Assessment of Progress Made by PHILADELPHIA DEPARTMENT OF HUMAN SERVICES In Implementing Child Welfare Reforms

Presented to the Mayor and the City of Philadelphia

Submitted by
The Community Oversight Board

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Executive Summary

The charge of the Community Oversight Board (COB) is to monitor the Department of Human Services' implementation of the recommendations of the Child Welfare Review Panel (CWRP). The recommendations were designed to improve the ability of the organization to respond to child maltreatment and to increase the safety of children by:

- Clarifying the mission and values of the organization with safety as the core function and aligning resources with the new mission
- Improving the consistency and quality of practice by adopting new safety assessment protocols, increasing face-to-face contact with children, conducting family team conferences and clarifying roles and responsibilities of public and contract staff
- Increasing accountability of DHS for its performance and enhancing the oversight of providers
- Strengthening leadership by improving morale of staff, increasing transparency and communicating with the multiple stakeholders in the child protection system

The COB has conducted an assessment of progress which was designed to document the status of the recommendations, accomplishments and areas where difficulties are anticipated. As a result of this assessment the following key findings are presented:

- Progress has been made in addressing many of the recommendations within the desired time frames. The following recommendations have been completed:
    - Reformulation of the mission statement
    - Expedited face-to-face contact for children under the age of five with credible GPS reports
    - Safety visits of children receiving in home services
    - Clarification of roles and responsibilities of providers in relation to DHS
    - Creation of the Commissioner's Action Response Line
    - DHS validation of Provider face-to-face contact with children
    - Ongoing community participation and input
    - Strengthening the child fatality review process
    - Assessment of in home protective services
    - Assessment of prevention services
    - Social Workers' access to consultation of other disciplines
    - Analysis on the realignment of in home services
- There are some recommendations where, although completion has been delayed, work has been initiated and major progress has been made, Additional work is required in the following areas:
    - Evidence based safety assessment tool
    - Family team decision making
    - Enhanced monitoring of provider agencies
- There are some recommendations that present implementation challenges:
    - Monthly face-to-face contact with children under the age of five years
    - Establishing a community based local office
    - Safety visits for children in placement

It is important to note that the change process is owned by DHS leadership. This process will **require sustained and focused effort** to assure that the changes that are under way permeate the entire organization and result in high-quality, predictable practice. DHS is a complex bureaucracy and the changes will not happen overnight. The development of new polices and protocols is the first step. Institutionalizing new practices requires training, supervision and monitoring. DHS is conducting the kind of foundational work that will lead to changes in practice that will be sustained over time. Intense change efforts which involve rapid and multiple initiatives create tension and stress in the workforce. This requires DHS to attend to change management strategies that recognize and respond to staff distress while moving the work forward.

The COB will **conduct verification activities** during the next 6 month to determine the extent to which the changes have permeated practice and increased the agency's ability to protect children. Those activities may include: data analysis, focus groups with staff, providers and clients, case reviews, tracking the proportion of caseload receiving recommend services (i.e., safety assessment, family team conferences, face to face contact, and review of new protocols).

The COB is encouraged by the progress that we have been able to document and the seriousness with which DHS and the City have undertaken these reforms. At the same time, this is a critical period. DHS has had a twenty year history of starting reforms which have not been sustained. The agency is anticipating a leadership transition in the near future. There are risks that momentum and the reform effort can slow or be diverted. The COB recommends that the highest levels of City government continue the commitment to the implementation of the CWRP recommendations and provide active oversight and support of the reforms.

Overview

Purpose of the Community Oversight Board

The Community Oversight Board (COB) to the Department of Human Services (DHS) was created by Mayor John F. Street in Executive Order No. 03-07 on June 14, 2007. The creation of this board was one of a series of recommendations[1] made by the Child Welfare Review Panel (Panel) [2] in its report to Mayor Street, *Protecting Philadelphia's Children: The Call to Action,* (*Call to Action*) issued on May 31, 2007.

The Executive Order required implementation of the recommendations in the *Call to Action* by DHS in an expeditious manner consistent with best practices and charged the COB to assess and report on the progress of DHS in implementing the recommended reforms.

The COB and DHS were guided by the following directives in the Executive Order:

> *The Board shall provide independent assessments, which shall be driven solely by consideration of implementation of reforms that improve the safety and well-being of Philadelphia's children.*
>
> *All DHS personnel shall cooperate fully with the work of the Board, shall provide the Board with all documents and information requested by the Board in an expeditious manner and shall provide the Board with resources necessary to carry out the Board's duties. The Board and its agents shall have access to all DHS documents and files, to the extent permitted by law and subject to the signing of appropriate confidentiality agreements. The Board will seek input and information from a wide body of sources as deemed necessary and useful, including outside experts, DHS staff, City officials, DHS clients, other stakeholders in the child welfare system, and members of the public.*

As an advisory body to the Mayor and the Department of Human Services, the COB fulfills three interconnected roles – independent assessors, expert advisors, and community advocates – for the purpose of improving safety, permanency, and well being for Philadelphia's vulnerable children and youth.

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[1] *Panel's Phase 1 – Recommendation 4.a*: DHS must establish a mechanism and process for ongoing community oversight. At a minimum, the City must establish a Community Oversight Board. Page vi.

[2] Child Welfare Review Panel (Panel) was created pursuant to Mayor John F. Street's Executive Order of November 2, 2006 ("Child Welfare Review Panel and The Department of Human Services") in response to the crisis triggered by public scrutiny of child fatalities. The Panel was charged with reviewing fatalities of children under DHS care since July 2001; auditing DHS' Child Safety Action Plan; examining policies, procedures, and practices; and developing recommendations of reforms.

By September 2007,[3] Mayor Street appointed the following individuals to the COB: Carol W. Spigner, DSW; Arthur C. Evans, Jr., PhD;[4] Susan Badeau; Cindy W. Christian, MD; Margarita Davis-Boyer, MSW; Carol Tracy, JD. Three additional appointments which were reserved for the City Council were not made. Dr. Spigner, Dr. Christian and Ms. Tracy also served on the Panel.

The Executive Order also requires public reports at the following intervals: three[5], six, twelve, eighteen months, and annually thereafter. The COB was expected to be transparent in its work to the extent allowed by law and policy.

The COB's mandate includes promoting continuity of actions through a period of political and administrative transition. The *Call to Action* cited persistent themes regarding problematic DHS practice and performance that remained unresolved and had been documented in numerous reports and studies over a 20-year period. Continuity is crucial to assure that reforms called for in the *Call to Action* and other reports take place.

Approach to the Assessment of Progress

In approaching this assessment and report the COB held a series of meetings with relevant DHS management and staff (as listed in the acknowledgements above) to discuss progress. Numerous source documents were reviewed and discussed in order to assess the status of DHS' reform efforts thus far. This deliberative process allowed for both oversight and consultation while promoting communication and accountability. The COB and DHS met face-to-face for approximately 18 hours and 45 documents[6] were reviewed as part of the process. The COB has received cooperation and support from DHS in completing this report.

This report examines each of the recommendations made and provides: (1) an assessment of progress; (2) a discussion of the basis for the findings; and (3) additional recommendations where needed. In addition, the report establishes the measures and verification activities that will be undertaken prior to the annual report to further document the impact of the changes on the Department's operations.

Continuing the Call to Action: Sustaining Change over Time

Overall, the COB is favorably impressed with the level of effort that has gone into structuring the activities of the Department to move toward the needed changes. Given that this is an organization that has had difficult responding to critiques in the past and sustaining change effort, the COB is encouraged by the current mobilization. DHS has responded to the specific recommendations and time frames in the *Call to Action* while simultaneously focusing on the need to develop an infrastructure to sustain change over time.

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[3] Mayor Street made his six appointments by June 30, 2007. When one of the six people could not serve, he asked another individual to fill the sixth appointment in September 2007.
[4] Acting Commissioner, Philadelphia Department of Human Services.
[5] The three-month report was not produced because the COB was not convened in time to accomplish this task.
[6] Appendix A: List of Documents Reviewed.

At the same time, the COB cannot overstate the urgency of continued efforts. Foundational elements of the change strategy have been developed and are owned by the leadership team. Focused and sustained efforts will need to occur over the next year and a half to assure that the changes continue to progress and become institutionalized through out the organization and among the partner organizations. The result will be policy and practice that improve the ability of the organization and the community to keep Philadelphia's children safe.

As this *Assessment of Progress* indicates, continued changes will need to be made to policy, practice, organizational structure, and community relations to alter the manner in which work is done by DHS and its partners. **Careful attention needs be maintained to assure progress. The transformation of organizational practice and culture that is underway will not be accomplished overnight.**

The Importance of Courageous Leadership and Departmental Commitment

It is also important to recognize that for more than a year DHS has experienced heightened public scrutiny from the media and the Department of Public Welfare while undergoing significant internal change. Under normal circumstances, the day-to-day crisis facing child welfare agencies causes strains on workers at all levels. The added public pressure and change in organizational practice during the past year has inevitably caused stress and disequilibrium within DHS. For example, staff turnover and unfilled positions has increased case loads; changes in practices – such as the new safety assessment tool – has necessitated new training; the two-hour response for children under five has led to the creation of new units. Rapid and multi-faceted change occurring simultaneously has undoubtedly over-stimulated the work environment and led to concern and confusion. The organizational leadership has recognized the stressors and is addressing them through a variety of means. Nevertheless, transformation of organizational practice and culture in general is not a painless process and has not been painless for the DHS workforce. However, **DHS has responded with remarkable resiliency and is actively moving towards a model of practice for itself and its provider community that reflects core child welfare principles.**

It is also essential to acknowledge the significance of Mayor John F. Street's willingness to open this system to such scrutiny, particularly in the last year of his administration. Rarely has such openness been afforded anywhere without litigation or taken place in such a non-adversarial environment. It is demonstrative of the Mayor's Street's unwavering commitment to the welfare of Philadelphia's children. Dr. Arthur Evans is also to be commended for stepping into such a volatile setting, for providing extraordinary leadership, for orchestrating a strong beginning to the needed transformation in organizational culture and practice, and for accomplishing significant, foundational change.

Assessment of Progress: Recommendation-by-recommendation

1. Mission Statement and Core Values

Panel's Phase 1 Recommendation 1.a. (Page iv)
DHS must develop a mission statement and core values that are centered on child safety.
Panel's timeframe for completion: December 31, 2007.

Recommendation 1.b. (Page iv)
DHS' core values must embody at a minimum the following principles: creating a culture of respect, compassion and professionalism; enhancing communication with, and responsiveness to stakeholders; instilling a greater sense of urgency among DHS staff and providers; providing services that are readily accessible; fostering a culture of collaboration; providing culturally competent services; and creating a transparent agency.
Panel's timeframe for completion: December 31, 2007.

Assessment of Progress: Completed

- Please see Appendix B: Mission Statement and Core Values.

Discussion:
The new mission and values statement for DHS is to serve as the foundation for policy and to practice change and guide the work of the Department at the most fundamental level. This is a required step in changing practice, community expectation and relationships with providers and other public agencies. DHS has taken both an analytical and internal/external engagement approach to developing and vetting the Department's mission statement and core values. Based on a national scan of child welfare mission statements, an initial mission statement was developed. Subsequently, the draft was discussed with staff and revised.

The new mission statement and core values were then presented for community discussion. The DHS Acting Commissioner and deputies have held forums with multiple stakeholder groups – specifically, community town-hall participants, advocacy organizations, child welfare advisory board, provider agencies contracted by DHS, and Family Court judges – to build consensus for the underlying core values.

The challenge before DHS is to have the mission and values infuse all of the operational areas by being used to guide the development of policy, infrastructure and practice change. This will require an organizational development strategy that focuses on articulation of the mission, incorporation of the mission into policy, the development of a practice model that operationalizes the mission, training and the provision of other supports to staff to implement service consistent with the mission.

Verification Activities for the Next Period:

- COB will examine the extent to which the mission and values are influencing the development of policy, practice, infrastructure and outcomes for children.

2. Evidence-based Safety Assessment Tools

Panel's Phase 1 **Reccommendation 2.a.i. (Page iv)
DHS must implement an adequate evidence-based safety assessment tool.
Panel's timeframe for completion: June 30, 2007.

This area of work has had two discrete foci: safety assessment for intake/investigation and in-home services and safety assessment for children in placement. This section discusses each one discretely.

Investigation and In-home Safety Assessment Tool and Training Curriculum

Assessment of Progress for Investigation and In-home Safety Assessment Tool and Curriculum: Initiated with substantial progress made

Discussion of Investigation and In-home Safety Assessment Tool and Curriculum:
The development of the safety assessment tool has occurred in an environment in which the assessment procedures are established by State policy and variation in that process must be negotiated and approved by the DPW. This recommendation required DHS to move beyond the mandated risk assessment or future oriented process to a here-and-now-safety-oriented process. Consequently, even thought the DHS created its own safety assessment tool, DHS was compelled to adopt the State tool.
.
Initially, DHS trained its Intake staff to use the Department of Public Welfare's (DPW) assessment tool based on a risk-driven intervention model. This training was completed in August of 2007. After some delay, DHS and DPW worked with Action for Child Protection, Inc., to revise the assessment tool and training curriculum to reflect a safety-driven intervention model. The new safety assessment tool and training curriculum is expected to be finalized by DPW by January 14, 2008. Training of staff will begin in January of 2008 and is projected to conclude in July of 2008. Implementation of the tool will begin as staff in each operational division completes the 15 hours of required training.

The COB had extensive discussions with DHS related to the quality of the training and the need to assure the consistent application of the new safety assessment process. Progress in this area should be closely monitored.

Placement Safety Assessment Tool and Training Curriculum

Assessment of Progress for Placement Safety Assessment Tool and Curriculum: Initiated with substantial progress made

Discussion of Placement Safety Assessment Tool and Curriculum:
As noted earlier, change in this area requires cooperation and approval of DPW. DHS submitted a draft tool to the State for approval. However, DPW decided to develop its own tool. Once

completed, DHS is prepared to implement the State tool. In the interim, DHS has developed guidelines that are being used by staff in the review of placement situations. The guidelines have been integrated into the structured case and placement notes to assure that safety is being assessed routinely. Once DPW approves the permanent safety assessment tool for placement, training will need to occur as the first step in the implementation process.

Verification Activities for the Next Period:

- Timeframe to finalize the placement safety assessment tool and training curriculum, conduct training, and implement tool – due to COB on February 1, 2008.
- Report on the number and proportion of employees completing the training on each of the safety assessment tools.
- Quality assurance report on the implementation of safety assessment tools by those units which are using the tools.

3. Intervals for Safety Assessments

Panel's Phase 1 **Recommendation 2.a.ii. (Page iv)

DHS must conduct a safety assessment for every child within its care – both children at home and children in out-of-home placements. The safety assessment must be updated at each contact with the child.

Panel's timeframe for completion: September 30, 2007.

This area of work has had two discrete foci: in-home safety visits and placement safety visits. This section discusses each one discretely.

In-home Safety Visits

Assessment of Progress for In-home Safety Visits: Completed and ongoing

Discussion for In-home Safety Visits:

In late 2006, DHS committed to see every child in their care or supervision to make an assessment of their safety. The Department began and completed visits on all children receiving in-home services in February of 2007 using a protocol developed internally and vetted with a variety of experts. As a result of those visits, 142 children were recommended for placement, and 287 cases were recommended to be closed. Subsequently, a more structured interim safety assessment process was instituted pending the development and approval of a permanent tool by DPW (See Appendix C: Interim Safety Assessment Process, Effective upon Completion of the Social Worker's Safety Training – dated June 4, 2007).

Safety is to be assessed using the **formal safety assessment tool** at a minimum of every six months. However, at every contact the worker is expected to make an **ongoing review of the safety** of every child served. Safety factors are now included in the structured case and progress notes as an area that must be assessed and documented for every visit. In light of the new safety model, DHS is working with Action for Child Protection and DPW to develop the curriculum for 24 hours of training about safety throughout the life of the case that includes risk assessment. In addition to the 15-hour training on the safety assessment tool, all DHS staff mentioned above

will receive the 24-hour training about safety throughout the life of the case that includes risk assessment.

Placement Safety Visits

Assessment of Progress for Placement Safety Visits: Initiated – more progress needed

Discussion of Placement Safety Visits:
When it became clear that there would be delays in the approval of the placement safety assessment protocol by DPW, DHS required workers to conduct a safety review for every placed child at the time of the routine semi-annual visits. This round of visits is in process, using the guidelines that DHS developed and the State approved. In November of 2007, a subsequent set of **safety guidelines** were developed and approved by the state for implementation. These guidelines will be used by staff until the State issues a safety assessment protocol for children in placement. (See Appendix D: Guidelines for Visits by DHS Worker for Children in Out-of-home Care Settings & Placement Visits Structured Case and Progress Notes for Foster and Kinship Home Visits). DHS and Providers will conduct an **ongoing safety review** of every child at every visit and at the time of the court hearings. For those children in placement or kinship care the ongoing safety reviews are documented using the structured case notes format which identifies the factors to be reviewed. Supervisory review and approval of the safety review are required.

