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County of Los Angeles

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SACHI A. HAMAI
Interim Chief Executive Officer

April 13, 2015

To: Mayor Michael D. Antonovich
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Don Knabe

From: Sachi A. Hamai
Interim Chief Executive Officer

LEVERAGING THE COUNTY'S HEALTH SYSTEM TO PREVENT CHILD ABUSE AND NEGLECT

Background

In its final report entitled, *The Road to Safety for Our Children*, the Blue Ribbon Commission on Child Protection (BRCCP) made several recommendations related to child safety and health services. The first recommendation called for the County to pair a Public Health Nurse (PHN) with a Children's Social Worker (CSW), when conducting a child abuse or neglect investigation for all children from birth at least until age one. The second recommendation called for the County to refer to the medical hub all detained children, and all other children under age one being investigated by the Department of Children and Family Services (DCFS). While the BRCCP indicated children under the age of one, the County expanded the age group to all children under 24 months of age. The third recommendation called for an assessment of the strengths and weaknesses of the medical hubs.

DHS Medical Hub Augmentation Plan

On January 9, 2015, the Department of Health Services (DHS) submitted a report of its assessment of the County's Medical Hub Clinics (medical hubs). DHS determined that additional resources would be required in order to: provide higher quality of service, reduce wait times, and increase the number of examinations conducted at the medical hubs. DHS recommended allocating $1,998,363 of its existing resources to enhance staffing resources at the six County-run medical hubs.

Joint Visit Conceptual Design by Chief Executive Office

On January 12, 2015, the Chief Executive Office (CEO) issued a report proposing a conceptual design of how PHNs could be paired with CSWs to conduct joint visits. The report also identified various tasks requiring completion and identified resources needed to implement the joint visit initiative. Finally, the CEO report recommended a phased in approach starting with one medical hub (Martin Luther King, Jr. Outpatient Center) and two DCFS Regional Offices (Compton and Vermont Corridor) rather than a simultaneous countywide roll-out.

Board's Motion Regarding Implementation

On January 13, 2015, this Board approved a motion introduced by Supervisor Mark Ridley-Thomas and Supervisor Sheila Kuehl directing the Interim Chief Executive Officer and Directors of DCFS, DHS, Mental Health and Public Health to:

1. Implement the recommendations, per the CEO's report dated January 12, 2015, for the actionable items related to pairing a PHN and a CSW when conducting abuse and neglect investigations for all children under 24 months of age;

2. Report back in 90 days on the milestones, performance outcomes, operational changes and additional board actions, including an update on the medical hub augmentation and its impact on appointment wait times and functionality of the medical hubs;

3. Finalize policy and recommendations regarding the provision of screenings of newly detained children, including coordination with existing initial comprehensive medical exams; and

4. Report back in the CEO's Recommended Fiscal Year 2015-16 Budget with an assessment of budget and operational changes needed to implement the recommendations.

The Office of Child Protection (OCP) submits this implementation plan for Phase I of the joint visit plan in response to the Board's January 13, 2015 motion. The plan is attached as Attachment I and has a July 1, 2015 launch date. The OCP has worked with the CEO, and DCFS, DHS, Public Health, Mental Health, and County Counsel to develop a workable plan. This report identifies milestones, performance outcomes, operational changes, and an update on the medical hub augmentation.

The screening of newly detained children at each medical hub, as opposed to non-detained children subject to an investigation, will be addressed after Phase I of the CSW-PHN Joint Visit Initiative launches. It is important to note, however, that detained children are seen at medical hubs as DCFS policy requires that detained children be seen at a medical hub within certain timeframes. Finally, the CEO will issue a separate report which includes an assessment of budget and operational changes needed to implement the recommendations necessary to implement the CSW-PHN joint visit initiative.

If you have any questions, please contact Fesia Davenport at (213) 974-1186, or by email at fdavenport@ceo.lacounty.gov.

