimes we look back and say they could have been hired through Civil Service. Well, one way to create a system of hiring that is a bit more forgiving of grant money and allows us to be fair to the employee, to make sure that the union, for instance, gets union dues, is to create a class of people that the Charter allows that are Civil Service exempt and have gone through the Civil Service Commission who are temporary employees but paid through the City and hired as exempt based on Civil Service rules as opposed to like

me, Charter exempt position. We've been very successful. So we have hired more than 80 people in that way. Some have moved into Civil Service. So they've been taking tests and moved into Civil Service, and the grant money has continued or they've moved into a different role. And I'm hopeful that if District Council 47 finds this relationship to have been a satisfactory one as well, that we would be able to help provide a different incentive when new money comes in in terms of hiring.

But I think you raise an important issue. We try very hard to think about the costs and have tried -- physicians are a good example -- to have parity in expense so that it doesn't cost the City more. You will notice in this budget that we are moving a substantial -- we propose to move a substantial number of physicians from contract into Civil Service. I think that's the right thing to do, and it is

an issue that we have tried to take seriously, that I'm committed to being on top of, and we have a succession plan for the Department that I think is thoughtful that anticipates what we need to do to continue Civil Service employment rather than using contracting out, because I don't think it's necessary. I think the City's system of hiring can work, but it requires advanced planning.

COUNCILMAN JONES: Thank you, Mr. Chairman. The notion that the private sector always does it better isn't always true. Thank you, Mr. Chair.

COUNCIL PRESIDENT CLARKE: Thank you, Councilman.

We're going to recess. I want to thank you for your testimony today.

We'll recess until 2 o'clock. Thank you.

(Recess.)

COUNCILMAN GREENLEE: We're going to get started.

Commissioner, why don't you

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start your summary and then we'll -- I'm sorry. This is the Department of Human Services.

If you could start, and then I'm sure the members will be coming in.

COMMISSIONER AMBROSE: Thank you.

Good afternoon, members of City Council. I am Anne Marie Ambrose, Commissioner of the Department of Human Services. I am pleased to appear before you today to share our FY14 budget request and report on the progress of the Department of Human Services. With me at the table are Chief of Staff of Finance Chanell Hanns.

DHS's FY14 General Grants Fund budget request is for over $650 million. Our FY General Fund budget request is $98 million. This is 3.321 million below the FY estimated obligation level of $101 million, mostly due to 1.2 million decrease in the cost for juvenile justice services as a result of significant

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reductions in delinquent placement population and the elimination of a one-time increase in debt service costs in FY13 due to the delayed opening of the new Youth Study Center.

Our FY14 General Fund request by class is as follows: Class 100, 18 million; Class 200, 78 million; Class 300, 645,000, and Class 400, 534,000. DHS's Class 200 allocation for FY14 is 515 million.

DHS currently has 1,614 employees, 72 percent are women, 76 percent of our workforce is African American, 17 percent are Caucasian, 1.7 percent are Asian, and 3.6 percent are of Hispanic ethnicity.

Increasing participation of minority, women, and disabled services providers for DHS-related contracts remains a very high priority for the Department of Human Services. For FY13, I am proud to report that to date approximately 50 percent of our total

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discretionary for-profit dollars have been spent on minority, women or disabled businesses.

I am pleased to share with you an update on the implementation of our systemwide transformation called Improving Outcomes for Children. This initiative builds on the belief that a community-neighborhood approach, with clearly defined roles between county and provider staff, will most positively impact safety, permanency, and well-being. Under IOC, providers will be responsible for providing case management services while DHS will maintain the hotline, investigations, and oversight monitoring. The first community umbrella agencies, Northeast Treatment Center and APM, have already started to receive cases. These cases are from the 25th and 24th and 26th Police Districts, respectively. By 2015, it is anticipated that the IOC rollout across the City will be completed.

As we transform our system and the way we deliver critical service to children and families, we have significantly improved our electronic case management system called ECMS. In January of 2013, DHS was able to successfully integrate the first two community umbrella agencies into ECMS. This means that those case managers in these agencies can utilize the same information and forms as DHS staff while at the same time allowing DHS to have realtime access to the information. In addition, we are also piloting a mobile workforce opportunity for a small group of DHS employees working with Northeast Treatment Centers. This pilot allows for more community presence, increased efficiency, and productivity.

Should any Councilmember wish to engage in further discussion of any of these matters or other matters related to my written testimony, my staff and I are happy to meet with Councilmembers at

their convenience.

COUNCILMAN GREENLEE: Thank you, Commissioner. Thank you very much. Let me ask a couple of questions.

On the community umbrella agencies --

COMMISSIONER AMBROSE: Yes.

COUNCILMAN GREENLEE: -- CUAs, that's what you call them, right, CUAs?

COMMISSIONER AMBROSE: CUAs, yes.

COUNCILMAN GREENLEE: CUAs, yes. I went to a briefing about that up in the Northeast a while back, and certainly the two you picked so far are well known, fine agencies, so I'm not questioning them, but could you just go over briefly the criteria that is used in selecting CUAs.

COMMISSIONER AMBROSE: Sure. It's actually a fairly extensive selection process. We have them do the written response to the RFP. That written response is evaluated by senior

DHS staff. It's scored in areas of the substance of the response. It's scored in areas of fiscal accountability and past performance. And then we rank those providers, and then they do presentations to my senior team. We listen to those presentations and make decisions based on quality service delivery and their track record for being able to take care of children and families involved in the DHS system.

COUNCILMAN GREENLEE: Okay. Great. All right. Thank you. And just one other question. The external providers that you have that do the in-home visits --

COMMISSIONER AMBROSE: Yes.

COUNCILMAN GREENLEE: -- how do monitor those, make sure they're following proper procedure? Can you go over that a little bit.

COMMISSIONER AMBROSE: So there's a variety of ways that we monitor our providers. We have an annual

evaluation of all of the provider agencies. We also have a visitation tracking system. So every month, providers are required to visit the children and families that they serve, and so we track those visits. We keep track of the work that they're doing based on the electronic case management system. So every contact that a provider agency has with a child or family, they write up notes of that visit. We have access to those notes, and we look at those notes.

We also have our ChildStat sessions, which is a quality improvement mechanism that we use to look at the performance of agencies. So we'll pull cases and we have the provider agencies come and present on those cases. We have a number of indicators for things that we think are important to quality service delivery, and we measure those outcomes based on those provider agencies.

We also do quality service

reviews where for every level of care, we pull about 12 cases. We have a team of DHS staff and external stakeholders that includes providers, the courts, the advocates. We spend about three days reviewing the case and then also talking to the people involved in the case. So we talk to the children, the families, the schools, the behavioral health providers. And then we rank those cases, how is this child doing, what's the system performance on this case.

In addition to that, we have a quality visitation service where we randomly go out and visit about 30 families a month. We talk to those families about their involvement with the provider, making sure that the provider is doing the required visits, making sure that the provider is spending time with that family and asking them questions related to their family service plan, and that the family gets an opportunity to say whether these services are helpful to

them. So there's all kinds of quality improvement measures that we've put into place.

COUNCILMAN GREENLEE: Okay. Thank you. Thank you very much.

Councilwoman Sanchez.

COUNCILWOMAN SANCHEZ: I'm going to make this easy for you. I'm not going to ask too many questions.

COUNCILMAN GREENLEE: We like easy.

COUNCILWOMAN SANCHEZ: Good afternoon.

COMMISSIONER AMBROSE: Good afternoon.

COUNCILWOMAN SANCHEZ: Speaking of the CUA situation, I want to get a sense from -- this is a huge undertaking. How are we doing with the contracts and the payments to the big guys, and has there been a seamless transition for the smaller guys? I'm more worried about our provider network kind of system.

COMMISSIONER AMBROSE: So I

would say that DHS's contracting system has never been a seamless transition, if I'm completely honest about our ability to do business properly in a way that helps providers. We are constantly delayed in processing the contracts in the way that is best for providers. We've recently, at the request of our partners in the provider community, pulled together a work group to meet with Chanell and her staff to really talk through now we might make this process better for the next fiscal year, and we're anxious to implement those recommendations that came from the providers.

COUNCILWOMAN SANCHEZ: As it relates to next year, one of the concerns -- and I had mentioned it to you earlier, and I think it's really important -- is the continuation of some of the relationships that were directly with your department and now with the CUAs. I have many of the smaller

providers who are going to be begin layoff plans because the CUAs' inability to have a commitment doesn't allow them to make a commitment to them moving forward, and a responsible provider can't wait until July 1st to do that.

What are we going to do with the smaller ones as it relates to that?

COMMISSIONER AMBROSE: So this is not an issue that I've heard about, so it's something that I'll have to look into. What we've tried to do -- and I actually think the providers have done an excellent job of doing this -- is create a memorandum of understanding with the subcontractors that they're thinking of partnering with. So there's that level of commitment that's occurred at least for the first two CUAs. We've also had for each of the upcoming CUAs a series of provider roundtables where the smaller providers have an opportunity to really network with larger providers and find what their place in the world is going to

look like.

I will look at Northeast Treatment Centers and APM to figure out why that's happening, because this shouldn't really penalize. Those smaller providers are going to be subs anyway. There should be some level of commitment.