Verification Activities for the Next Period for In-home and Placement Safety Visits:

- Documentation that specific items have been incorporated into structured case notes format to prompt DHS and Provider workers to provide narrative regarding safety.
- A report on compliance with completing the **formal safety assessment tool** at six-month intervals.
- A report on the quality of the case notes documenting the **ongoing safety reviews.**

4. Expedited Face-to-Face Response for Children Five Years of Age or Younger

Panel's Phase 1 **Recommendation 2.b.i. (Page iv)
DHS must conduct immediate (within 2 hours) face-to-face visits for every child 5 years of age or younger for whom a credible[9] report of suspected abuse or neglect is received by the Hotline. This face-to-face contact must be made regardless of whether the Hotline classifies the case as General Protective Services (GPS) or Child Protective Services (CPS).
Panel's timeframe for completion: June 30, 2007.

Assessment of Progress: Completed and ongoing

[9] The recommendation was modified to add the term credible to clarify the children who were to be seen.

Discussion:
Implement began on June 30, 2007 and was augmented by the creation of two new units staffed with expedited response workers who are responsible for seeing children five years of age or younger for whom a credible GPS report of suspected abuse or neglect is screened in by the Hotline.[10]

This strategy was selected because it was anticipated that it would result in another level of screening with the possibility of ruling out the need for a full investigation. Contrary to expectations, the strategy used has posed some problems including: adding an additional worker to the process rather than expediting the contact with the investigating worker.

Recommendation:
The COB recommends that DHS, in consultation with the COB, reassess the recommendation and strategy used to comply with the Panel's recommendation and develop, by May 31, 2008, a response that reduces redundancy and the number of people involved in the investigation process.

Verification Activities for the Next Period:

- Monthly reports of the percentage of children five years of age or younger seen within the two-hour timeframe.
- Proposal for an alternative strategy.

5. DHS' Monthly Face-to-face Contact with Children

Panel's Phase 1 Recommendation 2.b.ii. (Page v)
DHS staff must – on at least a monthly basis –conduct face-to-face contacts with all families receiving any service supported through the Children and Youth Division (CYD) that have a child 5 years of age or younger and physically observe the condition, safety and behavior of any such child, as well as parental capacity.
Panel's timeframe for completion: June 30, 2007.

Panel's Phase 2 Recommendation 2.a.iii. (Page ix)
DHS must enhance the frequency of face-to face contacts with children of all ages. Since face-to face contacts are the most important actions to ensure child safety, DHS staff must conduct a minimum of one face-to-face contact per month with each child in its care. More frequent contact may be warranted depending on the specific safety and risk factors in each case.
Panel's timeframe for completion: May 31, 2008.

Assessment of Progress:
Phase I. recommendation: Initiated – more progress needed
Phase II. Recommendation: Not yet due

Discussion:
DHS has addressed both of these recommendations together using a phased strategy. Starting with the units with the smallest caseload, the Department has initiated monthly visits for children of all ages.

DHS initiated the first phase of these recommendations on November 30, 2007, by requiring the specialized units to initiate monthly contact. The units include Sex Abuse, Family Preservation, and Adoptions.

From January through April 2008, DHS plans to roll out monthly visits by the Department's social worker, moving from the smallest to largest units/regions, as follows:

- January 2008 – Family Service Region I.
- February 2008 – Family Service Region II.
- March 2008 – Family Service Region III.
- April 2008 – Family Service Region IV.

Completing this recommendation requires resolution of number of issues that limit the availability of social workers for home visits, including:

- A substantial number (90) of vacancies in case-carrying social work positions which have required the reallocation of uncovered cases and resulted in higher than desired caseloads.
- Delays in the City hiring process that needs to be resolved.
- Need for increased capacity to train new workers in order for them to assume full caseloads.
- Lost time due to substantial waiting time for court hearings.
- Very extensive paperwork expectations that divert workers away from clients.[11]

The Department is taking action in each of these areas while creating the expectation of monthly contacts and preparing supervisors to facilitate the completion of these visits. Given the complexity of these issues, there needs to be routine monitoring of the percentage of visits completed each month and a sharing of that information with each unit so that progress is clear, and when progress is not occurring there can be a focus on identifying and resolving other impediments.

Verification Activities for the Next Period:

- DHS' progress report on roll-out of monthly face-to-face visits as of May 31, 2008.
- Monthly reports on the percentage of children visited each month.

[11] Refer to this *Assessment of Progress'* section on Streamlining Paperwork.

6. Community-based Local Office Presence

Panel's Phase 1 Recommendation 2.c. (Page v)

DHS must establish a local office presence in a least one geographic location deemed highly at-risk.

Panel's timeframe for completion: May 31, 2008.

Assessment of Progress: Not yet due-Possible delays
COB and DHS agree that completion by Panel's May 31, 2008 timeframe is not feasible.

Discussion:
The Child Welfare Review Panel envisioned an overall shift in DHS' framework, infrastructure and approach to service delivery from a centralized-office structure to a decentralized, community-based structure. As a first step on this path, the Panel recommended that DHS establish a local office presence in at least one geographic area.

To their credit, DHS understood that to be effective, establishing one local office could only be undertaken in the context of a more comprehensive plan for decentralized, community-based services. As a first step, DHS set up a Local Office Subcommittee, which developed preliminary recommendations and an implementation timeline. The Department also requested funding for not only this first Local Office but two additional Local Offices in its needs-based budget.

As the planning evolved, DHS quickly recognized that implementing this recommendation would divert key managers and staff from their work on priority safety-focused policy and practice reforms, and concluded that meeting this recommendation within the expected timeframe is not feasible.

Recommendation:
The COB concurs with DHS' conclusion and recommends that Community-based Local Office Presence, and Co-location of DHS, Police, Medical, and Forensic Interview Personnel,[12] be given sufficient fiscal and human resources and priority status within the broader scope of city planning to be effectively implemented in a comprehensive way without distracting DHS from the critical policy and practice reforms currently underway. It is, however, important for DHS to keep a focus on these structural changes because of their potential to make community and neighborhood partnership with residents and service providers more effective.

Verification Activities for the Next Period:

- COB and DHS need to the discussion of the rationale for and timing of this action and report to the public its thinking.

[12] Refer to this *Assessment of Progress'* section on Co-location of DHS, Police, Medical, and Forensic Interview Personnel.

7. Family Team Decision Making

Panel's Phase 1 **Recommendation 2.d. (Page v)

DHS must implement a team decision making process to determine service plans for all children 5 years of age or younger. A pre-placement conference must be held for all non-emergency cases where a child 5 years of age or younger may need to be placed into a substitute care setting. The pre-placement conference must include the child's family, including potential kinship placement resources; the DHS worker; the provider agency worker (where applicable); a physician or nurse; and individuals representing mental health, substance abuse, and domestic violence services, as needed, who have the authority to commit resources of their respective agencies; and individuals requested by the family representing their social support network. When feasible, the supervisors of both the DHS and provider agency workers should participate in the team decision making conference. The initial Family Service Plan (FSP) must be developed during this process.
Panel's timeframe for completion: August 31, 2007.

Panel's Phase 1 Recommendation 2.e. (Page v)

DHS must ensure that ongoing team case conferencing occurs routinely every three months,[13] for cases involving children age 5 years or younger, after the initial pre-placement conference, and the child's family, the DHS worker, the provider agency worker, and other interdisciplinary resources must be included as appropriate. Monitoring of service provided, progress, and revisions to the FSP must be made as part of this process.
Panel's timeframe for completion: November 30, 2007.

Assessment of Progress: Initiated with more progress needed

Discussion:

Although DHS has missed the Panel's timeframe for these recommendations, progress has been made in planning for this new practice over the last four months. As a result of reviewing information and practices in a number of jurisdictions, the Department's leadership team has embraced this practice as a critical reform strategy. The assessment of more work being need reflects the need to actually start the conferencing with families and in no way minimizes the work that has been done to date.

The family team decision making (FTDM) model is expected to improve engagement and respectful treatment of families, and become an integral part of the process for assuring child safety and permanence. As a result of current planning efforts, a request for proposals is scheduled to be released in January 2008 for the provision of facilitation and other supports to pilot the FDTM process. Starting in February 2008, a three-month pilot of pre-hearing FTDM will be implemented and evaluated in one region and involve 15 families per month. Based on the experience in the pilot, a strategy will be developed to institutionalize the practice.

Another issue that needs to be resolved immediately is the relationship between DHS and Family Court in the implementation of this practice. The Court has expressed an interest in developing a

[13] Ongoing team case conferencing (i.e., progress and quality assurance meeting) every three months in conjunction with Family Court moving to every three months.

similar process. If this occurs, it will be important for DHS and Family Court to collaborate so that there is no redundancy and families are not subject to conflicting processes.

Verification Activities for the Next Period:
A number of strategies have been identified to assess the implementation and impact of the FTDM model. The COB, in conjunction with DHS, will need to select those strategies that will provide the most information.

- Report on number of families served, number of facilitators engaged, and the outcomes for families who participated.
- Qualitative review of family service plans to discern the quality of the plans and the extent of participation by parents/caregivers, extended family, providers, and other stakeholders.
- Analysis of DHS' Internal Performance Management measures for families who have participated in FTDM.[14]
- Focus group with parents/caregivers, preferably those involved with DHS before and after implementation of FTDM.
- Focus group with staff and parents/caregivers and parent advocates to assess implementation.

8. Clarification of Provider Roles and Responsibilities Relative to DHS

Panel's Phase 1 Recommendation 2.f. (Page v)
DHS must clarify the roles and responsibilities for DHS workers relative to private agency workers, at both the supervisory and worker level.
Panel's timeframe for completion: August 31, 2007.

Assessment of Progress: Completed
Work products:

- Comprehensive SCOH Standards Effective July 1, 2007 – Roles and Responsibilities. See Appendix D.

Discussion:
DHS recognized that a comprehensive approach to the DHS/Provider relationship must include attention to safety, clarification of roles and responsibilities, and increased monitoring for accountability. In addition, the COB recommends that reimbursement rates for enhanced SCOH be reassessed in order to compensate Providers at higher rates for additional services.

After holding a series of monthly meetings with Providers, DHS issued enhanced SCOH standards with increased focus on child safety and protection (Appendix C) in July 2007. Follow-up training in December 2007 and January 2008 reinforces the standards and Provider roles and responsibilities in relation to DHS, at both the supervisory and worker level.[15]

[14] Refer to this *Assessment of Progress'* section on Internal Performance Management.
[15] Refer to this *Assessment of Progress'* section on Clarification DHS Supervisor's Role.

This clear definition of roles and responsibilities is also built into the new In-home Protective Services program (which will succeed the enhanced SCOH program in July 2008).[16]

Monitoring of provider agencies now includes the Provider Accountability Forum, random phone calls to families receiving in-home services, and the Consumer Satisfaction Team's visits to group homes and institutions. For more details on DHS' external accountability approach, refer to this report's section on Enhanced DHS Monitoring of Provider Agencies.

Verification Activities for the Next Period:

- Results of Contract Administration and Performance Evaluation (CAPE) annual and special evaluations.
- Updated Performance Accountability Forum (PAF) Program Recommendation Summary.
- Results of random phone calls to families receiving in-home services.
- Report on Consumer Satisfaction Team's visits to group homes and institutions.
- Commissioner's Action Response Office (CARO) report on nature of complaints (case issues v. systemic issues).

9. Annual Accountability Reports

Panel's Phase 1 Recommendations 3.a.i. (Page vi)

DHS must develop an annual report card that measures and communicates its performance on outcomes of interest, including at a minimum, those outcomes specified in Chapter 4 of the Report.

Panel's timeframe for completion: Strategy developed by November 30, 2007 and report card delivered by May 31, 2008.

Panel's Phase 1 Recommendation 3.b.i. (Page vi)

DHS must create an annual outcome report card for contracted agencies. At a minimum, the report card will focus on measures of child safety, which are detailed in Chapter 4 of the Report.

Panel's timeframe for completion: May 31, 2008.

Assessment of Progress: Not yet due-On track

Discussion:

Public reports of outcomes achieved by both DHS and their provider agencies can serve to enhance both accountability and the public trust in the city's child welfare system. Reforms can then be accurately guided by a careful assessment of meaningful data, and not focused on a few high-profile cases. The first Annual Public DHS and Provider Accountability Reports will focus on outcomes related to child safety and permanency. Later child well-being indicators will be measured.

Safety and permanency data necessary for the completion of these annual reports are being analyzed by the Chapin Hall Data Center which has experience offering similar services in other

[16] Refer to this *Assessment of Progress'* section on Realignment of In-home Protective Services.

large child welfare agencies. Chapin Hall will provide the data to DHS by May of 2008. DHS will then require approximately two months for configuring the raw data into reports with narrative and graphics for public dissemination.

Verification Activities for the Next Period:

- DHS will provide COB with updates, including data received from Chapin Hall. COB will participate in finalizing accountability reports for both DHS and Providers.[17]

10. Internal Performance Management

Panel's Phase 1 Recommendation 3.a.ii. (Page vi)

DHS must develop a comprehensive strategy for internal monitoring of its performance. DHS must be able to monitor the performance of regions, units and workers, and must use performance information to identify weaknesses and areas for improvement.

Panel's timeframe for completion: Strategy developed by November 30, 2007 and Tracking to begin May 31, 2008.

Assessment of Progress: Strategy development: Complete
Tracking performance: Not yet due-On track

Discussion:

Prior to the release of the Panel's recommendations, DHS engaged the Jerry Lee Center at the University of Pennsylvania to develop an Internal Performance Measurement (IPM) Strategic Plan which is being expanded in fiscal year 2008 to address the related Panel recommendations.

The IPM project tracks performance at each of the region, unit, and worker levels. The COB recognizes that it may be challenging for DHS to aggressively use internal performance data to manage and provide constructive feedback to staff in order to enhance performance at all levels in the Department. Management and supervisory staff will have to learn how to connect data with desired practice improvements in order for this tool to be useful and effective.

IPM quarterly reports are made to DHS management staff.

Verification Activities for the Next Period:

- IPM tracking report produced in May 2008 for integration with DHS' Annual Public Accountability Report.
- Interviews with DHS' directors and administrators to gauge the extent to which they have received support and technical assistance to use data in their day-to-day management.
- Interviews with DHS supervisors and social workers to gauge the extent to which their managers have been able to use data management to help them effectively serve children and families.

[17] *Establish an external accountability process that includes an annual public report card that covers the core outcomes*. Responsibility for the report, which should be funded by the City, should be placed in the hands of an independent body that is granted full, unfettered access to the data resources of DHS. (Panel's Report, page 20)

11. Enhanced DHS Monitoring of Provider Agencies[18]

Panel's Phase 1 Recommendations 3.b. (Page vi)
DHS must enhance oversight of contracted agencies
Panel's timeframe for completion: No overall timeframe given.

Assessment of Progress:
Work status:

- Initiated with substantial progress

Discussion:
Prior to the release of the Panel's recommendations, DHS' Contract Administration and Provider Evaluation Unit (CAPE) conducted annual evaluations which focused primarily on compliance. Beginning in January 2007, DHS has worked to improve the monitoring of contracted agencies by clarifying roles and responsibilities, issuing new standards, offering training on the new safety-focused model of practice, planning for an Annual Public Provider Accountability Report to address performance and outcomes, initiating Consumer Satisfaction Team[19] (CST) visits and conducting random phone calls with families. In addition, agencies receiving a low rating during their annual evaluation are then slated for more frequent (quarterly or bi-annual) follow-up visits.

DHS has established a new unit within CAPE to assist with the enhanced monitoring workload. In addition, a Provider Accountability Forum (PAF) meets twice monthly to review CAPE's provider evaluations and determine what actions need to be taken in response. DHS is also working with Casey Family Programs to retain a consultant to work with the Department to improve processes, procedures and methodologies for provider evaluation and monitoring.

As a result of this more aggressive approach to oversight, 13 contract agencies have been closed for intake in 2007 (compared to six in 2006). These agencies must demonstrate substantial improvement before being reopened for intake.

DHS is also working closely with the Department of Behavioral Health (DBH) to increase joint monitoring of providers and improved sharing of data. While these conversations are ongoing, implementation of joint visits and data sharing is pending.

By July 1, 2008, DHS would like to institute spot checking of providers (especially new providers).

Verification Activities for the Next Period:

- Reports from the PAF meetings including issues raised and action steps taken.

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[18] Refer to this *Assessment of Progress'* section on Clarification of Provider Roles and Responsibilities Relative to DHS.

[19] DHS' CST will visit the Achievement Independence Center, group homes, and institutions to speak with youth 14 years and older. The frequency of visits will be determined by the number of providers, their locations, and other criteria. CST will hold monthly Accountability meetings to present issues to DHS' upper management. The new monitoring unit in CAPE will follow up on the concerns presented by the CST evaluations, and present CST with written responses to the issues/concerns identified in the CST evaluations.

- Reports from the CST visits and CAPE random phone calls, including number of contacts, trends, concerns and issues raised and action steps taken.
- Focus groups with Provider staff and families.
- Report on status of joint DHS/DBH monitoring of agencies.
- Plan, with timeline for implementation, of spot-checking of agencies.
- Report of recommendations developed with consultant and timeline for implementation.

12. DHS' Validation of Provider Face-to-face Contact with Children

Panel's Phase 1 Recommendation 3.b.ii (Page vi)

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

Panel's timeframe for completion: June 30, 2007.