SAH:FD
VD:ljp

Attachment (1)

c: Executive Office, Board of Supervisors
Children and Family Services
County Counsel
Health Services
Mental Health
Public Health

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Executive Summary

The countywide CSW-PHN joint visit initiative will be rolled out in phases. Phase I will involve the Martin Luther King, Jr. Outpatient Medical Center (MLK Hub) and Compton and Vermont Corridor DCFS regional offices and will launch on July 1, 2015. On that date, recently hired DCFS PHNs will begin training and joint visits will commence later in the month. The July 1, 2015 launch date assumes the existence of several material factors identified in the table below:

Factor	Implementation Milestones and Next Steps	Status*
Hub Augmentation and Capacity	• DHS must hire staff to augment hubs placing an emphasis on the MLK Hub	IP
	• MLK Hub will offer expanded hours and ensure sufficient capacity exists to meet the increased demand for medical screenings	R
	• DMH will co-locate staff at the MLK Hub	IP
	• The DHS Nurse Advice Line will be operational	R
Adequate Space	• DMH staff co-located at the MLK hub must have space and equipment	IP
	• MLK hub space must be configured to enable DMH Medi-Cal certification**	IP
Adequate Staff Resources	• Hiring must be completed by all Departments and staff in place	IP
Procedures for Pairing CSW-PHN	• DCFS and DPH must finalize policies and forms necessary to implement operational changes including the PHN Assessment Tool and the joint visit protocol	IP
Operational Changes	• Streamlined PHN referral form must be finalized by DCFS and DHS	IP
	• Changes to e-mHub must be operational to accept the PHN referral form	IP
Training Staff	• Training Units from DCFS and DPH must finalize a joint training plan and curriculum to include: didactic training, hands-on training, and shadowing	IP

*Status: IP – In Progress; R – Ready to Launch; **Important but launch not contingent upon this factor

In addition, data collection metrics and tracking systems are needed to monitor and analyze results from Phase I and inform adjustments required to improve the process in subsequent phases. A preliminary list of metrics to measure safety, operational efficiency and effectiveness, and desired outcomes has been identified, and an electronic tracking system to capture most of this data is under development by DCFS.

The conceptual design of the joint visit initiative recommended that five PHNs be hired to launch Phase I – two for the Compton regional office and three for the Vermont Corridor office. After working closely with the PHN workgroups, uncovering more details about the logistics and timing of the referral process, and working on various staffing solutions, DCFS management recommends that the number of additional PHNs for the Phase I offices be increased as fully explained in Section III of this report. The OCP supports this request. In addition, DCFS has agreed to fund six additional Medical Case Workers, one for each hub, to assist DHS with the current workload at the Medical Hubs with an emphasis on responding to the needs of children and families referred to the hub through this joint visit initiative as fully explained in Section I of this report.

Lessons learned from Phase I will help to make the staffing projections closer to the actual need, and will enable each phase of the roll out to occur quicker than the phase that preceded it.

Phase I Planning Efforts Since January 2015 Board Motion

The OCP has worked closely with DCFS, DHS, DMH, DPH, and the Service Employees International Union (SEIU) representing PHNs and CSWs to ensure that all essential factors are in place before the launch date. The CEO's Office previously established the CSW-PHN Joint Visit Executive Leadership Committee. This committee consisted of executive managers and Directors from DCFS, DHS, DMH, DPH and helped to develop the conceptual design of the joint visit initiative presented in the CEO's January 12, 2015 Board report. The OCP met with the committee on March 3, 2015 to obtain an update on progress made since the Board issued its directive to take all actionable steps to implement the joint visit initiative.

After the Board's January 13, 2015 motion directing the CEO and other involved Departments with implementing all actionable items, DCFS established three implementation workgroups. These workgroups were established to begin the process of converting the joint visit conceptual design into practice. The workgroups are:

CSW-PHN Pairing: This workgroup was established to address all operational issues and identified implementation barriers to the conceptual design.

Policy & Training: This workgroup was established to address all policy and training issues associated with the joint visit initiative. The group is also charged with developing a workable training plan that equips PHNs and CSWs to team with each other during the joint visit, yet maintain an appropriate amount of independence to perform their separate functions.

Data & Measures: This workgroup was established to focus on the type of data needed to capture both operational and programmatic information that will help us determine whether the joint visit model as implemented is effective and supports the desired safety and health related outcomes.