The other thing that we've done to ensure that the smaller providers wouldn't be put too much at risk is for the prevention contracts, we've committed to keeping the DHS prevention contracts in place for a year after the implementation of the community umbrella agency, so that the CUA will have an opportunity to think through what they want prevention services in their community to look like. They may choose to keep some of the services that DHS currently has and they may choose to contract out with smaller providers, and that's actually one of the goals of IOC, is to make sure that some of those grassroot providers who have never had a

contractual relationship with the City is able now to be a little bit more involved in serving children and families at the neighborhood level.

COUNCILWOMAN SANCHEZ: What are we going to do to make sure that the CUAs all of the sudden don't start going into new program areas that they weren't before and, therefore, taking out some of the smaller providers?

COMMISSIONER AMBROSE: So as the Commissioner, I retain the right to approve any subcontract. So I can assure with my team that those kinds of things aren't happening. And I will say that the level of collaboration and partnership with the first two CUAs has been exceptional.

COUNCILWOMAN SANCHEZ: Everybody is playing nice in the sandbox right now.

COMMISSIONER AMBROSE: That's exactly right, and that's why we continue to meet on a weekly basis, and we will

continue to monitor that.

DHS isn't ultimately giving up any responsibility. We're just partnering in a different way with community-based providers.

COUNCILWOMAN SANCHEZ: And that's important, and so I want to make sure -- and I've said this both to both providers. I've been just as transparent as I am being with you -- that where we have grassroots providers who need technical or capacity support, that their role should be to provide that as opposed to I'm going to take this service in because I want to control it, I want to, you know -- I don't want to -- I don't want to be in the middle of those disputes. I will be if I see people going into service areas that are not their specialty, but it's easier for them to do and in some cases they can make a prettier presentation.

COMMISSIONER AMBROSE: You and I are having the same conversation with

the providers then. And certainly if that's come to your attention, if you could let us know, we would definitely want to work that through.

COUNCILWOMAN SANCHEZ: I would hope not, but I want us to continue to be as deliberate with them as possible so that -- I'm glad that we're both saying the same thing.

I want to talk a little bit about your diversity goals in terms of your staff. I notice that as it relates to bilingual, multicultural, and language access, your number is low. In light of kind of your shifting around, how do you see yourself being able to be more diverse, both on your executive level and on your staffing?

COMMISSIONER AMBROSE: So I think part of the way we're shifting around is exactly the right way. So the direct service staff who deal on a day-to-day basis with the children and families that we serve will be bilingual.

They will be able to communicate effectively.

DHS has to do a better job of that. I'm not exactly sure why we've had the shift, because I think we used to have higher numbers, and we probably need to pay a little bit more attention to that.

I'll also say that in a good way, we've gotten a lot more diversity with staff, African staff, those kinds of other diversity that's necessary, and their ability to also communicate with the children and families that we serve has been a good thing. But we'll pay closer to attention to that as we move forward.

COUNCILWOMAN SANCHEZ: Yeah. It would be nice to get some sort of goal so that you can say that and have your staff work towards that.

The bell has rung.

COUNCILMAN GREENLEE: Thank you, Councilwoman.

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Councilwoman Reynolds Brown.

COUNCILWOMAN BROWN: Thank you.

Good afternoon, Commissioner.

COMMISSIONER AMBROSE: Good afternoon.

COUNCILWOMAN BROWN: To you and your team here. Welcome back.

COMMISSIONER AMBROSE: Thank you.

COUNCILWOMAN BROWN: So you've given a us lots of great information, most of which I tried to get through, and I was struck by this beautiful annual report. I might add just for the record that the young lady on the inside used to work for me, and she decided to go on and go back to school, which is a great thing.

In the press release for the 2012 annual report, you state that there has been a decrease in the amount of young people held on an average day at the Juvenile Justice Center. To what might you attribute that progress,

improvement or change?

COMMISSIONER AMBROSE: I think it's really the partnership with Family Court under Administrative Judge Dougherty. He has been a tremendous partner to DHS. We've worked really hard in reducing the number of children in placement. I think that's had the same effect at the Youth Study Center.

Recently, we've started the Juvenile Detention Alternatives initiative, which is why Deputy Commissioner Farlow is not here with us. She's one of the leaders and is in Atlanta with Judge Dougherty right now learning how to best implement that initiative. That's really about how the City can create alternatives to secure detention when the risk that that youth poses to the community is low risk. And so we've really worked very hard at researching what was happening around the country and trying to implement those practices here in Philadelphia.

COUNCILWOMAN BROWN: Very good. Very good. That's become customary by the Department, to look to see who is doing it better and see what we can glean from that.

In the press release as well, you cite dramatic -- this was a huge issue for members like Quinones-Sanchez and the Chair of the health and human services committee Tasco and I when I first came here about so many children being placed outside of the state. So just discuss the update and how there's been a dramatic change.

COMMISSIONER AMBROSE: So, again, I will attribute that to the partnership between Family Court and Judge Dougherty in particular and Dr. Evans. When we came in, we made a commitment to making sure that the children of Philadelphia stayed as close to home as possible. I think at the time we came in, we had over 200 children, both on the delinquent and the dependent

side in out-of-state placement. We now, I think, have three on the delinquent side and I believe we have 41 on the dependent side, and most of those children are actually with relatives and kin. And so what we've decided to do is really work very closely with the provider community in Philadelphia and say to them, If you want our business, we want to keep our children close to home and how can we work together to think differently about what we can do about providing specialty services here in Philadelphia and in the State of Pennsylvania.

COUNCILWOMAN BROWN: That's huge.

COMMISSIONER AMBROSE: Very important for families and making sure that they can visit. If we really believe that children belong first and foremost in their communities with their families, there needs to be visitation. And so that's been a huge driver of the

change in Philadelphia.

COUNCILWOMAN BROWN: What are the factors that required the three to be placed outside of the City?

COMMISSIONER AMBROSE: It's special needs. So I think two of the children may be deaf and severe, on the delinquent side, sexual offending behavior and severe behavioral health issues.

COUNCILWOMAN BROWN: Well, that's a huge, dramatic improvement and a clear indication of what's possible if you just figure out strategically how to do it. And that means fewer dollars, of course, leaving the City as well.

COMMISSIONER AMBROSE: Absolutely. Absolutely.

COUNCILWOMAN BROWN: In your 2012 annual report, you note that in 2012, construction began on a new building with the one-stop shop for child victims of sexual abuse. So that's great and huge, some might say, right?

COMMISSIONER AMBROSE: Fifteen years it's been in my budget, and this is the year that we're finally delivering on something that's been best practice around the country for a long time. So I think that the Mayor had a little something to do with that, and Deputy Mayor Gillison was pretty instrumental in helping us move this. It was the commitment to best practice. It's something that we've been geared up to do between the Police Department, the DA's Office, and Philadelphia's Children Alliance for a long time. We're incredibly excited about the opportunity that allows us to work together to take care of children who have been victimized by child sexual assault.

The other really exciting piece of this for Philadelphia is that we hope to have a medical component. So if children are injured as a result of the sexual assault, they'll be able to be seen at the same location. So the trauma

is limited to hopefully one time, not multiple interviews by multiple agencies.

The other thing that PCA has secured for that location is behavioral health services on site. And so there'll be a trauma focus of what the child needs immediately after the event and what the family needs to try to help heal from the episode. And so we're very excited, and we plan to move hopefully at the end of May, and thanks to Councilwoman Quinones-Sanchez for her support of this project from the very beginning.

COUNCILWOMAN SANCHEZ: Both of those are mine.

COUNCILWOMAN BROWN: Aren't you lucky? That's outstanding.

COMMISSIONER AMBROSE: Yes. We're very excited.

COUNCILWOMAN BROWN: To have the willingness of a District Councilperson to embrace, if you will, and create a haven for that population.

COMMISSIONER AMBROSE: She is

always willing to have those conversations, which we really appreciate.

COUNCILWOMAN BROWN: That's huge.

One of the recommendations that came out of the report around Danieal Kelly -- and I clearly remember sitting up there and asking the question -- was how well are we doing with regards to providing professional development opportunities for the professionals in your department, as well as a chance for them to breathe and catch their breath given the enormity emotional balance they have to strike in dealing with these cases. So how well are we doing in that area?

COMMISSIONER AMBROSE: So I'll say that we're struggling, not because we're not working incredibly hard but because we're trying to help build up provider capacity at the same time we're trying to work on our own staff's

capacity. So with improving outcomes for children, the provider agencies have to be certified to do direct service. And so we've worked with the state to develop a training program that would get them up to speed. So we've been doing that, and at the same time, we're trying to help our own staff. So we've created something called DHS University, which is an online resource for our staff to use. And it's not just about the core elements of what it takes to be a child welfare worker. It's trying to look at what their interests are and how to help them build a career ladder. So we're in the very beginning stages of this, but it's really about building core competencies with DHS staff to make sure that they have an opportunity to grow professionally and advance throughout the agency. And so we're excited about it. It's at the convenience of the worker. So there is -- you can go on when it's convenient for you instead of having to

go to a training over at Temple University Center City. There's a pre and post testing opportunity, and I think it will be something that becomes a really great tool for our staff at DHS.