Assessment of Progress: Completed and ongoing

Discussion:

The new enhanced SCOH standards include an increased focus on safety as well as ongoing safety reviews at every contact with the child as previously discussed.[20] In order to establish a baseline and ensure that all children receiving SCOH services are safe during the transition to enhanced SCOH, DHS visited all SCOH families, conducting safety reviews in each home by February 2007. During these visits families were asked about their satisfaction with SCOH services and the frequency of visits they had previously received.[21]

In addition to the family visits, DHS' Contract Administration and Provider Evaluation Unit began phone calls on June 1, 2007, to a sample of families to confirm that provider visits are being made and to assess the quality of services provided. A minimum of 128 phone calls are made per month. Follow-up is done with agencies and DHS social workers when concerns are identified.

DHS has also contracted with Consumer Satisfaction Team Inc. (CST), an organization with 15 years experience. They will utilize parents and youth who have been served by DHS and provider agencies to visit families and solicit feedback on DHS and provider performance. DHS is currently planning a system of web-based interface for providers to log in visits with children and families.

The random phone calls, and CST visits will be ongoing tools to monitor the performance of SCOH agencies.

[20] Refer to this *Assessment of Progress'* section on Clarification of Provider Roles and Responsibilities Relative to DHS.

[21] Refer to this *Assessment of Progress'* section on Intervals for Safety Assessments.

Verification Activities for the Next Period:

- Quarterly Report on number of random phone calls and feedback, issues, and concerns raised.
- Quarterly report on number CST visits with feedback, issues and concerns raised.
- Plan, with timeline, to roll out web-based interface for providers to log in visits with children and families.

13. Commissioner's Action Response Office

Panel's Phase 1 Recommendation 3.c. (Page vi)
DHS must establish Commissioner's Action Line.
Panel's timeframe for completion: August 31, 2007.

Assessment of Progress: Completed

Discussion:
The Commissioner's Action Response Office (CARO) was established on April 20, 2007, absorbing the function of the previous Ombudsman's office. CARO provides an independent review of the questions, concerns, and complaints made by clients, providers, and other individuals. All biological parents, providers, foster parents, private attorneys, child advocates and attorneys, and parent attorneys have been advised of this office and its function. Currently, CARO has three professional and one clerical staff persons,[22] who:

- Investigate complaints, concerns, and suggestions that are received via phone or internet. CARO is currently receiving an average of 20 new referrals each week.[23]
- Accept SCOH Alerts from providers when a family being served is experiencing problems that are creating risks for children. CARO staff then alert SCOH managers who must report back to CARO within three working days on the actions taken to resolve the problems. Fifteen to 20 such calls are received each week.
- Are onsite at DHS' town hall meetings to speak privately with clients and family members who may have concerns and questions about individual cases.
- Analyze the information collected for trends.

While CARO has certainly improved DHS' transparency and the timeliness of its response to SCOH providers, the Department is working to resolve two challenges:

- *CARO has not been able to generate monthly reports categorizing the nature of the calls/emails received so that trends can be analyzed, or to document the actions taken to resolve issues identified.* The most frequent kinds of problems raised are (1) case handling complaints; (2) complaints of inappropriate behavior/harassment by DHS staff; (3) payment/Medical Assistance complaints; (4) requests by relatives to be considered as placement resources; and (5) communications problems.

[22] Two social workers have been added to the CYD Intake Center to handle chain of command and CARO type calls to the 4DHS phone line.
[23] This is double the number of referrals per week that the traditional Ombudsman's office handled prior to the establishment of CARO.

- *The Department would like to use CARO to handle complaints from children in placement. Creating a grievance procedure of children in placement requires clearance for the City Law Department which is still pending.* Once clearance has been received, all children in placement will have the grievance procedure explained to them by their DHS social workers and will be given a packet that contains information on contacting CARO.

Verification Activities for the Next Period:

- Analysis of reports received from April 30, 2007, through December 31, 2007 – due to COB by January 31, 2008.
- Quarterly reports analyzing complaints and documenting actions taken to resolve systemic issues that are identified through the complaints – due to COB on the 15th day of the month following the end of a quarter (e.g., April 15 and July 15).

14. Community Oversight Board

Panel's Phase 1 Recommendation 4.a. (Page vi)

DHS must establish a mechanism and process to establish ongoing community oversight. At a minimum, the City must establish a Community Oversight Board.

Panel's timeframe for completion: The Board must be appointed no later than June 30, 2007.

Assessment of Progress: Initiated with substantial progress made

Discussion:

The Community Oversight Board's (COB) was established by Executive Order in June 2007. The mayor appointed the six current members in the fall of 2007. To date, City Council has not appointed the three remaining members.

Recommendations:

Based on the experience to date the COB makes the following recommendations to the new Mayoral Administration:

- The COB continues with the important work of reporting to the Mayor and the public on DHS reforms.
- The City should increase the number of COB members to provide for local representation and national child welfare experts.
- The City should provide resources to hire staff or to contract for the needed verification activities.
- Persons appointed to the COB should be independent of DHS. The DHS Commissioner should serve in an ex-officio capacity.
- The City should consider a formal nomination process for future COB members.
- The City should consider forming an Expert Advisory Committee to the COB.

Verification Activities for the Next Period:

- Continuance of COB including the appointment of individuals to fill vacant seats.

- Commitment of resources for COB verification activities outlined in this Assessment of Progress, and engaging other experts.

15. Ongoing Community Participation and Input

Panel's Phase 1 Recommendation 4.b. (Page vii)

DHS must ensure ongoing community participation and input into the improvements undertaken by DHS. This participation shall include, at a minimum, a series of ongoing town hall meetings, focus groups, and other events that facilitate the input of community members, private provider agencies, parents, clients, and other stakeholders.
Panel's timeframe for completion: Plan of action must be in place by July 31, 2007.

Assessment of Progress: Completed and ongoing

Discussion:
Town hall meetings began on September 6, 2007, and continued through the fall. The six meetings provided an opportunity for DHS to update the community on its reforms and to solicit input and feedback from the community about the child welfare system. Meetings were held every two weeks in locations throughout the city with the highest concentration of DHS involvement. Attendance ranged from 30-60 participants.[24]

The statutorily-required Child Welfare Advisory Board was recently reactivated and provides an opportunity to enhance ongoing community participation and input. DHS actively sought the participation of present and former foster youth as well as foster and biological parents on this board.

The Department also met with a range of stakeholders to provide them with an update on the reform plan and current efforts. The advice of each of these stakeholder groups was solicited as well as their concerns about the agency's operations and directions. Among those consulted were DHS provider agencies, mayoral candidates, City Council, Child Welfare Advisory Board, Community Oversight Board, Philadelphia State Legislators, legal advocates and local judicial officers.

Verification Activities for the Next Period:
- Continuation of town hall meetings at least once a month.

[24] A town hall and follow-up meetings were held specifically for older youth in out-of home care to engage them in informing changes to DHS' practices and policies; the DHS Commissioner will meet with older youth in out-of-home care on a quarterly basis. In addition, separate town hall meetings were held with the Latino community, at which interpreters were available to facilitate communication; community meetings are also proposed for other language groups.

16. Realignment of Prevention Programs

Panel's Phase 2 **Recommendation 1.a. (Page vii)

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

Panel's timeframe for completion: Analysis to begin by November 30, 2007 and alignment to begin by November 30, 2008.

Assessment of Progress: Analysis: Completed
Realignment: Not yet due-On track

Discussion:

DHS has engaged The Center for the Support of Families (CSF) to identify strategies for aligning prevention services with core functions of Children and Youth Division (CYD). The report is expected in January 2008. The goal is to identify areas of duplication and gaps in service in order to develop a prevention strategy that meets the needs of CYD for diversion and aftercare.

Verification Activities for the Next Period:

- Review of the realignment plan and progress.

17. Realignment of In-home Protective Services

Panel's Phase 2 **Recommendation 1.b. (Page vii)

DHS must align more effectively in-home service programs and their utilization with the mission and values of DHS and with child safety.

Panel's timeframe for completion: Analysis to begin by July 31, 2007 and alignment and revisions to SCOH by March 31, 2008.

Assessment of Progress: Analysis: Completed
Alignment: Not yet due-On track

Discussion:

A comprehensive analysis of DHS' in-home services with a focus on child safety and protection was completed on January 31, 2007. Based on this report, revisions to Services to Children in Their Own Homes (SCOH) performance standards with an emphasis on child safety and protection were completed and were included in fiscal year 2008 contracts with in-home service providers.[25] See Appendix D for comparison of new and old standards.

A more comprehensive and intensive realignment of SCOH is scheduled to begin by July 2008, when the new In-home Protective Services program (IHPS) will replace SCOH and the new Alternative Response System (ARS) program will provide services to families who are not in need of protective services and include a mechanism to ensure that appropriate referrals are made.

[25] Refer too this *Assessment of Progress'* section on Clarification of Provider Roles and Responsibilities Relative to DHS.

The reassessment of SCOH services has resulted in the development of a continuum of care that will include not only intensive home-based services (via IHPS) but also alternative response services (via ARS) for non-maltreatment cases and family preservation services aimed at prevention of placement. The chart below organizes the various service components by function.

Diversion	Diversion	In-home Safety Services	In-home Safety Services	Out-of-home Safety Services
Prevention Services	Alternative Response System	Family Preservation Program	In-home Protective Services	Placement

Verification Activities for the Next Period:

- Report on implementation of ARS.
- Report on implementation of IHPS.
- Focus group with providers and consumers of ARS.
- Focus groups with providers and consumers of enhanced SCOH and new IHPS.

18. Comprehensive Model for Social Work Practice

Panel's Phase 2 **Recommendation 2.a. (Page vii)

DHS must develop a comprehensive model for social work practice that is based on DHS' core mission and values; includes a stronger focus on child safety, permanency and well-being; is family-focused and community-based; and allows for individualized services.
Panel's timeframe for completion: Comprehensive May 31, 2008.

Assessment of Progress: Not yet due-On track

Discussion:

Consistent with DHS' investment in developing a safety assessment tool to guide decision making, the Department has committed to adopting a model of practice based on child safety.[26] With the assistance of Action for Child Protection and DPW, DHS has started the model development process. The initial work of safety assessment has documented for the staff the importance of having a systematic way of examining the conditions of children and developing a service response. The development of this model will require the integration of several now disparate components – safety assessment,[27] risk assessment,[28] family team decision making

[26] Appendix A of Request for Qualifications for ARS & IHPS available online at http://dhs.phila.gov/intranet/pgintrahome_pub.nsf/Content/What%27s+New++RFQ+for+In+Home+Protective+Services+and+ARS.

[27] Refer to this *Assessment of Progress'* section on Evidence-based Safety Assessment Tools.

[28] Refer to this *Assessment of Progress'* section on Integration of Risk Assessment with New Safety Assessment & Family Team Decision Making Model.

process[29] and the family service plan – in a manner that meets state mandates and supports good practice.

Once the practice model has been developed, DHS will need to train supervisors and frontline staff to implement the model. A rigorous quality assurance process must also be implemented to provide supervisors and case-carrying social workers with timely feedback on their progress in implementing the integrated practice model. In addition, the impact of the new practices on child welfare outcomes will need to be tracked in order to assure that the model being adopted is improving the safety and permanency of children served.

Verification activities for the next period:

- Review and discussion of the practice model and the integration of the key components.
- Progress report on training and transfer of learning strategy.
- Focus groups with frontline workers and supervisors on practice change.
- Initial monitoring of the impact on outcomes for children.

19. Background Check on Family Members

Panel's Phase 2 Recommendation 2.a.ii.2. (Page viii)

DHS must conduct a background check on each member in the child's household. If an adult household member has prior involvement with DHS or a criminal record that includes convictions for a felony that suggests danger for a child, then DHS must conduct an assessment to determine whether the household is safe and appropriate for the child. ***Panel's timeframe for completion: December 31, 2008.***

Assessment of Progress: Not yet due-Requires discussion between DHS and COB

Discussion:

DHS and the COB will need to work to clarify the expectation on this Panel recommendation. The Department does not require background checks/police clearances on non-parental adults in SCOH households. Currently, DHS reports that it is conducting background checks as required by law and regulation and *appropriate* given the circumstances of the case. It is unclear what criteria are being used. There is policy language that allows for background check in "extraordinary circumstances," but what situations qualify as "extraordinary" need to be clarified. Despite this ambiguity, DHS is developing a plan to do quality assurance on a sampling of cases to make sure that background checks are being done appropriately.

Verification Activities for the Next Period:

- Policy clarification regarding DHS' criteria for requiring background checks on non-parental adults in the home.
- Copy of guidelines being developed by DHS and City Law Department that will define extraordinary circumstances under which background checks should be conducted.
- Quality assurance report on sampling of cases reviewed to determine if background checks are being done appropriately.

[29] Refer to this *Assessment of Progress'* section on Family Team Decision Making.

20. Social Workers' Consultation with Other Professionals

Panel's Phase 2 Recommendation 2.a.ii.3 (Page viii)

DHS must improve integration with physicians, nurses, and behavioral health specialists to ensure that each child's medical and behavioral health is appropriately assessed.
Panel's timeframe for completion: December 31, 2008.

Assessment of Progress: Completed and ongoing

Discussion:
In January 2007, two nurses were contracted to help identify medically needy children and provide consultation to DHS social workers and families in meeting their needs. DHS has requested additional funding for five additional nurses – one for each of the four Family Service Regions and one for Intake.

To date the nursing unit has provided the following assistance to DHS staff:

- Help in identifying, assessing and incorporating medical information into plans for children with major health needs.
- Care coordination and advocacy by following up with physicians and attending hospital discharge planning meetings.
- Collection and coordination of information sharing with Provider staff.
- Development of screening criteria and protocols to assess the capacity of caregivers for children with chronic and/or acute health needs.

To further strengthen the focus on child health, DHS is also seeking funds to support a Medical Director who will develop policy related to the health needs of children receiving child welfare services.

Behavioral Health consultants from the Department of Behavioral Health (DBH) are onsite at DHS and Family Court to team on difficult cases. In addition, DHS and DBH are working together on sharing reports,[30] reducing placement in residential care, and applying for joint financing to support children who are transitioning from residential care to community systems of care.

In January 2008, DHS in collaboration with the School District of Philadelphia will implement the Educational Support Center for children in out-of-home care. This will allow for smoother transition for children entering and returning from placement. It is anticipated that one School District staff person will be onsite at DHS to help negotiate educational plans for children in placement.

The COB supports DHS' funding requests for an additional five nurses and a Medical Director. Such funding will support: (1) assessment and treatment of the health needs of children needing protection and/or placement; (2) integration of knowledge from other disciplines (including

[30] DHS and DBH have entered into a confidentiality agreement to share data for clients who are in both systems.

developmental, educational, and health) into safety and placement decisions; and (3) development of policy to govern health of children served by CYD.

Verification Activities for the Next Period:

- Activity reports from interdisciplinary consultants.
- Tracking of the number of health screenings conducted.
- Documentation of policy changes related to health, mental health and educational needs of children served.

21. Integration of Risk Assessment with New Safety Assessment & Family Team Decision Making Model

Panel's Phase 2 **Recommendation 2.a.ii.4 (Page viii)

DHS must reexamine the risk assessment in the context of the new safety assessment and integrate it into the new team decision making model for placement and services.
Panel's timeframe for completion: December 31, 2008.

Assessment of Progress: Not yet due

Discussion:
DPW is statutorily required to provide oversight to DHS on: (1) Risk Assessment;[31] (2) Safety Assessment;[32] and (3) Family Service Plan.[33] DHS is developing a comprehensive model for child welfare practice which is anchored by DHS' core values.[34] Forward movement on this recommendation depends upon the full implementation of family team decision making[35] and the finalization of safety assessment tools. In addition, the practice model must include the state-mandated risk assessment and family service planning.

Recommendation:
The COB strongly encourages DHS and DPW to collaborate in crafting an integrated approach that can be implemented without redundancy and confusion.

Verification Activities for the Next Period:

- Ongoing discussion between COB and DHS.

[31] Refer to this *Assessment of Progress'* section on Integration of Risk Assessment with New Safety Assessment & Family Team Decision Making Model.
[32] Refer to this *Assessment of Progress'* section on Evidence-based Safety Assessment Tools.
[33] Questions for DHS to pursue with support from the COB: Would it be possible for the case plan to also function as the Family Service Plan? Does DPW allow waivers of certain forms? Does DHS have any waiver options? Connect with this *Assessment of Progress'* section on Streamlining Paperwork.
[34] Refer to this *Assessment of Progress'* section on Comprehensive Model for Social Work Practice.
[35] Refer to this *Assessment of Progress'* section on Family Team Decision Making.

22. Elimination of "Boilerplate" Referrals

Panel's Phase 2 **Recommendation 2.a.ii.5 (Page ix)

DHS must eliminate "boilerplate" referrals and ensure that each child receives appropriate referrals that are specifically tailored for his or her unique needs. DHS will follow-up and act to ensure that the services are actually obtained.

Panel's timeframe for completion: December 31, 2008.

Assessment of Progress: Not yet due-Initiated

Discussion:

Elimination of the boilerplate referral process requires more individualized assessment of child and family needs, and increased specialization by service providers. Individualized service planning will be strengthened as the following strategies are implemented;

- Family Team Decision Making,[36] which will provide more individualized assessments.
- In-home Protective Services,[37] a reformulation of SCOH services, which will result in the development of specialized services for families;
- Safety Driven Intervention Model,[38] which will help to clarify the risk factors that must be addressed in the service plan;
- Social Worker's Consultation with Other Professionals;[39]
- Reinstitution of quality assurance reviews for Family Service Plans.[40]

Verification Activities for the Next Period:

- Report on results from random quality review of Family Service Plans, on the extent to which plans and services are individualized and responsive to specific service needs.
- Provider monitoring review.
- Documentation on the development of specialized services.