On February 19, 2015, DCFS held a meeting with PHNs and a subsequent meeting with the SEIU management representing the PHNs. During those meetings, PHNs raised a number of questions regarding the joint visit initiative. The OCP has worked with SEIU, DCFS and DPH to prepare solutions and responses to the questions. While answers to some questions remain under consideration, none of the remaining questions pose a barrier to implementation. DCFS and SEIU must hold another meeting with staff to share the responses to the questions and also share the final plan for the Phase I roll-out before implementation. In addition, the OCP met with the workgroups, management from the involved Departments, SEIU Representatives, Nursing Directors from DHS and DPH, and County Counsel on March 10, 17, 20, 24, and 27 to obtain material updates, advice, and legal counsel to support the OCP's coordination of the planning efforts of all involved departments.

To aid understanding, this report provides updates and identifies next steps in the context of the following areas:

I. **Medical Hub Augmentation and Capacity** – This section provides an update on the Medical Hub expansion. This section also focuses on efforts to position the MLK Hub for Phase I of the joint visit initiative.

II. **Co-located Mental Health Services –** This section provides an update on the progress DMH has made in its plan to provide co-located mental health services at the MLK Hub.

III. **Public Health Nurses (PHNs) Staffing** – This section provides an update on the progress DCFS has made in developing a staffing and hiring plan to ensure sufficient resources for the Phase I DCFS regional offices.

IV. **Implementation Concerns and Solutions** – This section provides an update on concerns raised by Public Health Nurses and the solutions developed to address those concerns.

V. **CSW-PHN Joint Visit Policy, Training and Operations** – This section describes the major policy, procedural, and operational changes required to implement the joint visit initiative.

VI. **Measures and Outcomes** – This section describes the metrics to be measured and outcomes we seek to improve as a result of the joint visit initiative.

I. Medical Hub Augmentation and Capacity

Space

Hub space enhancements are in the planning stages at the MLK Hub. For MLK, DHS has determined that the existing Hub space will accommodate the Phase I joint visit initiative for the time being. On February 3, 2015, Supervisor Mark Ridley-Thomas introduced a motion that was approved by the Board to assess the feasibility of relocating the Hub to another MLK campus location. In the Board motion, the location was specified and a new building to accommodate the more collaborative and integrated vision for hub services is currently being planned. The preliminary timeline to construct the new building is approximately two years.

Space enhancements are also in the planning stages at the Harbor-UCLA Hub. At Harbor-UCLA, DHS has been working on a plan to relocate the Hub from two trailers on campus to a larger space. The Harbor Hub staff and hospital leadership are determining the correct clinic layout and working to minimize the structural modifications required to improve the space. DHS is working to propose a funding strategy for these renovations.

Hub enhancements for the Olive View Hub have been completed. Staff at the Olive View Hub moved into their new space in the hospital on January 26, 2015. The Hub now has four exam rooms compared to two previously, as well as more space for co-located DCFS and DMH staff.

Staff

On January 13, 2015, this Board directed the CEO to add 14 new positions to the DHS budget to augment staffing levels at all six DHS medical hubs. CEO has granted DHS hiring authority to fill the positions during the current budget year. The 14 items will be added in DHS' FY 2015-16 Recommended Budget and effective July 1, 2015. Of the 14 items, four are allocated to the MLK Hub as follows. Of these four positions, candidates for two positions (Senior Physician and Nurse Practitioner) have been identified. For the remaining two positions (Financial Services Worker and Medical Case Worker) there is not an existing

list for these items, meaning an exam must be prepared. The timeline for filling these positions is as follows:

- By April 30, 2015 – Exams posted for Medical Case Worker II and Financial Services Worker,
- By May 31, 2015 – Interviews will be completed,
- By June 15, 2015 – Employment offers will be extended, and
- By July 15, 2015 – Appointed candidates will commence work at the hubs.

In order to expedite the hiring for the MLK Hub, by April 10, 2015, DHS will post a transfer opportunity notice for existing Medical Case Workers who may be interested in transferring to the MLK Hub.