COUNCILWOMAN BROWN: And is it to the point where it's recommended or it's required if you want to grow professionally? What's attached to it to sort of serve as an incentive for the professionals over there?

COMMISSIONER AMBROSE: So we have a requirement under our state regulations to have an individual training plan. I think it's called individual training plan. And so our staff have to fill that out and work on that, and they're required to have 20 hours of professional development training in the year. And that's something that the state looks at when they come to do our reviews.

So hopefully it will be individualized for that staff and be able

to provide them with opportunities. I mean, the struggle for them is that the work is hard, and so we keep getting changes both from the state and the federal government on mandates for child welfare, and as those mandates come down, we have to continually train staff on the new mandates. And so how to find a balance between giving them an opportunity to look at more elective kind of courses that can continue to build their competencies in a way that allows them to develop professionally is something that we're trying to work on.

COUNCILWOMAN BROWN: Does DHS provide the service for -- persons who want to sponsor or host events for young people and children I've just discovered have to have a child -- please help me out.

COMMISSIONER AMBROSE: Clearance?

COUNCILWOMAN BROWN: Yes.

COMMISSIONER AMBROSE: Yes. So

all of our staff have to have those clearances in order to work with children. So they go through the state clearance process and the FBI clearance process. Volunteers who work at our agencies also have to go through those processes. And that can sometimes be difficult, particularly with the juvenile justice population. We have a lot of ex-offenders who have tremendous credibility and have gone through a lot who could work so closely with our youth and try to help them find a different way. And so we really struggle with being able to contract with them directly, and so we're trying now to work with Commissioner Slawson at the Rec Department to think through ways we can partner and still support those really great agencies out there.

COUNCILWOMAN BROWN: You know what, it might be useful to share with Councilmembers what comes out of that. My office partnered with the University

of the Sciences a week ago, and as a part of us being on their campus, we had to get child clearance, a first in the many years I've been involved in higher ed, but as a result of the Penn State awful recent experience, that is now a new requirement on university campuses, that if you're going to come on and sponsor any kind of program that involves young people under 18, it is a requirement. So our office had to work with University Sciences -- University of the Sciences, let's get it right, and Risk Management to get that form.

COMMISSIONER AMBROSE: It's a huge issue for us now that we're working with the School District on the school closures. As we think through what a safe corridor strategy might look like for Philadelphia, we really have to rely a lot on volunteers, and how we recruit those volunteers and get them through the child abuse clearance process is going to be a challenge for us. So it's something

that we're looking at. We're looking at the legal requirements and seeing if we can crosswalk that. And then DHS has the capacity to do some of those clearances, but not for the amount of staff that we're going to do it -- the volunteers that we're going to need to do it for, and also there's a cost associated with doing the clearances.

COUNCILWOMAN BROWN: A cost and a timeframe. So if you're up against the clock to pull off a program and you discover this new requirement, you could be in a really bad place.

COMMISSIONER AMBROSE: So we'll do more research on that and --

COUNCILWOMAN BROWN: I'm sorry.

COMMISSIONER AMBROSE: -- share that information with you, Councilwoman.

COUNCILWOMAN BROWN: The bell rang. So I'll --

COUNCILMAN GREENLEE: You were on a roll there, so I didn't want to interrupt you. Thank you, Councilwoman.

Councilwoman Sanchez.

COUNCILWOMAN SANCHEZ: You know I always cede to my older Councilperson -- senior. I'm sorry.

COUNCILMAN GREENLEE: I want to for the record, Councilwoman Sanchez said that, Councilwoman, not me.

COUNCILWOMAN SANCHEZ: She knows what I mean. She knows what I mean.

It would be important -- Councilwoman Tasco is not here and she asked me to ask this if she was not back for this session as it relates to you. The new CUA cycle includes the 15th and the 39th District. I think hers is the 39th. What's the timeline for the naming of that? I know we talked about it earlier, but...

COMMISSIONER AMBROSE: So it's actually the 15th is first. And the timeline for naming all three, the 15th is the third, the -- let me get this right. The fourth is actually the 2nd,

7th, and 8th, and the fifth is the 35th and the 39th. All of those will actually be decided in the next month, and then the rollout process for the 35th is April of 2014.

COUNCILWOMAN SANCHEZ: April of 2014?

COMMISSIONER AMBROSE: Correct.

COUNCILWOMAN SANCHEZ: If you could forward that to the Chair by the districts. I think she's particularly interested in who kind of made the final cut. I think that would be interesting to see who actually applied, the types of partnerships. I know she and I share the 2nd, and I realize that that was being combined with the 7th and the 8th.

COMMISSIONER AMBROSE: Yes. We can share this chart with all of the Councilpeople who would be interested.

COUNCILWOMAN SANCHEZ: Yeah, especially who were finalists, what type of collaborations were proposed, those types of things.

COMMISSIONER AMBROSE: And we're in the midst of that selection process, but once those decisions come out, we'll share, but we can share the timeline now.

COUNCILWOMAN SANCHEZ: Okay. That would be great.

What is the expectation with the CUAs and the interrelationship with schools? Are we prescribing some things that they must do with kids particularly who are in schools?

COMMISSIONER AMBROSE: Yes. So what I'll say is, I'll echo what Dr. Evans said this morning about the partnership with the School District. It's better than it's ever been, from my perspective. So Karen Lynch, who is the Deputy School District -- I don't know her exact title, but she is a deputy to the Superintendent -- is sitting on the Improving Outcomes for Children Steering Committee. So her leadership has been really helpful in making sure that

there's involvement at the CUA level of the schools.

What we've encouraged the CUAs to do without mandating it is make sure that principals are involved. And so there's a community advisory board for each of the CUAs. There's an expectation that there be somebody involved at the school level on each of those community advisory boards. And as things play out at the CUA level, we're hoping that we're going to do co-located services.

So this theme that you started this morning we think is incredibly important. And so behavioral health services will be co-located at the CUAs, school or educational liaisons. So DHS has an education support center. We do a tremendous amount of outreach and trying to work on cases together with the District. It's our expectation that at some point, once the transition of staffing has occurred, there'll be DHS education support center staff at each of

the CUAs to make sure that there's a seamless way of solving problems at an individual child level.

COUNCILWOMAN SANCHEZ: Let me encourage you to require that at minimum there be an orientation from principals and others from the CUAs. Too many times folks think, Well, I know the principal or I don't really need to do this, and requiring the CUAs to explain to the school leadership and the parent leadership at the school an outline of the services. Too many times I find that even the folks interfacing with the children, counselors, teachers, are unaware of the types of support services, because we assume people know, and they don't. And so I strongly, at least at the beginning, that every school leadership team and parent team get that general orientation, because we are moving in a different direction. The footprints are based on police districts. It's a little complicated, but it's

supposed to make people's lives easier, and we can't assume that that information trickles down.

COMMISSIONER AMBROSE: I actually think that's a great example of what we should be doing. I'll also say that Luciana Terrell, who is here, who runs the Education Support Center, what she's done is gone to the District and done training on the resources available, not only with the Education Support Center but with all of our prevention services to the counselors who are in the schools for exactly the reason that you highlighted.

COUNCILWOMAN SANCHEZ: Okay. The bell has rung.

COUNCILMAN GREENLEE: Thank you. Thank you, Councilwoman.

Councilman Jones.

COUNCILMAN JONES: Wow. Thank you, Mr. Chairman.

Good afternoon.

COMMISSIONER AMBROSE: Good

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afternoon.

COUNCILMAN JONES: I want to thank you early on in my tenure here for bringing me over and making me sit through approximately a half a day of orientation on DHS. I will admit again for the record, that side of things, social service side of things, wasn't my natural -- like Councilwoman Sanchez knows social service like the back of her hand. I had to struggle to learn a lot of the things that you guys know, and your staff has always been helpful whenever we've had an issue to try to bring constituents' needs to government's needs. You guys have always been a good bridge, so I thank you for that.

COMMISSIONER AMBROSE: It's a pleasure working with you, Councilman Jones.

COUNCILMAN JONES: Secondly, I'd like to ask is, early on one of your goals and objectives was to regionalize or relocate a lot of the services offered

to particularly young people by way of in a natural habitat as opposed to shipping them to Opieville where Sheriff Mayberry is, but to give them coping skills within the neighborhoods and environment that they're used to. How has that been progressing?

COMMISSIONER AMBROSE: So that's what our Improving Outcomes for Children initiative is all about, and it's progressing very well. We've implemented services in the first two community umbrella agencies in Eastern North Philadelphia. The providers I think have done a really good job. It remains a hand in glove partnership, because we want to make sure that we're available to help them be successful with the children and families that we serve, but by the end of 2015, the neighborhood approach that we've taken should be instituted citywide.

I'll say on the juvenile justice side, we've also been pretty

successful in trying to do that as well. We continue to work very hard in reducing the number of children in placement, both on the dependent and the delinquent side. We believe with the right supportive community-based services, children and families can thrive and stay in their own communities. And so we're working really hard with our provider community to create those resources.

COUNCILMAN JONES: So if you were to grade it, rate it by way of a work in progress, understood, how far have you gotten along on that?