23. Co-location of DHS, Police, Medical, and Forensic Interview Personnel

Panel's Phase 2 Recommendation 2.a.ii.6 (Page ix)

DHS must complete the long-planned co-location of DHS, police, medical and forensic interview personnel at a community site to facilitate collaborative decision making in the investigative phase of casework.

Panel's timeframe for completion: December 31, 2008.

Assessment of Progress: Not yet due-Substantial progress but delays anticipated

[36] Refer to this *Assessment of Progress'* section on Family Team Decision Making.
[37] Refer to this *Assessment of Progress'* section on Realignment of In-home Protective Services.
[38] Refer to this *Assessment of Progress'* section on Safety Driven Intervention Model.
[39] Refer to this *Assessment of Progress'* section on Social Work's Consultation with Other Professionals.
[40] Random quality review of Family Service Plans to help ensure individualization of services, with feedback provided to supervisors.

Discussion:
This recommendation is the subject of active work, however completion by the recommended timeframe may not be possible. The Philadelphia Authority for Industrial Development introduced an ordinance to City Council on May 23, 2007, that was approved on June 7, 2007. There have been some delays in the execution of the lease. Construction timeline is 18 months from the time of Council approval.

Co-location of multiple city services is part of a broader approach to community-based, integrated service delivery that must involve leadership and decision-makers from multiple city agencies beyond DHS. While completion by the timeline envisioned by the Panel may not be feasible, DHS must continue to play a leadership role with the City to ensure that this recommendation moves forward as the city transitions to a new Mayoral Administration.

Recommendation:
The COB recommends that the Co-location of DHS, Police, Medical, and Forensic Interview Personnel be given sufficient fiscal and human resources and priority status within the broader scope of city planning to be effectively implemented in a comprehensive way without distracting DHS from the critical policy and practice reforms currently underway.[41]

Verification Activities for the Next Period:
- Site selection and acquisition completed.
- Timeline for co-location.

24. Clarification of DHS Supervisor's Role

Panel's Phase 2 Recommendation 2.a.iv. (Page ix)
DHS must clarify the role of supervisors to support the DHS practice model being implemented.
Panel's timeframe for completion: March 31, 2008.

Assessment of Progress: Not yet due-Substantial progress

Discussion:
DHS recognizes the critical role of frontline supervisors and managers in facilitating change in practice, the organizational culture, management of work and supporting staff. A number of activities currently underway will assist in the clarification of the supervisor's role. The development of the comprehensive social work practice model will clarify the nature of the work to be managed.[42] In addition, the roles and responsibilities of DHS and Provider staff have been and will be further clarified through contracts with clear standards.[43]

DHS has initiated a comprehensive professional development plan for supervisors and managers by providing leadership development and coaching. Leadership development classes for

[41] Refer to this *Assessment of Progress'* section on Community-based Local Office Presence.
[42] Refer to this *Assessment of Progress'* section on Comprehensive Model for Social Work Practice.
[43] Refer to this *Assessment of Progress'* section on Clarification of Provider Roles and Responsibilities Relative to DHS.

managers began in July 2007. Three cohorts with 15-20 participants each have completed training, and one cohort has begun coaching. DHS reports that the participants are responding enthusiastically to this opportunity.

The leadership development program plans to have the participants complete a written survey to provide feedback on lessons learned through and strengths of the coaching approach, as well as ideas for improving the training for future cohorts. The trainer has agreed to have the first cohort complete the survey during the post-training follow-up in January 2008. In addition, all other participants, including the two cohorts currently in training, will complete the written survey. The professional development plan for supervisors also includes: (1) technical assistance and peer support on how to use data to provide constructive guidance to their staff;[44] and (2) training supervisors with their staff in using safety assessment tool.[45]

In addition, DHS has developed several automated tools to assist supervisors in their work.

- Automated court tracking log, implemented in July 2007, allows DHS staff to view Family Court orders electronically.
- Implementation is planned for the following tools: (1) Automated supervisory compliance tool to ensure that all mandated assessments, visits and records are completed; and (2) Automated supervisory conference log to monitor progress on work plans established during supervisory conferences.

Verification Activities for the Next Period:

- Report on results of written survey completed by Leadership Development Coaching participants.
- Plan, with specific timeframes, to implement automated supervisory compliance tool and conference log.

25. Streamlining Paperwork

Panel's Phase 2 Recommendation 2.a.v. (Page ix)
DHS must streamline its paperwork and records management practices.
Panel's timeframe for completion: August 31, 2008.

Assessment of Progress: Not yet due-On track

Discussion:
Implementing a strategy to eliminate redundancy in documentation and improve the quality of information in case records is critical to good decision making, improved frequency of contacts with children and families[46] and practice improvement. DHS has commissioned a study of the paperwork process, which will include recommendations for a reduction strategy. Based on this analysis, which will be submitted to DHS in January 2008, DHS will develop a strategy to

[44] Refer to this *Assessment of Progress'* section on Internal Performance Management.
[45] Refer to this *Assessment of Progress'* section on Evidence-based Safety Assessment Tool.
[46] Refer to this *Assessment of Progress'* section on DHS' Monthly Face-to-face Contact with Children

streamline the documentation process. DHS anticipates that the plan will be implemented by August 31, 2008.

Verification Activities for the Next Period:

- Review of the consultant report and recommendations related to paperwork reduction.
- Review and discussion of the paperwork reduction strategy, timelines and progress as of May 31, 2008.

26. Child Fatality Review Process

Panel's Phase 2 Recommendation 2.a.vi. Page x)
DHS must enhance the child fatality review process.
Panel's timeframe for completion: December 31, 2007.

Recommendation 2.a.vi.1. (Page x)
DHS must ensure that the child fatality review is multidisciplinary and that there is a mechanism for implementing its recommendations
Panel's timeframe for completion: December 31, 2007.

Assessment of Progress: Enhanced process: Completed
Mechanism for responding to recommendations: Completed and on going

Work status:

- Initiated with substantial progress made.
    - Ongoing implementation begun in April 2007.

Work product(s):

- Revised Protocol for Child Fatality Reviews.
- Summary chart for 2007 child fatality reviews.

Discussion:
Improvements have been made to the child fatality review process including the appointment of a full-time manager on December 3, 2007, the addition of specialists from pediatrics and psychiatry and updating the protocol for child fatality reviews. A major concern has been DHS' past failure to follow up on the recommendations that come out of the child fatality reviews. To address this problem, the findings are presented to the DHS' Operations Cabinet for discussion and development of recommendations and then forwarded to DHS' Executive Cabinet for discussion and action.

Augmenting these efforts, DHS has developed a rapid response fatality team that meets within 24 to 48 hours of a death in a family active with DHS. The point is to immediately gather all available information and assess if there are any issues that need to be addressed, and to discuss an action plan. An example of the kind of systemic problems that have been found as a result of this new process is as follows:

> A fatality that occurred in the last year revealed that a number of cases were not assigned to workers due to vacant positions. DHS immediately reassigned all of

those cases to active caseloads and has institutionalized a process of assigning cases that have become uncovered.

In response to the number of deaths that resulted from co-sleeping, a public heath rather than a maltreatment issue, DHS and the Department of Health has developed a public education campaign as a major preventive strategy. A local organization has been funded to provide cribs to the families of infants as part of that campaign.

Verification Activities for the Next Period:

- Full report on 2007 child fatality reviews.
- Summary chart for January through May 2008 child fatality reviews.

27. Focus on Permanency and Well-being Outcome Measures

Panel's Phase 2 Recommendation 3.a (Page x)

DHS must revisit and expand the list of outcomes to be measured- whereas Phase One was largely focused on child safety, Phase Two will expand the focus to include permanency and well-being measures.

Panel's timeframe for completion: Beginning June 1, 2008, following the development of the first DHS annual report card.

Assessment of Progress: Not yet due

Discussion:

DHS' safety-focused model of practice reflects an understanding that children's safety is best ensured in a context of family permanence and when adequate attention is paid to critical measures of child well-being. Thus, while the first set of performance reports will focus largely on safety-related data, subsequent reports will reflect a more comprehensive accounting for children's safety in the context of permanency and well-being.

DHS is also looking to increase the measures used in its Internal Performance Measurement (IPM) project, in collaboration with the Jerry Lee Center at the University of Pennsylvania. As the project is expanded, DHS will make sure measures address permanency and well-being as well as safety.

Verification Activities for the Next Period:

- Outline of data indicators measuring permanency and well being which will be captured in data and included in subsequent Annual Public DHS and Provider Accountability Reports.

28. Outcomes Accountability

Panel's Phase 2 Recommendation 3.b (Page x)

DHS must link its performance and the performance of its contracted providers to outcomes of accountability, including financial incentives.

Panel's timeframe for completion: June 1, 2008.

Assessment of Progress: Not yet due

Discussion:

The foundation for rewarding Providers based on outcomes rather than compliance is being built with DHS' phased implementation of a safety-driven social work practice model. DHS will also review the Provider Accountability Report[47] and new provider monitoring and assessment tools to determine what type of incentive system is useful.

Verification Activities for the Next Period:

- Review of DHS' plan for performance-based monitoring and fiscal incentives.

29. DHS as a More Transparent Agency

Panel's Phase 2 Recommendation 4.a. (Page x)

DHS must continue to expand its emphasis on making DHS a more transparent agency.

Panel's timeframe for completion: Develop plan by June 30, 2008 and implementation to begin by August 1, 2008.

Assessment of Progress: Not yet due-Completed and ongoing

Discussion:

DHS has developed a communications plan, hired a communications director and initiated a number of activities to promote transparency. In addition to the items noted in the discussion of community participation and input, other activities are underway. Examples include: regular updates to the DHS web site; distribution of the newsletter 'DHS News Flash' internally and externally; media briefings; strengthening the advisory structure; and regular communication and updates to key stakeholders.

Current leadership has placed a great deal of emphasis on openness and transparency as part of needed culture change and accountability to the community. A significant barrier to DHS transparency is the limitation of state confidentiality laws. The Commissioner has advocated for more openness in an op-ed to the Inquirer in early 2007.

Verification Activities for the Next Period:

- Continued tracking of DHS' Communications plan activities.

[47] Refer to this *Assessment of Progress'* section on Annual Accountability Reports.

Panel's Phase 2 Recommendation 4.c. (Page xi)
DHS must enhance its ability to proactively and transparently manage crisis, including strengthening process related to child death reviews and increasing public access to information.
Panel's timeframe for completion: March 31, 2008.

Assessment of Progress: Not yet due-Completed and ongoing

Discussion:
This recommendation is a continuation of the previous one. It adds to the transparency agenda, management of crisis and making the child fatality review more visible. Regarding crisis management, a rapid response team (RRT) has been created.[48] The RRT meets within 24 to 48 hours of a death in a family active with DHS. The point is to immediately gather all available information and assess if there are any issues that need to be addressed, and to discuss an action plan.

The child fatality review process[49] which was found to be functioning well by the Child Welfare Review Panel has been strengthened by establishing new leadership, adding representatives from pediatrics and psychiatry to the team, and creating a process for reviewing recommendations to determine actions to be taken.

One of the factors that limits transparency is the existing state policy on confidentiality which restricts the information that can be shared when there has been a fatality or serious injury to a child. Opinion editorials by the DHS Acting Commissioner have been published calling for changes in the state law so that information can be shared in situations of serious maltreatment, and in updating the community on reform efforts.

Verification Activities for the Next Period:
- Continued tracking of DHS' communication efforts.
- Tracking implementation of recommendations from the child fatality review team.

30. Enhancing Healthiness of Infrastructure and Staff Morale

Panel's Phase 2 Recommendation 4.b. (Page x)
DHS must take positive steps to enhance the healthiness of infrastructure and staff morale
Panel's timeframe for completion: March 31, 2008.

Assessment of Progress: Not yet due-Substantial progress

Discussion:
Actions taken to improve staff morale began on March 31, 2007 and include open communication between leadership and staff, enhanced training, improved protocols clarify practice expectations, and providing material supports.

[48] Refer to this *Assessment of Progress'* section on Child Fatality Review Process.
[49] Refer to this *Assessment of Progress'* section on Child Fatality Review Process.

Efforts to open communication include:

- Three series of three meetings (about 300-500 employees attended each meeting) of all-staff meetings were held to provide information about DHS' Action Plan on reforms and answer staff questions.
- Brown Bag sessions providing an opportunity for staff to meet with the Commissioner in a small group setting are regularly held.

Examples of enhanced training include:

- Supervisors are participating in Leadership Development Coaching.
- Supervisors and their frontline staff (by specific units) will be trained in the same sessions on using the new safety assessment tools.[50]

Examples of management responding quickly to address workers' concerns and needs include:

- Provision of additional cell phones and vehicles to assist workers with visits;
- Plans for a new resource library equipped with internet access, books, journals and other materials;
- Protocol for police response to DHS requests for assistance has been strengthened to address workers' safety concerns.

Verification Activities for the Next Period:

- Focus groups with staff to assess changes in the work environment and the impact on practice/work and morale.

[50] Refer to this *Assessment of Progress'* section on Clarification of DHS Supervisor's Role.

Appendix A
List of Documents Reviewed

1. Child Deaths Requiring State Mandated Fatality Reviews (6/1/07 – 12/20/07)
2. Child Health Consultation Project's Quarterly Report (7/1/07 – 9/30/07)
3. Commissioner's Action Response Office Update (11/5/07)
4. Communications Strategy for DHS (11/5/07)
5. Community Oversight Board Meeting Minutes (10/5/07)
6. Comparison of Existing SCOH Standards with Enhanced Standards (6/20/07)
7. Comprehensive SCOH Standards Effective 7/1/07 – Roles & Responsibilities
8. Contract Administration & Performance Evaluation's Monitoring Unit Status Report (11/5/07)
9. Courtroom Timeliness Graph (12/12/07)
10. Expedited Report Statistics (8/27/07 – 10/24/07)
11. Family Team Decision Making Structure, Implementation Plan & Values (Draft – 11/5/07)
12. FY2008 Enhanced SCOH Services Standards (8/8/07)
13. Guidelines for Visits to DHS Workers for Children in Out-of-home Care Settings (10/24/07)
14. Hotline Guided Decision Making Tool (Draft – 11/7/07)
15. In-home Safety Assessment Worksheet (11/6/07)
16. Interim Policy and Procedure Guide – Safety Assessment Process, Effective upon Completion of Social Worker's Safety Training (7/4/07)
17. Internal Performance management for Children & Youth Division (12/11/07)
18. Internal Performance Management Strategic Plan for 2007-08
19. Kinship Caregiver Placements (6/03)
20. Local Office Subcommittee Update (11/19/07)
21. Mission Statement and Core Values (Final Draft – 12/31/07)
22. Online Access to Pennsylvania State Police Criminal History Record Information (4/1/05)
23. Placement Visits Structured Case & Progress Notes for Foster & Kinship Home Visits (11/1/07)
24. Prevention Assessment Summary (10/31/07)
25. Protocol for Child Fatality Reviews (6/21/07)
26. Provider Accountability Forum Recommendation Summary (10/15/07)
27. Provider Accountability Forum Updated (11/5/07)
28. Provider Accountability Strategy (Draft – 12/19/07)
29. Report from DHS Personnel on Vacancies (12/12/07)
30. RFP for Family Team Decision Making Meetings (12/13/07)
31. RFQ for Alternative Response System and In-home Protective Services (11/9/07)
32. Safety Alert #1: Common Factors in Child Fatalities (4/10/07)
33. Safety Alert #2: DHS Nurses Can Help You (5/30/07)
34. Safety Alert #3: Consider Family History with DHS – Safety Tips (6/20/07)
35. Safety Alert #4: Educate Clients about Safe Sleeping (7/12/07)
36. Safety Alert #5: Domestic Violence Is a Child Welfare Issue (10/4/07)
37. Safety and Well-being Visits Report (3/14/07)
38. Safety Assessment & Tool Implementation Update (11/19/07)
39. SCOH Provider's Letter from Arthur C. Evans, PhD, DHS Acting Commissioner (5/23/07)
40. Ten Step Transfer of Learning Process
41. Town Hall Meeting Flyers
42. Town Hall Meetings (9/6/07 – 11/29/07) Report
43. Update Grid on DHS' Status in Implementing Child Welfare Review Panel's Recommendations
44. Visits to All Children in Placement Memo (10/23/07)
45. Walter R. McDonald & Associates, Inc. Report on Mission & Values Statements (10/23/07)

Appendix B

Mission Statement

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

Core Values

Safety: Safety is our highest priority. We respond urgently and appropriately to all concerns about the safety of children and youth.

Permanency: We value and seek lifelong connections to family and community for all children and youth.

Well Being: We provide services which promote healthy physical, social, educational and emotional development.

Respect: We value each other, families, children and community partners and treat them with the utmost respect and compassion. Families are treated with dignity and provided culturally sensitive services.

Competence: Our employees and providers will continue to be proficient in their jobs through on going training and professional development

Team Work: We actively promote team work as a method to support staff in an effort to enhance their ability to work with families. Families have a voice that will be heard, supported and recognized as part of the team.

Accountability: We hold ourselves accountable to the children and families we serve, our fellow employees and the community to provide quality services while managing public resources effectively.

Transparency: We will continue to maintain an open dialogue with the public, providers and our staff regarding practices, standards and outcomes.

Communication: We are proactive in providing information to the public, families and other stakeholders about services that the Department provides. The Department is committed to keeping staff informed regarding new developments, policies, procedures and expectations.

Trust: We foster an environment of trust by maintaining the highest level of professional conduct, honesty and integrity.

Final Draft – 12/31/07

Appendix C

THE PHILADELPHIA DEPARTMENT OF HUMAN SERVICES
Children and Youth Division
Interim Policy and Procedure Guide

Issue Date: **June 4, 2007**

TO: **All CYD Social Work Staff and In-Home Service Providers**

FROM: **Joseph E. Kuna, Ph.D. Acting Deputy Commissioner, CYD**
Pamela Mayo, Operations Director

RE: **Safety Assessment Process**

Effective: Upon Completion of the Social Worker's Safety Training

The purpose of this interim policy and procedure guide is to introduce a new Safety Assessment process developed by the Department of Public Welfare (DPW). The guide details the protocol and format for safety assessments and safety planning that must be completed with every CPS, GPS and General Report investigation/assessment for the subject child(ren) and all other children in the household. The protocol must also be used to assess the safety of children who receive in-home services or who are being discharged from placement.

DHS staff will use the new Safety Assessment tool and protocol as they are trained. A separate tool for visits to children in placement is also being developed by DPW and will be introduced in the near future.

Discussion:
Safety is the primary focus of child welfare services that informs and guides all decisions made from intake through case closure, including removal and reunification decisions. The focus is on identifying safety threats, present and/or impending danger and determining the protective capacities of the child's caregivers. It also entails working with caregivers to supplement their protective capacities through safety interventions. The process leads to making informed decisions about safety planning for children.

Safety analysis and decision making uses all available information to decide if a safety plan is needed and what specific interventions are available and accessible to control identified threats to a child. The interventions provided may be in-home, out-of-home or a combination of the two.

Decisions concerning safety cannot be made solely on the social worker's observation of the family. Family members hold information critical to making a sound safety decision and must be engaged and encouraged to share necessary information. In addition, the role of the DHS supervisor in providing consultation, support, oversight and approval of the safety assessment (as documented on a Safety Assessment Worksheet and/or in structured case notes), safety decision and safety plan is critical. One of the primary functions of the supervisor is to ensure the quality of work related to safety decision making and management.

Policy

Definitions

The following words and phrases are used within the context of the Safety Assessment process.

Safety Assessment and Management Process: The on-going method of assuring the immediate safety of the child. There are five phases to this process: Safety Assessment, Safety Analysis, Safety Decision, Safety Plan and Safety Management:

- **Safety Assessment**: The continuous process of collecting information related to child safety in six domains to identify threats to safety and protective capacities. These domains include the extent of maltreatment, circumstances surrounding the maltreatment, child functioning, adult functioning, parenting and discipline.

    - **Safety Threats**: The conditions or actions within the child's current living situation that represent the likelihood of imminent serious harm to the child. There are two types of safety threats:

        - **Present danger** is an immediate, significant and clearly observable threat to a child occurring in the present.

        - **Impending danger** refers to threatening conditions that are not immediately obvious or currently active but are out of control and likely to cause serious harm to a child in the near future.

    - **Safety Threshold**: The point when a caregiver's behaviors, attitudes, emotions, intent, or situations are manifested in such a way that they are beyond being risk influences and have become an imminent threat to child safety. In order to reach the safety threshold a condition must meet all of the following criteria:
        - Affect a vulnerable child;
        - Be specific and observable;
        - Be out-of-control;
        - Be imminent; and
        - Have potential to cause serious harm to a child.

    - **Protective Capacity:** A specific quality that can be observed and understood to be part of the way a caregiver thinks (cognitive), feels (emotional), and acts (behavioral) that makes him or her protective, that is, able to keep a child safe.

- **Safety Analysis**: The process by which a county agency systematically evaluates the information gathered related to safety threats and protective capacities. The purpose of the safety analysis is to identify and explain what is associated with or influences a safety threat or protective capacity. The results of the analysis lead to a safety decision.

- **Safety Decision**: A determination that a child is safe, safe with a comprehensive safety plan or unsafe in their current living environment which is based on the conclusions of the safety analysis.

    Safe: Either caregivers' existing protective capacities sufficiently control identified safety threats or no safety threats exist. Child can safely remain in the current living arrangement. No safety plan necessary as no external controls are needed to control safety threats.

Safe with a Comprehensive Safety Plan: Caregivers' existing protective capacities can be supplemented by safety interventions to externally control safety threats. Child can safely remain in the current living arrangement with implementation of appropriate safety interventions. Safety Plan required.

Unsafe: Caregivers' existing protective capacities cannot be sufficiently supplemented by safety interventions to externally control safety threats. Child cannot remain safely in the current living arrangement; child's removal necessary.

Preliminary (Initial) Safety Decision: A determination made that a child is safe, or that present danger and/or impending danger exists based on information gathered prior to the completion of the safety analysis, which require implementation of a preliminary safety plan or removal.

Safety Plan: A written arrangement between caregivers, responsible persons and the county agency that establishes how present or impending threats of serious harm to the child will be controlled.

- **Preliminary (Initial) Safety Plan**: A written arrangement between caregivers, responsible persons and the county agency designed to control present danger and/or impending danger in order to allow the CPS investigation, GPS assessment, General assessment and/or safety assessment to occur. A preliminary safety plan is only used when present danger and/or impending danger has been identified prior to the completion of the safety analysis.

- **Responsible Persons**: Any individual(s) who has a role and responsibility to assure the child's safety for compliance with the plan; types of responsible persons could include family, caregivers, kin, household members, service providers, resource families, agency staff, and/or any other identified resources. Action steps identified in the safety plan must be specific and measurable and agreed upon by all of the identified responsible persons prior to the plan going into effect.

- **Safety Management**: The interventions or actions implemented to control safety threats. Safety management includes five actions that may be implemented alone or in combination. Specifically, these five areas include: behavior management; crisis management; social connection; separation; and resource support. Safety management includes the continuous review of the safety threats, protective capacities, safety decisions and safety interventions to determine their current effectiveness.

Other Applicable Definitions:

- **Contact**: The process by which the caseworker or supervisor interacts with children, families and/or collateral persons to receive and share information. Types of contact may include direct contacts with persons at school, home, office and court visits as well as indirect contacts such as phone calls, e-mails and written letters.

- **Risk Assessment**: The process by which the caseworker assesses the current level of risk to a child to determine the likelihood of future harm, abuse, or neglect as prescribed by the Pennsylvania Risk Assessment Model.

- **Placement**: Twenty-four hour out-of-home care and supervision of a child.

Interval Policy

A child's safety must be assessed throughout the life of the case, including at each contact. Formal Safety Assessment documentation via the Safety Assessment Worksheet need only be written or amended during specific intervals. It is expected that the Safety Assessment be completed at a face-to-face contact where the child resides.

Hotline/Screening:

When the initial referral is received, the Hotline /Screening social worker taking the referral must make a judgment as to whether or not present danger exists for the child(ren). If the after hours/weekend staff determines that a visit must be made, a Safety Assessment worksheet must be completed and, if necessary, a Safety Plan prepared. This judgment should be based on the fourteen assessment factors and the available information received from the referral source and documented on the revised Hotline Screening Factors form.

Investigations and Assessments:

After the initial face-to-face visit by the Hotline or Intake worker and assuring the child(ren)'s safety, the DHS social worker must periodically document safety assessments by using the Safety Assessment Worksheet as follows:

- Within one work day of the first face-to-face contact by the newly assigned social worker in order to confirm that the safety decision made by the prior worker is still accurate.
- Whenever evidence, circumstances (for example, the birth of a child, the absence of primary caregiver(s), new household members), or new information suggest a change in the child's safety
- At the conclusion of the investigation/assessment, which may not exceed 60 calendar days from the date the referral was received.

Cases Accepted for Service:

Once a case is accepted for ongoing services, a new Safety Assessment Worksheet must be competed at certain intervals. If there is a Safety Plan in place, it must be reviewed and amended, if necessary, based on the assessment. The intervals are as follows:

- Within one work day of the first face-to-face contact by the newly assigned social worker in order to confirm that the safety decision made by the prior social worker is still accurate. This should occur each time the case is transferred;
- Whenever evidence, circumstances or new information suggests a change in the child's safety
- Every six months from the date the case was accepted for service, in conjunction with the risk assessment, family service plan review or judicial review if court involved.
- Within 30 days prior to any planned return home from placement.
- Within one work day after an unplanned return from placement
- Within 30 days prior to any case closure, along with the risk assessment, unless the court has terminated DHS jurisdiction.
- Within 30 days of any return home (planned/unplanned) unless the court has terminated DHS jurisdiction.

Note: If assessing safety in preparation for a court review, the Safety Assessment must be conducted within 30 days prior to the scheduled review.

Documentation

DHS social workers are required to document their contacts with families in the case record. The Safety Assessment Worksheet only needs to be completed according to the interval policy and/or if changes arise to the safety analysis, decision, and plan. If there are any changes, social workers must complete and/or update the Safety Assessment Worksheet and Plan and incorporate any supplemental information related to that change in the structured case notes.

For the purposes of Safety Assessment, contacts that are not part of the Interval Policy outlined above, are documented in structured case notes. As part of the structured case notes, information should be included which documents and supports the safety assessment, including the analysis and decision. Information should clearly show that the safety decision is consistent with the analysis, identification of safety threats and caregiver protective capacities.

All of the identified elements from the safety assessment worksheet should be considered and documented, as necessary, in the structured case notes. Elements to consider are:

- Any or all of the fourteen safety threats present within the child's living situation that threaten a child's safety;
- Any or all protective capacities which operate to control the identified safety threat;
- The safety decision and analysis for that decision; and
- The safety plan to include which person is responsible for each action step/safety intervention.

Also documented within the structured case notes should be:

- The type and frequency of the social worker's management efforts including dates, the nature of the management activity and who was involved;
- Judgments about changes within the family that reflect on safety;
- The status of present or impending danger; and
- Changes related to caregiver protective capacities.

As part of the ongoing safety management, structured case notes should continue to reflect not only that the child is safe or unsafe, but the criteria used to determine this including all information obtained during the continuing assessment process.

When assessing child safety for a child at home, the social worker must consider **ALL** of the children residing in the home as well as all of the household members, in addition to the alleged perpetrator(s). Unrelated children living in the household (Suffixes "Q, R, S" on the face sheet), should be included on the worksheet, unless those children already have an open case. It should be noted on the worksheet that these children have a different mother. As mandated reporters, if the social worker suspects abuse or neglect of other children residing in the home who are not part of the case family, a Hotline report must be made. If a new report is to be made, a new separate Safety Assessment Worksheet would be required for those children. Each case should reference the other.

Although the DHS social worker has primary responsibility for all three components of the safety process (Safety Assessment, Safety Decision and Safety Plan), the DHS worker must also rely on information from other service providers and agencies.

The DHS social work supervisor role is critical in the decision making process and involves discussion with the social worker regarding his or her:

- Assessment of safety threats;
- Identification of protective factors;
- Safety decision recommendation; and,

- Recommended Safety Plan.

Each Safety Assessment (as documented in a Safety Assessment worksheet and/or in structured case notes) and/or Safety Plan must be reviewed and approved by the supervisor no later than the next business day. For safety assessments that don't require completion of a worksheet, the supervisor must document their approval in their conference notes. In the event the supervisor is out, the social worker **must** review his/her Safety Assessments and Safety Plans with the designated alternate supervisor and/or the administrator. The Supervisor has the **final** approval responsibility for the Safety Assessment and Safety Plan.

Developing and maintaining a Safety Plan is the primary responsibility of DHS through the social worker's investigation and/or case management role, which is informed by the caregivers, private providers and collaterals involved with the child.

Each child has only one active Safety Plan that addresses the child's needs in his/her current living arrangement. The Safety Plan needs to be integrated into the FSP/CPP and Visitation Plan. At every contact, the Safety Plan should be used as a guide to evaluate safety issues and should be modified as necessary. The Safety Assessment Worksheet, or Safety Plan, if one was required, must be shared with the private provider who must promptly communicate any changes to the child's safety to the DHS social worker or his/her chain of command.

Confidentiality Issues
Any Safety Plan that involves individuals other than the parent or legal guardian requires the parent/legal guardian to sign a **Parent/Legal Guardian Waiver** in the Safety Plan. This allows the other individual(s) to have a copy of the plan. If the parent/legal guardian refuses to sign the waiver, then an alternative plan must be developed or the child(ren) may need to be removed.

In the narrative section of the Safety Plan, social workers must not make specific references to the facts of the CPS investigation because of the CPS confidentiality requirements.

Provider Role
When immediate safety concerns are identified by the provider social worker, he or she must immediately notify the DHS social worker or someone in his/her chain of command and must document such notification. If there is a Safety Plan in effect, the DHS social worker must confer with his/her supervisor or in their absence, the alternate supervisor and/or administrator, and must visit the home.

If the provider worker believes there are immediate safety threats to the child, he/she is to follow their established agency protocol for ensuring child safety. If there is an increased threat to child safety, but the child is not in immediate threat of harm, the provider worker must notify the DHS social worker or someone in his/her chain of command, and document the notification. The DHS worker must immediately consult with his/her supervisor and a decision must be made regarding the need for a home visit. The DHS social worker is responsible for any revisions to the Safety Plan.

Provider Social Worker Responsibilities:
If the provider social worker participates in the development of the Safety Plan, he/she will sign the Plan. Providers must also:

- assess the safety of **all** of the children in the household at every contact.
- communicate any increased threat to a child's safety to the DHS social worker or, if unavailable, his/her chain of command.
  - notify the DHS social worker **immediately** of any immediate safety concerns.

- ensure the child's safety by following their established agency protocol If a child is believed to be in immediate threat of harm,
- document any notifications made to DHS of a change in child safety.

· Integrate the DHS Safety Plan into any quarterly progress reports or any other documents used to manage the cases they serve.

Procedure

A new Safety Assessment Worksheet must be completed within one work day of the first face-to-face contact by a newly assigned social worker in order to confirm that the safety decision made by the prior social worker is still accurate

Reports Made to Hotline After Hours/Weekend:

If the Hotline social worker has to go out for the initial investigation/assessment, he or she must complete the Safety Assessment Worksheet and make the preliminary safety decision. If the child is determined to be "Safe with a Comprehensive Plan," a Safety Plan is required. No plan is required if the child is "Safe." If the child is "Unsafe," a Restraining Order or Voluntary Placement Agreement is needed to remove and place the child. The report is forwarded, as appropriate, to Intake, the Repeat Abuse unit, or the assigned worker on an active case, to continue the investigation/assessment the next business day.

Reports Made During Business Hours

The assigned Intake, Repeat Abuse or active social worker completes a Safety Assessment Worksheet within one work day of their first face-to-face contact. The Safety Assessment and, if required, the Safety Plan, must be completed within 24 hours of initiating the investigation/assessment for each child seen. It must include the subject child(ren) and all other children residing in the home who can be seen that day. All children will need to be seen during the course of the investigation/assessment consistent with current policy. The follow-up visit to see any child(ren) who was not present at the initial visit must be made within 24 hours by the assigned social worker or Hotline/Screening staff.

A new Safety Assessment Worksheet must be used to capture the information on the other children as they are seen during the return visit.

If a contact suggests a change that impacts the child's safety and the Safety Assessment factors change, the social worker must consult with the supervisor no later than the next business day. The supervisor will make the decision regarding the need for a home visit by the DHS social worker. The Safety Plan must be reviewed and revised, if necessary. The DHS supervisor or, in his/her absence, the alternate supervisor and/or administrator, must approve a revised Safety Decision and Plan by the next business day.

When a CPS report is assigned to the Repeat Abuse unit, that social worker completes a new Safety Assessment Worksheet, Identification of Protective Capacities, Safety Decision and if necessary, a Safety Plan. The Repeat Abuse unit worker and the ongoing worker will maintain communication throughout the investigation process. A revised Safety Assessment and Safety Plan must be given to the ongoing worker by the next business day following its completion. Safety assessments following receipt of new GPS and General reports on active cases are the responsibility of the assigned worker.