COMMISSIONER AMBROSE: So it's definitely a work in progress, but what I'll say is that we spent three years planning this initiative. So we have the support of the two largest child welfare foundations in the country. So the Casey Family Programs has been with us from the very beginning. They exposed us to sort of the national best practice, helped us visit some of the other jurisdictions who

were doing this.

And then we've had two years of planning with about 150 different stakeholders. We formed a steering committee in December of 2010. We created six different work groups, and we've included advocates, providers, other system leaders and stakeholders in planning for this initiative.

And so I think we're in the implementation phase of all that planning, and I'm more optimistic than I was at the beginning about how well the partnership has been going. This is kind of intuitive, so we know it's better for families to stay together in their own communities whenever that's possible, and I think everybody has moved forward in the philosophy of that and really trying to think creatively about how we use natural, community, and neighborhood supports to help families get better when they can and obviously when there's a safety issue, being very clear about the

need for the Department to intervene in a different way.

COUNCILMAN JONES: So I remain real clear about my areas of expertise and I yield that to Councilwoman Tasco and people with far greater experience than that, but I understand the economic value of providing services nearer to home. When a child gets a clothing voucher and they spend it in neighborhood stores, it also serves as an economic driver to help the local economy as well.

COMMISSIONER AMBROSE: I think one of the biggest economic drivers that we see as a benefit to the community is recruitment of foster parents from the neighborhood our children come from. So the foster care per diem could go back into Philadelphia instead of to Montgomery County or Bucks County or Adams County. And so that's been one of the huge focuses that we've had with improving outcomes for children, is encouraging those community-based

providers to develop resources in the communities that our children come from and also play a role as a mentor to the parent instead of always expecting that there's going to be adoption. If we have to do an adoption, we obviously will, but first and foremost, we need to try to reunite that child with that family and give them the services necessary to ameliorate any other problems that occur.

COUNCILMAN JONES: Could I segue quickly before the bell rings. There's a conspiracy about shortening my time. But could we talk about children in foster care and how we are fairing with that population and particularly with an eye towards what happens while they're in foster care but also the process by which they age out?

COMMISSIONER AMBROSE: So we've paid particular attention to really making sure that the children in foster care in Philadelphia need to be in foster care. So there's a level of looking at

reunification and facilitating that process when necessary, and then if children need to be out of their natural homes for whatever reason and can't go back, how do we expedite a permanency process for them. So we've really been trying to do that.

Half of the children that we have in out-of-home placement right now are over the age of 14. So we spend a tremendous amount of time looking at the older youth population and trying to do a variety of different things. We've recently hired an older youth coordinator, who has been really helpful in pulling all of our efforts together, and this is also an area that the Community Oversight Board is going to take on.

So we're working very closely with our partners at the behavioral health system and the education system to make sure that those children who are in DHS's care are really there because of

abuse and neglect and not because of other issues, and then really trying, to the best way we can, is making sure that we have the right foster parents for older youth in particular. A lot of times when you talk to youth who have aged out of the foster care system, they felt unloved and unwanted and they've only been there as like a paycheck for the foster parent. So how do we really recruit and train those foster parents in a way that makes foster care, if it's going to be a temporary solution for children, as much of a family-like setting as it possibly can be, also working very hard with our system partners to look at educational outcomes for youth in foster care, because those are not good, and how can we really enhance that educational experience for youth by making sure that their placement is stable, so if they have to move from foster home to foster home, at least they'll stay in the same school. So a

variety of strategies we've been working on with older youth.

COUNCILMAN JONES: So on my next round -- I'm going to yield the mic -- but I want to drill down on some of those outcome, how we're fairing in graduation rates, this, that, and the other, and we'll go through that, Mr. Chairman.

COUNCILMAN GREENLEE: Okay. Thank you, sir. You know what they say about conspiracy theories, don't you?

COUNCILMAN JONES: Yes.

COUNCILMAN GREENLEE: Okay. Councilwoman Brown.

COUNCILWOMAN BROWN: Councilman Jones was reading from my notes over here, I want you to know, because I have questions also --

COUNCILMAN GREENLEE: So he's a copycat also, okay.

COUNCILWOMAN BROWN: I too have questions directly related to foster care. So tell me, if you don't know now,

I'd be curious to know how many young people in foster care are high school age, 9th through 12th graders?

COMMISSIONER AMBROSE: So I don't know if we have that exact number, but we can get it for you.

COUNCILWOMAN BROWN: And better than that, those who would be -- well, 9th through 12th graders are fine. Actually, 8th through 12th graders, because next year they'll be 9th grade and need to be in that pipeline of at least having a conversation about higher education. Okay?

COMMISSIONER AMBROSE: Yes.

COUNCILWOMAN BROWN: So that would be great to know.

The Achievement Center, an update on that and the programming there.

COMMISSIONER AMBROSE: So the Achieving Independence Center continues to, in my opinion, improve. A lot of that is because of the leadership sitting behind me. Vanessa Garrett Harley, as

you all know, has been a tremendous leader and focused a lot on older youth. We also have a new administrator, Brenda Kinsler behind me, who has brought tremendous energy into looking at the Achieving Independence Center. We're getting ready to actually move very close to Temple University. We think that will be a really good opportunity for our kids to think differently about what their future might look like, get them close to the college campus and expose them to the opportunities that higher education can offer for them.

Also, Vanessa and Brenda thought it's really important for us to focus on younger youth, and so the Achieving Independence Center currently starts with age 16. They start at a younger -- we're going to have a fancy name for it at some point, but right now it's just the younger AIC kids, where we're starting age 13 to 15 to really get them prepared for all the independent

living skills that are going to be necessary for them to successfully move forward as DHS-involved youth.

COUNCILWOMAN BROWN: Outstanding.

COMMISSIONER AMBROSE: Also, just Margarita Davis-Boyer, who I don't think is here today, is our older youth coordinate. She's an alumni of the foster care system. She is amazing.

Is she here?

She's amazing. I just have the best team behind me. And she's one of those people who really has taken a very close look at all the services that we're providing to older youth and has helped us assess those services and has intervened on individual -- I actually e-mailed her about a young person who appeared in our lobby today. And so we're really looking at how we can do a better job of working with youth who are part of the foster care system.

COUNCILWOMAN BROWN: And

getting them ready to stand on their own.

COMMISSIONER AMBROSE: That's right.

COUNCILWOMAN BROWN: So we spoke about professional development for those inside the tangible walls of DHS. Technical assistance for organizations that need it, if they want to continue to be considered to do -- considered in doing business with DHS, where are we with that?

COMMISSIONER AMBROSE: So we actually just had another really good meeting with UAC and their team. Part of this is, we can provide our level of technical assistance, and then there are people who have been doing this for a long time, and Sharmain Matlock-Turner and her team have been providing technical assistance to smaller community-based providers for a long time. And so what we talked about is getting them involved with the provider roundtables and hooking them up with some

of the CUAs now so that they can figure out what their place in this might look like. But DHS still stands poised to provide technical assistance when necessary.

Some of the CUAs will be better positioned to do their own administrative work and some will have to rely on agencies like UAC who have a good track record for trying to support the administrative infrastructure that's necessary to run a child welfare agency.

COUNCILWOMAN BROWN: Just a couple more questions, if I can, before the bell rings.

It's no secret that Council is looking at this huge unprecedented issue known as AVI, and one thing we've discovered is there doesn't appear to be adequate coordination across systems, all who deal with families, in making sure that they are aware, up to speed of the protections and the information, period. So in the CUAs, the world of the CUAs,

has there been an opportunity to bring the AVI, the Office of Property Assessment, to have a conversation with those communities who are working with families that may live in homes that will have to go under the AVI?

COMMISSIONER AMBROSE: We have not done that. However, we could facilitate that opportunity, and we can work with your office to think about what that might look like.

COUNCILWOMAN BROWN: That might be important, because it captures another layer and segment of our city who are going to be struggling with how they get captured in a way that's fair and even, for whatever that ultimately looks like.

Thank you, Mr. President.

COUNCIL PRESIDENT CLARKE: Finished?

COUNCILWOMAN BROWN: Yes.

COUNCIL PRESIDENT CLARKE: Thank you, Councilwoman.

The Chair recognizes

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Councilwoman Sanchez.

COUNCILWOMAN SANCHEZ: Thank you.

I wanted to cover some of the issues around your older youth component and congratulate you, that there's a group there that we sometimes are missing. We focus a lot on early education and some of those things -- I'm very happy that you're trying to capture that. And in looking at some of our line items on the Grants Revenue, I see some new programming or some enhanced programming, like the creation of two evening reporting centers, some of the expansion of community-based alternatives for placement.

Can you talk to those? The creation of the evening reporting centers, about a half a million dollars, and I know this is an area -- President Clarke remembers this -- we had a lot of issues when we closed some of the youth centers and the evenings and the

beginning of these budget discussions. So I kind of see this popping up again, but I hadn't heard how the Administration was looking to implement that.