Appendix D

Comprehensive SCOH Standards Effective July 1, 2007
Roles and Responsibilities

Standard Code	Provider Responsibility	DHS Responsibility
P2: Services to Children in their Own Homes (SCOH) must focus on the safety and protection of children, reduction of risk, and enhanced well-being of the children and families. Provider will demonstrate in case record that services and contacts are safety focused. The CYD Safety Assessment and Plan, Social Summary, Risk Assessment and Family Service Plan (and Provider Service Plan) are guiding the provider agency's work with the family.	○ Provider is responsible for ensuring that practice is focused on child safety and well-being and the reduction of risk. They will demonstrate this through training, program descriptions, and utilization of new tools and assessments	○ DHS is responsible for completing Safety Assessments and Plans (as needed), Risk Assessments and FSPs, with a focus on child safety and well-being. ○ DHS will ensure that the Provider Agency receives the Social Summary packet and copies of the Safety Assessment and Plan, Risk Assessment and Family Service Plan as well as any updates to these documents.
X-3-1 Family case record established w/in 1 day of date of SCOH acceptance of admission. Family case record to include: FSP or FSP request, AFS date, name & phone umber of DHS & SCOH worker & sup, personnel changes, FAF w/summary, FRS, contact notes, missed contacts, indirect service efforts, referrals, report cards, monitoring of family participation in referred services, immunization records, medical providers for all children, schools for all school age children, social summary, reports to DHS, correspondence w/other agencies, case reviews, out of home care resources, discharge summary, Dispositional Review Orders (DROs), Safety Assessments and Safety Plan (if completed) and Critical Incident reports.	○ The Provider is responsible for creating a case record for each family that they serve within one day of the family being admitted for in-home services. ○ While it is not assumed that the list of contents will be in the case record in this first day, it is the responsibility of the Provider to obtain these records, as they are completed, or to order these records.	○ DHS is responsible for providing the Social Summary Packet, the FSP, FSP revisions, the Risk Assessments, Dispositional Review Orders (DROs), and most recent Safety Assessment and Safety Plan (if completed) in a timely manner ○ DHS is responsible for updating the Provider agency of any personnel changes, or other information made available to DHS that impacts the family case.
P3: Provider will initiate service within 2 business days of SCOH acceptance unless a more urgent response time is requested at referral. Subsequently, the joint visit will be initiated by CYD.	○ Provider is responsible for initial home visit within 2 business days of SCOH acceptance unless a more urgent time is noted.	○ Intake/DHS is responsible for contacting the family that the Provider will be initiating services with the family. ○ Intake is responsible for informing the family the reason for referral for

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		services, an explanation of SCOH services, and that the Provider will be making the initial visit, likely without DHS. ○ DHS is responsible for contacting the Provider immediately upon receiving the case to set up the joint visit.
P6: SCOH must service every child in the open family who is living in the home.	○ Provider must provide in-home services for all children in the family who are living in the home that has an open case with CYD. ○ If there is extended family in the home (ie other children not of the mother), the Provider is responsible for reporting any suspicious or dangerous activities with other children in the home, as mandated reporters, but not for providing services. ○ Regardless of court ordering services for one child, services must be provided to all children in the identified family living in the home.	○ DHS is responsible for informing family of this policy.
P7: SCOH provider develops a Provider Service Plan within 7 business days of acceptance of referral date detailing the services SCOH will provide or within 24 hours if SCOH is mobilized during the CPS investigation. The plan will include measurable time limited activities and will be individualized to meet the family's needs. The parents and child, if age appropriate, will be involved in the development of the plan. Subsequently PSPs must be updated /completed in such a timeframe to coincide with the FSP cycle.	○ The initial PSP must be created within 7 business days of the initial visit. ○ The initial PSP is required to be reflective of all information obtained as of that date (likely the Risk Assessment and Safety Plan, if one exists). Future PSPs will reflect more information as it is made available, like the FSP.	○ CRU is responsible for adding the Safety Plan to the referral packet. If no Safety Plan has been completed, CRU must indicate as such on the referral packet.
P8: PSP reflects safety threats identified in the CYD Safety Assessment and Safety Actions identified in the Safety Plan (if applicable), the FSP Objectives, and the Risk Assessment factors. PSP will be updated when any changes occur that will impact the child's safety or achievement of identified goals. At a minimum the PSP must be updated at 6 month intervals.	○ Provider is responsible for ensuring that the PSP reflects and is tied to latest FSP, Safety Plan (if applicable) and latest Risk Assessment ○ Between the 6 month minimum, changes will occur when the Provider and DHS both agree that the PSP needs to be updated	○ DHS will complete the FSP, risk assessment, safety assessment and safety plan as required.
P9: The PSP will be distributed within 5 days of completion to the following: ○ Child, if age appropriate	○ Provider must distribute all PSPs to listed persons within 5 days of completion. ○ Provider is responsible for obtaining	○ The CYD social worker will review the PSP and put a copy of the PSP in the client's file.

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○ Parent/guardian ○ CYD Social Worker ○ Others who participated in the development of the PSP ○ Copy placed in file.	signatures on the PSP, and noting refusal to do so on the document. ○ Upon request, Provider will provide a copy of the PSP to Parent/Child Advocates	○ The CYD social worker will discuss PSP during compliance visits.
X-0-1 FAF, FAF summary, FRS, BOC to be completed for children over 2, Within 20 working days of initial joint visit, & every six months	○ The Provider will complete and transmit a FAF, FAF summary, FRS and BOC within 20 working days of the first visit & every six months afterward. ○ **Provider will send DHS the FAF summary**	○ DHS will review the FAF summaries, FRS and the BOC and make appropriate follow-up actions
X-4-2 FAF & FRS during required period with name of case manager and initialed by the supervisor. Within 20 working days of initial joint visit, & between the 5th and 15th of the month prior to the DHS AFS month and the AFS 6 month anniversary every six months. FAF distributed to SCOH supervisor, DHS case manager, five to 15 days prior to the AFS month/6 month anniversary of AFS month or 30 days if the case is open more than one year. Signature by a relevant person, dated fax cover sheet or documentation of postal transmission constitutes distribution	○ Example: if DHS AFS date is January 1st and the SCOH DOA is January 21st and the initial visit is January 28th, the initial FAF & FRS are due by approximately February 17th. The next FAF & FRS would be due between the 5th and the 15th of June, followed by in between the 5th and 15th of December, and so on throughout the life of the case. ○ It is the Provider's responsibility to distribute the FAF to the Provider Supervisor and DHS worker based on the above schedule, with Provider supervisor initials approving the documents for case record purposes.	○ DHS will review the FAF summaries, FRS and the BOC and make appropriate follow-up actions
P5: <u>Primary Parent/Caregiver and Child(ren) Face-to-Face Contact</u>: Level 2-One visit per week, must be for a total of at least one hour with primary parent/caregiver/children with some time spent alone with child(ren); Level 3-Two visits per week must be a total of at least two hours with primary parent/caregiver/child(ren) with some time spent alone with child(ren) <u>Two Parent/Caretaker Households</u>: In two parent/caretaker households, there must be at least 2 face-to-face contacts with each primary caregiver each month <u>Collateral Contacts</u>: Face to Face or other collateral contacts twice per	○ Providers are responsible for spending at least one hour a week in visits with level 2 families (some time must be spent with the child(ren) alone); at least two visits per month must occur in the home. Providers are responsible for seeing the family at least two times per week for at least a total of two hours a week in visits with level 3 families (some time must be spent with child(ren) alone), at least one visit per week must be in the home. ○ For Level 3 cases, Provider is responsible for 6 out of the 8 visits to be in the home.	○ DHS will make joint visits with the family during the course of service. ○ DHS should help facilitate the process of Providers gaining access to the teachers and/or other officials in the school setting. ○ DHS is responsible for seeing child(ren) not more then 30 days prior to a court hearing. ○ DHS is responsible for seeing families in their home on a quarterly basis. ○ DHS should facilitate joint visits with the Provider.

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week. Indirect service means telephone or in person contact with people that support the family (extended family, schools, doctors, therapists, etc.) School Contact: Within 30 days of issuance of report cards, Provider must have face-to-face contact with teacher/counselor if: - child receives D or less - child receives less then satisfactory for behavior - child has 8 or more unexcused absences - child has been suspended - child's performance level drops 2 levels If there is a CSAP meeting at the school, the Provider must attend with the parent/caretaker and advise CYD worker who will determine if they should participate. Within 30 days of 85-29 date, Provider must advise, via phone or email, each child's school counselor of SCOH involvement. Visits in the Home: Level 2: At least 2 visits per month in the home. Level 3: At least 1 per week in the home. Duration of Visits: Level 2: One visits per week-must be at least one hour with parent/primary caregiver/child(ren) with some time spent alone with child(ren). If child(ren) is not present, extra visit is required. Level 3: Two visits per week-must be a total of at least 2 hours with parent/primary caregiver/child(ren) with some time spent alone with child(ren). If child(ren) is not present, extra visit is required. Provider: Responsiveness by phone required 24 hours per day, seven days per week. Non-Custodial Parents: Attempt to engage non-custodial parent face-to-face once per month in family contacts in families home (if appropriate), depending on their willingness to participate. Responsiveness by phone for non-custodial parents is 5 days a week. Extended Families: Face-to-face contact with extended families as needed in the family's home (as part of the P/C visit) with the purpose of engaging to provide support to parents/caregivers or child(ren).	○ If a child is 2 years of age or younger, or has a critical physical or mental health issue or diagnosis, and is not present for a visit, the Provider is required to do an alternate face to face contact with the child that week to meet the standard. ○ Providers must meet with each parent/caretaker in two parent/caretaker homes at least twice a month. ○ Providers are responsible for making at least two collateral contacts a week. This includes telephone, in person contact, email or other correspondence. ○ Provider is responsible for seeing child(ren) not more than 2 days prior to a court hearing. ○ Collateral Contacts include: DHS, extended family outside the home, schools, doctors, therapist, etc. ○ The Provider should facilitate the process of assisting the parent, if necessary to meet with the teacher/counselor. Providers must meet with teacher/counselor within 30 days of the issuance of report cards if any of the listed outcomes occur. ○ The Provider is responsible for notifying the school counselor of the child(ren)s involvement with in-home services within 30 days of the 85-29. ○ The Provider is to try to engage the extended family and non-custodial parents and invite them to home visits, as appropriate with each individual case. ○ The Provider must be responsive by phone 24/7 to all case persons and DHS. ○ If a medical visit is missed the provider is responsible for facilitating attendance to the next meeting. This can include, ensuring the parent attends, providing	○ DHS should visit with families who do not appear to be receptive to services to encourage their active involvement. ○ Social work team is responsible for ensuring that Providers are visiting with families and CAPE is responsible for ensuring agencies are providing contracted services.

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Medical Visits: If there is a missed medical visit, Provider must escort and/or facilitate attendance of next medical visit. Provider must contact each medical providers (physical health, dental, vision, behavioral health, early intervention, etc.) for all children within 30 days of 85-29 date and annually unless medical needs or FSP indicate more. If child presents with specific medical needs, the level of contact will be determined by those needs.	tokens or transportation, or in extreme cases, physically attending the next medical visit with the caretaker and the child.	
X-1-4 At least 50% of face to face contacts must occur out of the agency	○ For all face to face contacts, more than 50% need to occur outside of the Provider's offices.	○ CAPE is responsible for ensuring that face to face visits occur at least 50% of the time out of the Provider Agency's premises.
P11: Contact notes will be completed following the CAPE DAP model approach: D – Describe, A- Assess, P – Plan. Contact notes demonstrate that activities focus on the Safety Plan, PSP and FSP goals, the family's assessment of the status of the goals, and how the child's safety is being assessed.	○ The Provider is responsible for using the new contact note template, in D-A-P format to complete all contacts. ○ The Provider should focus the notes on the pertinent assessments, plans and goals provided by DHS.	○ DHS is responsible for providing Safety Plans (should they exist), Risk Assessment and the FSP in a timely manner to ensure that cases progress toward closure and ensuring the safety and well-being of children.
P12: Missed contacts must be noted using the DAP approach and should include purpose of contact, plan for contacting family and any safety concerns resulting from the missed visit.	○ All missed contacts need to be documented on the new contact note template, or other DHS appropriate form.	○ DHS should reinforce with the families to be available for Provider visits.
P13: SCOH initiates monthly phone or email contact with CYD Social Worker to ensure services are provided as stipulated in the PSP and FSP. These contacts should be noted in contact notes. If the SCOH worker is not able to contact the Social Worker for one month, SCOH will contact the CYD Social Worker Supervisor. Missed contacts will be noted in contact notes.	○ Provider is responsible for initiating contact with CYD social workers every month to update on cases, which is to be documented in contact notes. If no response is received, the contact should be escalated up the chain of command.	○ CYD is responsible for responding to the SCOH agency worker in a timely manner.
P14: The SCOH agency provides CYD with Critical Incident Reports in situations that have a high potential of impacting the safety of any children in the home and experienced by either the primary caregiver or the children including: ○ Pregnancy ○ Birth of a child ○ Death of a family member ○ Hospitalization ○ Serious Injury ○ Serious Illness ○ Serious Accident ○ Report of abuse or neglect*	○ The new Critical Incident Report template is to be used when any of the listed circumstances occur. This template replaces the critical incident and 'formal alerts' processes previously in place. ○ The Provider is responsible for distributing the Critical Incident Reports to the listed people. ○ The Provider is only responsible for submitting the report to CARO if the Incident involves one of the items listed on the Memo sent to Providers in (**MAY/JUNE**	○ DHS is responsible for providing a response via email to Providers, including action steps and persons responsible to address the incident, within 72 hours of receipt.

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○ Child reports they are fearful of people living in home or coming to home* ○ Caregiver or other household member has threatened to harm the child.* ○ Home has no heat, water service or food.* ○ Family has lost their housing* ○ Household member is <u>currently</u> abusing alcohol or other drugs and/or using illegal drugs.* ○ Household environmental hazards (including unsecured weapons) are present and place the child in immediate danger of serious harm.* ○ The presence of dangerous pets ○ Family is about to flee or has fled the area.* ○ Change in family or household composition ○ Incarceration or arrest of a household member ○ Voluntary or involuntary psychiatric commitment ○ Violence toward people or property ○ Suicide attempts ○ Sexual abuse or aggression ○ Severe psychological symptoms ○ Being a victim of assault or another crime ○ 14 days has elapsed without face to face contact with the child or primary caregiver. * Forwarding a Critical Incident Report does not remove the worker from their responsibilities as a mandated reporter of suspected child abuse and/or neglect. The SCOH agency provides CYD with Critical Incident Reports within 2 hours by phone (with follow-up email within 1 business day to the social work chain of command including the social worker, social work supervisor and administrator, as well as the Commissioner's Action Response Office) Other Reports: The SCOH agency provides CYD with a Critical Incident by phone within 3 working days (follow-up email the next day) for the following issues: ○ 8 or more unexcused school absences	**2007**). The listed 5 issues require that a Critical Incident be relayed within 3 business days as opposed to 2 hours for the other issues	

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○ Family or child misses two consecutive behavioral/medical evaluations or appointments ○ Family relocation ○ Interaction with truancy/curfew violation center ○ Absent family member notification		
X-4-4 Alerts resulting in approval to continue and outcome was distributed to the agency service deliverers, supervisor and case manager.	○ The Provider is responsible for sending Critical Incidents reports, with DHS responses, to Provider supervisor and appropriate staff.	○ DHS is responsible for responding to Critical Incident Reports within 3 days, specifically noting next steps for Providers to follow, including whether or not Providers are to continue serving the family.
X-4-3 The number of Quarterly reports in file compared with the number of quarters. The quarterly reports submitted to the DHS social worker between the 5th and 15th of the month prior to the AFS month and every three months thereafter. Quarterly reports exist which should have been prepared during the period of interest using the standard quarterly report format. Most current report card and/or IEP for all school age children is attached to Quarterly report. SOS was submitted for the period between the initial joint visit to the end of the three month cycle as determined by the AFS between the 5th and 15th of the month.	○ The protocol for SOS remains the same. ○ The Provider is responsible for completing, submitting and maintaining in the case record a quarterly report for every quarter that the family is being serviced. ○ If the DHS AFS is January 1st, the quarterly report is due Dec.5-15, Mar 5-15, Jun 5-15 and Sep 5-15. If the DHS AFS is January 1st, the Provider DOA is January 21st, and the initial Joint Visit is January 28th, the Summary of Service will cover the period January 28th-February 28th ○ The Provider is responsible for using the new quarterly report template. ○ When submitting the quarterly report to DHS, the Provider is responsible for including the most current report card and/or IEP. ○ The SOS starts with the referral, not the joint visit	○ DHS is responsible for monitoring the receipt of quarterly reports, and documenting efforts to obtain quarterly reports. ○ DHS is responsible for reviewing the latest quarterly reports with their supervisor, and taking appropriate action. Actions may include: joint visits with the family and Provider, initiating court action, and updates to the FSP.
X-2-2 Each service manager will receive supervision at once a week for level 3, and twice a month for level 2.	○ Case workers must receive supervision once a week for level 3 and twice a month for level 2, to ensure accurate and consistent practice on cases for ensuring child safety.	DHS's CAPE Evaluation Analyst will look for written verification that case workers with level II cases are supervised twice monthly and that case workers with level III cases are supervised weekly during any evaluation of the SCOH provider agency.

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X-3-4 Supervisor's calendar with notation of date, time and person supervised must be included in the documentation of supervision of service delivery,	○ Documentation of required supervision must be clearly noted, and kept in supervision files	DHS's CAPE Evaluation Analyst will look for written verification that the SCOH supervisor's "log" includes the date supervision occurred with the individual worker, the time it started, name of the specific SCOH worker, name of the SCOH case being discussed and level, family or service delivery problems identified in the supervision, and the outcome and action plan arrived at during supervision.
X-2-3 A. Quarterly reviews of cases by Agency Supervisors for Level 2 & monthly review for Level 3 cases. B. Agency/DHS joint visit conducted no later than 5 working days after the 3 month end of service may be considered a case review within the ending quarter.	○ Provider Supervisors are responsible for conducting case reviews of their worker's cases quarterly for level 2s and monthly for level 3s. ○ For level 2 cases, if a joint visit occurs within 5 business days of the quarter, this may count as the Supervisor case review for that quarter.	DHS's CAPE Evaluation Analyst will look for written verification within each SCOH case which confirms that SCOH supervisor performed a "file audit" according to the frequency specified ; III = monthly II = quarterly. (Each agency may develop its own SCOH file audit checklist with space for SCOH supervisor's signature/date)
X-3-5 Case review by supervisor documented in case file. In case record: Date, name, signature, comments on quality & direction of future service delivery. Joint visits used as case reviews must be initialed by the supervisor.	○ The case reviews, noted in X-2-3 need to be documented in the case file. ○ In addition to signing off on the case documentation, it is important for the supervisor to note the quality of the work being done, whether the case is making appropriate progress toward meeting the goals of closure, and if not, what steps need to be taken to make progress in the case.	○ CAPE is responsible for ensuring that client case files reflect supervisory reviews and signatures, with a focus on quality and direction for future service delivery.
X-4-5 Notification of the suspension of service delivery is given to the client family within 5 working days of the decision to suspend services. Notification of the suspension of service delivery is given to the client family, agency service deliverers, supervisor, billing unit and DHS case manager within 5 working days of the decision to suspend	○ All case persons and pertinent DHS and Provider representatives to be provided with notification within 5 working days of the decision to suspend (terminate) services	○ DHS is responsible for actively engaging with the Provider in the decision to suspend (terminate) service. ○ DHS is responsible for responding to

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services. Documentation of **alerts (critical incidents)** which resulted in notification of suspension of service delivery and client family received notification of suspension of service delivery containing directions for contacting the DHS case manager for reactivation or reassignment.		notification from the Provider of plans to suspend (terminate) services on any cases. ○ In those circumstances where decision to suspend (terminate) for reasons other than no longer needing in-home services, DHS should make efforts to address any safety and service concerns. ○ Follow up steps should include: Safety Assessment and supervisory review. ○ Other actions may include referrals to other in-home service agencies, service referrals, and court action.
X-1-8 Notification by telephone or in writing at least 30 days prior to termination sent to DHS case manager and supervisor. Telephone notification must be confirmed in writing within 5 days	○ The Provider is responsible for notifying the DHS social worker and supervisor of plans to terminate a case for services 30 days prior to termination. ○ Written documentation includes email or postal mail. ○ If the notification is done by phone, the Provider is responsible for following up with written documentation within 5 days	○ DHS is responsible for actively engaging with the Provider in the decision to terminate service. ○ DHS is responsible for responding to notification from the Provider of plans to terminate services on any cases. ○ In those circumstances where decision to terminate for reasons other than no longer needing in-home services, DHS should make efforts to address any safety and service concerns. ○ Follow up steps should include: Safety Assessment and supervisory review. ○ Other actions may include referrals to other in-home service agencies, service referrals, and court action.
X-4-6 Notification of the termination of service was sent to the client family either within 5 days of the termination date when termination is with DHS consent or at least 30 days prior to the termination date when the termination is without DHS consent. Termination notification sent to family members, case record, provider agency service deliverer, provider agency supervisor, provider agency staff responsible for billing, DHS case manager and supervisor within 5	○ Provider is responsible for actively engaging with DHS in the decision to terminate service. ○ In those circumstances where decision to terminate for reasons other than no longer needing in-home services, Providers should make efforts to address any safety	○ DHS is responsible for actively engaging with the Provider in the decision to terminate service. ○ DHS is responsible for responding to notification from the Provider of plans to terminate services on any cases. ○ In those circumstances where decision

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working days of termination. Termination notification sent to client family must contain directions for how to contact the DHS case manager for reactivation or reassignment of the case. If service terminated and the previous FAF is dated less than 60 days prior to termination date then N/A. Otherwise agency completed and forwarded to DHS a final FAF, current medical information, current education reports and the latest completed quarterly.	and service concerns prior to termination. ○ In addition to notifying DHS, the Provider must notify the family of plans to terminate services (within 5 days if DHS approved and 30 days if not). This notice to the family must include contact information for DHS, should the family want to reactivate or reassign the case. ○ Within 5 days of termination, the Provider must send another notification of termination to family members, case record, provider agency service deliverer, provider agency supervisor, Provider agency staff responsible for billing, DHS case manager and supervisor. ○ For example, if the last FAF was completed on Dec. 5-15th and services are terminated on February 1st, then no additional FAF is required. If services are terminated on March 1st (more then 60 days after Dec 5-15th), then a final FAF, current medical information, current education reports and the latest completed quarterly need to be submitted to DHS.	to terminate for reasons other than no longer needing in-home services, DHS should make efforts to address any safety and service concerns. ○ Follow up steps should include: Safety Assessment and supervisory review. ○ Other actions may include referrals to other in-home service agencies, service referrals, and court action.
X-4-7 Discharge summary using required format. Discharge summary submitted to Temple and DHS social worker within 10 days.	○ When services are being terminated for whatever reason, the Provider is responsible for completing a discharge summary, and submitting it to Temple and DHS within 10 days of termination.	○ DHS is responsible for reviewing the discharge summary, placing a copy in the case record, and submitting a copy to the CRU, if other services are to be provided.
P22: A closing joint visit between SCOH worker, CYD worker and family will occur prior to the case officially being closed.	○ Joint visits must occur before a case can be officially closed. Both parties need to make themselves available for this to occur.	○ Joint visits must occur before a case can be officially closed. Both parties need to make themselves available for this to occur.

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X-4-8 If the case is still active then N/A. If there is an indicated CPS, substantiated GPS or placement within one year of termination, the agency has prepared a "SCOH Cases Discharged By Provider Agency Which Have an Indicated Report or Placement within One Year" form. Agency documentation indicates that the "SCOH Cases Discharged by Provider Agency which Have an Indicated Report or Placement within one year" form was sent to DHS data analysis administrator with 45 business days of receipt of notice from DHS.	○ If a case that has been terminated receives an indicated/substantiated CPS/GPS report, the Provider is responsible for preparing the noted form within 45 business days of receiving notice from DHS of the CPS/GPS report.	○ DHS is responsible for notifying Providers of all indicated/substantiated CPS/GPS reports on cases where families have received in-home services within 1 year.
O3: Each agency will develop protocol to maintain the confidentiality of each family's file and personal information.	○ Information that may identify a child or the family, as well as other information contained in the client record is confidential ○ SCOH provider agency shall ensure that no staff person discloses or makes use of information, directly or indirectly, concerning a child or the family, or both, other than in the course of the performance of his/her duties ○ a family's record shall be kept in a locked location when unattended.	○ DHS's CAPE Evaluation Analyst will verify through record review and by observation that, pursuant to Ch.3680.34
X-0-3 Agency provides structured interventions that promote the development of life skills by members of the family: parenting; family planning; resource management, consumerism, meal planning, preventive health, & vocational planning	○ The listed services should be among those that the Provider agency is prepared to provide to the client family. ○ These interventions, if applicable, should be documented in the PSP and the Quarterly Report	○ DHS will ensure that FSP objectives and actions reflect necessary interventions provided to family members
X-0-2: Agency has demonstrated through documentation the capability to provide counseling, intervention and direct social work services for members of client families.	○ Provider is responsible, through documentation in case records and personnel documents, for proving the ability to provide direct social work services, including counseling and interventions, to clients and families. ○ Provider shall be rated according to this scale: ○ Little or no documented capability = 1/3 ○ Some documented capability= 2/3 ○ Considerable documented capability=3/3	DHS's CAPE Evaluation Analyst will verify through 1) written documentation which is present within SCOH family files collectively and 2) a review of the provider's Annual Program Description their capability to intervene, counsel and provide social work service to members of SCOH families.

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O13: Agency has documentation and program practices that demonstrate its capacity to provide referral readiness and advocacy for preparing families, acquiring, coordinating and monitoring the use of other community resources necessary to meet family needs.	○ The Provider is responsible for providing referrals as needed and accessing necessary resources.	○ DHS will include the need for referrals and accessing resources in the FSP and monitor the provision of service.
O14/O15: Agency will assure that all SCOH staff are provided with the following resource information to be used for making referrals as needed: ○ Mobile Crisis number and contacting procedures; ○ Suicide Prevention Hotline number; ○ Poison Control number and contacting procedures; ○ A copy of the DHS procedures for securing a smoke detector, should the family not have proper detectors in the home; ○ Police Department number and contacting procedures; ○ Drug and Alcohol Intervention numbers and contacting procedures;	○ In order to ensure child safety, all workers will be provided with resource sheets, which they are to take into the field, detailing the contact numbers and procedures listed.	○ DHS will provide the SCOH agency with the information required by this standard.
X-1-8 A. Documentation of training of family workers must be in the employee's personnel file. B. Case Workers must have a BA in human services or BA in another discipline and 2 years experience in human services.	○ Provider is responsible for documenting that family workers (non-case management staff) have been appropriately trained.	A. DHS CAPE Evaluation Analyst will verify through staff files that non-degreed "family worker" has participated, at a minimum, in the Pre-Service New Worker Orientation training described in detail below under performance standard O-20 prior to working alone with any SCOH family member. B. DHS CAPE Evaluation Analyst will verify that SCOH case worker has a Bachelor's degree in a human services discipline or a Bachelor's degree in a non-human services discipline supplemented by 2 years of experience in human services.
O16: Supervisors will have a Master's degree and a minimum of two years experience in human services, preferably in child welfare.	○ All supervisors hired after July 1st are required to have a Masters and minimum of two years of human services experience. Anyone hired prior to July 1st will be grandfathered in; unless they are working under a current waiver. If there is a current waiver, the waiver will need to be resubmitted for approval.	DHS's CAPE Evaluation Analyst will verify that SCOH provider supervisors currently have a Masters degree and 2 years of experience in human services. Supervisors hired prior to 7/1/07 without a Masters degree shall have a current waiver letter from the DHS commissioner or designee within their personnel file

Standard Code	Provider Responsibility	DHS Responsibility
		explaining the conditions under which the waiver was granted. Waiver letters must be renewed each fiscal year, or sooner if the conditions under which the waiver was granted have changed.
O20: New workers will be required to participate in a pre-service new worker orientation training that will include, at a minimum: ○ Overview of the SCOH Program; ○ Overview of the Department of Human Services with a focus on the Children and Youth Division; ○ Overview of Child Abuse and Neglect; ○ Overview of the FSP and the planning process. ○ Development of the Provider Services Plan; ○ Overview of the Safety and Risk Assessment processes and importance of each; ○ How to determine what is a Critical Incident, ○ DAP and Quarterly Report requirements; and ○ Provider agency's responsibilities as a Mandated Reporter.	○ In order to ensure consistent practice with a universal knowledge of safety and risk issues, the focus of in-home services, and how to adequately perform job functions, all new workers hired after July 1st will need to participate in a structured pre-service orientation, prior to entering into field work, covering the topics listed.	DHS's CAPE Evaluation Analyst will verify through a review of the staff files, including any staff member that has face-to-face contact with SCOH family members, that pre service orientation training was provided. Acceptable verification is a training agenda, syllabus, or "Training Completed" form that includes the date of training, topic that coincides with the list in O20, length of training, name of employee in attendance, name of trainer, signature of agency representative.
O21: Supervisors and case management staff will receive at least 20 hours of training annually, ten of which must focus on skills, practices or issues related to SCOH.	○ Provider must ensure that supervisors and case managers receive at least 20 hours of training a year, 10 of which is skill focused on practice or related in-home issues	DHS's CAPE Evaluation Analyst will verify through a review of supervisor and case manager staff files that each has completed 20 hours of annual training. Acceptable verification is a training agenda, syllabus, or "Training Completed" form that includes the date of training, topic, length of training, name of employee in attendance, name of trainer, signature of agency representative.
X-0-5 All requirements in the case management section were performed by an individual qualified as a social worker in accordance with specifications. Indirect and direct services provided and tied to FSP. Case management includes family assessment, monitoring of safety and well being, family focused social case work, life skills, advocacy and service coordination.	○ Provider is responsible for ensuring that the worker assigned to and working on the case has met the requirements of O17, X-1-8, O21, O22 and X-2-2. ○ **All services provided to the family need to be tied to the FSP, the PSP, and Safety Plan (if applicable)** ○ The work of the Provider worker and the services being provided should be tied to and focusing on family assessment,	○ DHS will complete the Risk Assessment, Safety Assessment and Safety Plan (if necessary), FSP and revisions.

Standard Code	Provider Responsibility	DHS Responsibility
	monitoring of safety and well being, family focused social case work, life skills, advocacy and service coordination.	
O22: All staff will obtain criminal and child abuse clearances on a bi-annual basis: Direct service staff and supervisors will obtain vehicular and traffic checks (if transporting clients) on a bi-annual basis.	○ Provider must ensure that all staff have criminal and child abuse clearances every other year. ○ Provider must ensure that all direct service staff and supervisors (if they transport clients) must obtain vehicular and traffic checks every other year. This includes tickets received, as well as proof of insurance.	The DHS CAPE Evaluation Analyst will verify through staff files that the background check and clearance on any and all agency staff are renewed every other year based on the date of the previously submitted background check and clearance
X-4-1: Based on a sample of client records and CY 85-29 dates the Provider appears to provide an accurate monthly billing report on service delivery.	○ Provider is responsible submitting to DHS accurate monthly billing information.	○ DHS is responsible for reviewing 85-29 for accuracy.

Appendix E

Summary of Progress

This chart provides an overview of each of the recommendations of the Child Welfare Review Panel and the COB's assessment of progress as of December 31, 2007. There has been considerable activity with DHS geared toward improving policies, practices and the quality of child welfare services. The actions taken to date reflect the mobilization of the talents and commitment of the leadership staff to create an environment in which services can be provided in an effective way. There is additional work that must be done to assure that the changes started move through the organization and effect direct practice and supervision of frontline workers. If the momentum that has been established can be maintained and the systemic reforms started can be spread, the results will be significant for the most vulnerable children of the City of Philadelphia.

Call to Action Recommendation	Time Frame	Current Status	Verification Activities
1. Mission Statement and Core Values <u>Panel's Phase 1 Recommendation 1.a. (Page iv)</u> DHS must develop a mission statement and core values that are centered on child safety. *Panel's timeframe for completion: December 31, 2007.* <u>Recommendation 1.b. (Page iv)</u> DHS' core values must embody at a minimum the following principles: creating a culture of respect, compassion and professionalism; enhancing communication with, and responsiveness to stakeholders;	12/31/07 12/31/07	Completed Completed	• COB will examine the extent to which the mission and values are influencing the development of policy, practice, infrastructure and outcomes for children.

Call to Action Recommendation	Time Frame	Current Status	Verification Activities
instilling a greater sense of urgency among DHS staff and providers; providing services that are readily accessible; fostering a culture of collaboration; providing culturally competent services; and creating a transparent agency. *Panel's timeframe for completion: December 31, 2007.*			
2. Evidence-based Safety Assessment Tools <u>Panel's Phase 1 **Recommendation 2.a.i. (Page iv)</u> DHS must implement an adequate evidence-based safety assessment tool. *Panel's timeframe for completion: June 30, 2007.* This area of work has had two discrete foci: Safety assessment for intake/investigation and in-home services Safety assessment for children in placement.	6/30/07	Initiated-substantial progress made Initiated-substantial progress made	• Timeframe to finalize the placement safety assessment tool and training curriculum, conduct training, and implement tool – due to COB on February 1, 2008. • Report on the number and proportion of employees completing the training on each of the safety assessment tools. • Quality assurance report on the implementation of safety assessment tools by those units which are using the tools.
3. Intervals for Safety Assessments <u>Panel's Phase 1 **Recommendation 2.a.ii. (Page iv)</u> DHS must conduct a safety assessment for every child within its care – both children at home and children in out-of-home placements. The safety assessment must be updated at each contact with the child.	9/30/07		• Documentation that specific items have been incorporated into structured case notes format to prompt DHS and Provider workers to provide narrative regarding safety. • A report on compliance with completing the formal safety assessment tool at six-month

Call to Action Recommendation	Time Frame	Current Status	Verification Activities
Panel's timeframe for completion: September 30, 2007. In-home Safety Visits Placement Safety Visits		Completed & ongoing every 6 months Initiated-more progress needed	intervals. • A report on the quality of the case notes documenting the ongoing safety reviews.
4. Expedited Face-to-Face Response for Children Five Years of Age or Younger Panel's Phase 1 **Recommendation 2.b.i. (Page iv) DHS must conduct immediate (within 2 hours) face-to-face visits for every child 5 years of age or younger for whom a credible1report of suspected abuse or neglect is received by the Hotline. This face-to-face contact must be made regardless of whether the Hotline classifies the case as General Protective Services (GPS) or Child Protective Services (CPS). *Panel's timeframe for completion: June 30, 2007*	6/30/07	Completed and ongoing	• Recommendation: The COB recommends that DHS, in consultation with the COB, reassess the recommendation and strategy used to comply with the Panel's recommendation and develop, by May 31, 2008, a response that reduces redundancy and the number of people involved in the investigation process. • Monthly reports of the percentage of children five years of age or younger seen within the two-hour timeframe. • Proposal for an alternative strategy.
5. DHS' Monthly Face-to-face Contact with Children Panel's Phase 1 Recommendation 2.b.ii. (Page v) DHS staff must – on at least a monthly basis –conduct face-to-face contacts with all families receiving any service supported through the Children and Youth Division	6/30/07	Initiated-more progress needed Not yet due	• DHS' progress report on roll-out of monthly face-to-face visits as of May 31, 2008. • Monthly reports on the percentage of children visited each month

1 The recommendation was modified to add the term credible to clarify the children who were to be seen.

Call to Action Recommendation	Time Frame	Current Status	Verification Activities
(CYD) that have a child 5 years of age or younger and physically observe the condition, safety and behavior of any such child, as well as parental capacity. *Panel's timeframe for completion: June 30, 2007.* <u>Panel's Phase 2 Recommendation 2.a.iii. (Page ix)</u> DHS must enhance the frequency of face-to face contacts with children of all ages. Since face-to face contacts are the most important actions to ensure child safety, DHS staff must conduct a minimum of one face-to-face contact per month with each child in its care. More frequent contact may be warranted depending on the specific safety and risk factors in each case. *Panel's timeframe for completion: May 31, 2008.*	5/31/08		
6. Community-based Local Office Presence <u>Panel's Phase 1 Recommendation 2.c. (Page v)</u> DHS must establish a local office presence in a least one geographic location deemed highly at-risk. *Panel's timeframe for completion: May 31, 2008.*	5/31/08	Not yet due-Possible delays	• COB and DHS need to the discussion of the rationale for and timing of this action and report to the public its thinking.