COMMISSIONER AMBROSE: So the evening reporting centers are actually based on a model that the Pennsylvania Commission on Crime and Delinquency has developed in Berks County, and it's actually an alternative to detention. So it's really a very focused, after-hours program. So kids come right from school. They spend a significant amount of time on programming, including homework help. They're brought to the center and they're taken home. There are meals that are provided. It's really those critical after hours, after school hours, where lots of kids can get into trouble. And so it's a model that we have implemented in partnership with Judge Dougherty and with support from PCCD. That RFP is out right now, and we're in the process of hopefully making some selections.

The other thing that we've identified, as the court has moved forward with our request to not place as many kids, what are the community-based alternatives that can be helpful for keeping kids out of trouble. And so the one RFP that we're putting out is getting some of those providers to give us their most creative ideas about instead of us being really prescriptive, what do they think it's going to take. So we're looking forward to continuing to partner with them on that work as we continue to work with the court.

COUNCILWOMAN SANCHEZ: As it relates to the evening centers, do we know who has applied, where are you looking?

COMMISSIONER AMBROSE: I do not know.

COUNCILWOMAN SANCHEZ: Okay. As it relates to the community-based alternatives, do you have a range in terms of what types of providers or are

you leaving it open? When does that RFP go out?

COMMISSIONER AMBROSE: I think what -- I don't think that we've identified when that RFP is going to go out. A piece of that would be site mentoring for older youth, which is one of the models that we've looked at and actually consulted with Mayor Goode on. And so building those components into the process would be something that we're looking to do.

COUNCILWOMAN SANCHEZ: There were a lot of folks, again, before we cut all that funding for all of those programs, there were a lot of folks who did a lot of work in that. I can think of groups in my district, like Mimic, ex-offenders who are doing really incredible things with youth and stuff. I want to make sure that we disseminate that information to those types of groups, that they look at themselves, because they do do that work, that they

can get plugged in and that we don't make the range so difficult that the smaller groups by area, whether it's rec centers or communities where we know where there has been spikes in crime, that those communities -- that there is a real correlation between incidents. We've had these flash mob stuff downtown, that we could really track where we're having an increase of youth incidents and that we're reaching out to those communities to get those types of specialty providers.

COMMISSIONER AMBROSE: So what I'll say is, I think that the -- part of the delay is based on the work we're doing with the Violence Prevention Collaborative, which is really bringing those stakeholders into the conversation. So a couple of the ex-offenders are a part of my prevention work group, and they've been helping advise us. And Commissioner Slawson has been really a terrific partner in this in the things

that -- she had me do a tour of the area around the MLK Rec Center with a bunch of community folks. We went in a bus and drove around and talked to a lot of folks about what those services might look like, and then we facilitated a focus group. And Sue has continued to actually do those focus groups with both youth who are involved in the system and parents of those youth to try to identify what services need to take place.

The only other piece I'll add to that is that -- we just closed the OST, the out-of-school time, RFP. We really focused on using rec centers and encouraging providers to bring good programming that DHS funds into those rec centers with a connection back to school. And so I think that partnership has been enhanced, and a lot of that is because of Commissioner Slawson and her leadership. She's just terrific to work with.

COUNCILWOMAN SANCHEZ: Okay. Thank you. My time is up.

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COUNCIL PRESIDENT CLARKE: Thank you, Councilwoman.

The Chair recognizes Councilman Jones.

COUNCILMAN JONES: Thank you, Mr. President. I hope you're feeling better, sir.

COUNCIL PRESIDENT CLARKE: I'm feeling much better, sir. I medicated myself. I'm fine.

COUNCILMAN JONES: We talked about self-medication.

COUNCIL PRESIDENT CLARKE: Excuse me. Just a simple cough drop. I know people are watching.

COUNCILMAN JONES: All right.

Commissioner, a couple of things. Number one, I would be remiss if I didn't recognize Stacy Graham of my staff who has worked with you and your department and has in fact, formerly with Councilman Green, created some protocols and procedures by way of dealing with abuse in your system, and I thought it

was appropriate and us in Council all working together on the issue of siblings.

You took me and I was introduced to three young men who had graduated out of the shelter system. I've dealt with a lot of things and I consider myself fairly macho. They had me in tears by the end of each of their experiences throughout the system and had dedicated themselves to come back and help other young people navigate themselves through this.

So a couple of things I wanted to get an update on. We did a piece with Ordinance Bill No. 100755, which dealt with foster care and the standard by which young people, siblings in particular, could have input about placement with their sibling. So what we had identified as an issue and a problem was that if an older sibling realized through conversations confidential with a brother or sister that there was a

problem with a placement, how they could have input to say and have that dealt with.

So I wanted to know -- we write laws; you guys have the burden of dealing with it. How are we doing in that category?

COMMISSIONER AMBROSE: So particularly with siblings, we paid really close attention to this -- and this isn't just a Philadelphia issue; it's really a national issue -- is that children who have to be removed from their homes for whatever reason deserve to be together with their siblings whenever possible. So that's now a measure that we track with our ChildStat sessions. It's a measure that we track with our providers around performance. So sibling groups being placed together.

I also think that the system has come a long way with fostering connections in youth being heard from at their hearings. So what I'll say is that

I think the court has done a good job of allowing kids to testify and to speak directly to the court about placement decisions and the impact that it's going to have on them and their siblings.

COUNCILMAN JONES: Is there an outcome measure quantifiable that we can say from this year to that year?

COMMISSIONER AMBROSE: Sure. We have the sibling -- keeping sibling groups intact measure, and we've been measuring that, I think, for about two years now. So we can give you that information. We've improved in that measure over the years, and some providers are better than others. And so it's something that we review on a continuous basis. It's something we track with our own staff. So their ability to try to keep sibling groups together or reunite siblings is something that we also track.

COUNCILMAN JONES: By way of outcomes I mentioned earlier, are we

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tracking the number of young people that graduate, graduation rates, college-bound rates, avoidance of contact with the law? I don't know how to quantify that.

COMMISSIONER AMBROSE: So on the last one, we probably have a little bit further to go. On the educational outcomes, we remain a partner with Project U-Turn, which was the group that initially worked with Johns Hopkins in identifying how poor our graduation rates were for youth in foster care and in the delinquent system. So we remain an active partner on that group.

I can say that for foster care in particular, we've improved a little bit, but not a lot. It is something that we're starting to track in our ChildStat measures. We had a bit of a glitch about two years ago in continuing to get that data, but with the new Administration, they're now looking at that data. And the things we're tracking are attendance, graduation rates, ability to read in the

third grade and the early warning indicators, and proficiency in math in the fifth grade. So we're continuing to look at those issues, because those are really important outcome measures for us to pay attention to.

COUNCILMAN JONES: We would appreciate if you provided to the President's Office those kinds of measurements. And I want you to understand that this body does not think you have a magic wand, that somehow all of the ills of society that you and your professional staff make this magically disappear, but what we do expect, that if it isn't measured, it can't be managed. If it isn't measured, you can't apply remedies or solutions and determine if it's working. So we don't always -- if you have a glitch, that's fine, but if you have an adjustment to that glitch, it's better.

COMMISSIONER AMBROSE: And what I will say is that the Mayor's Office and

Children's Hospital have come together over the last couple of months and we've had a foster care planning group that includes a member of the SRC. We're actually looking at foster care data. CHOP's policy lab under Dr. Rubin has done some initial assessment of kids' educational outcomes in foster care, and surprisingly one of those findings is that kids in foster care do better. It's what happens before foster care and after foster care that we have to pay attention to, particularly around attendance.

COUNCILMAN JONES: That's an important measurement. And if you have a grid -- again, we're going to allow the Chair of Human Services to have a briefing session that drills down into these issues, similar to Dr. Evans, so that we can learn the triangle -- you did it a year ago where the three of you showed the interrelationship with the three departments. That was helpful to me, and I think it could be equally

helpful to the new members of Council. So if the three you got together kind of in a human-services-made-easy-for-elected-officials manner, I think that the President would entertain that rather than me keep pressing my button.

COMMISSIONER AMBROSE: We'd be happy to do that.

COUNCILMAN JONES: All right, Mr. President?

COUNCIL PRESIDENT CLARKE: Thank you, sir. I absolutely will do that.

The Chair recognizes Councilman Kenney.

COUNCILMAN KENNEY: Wow. How did that happen?

COUNCIL PRESIDENT CLARKE: Sir, timing is everything.

COUNCILMAN KENNEY: I just walked in the room.

I know a number of same-sex couples that have adopted, and the children are thriving and the parents are

happy. Where are we at in the realm of things compared to other cities and just how are we moving -- do we do that?

COMMISSIONER AMBROSE: Sure. Sure we do that, and actually we just had somebody do a presentation to one of our provider groups about that. I don't know where we do compared to other jurisdictions, but I can look at that and see.

COUNCILMAN KENNEY: Obviously the more capable people, loving people that are available to take these kids out of foster care would be wonderful.

COMMISSIONER AMBROSE: Yeah. What I can say is that anecdotally we've seen a lot more of same-sex adoptions at National Adoption Day. So it's something that's not unusual. It's something that --

COUNCILMAN KENNEY: Do we have a specific policy or it's not something that needs a policy, it's just something that happens by --

COMMISSIONER AMBROSE: I think we have a policy that says you can't discriminate. And so we believe that's a really important policy to have. So if we heard that a provider agency was discriminating against same-sex adoptions, I'm sure we would intervene in that some way, but that hasn't been an issue for us.