Call to Action Recommendation	Time Frame	Current Status	Verification Activities
7. Family Team Decision Making Panel's Phase 1 **Recommendation 2.d. (Page v) DHS must implement a team decision making process to determine service plans for all children 5 years of age or younger. A pre-placement conference must be held for all non-emergency cases where a child 5 years of age or younger may need to be placed into a substitute care setting. The pre-placement conference must include the child's family, including potential kinship placement resources; the DHS worker; the provider agency worker (where applicable); a physician or nurse; and individuals representing mental health, substance abuse, and domestic violence services, as needed, who have the authority to commit resources of their respective agencies; and individuals requested by the family representing their social support network. When feasible, the supervisors of both the DHS and provider agency workers should participate in the team decision making conference. The initial Family Service Plan (FSP) must be developed during this process. *Panel's timeframe for completion: August 31, 2007.*	8/31/07	Initiated-more progress needed	A number of strategies have been identified to assess the implementation and impact of the FTDM model. The COB, in conjunction with DHS, will need to select those strategies that will provide the most information. • Report on number of families served, number of facilitators engaged, and the outcomes for families who participated. • Qualitative review of family service plans to discern the quality of the plans and the extent of participation by parents/caregivers, extended family, providers, and other stakeholders. • Analysis of DHS' Internal Performance Management measures for families who have participated in FTDM.[3] • Focus group with parents/caregivers, preferably those involved with DHS before and after implementation of FTDM. • Focus group with staff and parents/caregivers and parent advocates to assess implementation.

2 Ongoing team case conferencing (i.e., progress and quality assurance meeting) every three months in conjunction with Family Court moving to every three months.

[3] Refer to this *Assessment of Progress'* section on Internal Performance Management.

Call to Action Recommendation	Time Frame	Current Status	Verification Activities
Panel's Phase 1 Recommendation 2.e. (Page v) DHS must ensure that ongoing team case conferencing occurs routinely every three months,2 for cases involving children age 5 years or younger, after the initial pre-placement conference, and the child's family, the DHS worker, the provider agency worker, and other interdisciplinary resources must be included as appropriate. Monitoring of service provided, progress, and revisions to the FSP must be made as part of this process. *Panel's timeframe for completion: November 30, 2007.*	11/30/07	Initiated-more progress needed	
8. Clarification of Provider Roles and Responsibilities Relative to DHS Panel's Phase 1 Recommendation 2.f. (Page v) DHS must clarify the roles and responsibilities for DHS workers relative to private agency workers, at both the supervisory and worker level. *Panel's timeframe for completion: August 31, 2007.*	8/31/07	Completed	• Results of Contract Administration and Performance Evaluation (CAPE) annual and special evaluations. • Updated Performance Accountability Forum (PAF) Program Recommendation Summary. • Results of random phone calls to families receiving in-home services. • Report on Consumer Satisfaction Team's visits to group homes and institutions. • Commissioner's Action Response Office (CARO) report on nature of complaints (case issues v. systemic issues).

Call to Action Recommendation	Time Frame	Current Status	Verification Activities
9. Annual Accountability Reports Panel's Phase 1 Recommendations 3.a.i. (Page vi) DHS must develop an annual report card that measures and communicates its performance on outcomes of interest, including at a minimum, those outcomes specified in Chapter 4 of the Report. *Panel's timeframe for completion: Strategy developed by November 30, 2007 and report card delivered by May 31, 2008* Panel's Phase 1 Recommendation 3.b.i. (Page vi) DHS must create an annual outcome report card for contracted agencies. At a minimum, the report card will focus on measures of child safety, which are detailed in Chapter 4 of the Report. *Panel's timeframe for completion: May 31, 2008.*	11/30/07 5/31/08	Completed Not yet due-On track	• DHS will provide COB with updates, including data received from Chapin Hall. COB will participate in finalizing accountability reports for both DHS and Providers.4
10. Internal Performance Management Panel's Phase 1 Recommendation 3.a.ii. (Page vi) DHS must develop a comprehensive strategy for internal monitoring of its performance. DHS must be able to monitor the performance			• IPM tracking report produced in May 2008 for integration with DHS' Annual Public Accountability Report. • Interviews with DHS' directors and administrators to gauge the extent to

4 *Establish an external accountability process that includes an annual public report card that covers the core outcomes*. Responsibility for the report, which should be funded by the City, should be placed in the hands of an independent body that is granted full, unfettered access to the data resources of DHS. (Panel's Report, page 20)

Call to Action Recommendation	Time Frame	Current Status	Verification Activities
of regions, units and workers, and must use performance information to identify weaknesses and areas for improvement. *Panel's timeframe for completion: Strategy developed by November 30, 2007 and Tracking to begin May 31, 2008.* Strategy Tracking	 11/30/07 5/31/08	 Completed Not yet due-On track	which they have received support and technical assistance to use data in their day-to-day management. • Interviews with DHS supervisors and social workers to gauge the extent to which their managers have been able to use data management to help them effectively serve children and families.
11. Enhanced DHS Monitoring of Provider Agencies <u>Panel's Phase 1 Recommendations 3.b. (Page vi)</u> DHS must enhance oversight of contracted agencies *Panel's timeframe for completion: No overall timeframe given.*		Initiated-substantial progress	• Reports from the PAF meetings including issues raised and action steps taken. • Reports from the CST visits and CAPE random phone calls, including number of contacts, trends, concerns and issues raised and action steps taken. • Focus groups with Provider staff and families. • Report on status of joint DHS/DBH monitoring of agencies. • Plan, with timeline for implementation, of spot-checking of agencies. • Report of recommendations developed with consultant and timeline for implementation.

Call to Action Recommendation	Time Frame	Current Status	Verification Activities
12. DHS' Validation of Provider Face-to-face Contact with Children Panel's Phase 1 Recommendation 3.b.ii (Page vi) DHS must validate that contracted agencies are making face-to-face contact with children, that they are performing safety assessments at each contact, and that the contacts are sufficiently frequent and adequate to determine the safety of the child. *Panel's timeframe for completion: June 30, 2007*	6/30/07	Completed & Ongoing	• Quarterly Report on number of random phone calls and feedback, issues, and concerns raised. • Quarterly report on number CST visits with feedback, issues and concerns raised. • Plan, with timeline, to roll out web-based interface for providers to log in visits with children and families.
13. Commissioner's Action Response Office Panel's Phase 1 Recommendation 3.c. (Page vi) DHS must establish Commissioner's Action Line. *Panel's timeframe for completion: August 31, 2007.*	8/31/07	Completed	• Analysis of reports received from April 30, 2007, through December 31, 2007 – due to COB by January 31, 2008. • Quarterly reports analyzing complaints and documenting actions taken to resolve systemic issues that are identified through the complaints – due to COB on the 15th day of the month following the end of a quarter (e.g., April 15 and July 15).

Call to Action Recommendation	Time Frame	Current Status	Verification Activities
14. Community Oversight Board Panel's Phase 1 Recommendation 4.a. (Page vi) DHS must establish a mechanism and process to establish ongoing community oversight. At a minimum, the City must establish a Community Oversight Board. *Panel's timeframe for completion: The Board must be appointed no later than June 30, 2007.*	6/30/07	Initiated-substantial progress made	• Continuance of COB including the appointment of individuals to fill vacant seats. • Commitment of resources for COB verification activities outlined in this Assessment of Progress, and engaging other experts.
15. Ongoing Community Participation and Input Panel's Phase 1 Recommendation 4.b. (Page vii) DHS must ensure ongoing community participation and input into the improvements undertaken by DHS. This participation shall include, at a minimum, a series of ongoing town hall meetings, focus groups, and other events that facilitate the input of community members, private provider agencies, parents, clients, and other stakeholders. *Panel's timeframe for completion: Plan of action must be in place by July 31, 2007.*	7/31/07	Completed and ongoing	• Continuation of town hall meetings at least once a month.
16. Realignment of Prevention Programs Panel's Phase 2 **Recommendation 1.a. (Page vii) DHS must align prevention programs and resources with mission and values developed in Phase One, and also with the core principle			• Review of the realignment plan and progress.

Call to Action Recommendation	Time Frame	Current Status	Verification Activities
of ensuring child safety. *Panel's timeframe for completion: Analysis to begin by November 30, 2007 and alignment to begin by November 30, 2008* Analysis Alignment	 11/30/07 11/30/08	 Completed Not yet due-On track	
17. Realignment of In-home Protective Services <u>Panel's Phase 2 **Recommendation 1.b. (Page vii)</u> DHS must align more effectively in-home service programs and their utilization with the mission and values of DHS and with child safety. *Panel's timeframe for completion: Analysis to begin by July 31, 2007 and alignment and revisions to SCOH by March 31, 2008.* Analysis Alignment	 7/31/07 3/31/08	 Completed Not yet due-On track	• Report on implementation of ARS. • Report on implementation of IHPS. • Focus group with providers and consumers of ARS. • Focus groups with providers and consumers of enhanced SCOH and new IHPS.
18. Comprehensive Model for Social Work Practice <u>Panel's Phase 2 **Recommendation 2.a. (Page vii)</u> DHS must develop a comprehensive model for social work practice that is based on DHS' core mission and values; includes a stronger focus on child safety, permanency and well-being; is family-focused and community-based; and allows for individualized services.	 5/31/08	 Not yet due-On track	• Review and discussion of the practice model and the integration of the key components. • Progress report on training and transfer of learning strategy. • Focus groups with frontline workers and supervisors on practice change. • Initial monitoring of the impact on outcomes for children.

Call to Action Recommendation	Time Frame	Current Status	Verification Activities
Panel's timeframe for completion: Comprehensive May 31, 2008.			
19. Background Check on Family Members Panel's Phase 2 Recommendation 2.a.ii.2. (Page viii) DHS must conduct a background check on each member in the child's household. If an adult household member has prior involvement with DHS or a criminal record that includes convictions for a felony that suggests danger for a child, then DHS must conduct an assessment to determine whether the household is safe and appropriate for the child. *Panel's timeframe for completion: December 31, 2008.*	12/31/08	Not yet due-Discussion needed	• Policy clarification regarding DHS' criteria for requiring background checks on non-parental adults in the home. • Copy of guidelines being developed by DHS and City Law Department that will define extraordinary circumstances under which background checks should be conducted. • Quality assurance report on sampling of cases reviewed to determine if background checks are being done appropriately.
20. Social Workers' Consultation with Other Professionals Panel's Phase 2 Recommendation 2.a.ii.3 (Page viii) DHS must improve integration with physicians, nurses, and behavioral health specialists to ensure that each child's medical and behavioral health is appropriately assessed. *Panel's timeframe for completion: December 31, 2008.*	12/31/08	Not yet due but Completed	• Activity reports from interdisciplinary consultants. • Tracking of the number of health screenings conducted. • Documentation of policy changes related to health, mental health and educational needs of children served.

Call to Action Recommendation	Time Frame	Current Status	Verification Activities
21. Integration of Risk Assessment with New Safety Assessment & Family Team Decision Making Model Panel's Phase 2 **Recommendation 2.a.ii.4 (Page viii) DHS must reexamine the risk assessment in the context of the new safety assessment and integrate it into the new team decision making model for placement and services. *Panel's timeframe for completion: December 31, 2008.*	12/31/08	Not yet due-Initial progress	Verification Activities for the Next Period: • Ongoing discussion between COB and DHS.
22. Elimination of "Boilerplate" Referrals Panel's Phase 2 **Recommendation 2.a.ii.5 (Page ix) DHS must eliminate "boilerplate" referrals and ensure that each child receives appropriate referrals that are specifically tailored for his or her unique needs. DHS will follow-up and act to ensure that the services are actually obtained. *Panel's timeframe for completion: December 31, 2008.*	12/31/08	Not yet due-Initiated	• Report on results from random quality review of Family Service Plans, on the extent to which plans and services are individualized and responsive to specific service needs. • Provider monitoring review. • Documentation on the development of specialized services.
23. Co-location of DHS, Police, Medical, and Forensic Interview Personnel Panel's Phase 2 Recommendation 2.a.ii.6 (Page ix) DHS must complete the long-planned co-location of DHS, police, medical and forensic interview personnel at a community site to facilitate collaborative decision making in the	12/31/08	Not yet due-Substantial progress (leasing delays)	• Site selection and acquisition completed. • Timeline for co-location.

Call to Action Recommendation	Time Frame	Current Status	Verification Activities
investigative phase of casework. *Panel's timeframe for completion: December 31, 2008.*			
24. Clarification of DHS Supervisor's Role Panel's Phase 2 Recommendation 2.a.iv. (Page ix) DHS must clarify the role of supervisors to support the DHS practice model being implemented. *Panel's timeframe for completion: March 31, 2008.*	3/31/08	Not yet due-Substantial progress	• Report on results of written survey completed by Leadership Development Coaching participants. • Plan, with specific timeframes, to implement automated supervisory compliance tool and conference log.
25. Streamlining Paperwork Panel's Phase 2 Recommendation 2.a.v. (Page ix) DHS must streamline its paperwork and records management practices. *Panel's timeframe for completion: August 31, 2008.*	8/31/08	Not yet due-On track	• Review of the consultant report and recommendations related to paperwork reduction. • Review and discussion of the paperwork reduction strategy, timelines and progress as of May 31, 2008. •
26. Child Fatality Review Process Panel's Phase 2 Recommendation 2.a.vi. Page x) DHS must enhance the child fatality review process. *Panel's timeframe for completion: December 31, 2007.* Recommendation 2.a.vi.1. (Page x) DHS must ensure that the child fatality review is multidisciplinary and that there is a mechanism for implementing its	12/31/07 12/31/07	Complete Complete and ongoing	• Full report on 2007 child fatality reviews. • Summary chart for January through May 2008 child fatality reviews.

Call to Action Recommendation	Time Frame	Current Status	Verification Activities
recommendations *Panel's timeframe for completion: December 31, 2007.*			
27. Focus on Permanency and Well-being Outcome Measures Panel's Phase 2 Recommendation 3.a (Page x) DHS must revisit and expand the list of outcomes to be measured- whereas Phase One was largely focused on child safety, Phase Two will expand the focus to include permanency and well-being measures. *Panel's timeframe for completion: Beginning June 1, 2008, following the development of the first DHS annual report card.*	6/1/08	Not yet due	• Outline of data indicators measuring permanency and well being which will be captured in data and included in subsequent Annual Public DHS and Provider Accountability Reports.
28. Outcomes Accountability Panel's Phase 2 Recommendation 3.b (Page x) DHS must link its performance and the performance of its contracted providers to outcomes of accountability, including financial incentives. *Panel's timeframe for completion: June 1, 2008.*	6/1/08	Not yet due	• Review of DHS' plan for performance-based monitoring and fiscal incentives.
29. DHS as a More Transparent Agency Panel's Phase 2 Recommendation 4.a. (Page x) DHS must continue to expand its emphasis on making DHS a more transparent agency.	6/30/08	Not yet due-Completed and ongoing	• Continued tracking of DHS' Communications plan activities. • Continued tracking of DHS' communication efforts. • Tracking implementation of

Call to Action Recommendation	Time Frame	Current Status	Verification Activities
Panel's timeframe for completion: Develop plan by June 30, 2008 and implementation to begin by August 1, 2008. Panel's Phase 2 Recommendation 4.c. (Page xi) DHS must enhance its ability to proactively and transparently manage crisis, including strengthening process related to child death reviews and increasing public access to information. *Panel's timeframe for completion: March 31, 2008*	3/31/08	Not yet due-Completed and ongoing	recommendations from the child fatality review team.
30. Enhancing Healthiness of Infrastructure and Staff Morale Panel's Phase 2 Recommendation 4.b. (Page x) DHS must take positive steps to enhance the healthiness of infrastructure and staff morale *Panel's timeframe for completion: March 31, 2008.*	3/31/08	Not yet due-Significant progress	• Focus groups with staff to assess changes in the work environment and the impact on practice/work and morale.