COUNCILMAN KENNEY: Do we have issues with religious organizations who we contract with?

COMMISSIONER AMBROSE: They haven't been raised to my level. I mean, those agencies just might not recruit same-sex foster families, but other agencies certainly do.

COUNCILMAN KENNEY: If you have an opportunity, I really would like to know how we rank in the top five to ten cities in the country. Thank you.

Thank you, Mr. President.

COUNCIL PRESIDENT CLARKE: Thank you, Councilman.

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The Chair recognizes Councilwoman Sanchez.

COUNCILWOMAN SANCHEZ: Thank you.

Just for the record -- and you can provide it for the Chair -- another question Tasco had told me and I just remembered was around the E3 centers, and one of the centers in her location was de-funded. They were recently highlighted in a Channel 6 expose. So I know she wanted some answers around that. So that should be provided with the last selection.

Going back to children, there is growing poverty, hunger. How are we at DHS through the CUAs and all these networks dealing with the issues of hunger, particularly at the end of the month where we see families really struggling to feed children?

COMMISSIONER AMBROSE: So obviously this is a huge issue for us when 40 percent of the children in the

City live in poverty. Those families involved with DHS, I could almost say to a certain, that most of them are actually -- poverty is just an issue for every family that we're involved with. And so what we do is, we have emergency funds available, not just at DHS but we've actually made those emergency funds available at the CUA level. So if there's a concrete goods request or need, we meet that need, and we do it family by family. So it might be food and it might be a bed so that a child can be reunited with their mom and mom doesn't have enough money to buy a bed for that child. So those are things that we deal with on a daily basis. Clothing is a huge issue, particularly when kids move from one place to another. So that clothing allowance and making sure that those goods are made available immediately, that children shouldn't have to wait for the kinds of things that they need to survive on a day-to-day basis. So that's

a constant issue that we deal with.

COUNCILWOMAN SANCHEZ: I know I went to Casa Del Carmen. They have their whole clothing. They have a little shopping area with the food, the food cupboard, very, very nice.

Can we figure out how in these CUAs as we move forward we make it a requirement? I'm a little concerned that, again, if you don't know the services are there, people don't know to access it. I mean, the goal behind bringing services into the neighborhood is that we're going to bring services to the neighborhood. And so looking at where are the gaps and how do we utilize these CUAs to provide services that go as part of their scope, but not leave it to them to decide that that's a need, so that people begin to identify them where you can get clothes, you can get the food. Again, I don't want to leave it by choice. If these guys are going to be big guys, they want to be big guys, they

want to be in the neighborhood, they got to do the pretty, the ugly.

COMMISSIONER AMBROSE: I think that's exactly right. The exact vision for the CUA is what you're describing. It's a one-stop shop in the neighborhood where children and families can go to get help, and that help can take on all kinds of different forms.

The other thing that we facilitated with NET and APM was a connection with Cradles to Crayons. So that's an agency that's in -- I believe they started in Norristown. They wanted to have more of a Philadelphia connection, and so the way we've done that is through the CUAs. But it's a really good point that you're making. And food and Philabundance, how we pull them in and try to do some things creatively is something that we're --

COUNCILWOMAN SANCHEZ: And that that's built into an expectation.

COMMISSIONER AMBROSE: Yes.

COUNCILWOMAN SANCHEZ: Not by chance.

COMMISSIONER AMBROSE: Yes.

COUNCILWOMAN SANCHEZ: Thank you.

COUNCIL PRESIDENT CLARKE: Thank you, Councilwoman.

The Chair recognizes Councilwoman Brown.

COUNCILWOMAN BROWN: There were two items I overlooked. Upon your arrival years ago, a lot of questions were raised around the Department's ability to do what's required to ensure diversity amongst your non-profit service providers. In your testimony, you state that DHS continues to require non-profit service providers to submit supplier diversity plans.

When are the plans submitted to your office? Who oversees or reviews the supplier diversity plans? And does your office provide feedback to those agencies regarding the plans? And Councilman

Kenyatta Johnson always raises the concern about the accountability of that, assurances that what is on paper is actually real.

COMMISSIONER AMBROSE: So Yvonne Farrell, who is sitting behind you, is actually responsible for all of the contact that we have with OEO and our providers around the supplier diversity plans. I'll say that I'm very pleased with their use of and the requirement of it. So this year we had an 89 percent compliance rate, which is up considerably from when we first started to require them.

COUNCILWOMAN BROWN: Yes.

COMMISSIONER AMBROSE: I think they've gotten much better and much more substantive. I think there's been a lot of learning between providers. So OEO has helped us do -- we did a networking session for all of our providers last year. We're doing it again this year. This year it will actually be mandatory.

But they've learned a lot from each other about suppliers that they can use that they didn't know existed, and so that's been a good thing. Some of them have actually taken advantage of training. So Catholic Social Services, one of our biggest providers, went to Cornell University to participate in one of the trainings that they've provided.

What we do is, at my level we deal directly with the top ten, five non-profit, five for-profit. We meet and sit down with them and go over their supplier diversity plan, because I think initially people weren't taking this very seriously. And we've seen since we've been very invested in this and made it clear to them that the expectation was that they really do something about this, we've seen a tremendous increase in not only their contracting opportunities but also the level of conversation that's going on among the provider community so that they can learn from each other about

who are the contractors out there that they can actually contract with.

COUNCILWOMAN BROWN: Yes. And that also requires leadership from you to help folks understand that it's not optional, it's required.

COMMISSIONER AMBROSE: That's right.

COUNCILWOMAN BROWN: Lastly, let me thank you and your department and specifically Vanessa Garrett for being a real participant and contributor to our task force around human trafficking. It's a great group of stakeholders around that table, and as a result of the first couple of meetings, we've introduced a piece of legislation around touch therapy and how that hopefully would create a deeper dent into that illegal trade.

So I did want to go on the record to say thank you very, very much for allowing her to be present and to be an active, active voice at the table.

COMMISSIONER AMBROSE: She's

terrific. So, yes.

COUNCILWOMAN BROWN: Thank you. Thank you very much.

Thank you, Mr. President.

COUNCIL PRESIDENT CLARKE: Thank you, Councilwoman.

There being no other questions, I want to thank you very much for your testimony today.

COMMISSIONER AMBROSE: Thank you, Council President.

COUNCIL PRESIDENT CLARKE: You're welcome.

Good afternoon. Next up we'll have OESS.

(Witness approached witness table.)

MS. MINTZ: Good afternoon.

COUNCIL PRESIDENT CLARKE: Good afternoon.

MS. MINTZ: Good afternoon, Council President Clarke and distinguished members of City Council. My name is Dainette Mintz and I am the

Director of the Office of Supportive Housing. The mission of OSH is to plan and coordinate Philadelphia's response to homelessness and the administration of Riverview Home, a state-licensed personal care home that provides housing to low-income, elderly, and disabled persons. Our goal is to assist individuals and families experiencing homelessness to achieve greater self-sufficiency and long-term housing. I am pleased to offer a summary of the OSH Fiscal Year '14 City Council budget testimony.

The proposed Fiscal Year 2014 budget is 91,996,341, includes an allocation of 42,613,828 in General Funds, which is 46 percent of our budget, and 49,352,513 in Grant Funds, which represents 54 percent of our budget.

In Fiscal Year '13, OSH received an additional annual allocation of $3 million under the Fiscal Year '13 transfer ordinance to create 100 new

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emergency housing beds for victims of domestic violence. The Fiscal Year '14 General Fund budget request represents an $81,727 decrease over the Fiscal Year '13 estimated obligations.

The budget includes an 18,273 adjustment made to our Class 100 allocation due to the annualized 2.5 percent increase in pays for exempts, non-reps, and DC 47 Local 2186 employees. A breakdown of the General Funds by class is as follows: Class 100, 7,725,659; Class 200, 34,511,621; Class 300, 208,177; Class 400, 135,950; Class 500, 32,421, for a total in General Funds of 42,613,828.

The OSH budget supports 135 contracts with 62 distinct entities. The breakdown is 8 for-profit and 54 non-profit entities. The Fiscal Year '13 OSH minority, women, and disabled business participation goal is 25 percent, and to date OSH has exceeded that goal and achieved 33.91 percent.

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Ridge Avenue Center replacement status: The Ridge Avenue Center, which had 280 annual beds and was the location of the Homeless Intake Center for single homeless males, closed on June 30th, 2012. The OSH plan was to replace the center with several smaller sites with a combined capacity of 250 beds. Thus far, OSH has opened the new City-staffed Homeless Intake Center for single males, relocated 100 single females from an existing facility to a new facility in West Philadelphia, and converted the vacated facility to serve 100 single males. OSH has completed lease negotiations on a site to house 75 single homeless males. OSH will create the final 75 beds by changing the use of an existing facility by relocating 66 single homeless females to two smaller bed emergency housing facilities. Negotiations for one site are complete and the site will open July 1st. Terms are being negotiated on the last site.

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In regards to the allocation of $3 million to create 100 new beds for victims of domestic violence, OSH received the annual 3 million allocation increase in General Funds under the Fiscal Year '13 transfer ordinance in November of 2012, Bill No. 120818, to create 100 new emergency housing beds for victims of domestic violence. OSH issued a competitive request for proposals, RFP, for emergency housing services for victims of domestic violence and selected Women Against Abuse, WAA, to create and operate the new 100-bed facility. Additionally, an acknowledgement of the challenge of serving Latina victims outside of the Hispanic/Latina community, OSH also awarded funding to Congreso de Latinos Unidos Latina Domestic Violence Program to provide emergency assistance and/or rapid rehousing activities to prevent Hispanic/Latina victims from experiencing homelessness.

OSH is working to expedite

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contract conformance for both organizations and anticipates that WAA and Congreso will utilize a substantial amount of the funding in Fiscal Year '13. WAA will utilize the bulk of the Fiscal Year '13 funding for site renovations. The 100 new beds are projected to be online by late fall 2013.

Lastly, I'd like to talk about the homeless housing need and capacity challenges. Because of the lack of available affordable housing, poverty, and unemployment, OSH has continued to experience a consistent increase in the demand for emergency housing by homeless families. OSH is operating at almost full capacity on any given day, resulting in the painful reality of being unable to accommodate all who may request emergency housing.

For households already in our system, OSH is challenged to identify sources of affordable housing to move the households out of shelter to create flow

at the front door. OSH has 2,460 emergency housing beds that include 736 single male beds, 231 single female beds, and 1,493 family beds. The family beds include an additional 84 beds added in response to the increased homeless family demand.

OSH continues to maximize long-term housing opportunities through the partnership between the City and the Philadelphia Housing Authority and the use of federal dollars to provide rapid rehousing and rental assistance through local, federal, and state-funded resources to address this demand.

Thank you very much.

COUNCIL PRESIDENT CLARKE: Thank you.

A couple of quick questions. First -- and you may not be able to give me specifics -- what do you think the homeless population is currently, the number?

MS. MINTZ: In Philadelphia?

COUNCIL PRESIDENT CLARKE: Yes.

MS. MINTZ: In Philadelphia, we do a quarterly count, and we also, in partnership with the federal government, we do an annual account that includes City-funded and privately operated facilities. So I can give you an update as far as our winter count.

We have -- in the night of January the 30th, 2013, there was 388 persons counted on the street, another --

COUNCIL PRESIDENT CLARKE: Is that citywide or is that --

MS. MINTZ: That's citywide, in the portions of the City that's counted, which include Center City, parts of West, North Philadelphia, Kensington, and the Airport.

COUNCIL PRESIDENT CLARKE: Any particular reason why you --

MS. MINTZ: Those are the areas in which we know that there's a homeless presence.

COUNCIL PRESIDENT CLARKE:

Okay.

MS. MINTZ: Also on that night, we were operating winter initiative cafes. That's three sites, and there were 136 people at that site. In the shelters on that night, there was 1,037 folks. And so total overall in the City system was 1,561 persons.

In addition to that, we also know that there are at least another thousand units scattered citywide that operate as well. That includes transitional, other permanent housing units that also have folks that they were able to count on that given night. We have not completed the count as yet, so when we do that, I can forward to you what the final count was as we compile all of that information from the private providers as well, and I can provide you with that overall count for the City.

COUNCIL PRESIDENT CLARKE: Where is that at in, say, the prior years? Up, down, the same?

MS. MINTZ: It is probably level. One of the things that just happened last week was the release of a national report by the National Alliance to End Homelessness, which identified that the number of homelessness is level nationally, although some states have seen some fluctuations. There is decreases in street homelessness, and that's referred to as chronic homeless. There's some slight decreases in veteran homelessness, but there is increases in family homelessness.

For Pennsylvania, we were pretty much at level in terms of looking at all of the counties statewide. In Philadelphia, our numbers continue to be impacted by increase in families, and that is the biggest challenge that we deal with on a daily basis, is the number of families who present for placement and having adequate resources to address their needs. And we've tried to expand our response beyond just placing in

shelter. We also try to provide assistance to place people back into housing with their family. We try to provide them with opportunities to identify affordable housing where we might be able to provide a security deposit or first month's rent for them to move in if they could stay with their family members for a limited period of time until we could assist them in finding alternate housing. We also use those resources as well.

COUNCIL PRESIDENT CLARKE: Okay. The $3 million transfer for shelter beds, I hate to use that term, but essentially for shelter beds for victims of domestic violence, that's been annualized over the Five Year Plan for your agency?

MS. MINTZ: Yes.

COUNCIL PRESIDENT CLARKE: I just want to make sure that that's there.

I just want to get a little clarity. As we talk to Ms. McColloch

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from OHCD and she talks about consistent reduction in funding from HUD, and we actually saw the numbers. They're like pretty amazing in terms of --

MS. MINTZ: Right.

COUNCIL PRESIDENT CLARKE: But here in your testimony you talk about the award, $29 million, which is the largest award to date. Is that separate and aside from OHCD?

MS. MINTZ: Yes, it is. And that represents funding awarded through a competitive Homeless Continuum of Care application for existing homeless projects that HUD invested in funding since 1992 that continue to operate as transitional or permanent housing. So that represents funding that we're able to go to HUD on an annual basis to ask for continuation funding. So that represents the funding that those projects and programs need to continue to operate in Philadelphia. So HUD categorizes it as renewal funding, and

for us, we're always allocated share or an amount that we could apply for, and that usually ranges anywhere between 25 and 28 million per year, and that's the burden that we carry for keeping those projects operational. So every year we go through a very elaborate and comprehensive process of soliciting from those providers who are about to run out of their federal dollars, who need to go in, what their measures have been in meeting the national outcome measures, and then we submit an application that HUD still reviews and it's still competitive nationally, and then we're awarded funding.

So we're very proud of the fact that consistently for the past five years, we've been awarded more than our pro rata share, and this year represents the largest amount of renewal funding that we received at that 29 million amount.

COUNCIL PRESIDENT CLARKE:

Okay. You talked about in your testimony overall homeless housing inventory increased by 50 percent during the Nutter Administration. What I'd like to see is -- because sometimes the Administrations overlap. Things get funded in one Administration and then the next person gets to cut the ribbon. And in all honesty, a 50 percent increase is significant and I'm, frankly speaking, not seeing it over the last five, six years.

So can you tell me or give me the specifics of those units.

MS. MINTZ: I will need to provide you with a specific breakdown, but I can tell you that in general, much of that increase represents our partnership with the Philadelphia Housing Authority. They have partnered with us to provide us with 500 housing opportunities a year, and that --

COUNCIL PRESIDENT CLARKE: So -- I'm sorry. Go ahead.

MS. MINTZ: So that has been 200 vouchers for single persons and 300 housing opportunities for families to move into existing PHA conventional placements.

COUNCIL PRESIDENT CLARKE: That's kinds of like a double count there.

MS. MINTZ: No.

COUNCIL PRESIDENT CLARKE: I'm saying the units were already built by the Housing Authority.

MS. MINTZ: Oh, yeah. They're not --

COUNCIL PRESIDENT CLARKE: And I anticipate that they took credit for the units.

MS. MINTZ: Yeah. It's not housing development. It's housing opportunities.

COUNCIL PRESIDENT CLARKE: All right.

MS. MINTZ: So we're counting really the number of households we're

able to provide, and we're counting those as that 500 annually from PHA over the last five years that has provided us with the opportunity to realize a dramatic increase. Those would have represented 500 households annually that would still be in our system if we didn't have that partnership with PHA. So it's critical for us.

COUNCIL PRESIDENT CLARKE: All right.

MS. MINTZ: And, again, you know, I'm not a housing development agent.

COUNCIL PRESIDENT CLARKE: I'm not a picky person, but when I see a statement here that says this particular Administration created one more than 50 percent housing over prior years, and the reality is is that Philadelphia Housing Authority created those units --

MS. MINTZ: They provided us with the opportunity to house. So perhaps we might need to change our

wording if the wording is misleading.

COUNCIL PRESIDENT CLARKE: It's very misleading.

MS. MINTZ: For us what we're looking at is the number of households we're able to place in long-term housing. So our goal is always to move folks out of temporary housing into long term.

COUNCIL PRESIDENT CLARKE: When I read this, it implies that this Administration created the units by itself.

MS. MINTZ: Right. We can change the wording on that to make that clearer.

COUNCIL PRESIDENT CLARKE: Thank you.

You actually answered all my questions this round. I'll come back.

I'd like to recognize Councilwoman Blackwell.

COUNCILWOMAN BLACKWELL: Thank you, Mr. President.

Certainly, as you know, this is

my passion and my lifelong commitment dealing with this issue. And, yes, we did do a lot previously, previous Administrations, with housing and homelessness, and it is so very, very important. I only wanted to say thank you. And I regret -- you know, these are difficult times when you try to do anything dealing with people in trouble, whether it be reentry and whether it be homelessness, whether it be housing. We've had even our issues in trying to convince communities that people are just people and that people want to live in areas where they were born. So whether they've been incarcerated, whether they are homeless, all people want to live in their neighborhoods. But it's a difficult issue, and everybody is afraid of everybody, and everybody is worried about crime.

But certainly we want to thank OSH, Dainette Mintz and Letty and the whole department for all that they

continue to do, and we'll continue to do our part to ameliorate some of the issues and problems that exist and to try to certainly continue to talk to our communities about being open and allowing us to have various homes within the neighborhoods.

Thank you.

MS. MINTZ: Thank you, Councilwoman.

COUNCIL PRESIDENT CLARKE: Thank you, Councilwoman.

COUNCILWOMAN BLACKWELL: Thank you.

COUNCIL PRESIDENT CLARKE: The Chair recognizes Councilwoman Sanchez.

COUNCILWOMAN SANCHEZ: I'm sorry. Good afternoon. I just wanted to publicly thank you for the way that you've managed. You do God's work in so many different ways, and your whole team, and particularly the new allocation and your sensitivity to language access and culturally sensitive programming. I want

to thank you for that. I know that for a long time, you haven't seen additional money from us, and it was just great to see how you managed that you already knew where you needed to go.

I want to strongly suggest -- we've been talking a theme all day today around how do we break down silos, and recognizing that when you're siting a program, the difficulty that you go through, and really want to challenge the Administration. I said it to Dr. Schwarz, said it to Dr. Evans. The reason you have to do the volume is because you're self-supporting the program, and if we look at co-locations and we recognize, particularly as you've acknowledged, family services and family shelter needs, that as we co-locate these things, that they think of you and they say, In this facility where we're providing behavioral health, health services, preventive services, can we accommodate smaller sizes of this stuff

so that you don't get the community resistance.

I think it's so challenging to see the resistance to such vital programs. And so I just want to put that on the record and challenge the other departments. I know Dr. Schwarz gets it, I know Dr. Evans, but that folks don't forget about you.

MS. MINTZ: Thank you.

COUNCILWOMAN SANCHEZ: And that people deserve the types of programs and services you provide in every part of the City.

MS. MINTZ: Thank you very much.

COUNCILWOMAN SANCHEZ: Thank you.

COUNCIL PRESIDENT CLARKE: Thank you, Councilwoman.

The Chair recognizes Councilwoman Brown.

COUNCILWOMAN BROWN: Thank you.

Good morning. I need to join

the chorus too and publicly thank you under your leadership and members of your organization for partnering with my office for the past 12 years around the Warmth in Winter effort, that it really does make a difference in the lives of those women and children and men throughout all those locations that you have that I was unaware of.

In your testimony, you stated that there are eight for-profits?

MS. MINTZ: Yes.

COUNCILWOMAN BROWN: Just tell us who they are. I'm curious.

MS. MINTZ: Okay. I'll start. The -- no particular order. We contract with Core Care Food, which provides food to emergency housing facility. That's a for-profit. U.S. Facilities, that provides maintenance assistance to six City-supported emergency housing facilities in our intake. Food Management Services, that provides food to Riverview Home.

COUNCILWOMAN BROWN: To where?

MS. MINTZ: Riverview Home, our boarding home.

Darlene Morris, which is a small for-profit that operates an emergency housing program. Coello Consulting, which provides ongoing development of our automated homeless tracking system. And we have three small programs that provide services at Riverview. One is providing arts and craft assistance, the other is providing physical therapy and therapeutic therapy, and the third is -- I'd have to get back to you on the other one.

COUNCILWOMAN BROWN: I was struck by the fact that there are for-profits --

MS. MINTZ: Yes. Yes.

COUNCILWOMAN BROWN: -- that are able to conduct business with the City of Philadelphia. So are they all local, mostly local?

MS. MINTZ: They're all local.

COUNCILWOMAN BROWN: So we're able to --

MS. MINTZ: I'm sorry; with the exception of one.

COUNCILWOMAN BROWN: The consulting?

MS. MINTZ: The consulting is not.

COUNCILWOMAN BROWN: And their services they render are what?

MS. MINTZ: They provide consultant services on our management information tracking system. So they -- and we currently have that out to bid right now, and so we are looking at who we will select for Fiscal Year '14.

COUNCILWOMAN BROWN: So walk that through. How does that happen? You put it on the website, you have a vendor list?

MS. MINTZ: Yes. We work in concert with DOT and the City's internal processes to establish the requirements for the RFP for IT, and we issue a

request for proposal, which also includes it being on the City website. The response process requires you to submit both a written and electronic proposal submission, and the electronic submission is the one that carries the weight. You have to submit electronically. Even if you submit a hard copy, if you haven't submitted electronically, you haven't met the requirement. And then we do a review to determine if the proposal is complete, and then we have a panel that reviews and makes recommendations to me as the Director for funding.

COUNCILWOMAN BROWN: Where are there greater numbers, homeless men or homeless women?

MS. MINTZ: Homeless single men are greater in number than women.

COUNCILWOMAN BROWN: Is that right?

MS. MINTZ: However, homeless women are presenting with more serious mental health issues.

COUNCILWOMAN BROWN: So there's some level of coordination with CBH?

MS. MINTZ: Oh, absolutely. We work very closely through the Department of Behavioral Health and Intellectual disAbilities, along with CBH, who provides an array of services through their combined resources for existing project-based programs, primarily those that are long term in nature, permanent housing programs that are targeting populations that have behavioral health. They fund the predominant amount of the services, as well as trying to work with us with our partnership with PHA. For example, our commitment was that we will provide one year of follow-up case management. OSH pays for that for the families, and DBH pays for the followup in all the services that any of the single individuals may need for as long as they need it.

COUNCILWOMAN BROWN: I see. And then, lastly, of course, the goal is

always to help these families, as neatly as whatever that looks like, seamlessly transition to be able to become self-sufficient. So what linkages with organizations like ACHIEVEability or OIC to move families in that direction?

MS. MINTZ: We contract with ACHIEVEability. They operate a number of our federal homeless continuous care-funded projects, where they would have a permanent housing project or a transitional housing project for families. And we would be working with them to ensure, one, that the housing is there, but also that the goals they set up to move families into greater independence and self-sufficiency are being met. So as the provider, they would identify what their goals are for the families that they would be assisting, and the funding would have been awarded based on that commitment, and then we follow up to make sure that they've met those outcomes. And all of

that really works into the competitive application that I was speaking to Council President about that we have to submit on an annual basis to be awarded the ongoing funding for those types of projects.

COUNCILWOMAN BROWN: Real short followup?

COUNCIL PRESIDENT CLARKE: You're the last one, Councilwoman.

COUNCILWOMAN BROWN: Okay. Thank you.

So is there any relationship with Dress for Success or Career Wardrobe or MenzFit?

MS. MINTZ: Yes. Many of our providers work directly with those programs and refer families and women who are preparing to go on interviews and things of that nature. So we have quarterly meetings where this information is shared with all of our providers, and they all take advantage of it to the opportunity that we have for folks to do

that.

COUNCILWOMAN BROWN: Very good. So that takes care of the women. What about the men?

MS. MINTZ: For the men, it is actually more of a challenge, because there is not as many opportunities that is presented for men in our system and most of the men are really having to be self-reliant. There are some programs that folks are taking advantage of. We work very closely with RISE and many of those, because there are a large number of men in our system who have criminal histories, but they're not sufficient for the number of men who are in our system.

In an annual -- on an annual basis, we have about 3,800 men that come through our system, and for females, in response to your earlier question, it's about 1,200, and for many of those men, we've really been challenged to provide them with the same --

COUNCILWOMAN BROWN: Clothing

and the like?

MS. MINTZ: Yeah, the same array of opportunities as there is for --

COUNCILWOMAN BROWN: So there are some programs that have that service or they need to bring that service in?

MS. MINTZ: They have to bring that service in. We're primarily funding strictly the housing and the operating costs.

COUNCILWOMAN BROWN: Okay. Very helpful.

Thank you, Mr. President.

COUNCIL PRESIDENT CLARKE: Thank you, Councilwoman.

One last question. On the 4,500 units, can you provide to us a detailed list on those units that have either been created or vouchers or --

MS. MINTZ: Sure.

COUNCIL PRESIDENT CLARKE: -- whatever, to get to that total?

MS. MINTZ: Sure.

COUNCIL PRESIDENT CLARKE: And

the type of founding, the location, and the developer.

MS. MINTZ: Okay. Location, developer.

COUNCIL PRESIDENT CLARKE: And timeline.

MS. MINTZ: When it came online?

COUNCIL PRESIDENT CLARKE: Yes.

MS. MINTZ: Sure.

COUNCIL PRESIDENT CLARKE: Thank you. Thank you so much for your testimony.

MS. MINTZ: Thank you.

COUNCIL PRESIDENT CLARKE: Thank you.

This Committee will stand at recess until later today, April 17th, 2013 at 6:00 p.m., at which time we will reconvene at Penn's Landing Caterers, the Sheet Metal Union Hall, 1301 South Christopher Columbus Boulevard.

Thank you.

(Committee of the Whole

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adjourned at 3:50 p.m.)

- - -

CERTIFICATE

I HEREBY CERTIFY that the proceedings, evidence and objections are contained fully and accurately in the stenographic notes taken by me upon the foregoing matter, and that this is a true and correct transcript of same.

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MICHELE L. MURPHY
RPR-Notary Public

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