In order to support expansion of capacity at the medical hubs and handle the work created by the joint visit initiative, DCFS will supplement the Medical Case Workers at each hub by funding six additional Medical Case Workers – one allocated to each hub. This will result in two Medical Case Workers at the MLK hub. Medical Case Workers will provide care coordination and link children with needed resources to address issues identified by hub providers. For example, Medical Case Workers may follow-up with DCFS, a Regional Center, and/or the child's school for a child with developmental issues. These positions will work closely with the DCFS PHN and CSW to form a case management team, to ensure that services are coordinated and duplication of effort is avoided. The Medical Case Worker will also work to ensure that children and their families receive follow-up appointments and increase the likelihood that parents attend follow-up appointments by contacting the family if an appointment is missed.

Cost: The full cost (i.e. salary and employee benefits) for six Medical Case Worker II items is $416,000. CEO has given DHS authority to hire during this budget year. DHS will request in Final Changes that the six permanent Medical Caseworker II items be added to its FY 2015-16 budget.

In addition, DHS is recruiting to fill three daytime Registered Nurse II positions to staff an advice line as fully described below. No new position has been added to the DHS budget to provide the advice line service.

Operational Changes

Nurse Advice Line

DHS has installed a new telephone line for a Nurse Advice Line at the LAC+USC Medical Center. This telephone line will be staffed twenty-four hours a day, seven days a week by DHS Registered Nurses. In addition to serving caregivers, patients and CSWs, the Nurse Advice Line will be available for DCFS PHNs to contact, if they have a question or are seeking advice to assist them during a joint visit. In instances when a nurse is assisting another caller or is otherwise temporarily unavailable, the PHN will be able to leave a voicemail message and have his or her call returned by the DHS nurse within two hours. The outgoing voicemail message will note that if the caller is unable to wait two hours for a return call, the child should be brought to the closest emergency room or urgent care for evaluation.

Expansion of MLK Hub Hours

DHS has developed a staffing plan that will enable the MLK Hub to extend hours from 5:00 pm to 7:00 pm. Extended hours will be implemented before the Phase I launch date. DHS will continually assess the demand once Phase I begins, and will extend hours of operation to 8:00 pm if necessary. For situations

that require a child to be seen at the Hub after extended hours or on weekends, the child and parent will be referred to LAC+USC Medical Hub.

Streamlined Hub Referral Form

DHS and DCFS are working together to define any changes needed to the existing hub referral form in order to streamline the form for PHN use. They have also developed the technical requirements for a change that will need to be made to the e-mHub system to recognize and accept the streamlined referral form. The work to operationalize these changes is underway and expected to be completed by June 30, 2015.

Next Steps

- Hire all staff ensuring that MLK Hub staff are hired before launch date;
- Operationalize the Nurse Advice Line in advance of the launch date
- Extend hub hours and give notice to all Phase I involved Departments
- Finalize and test the streamlined e-mHub referral form
- Implement changes to the e-mHub system that will enable use of streamlined referral form

II. Co-located Mental Health Services at the MLK Hub

DHS identified the need for children and families served at the Medical Hubs to have onsite access to crisis intervention and a bridge of mental health services, until a family is connected with a mental health provider in the family's community. To address this need at the Medical Hubs and for the Phase I roll-out at the MLK Hub, DHS has worked with DMH to co-locate DMH staff at the hubs including the MLK Hub. The components of co-location include: 1) space and equipment; 2) staff, 3) training, and 4) Medi-Cal certification.

Space

On January 13, 2015 and February 12, 2015, DMH visited LAC+USC Medical Hub facility to learn more about the day to day operation of mental health staff in the medical setting. DMH has been in discussion with DCFS and DHS regarding the needs of co-located mental health staff at the MLK Hub. On February 18, 2015, the Departments discussed the space needs for the co-location of mental health staff at the Medical Hub. After the meeting, DHS provided DMH an approximate number of children and youth referred and general reasons for referral to the medical hub. DMH invited DHS to participate in the interview process of the mental health co-located clinicians. DMH is currently collaborating with DHS on developing a guideline and an agreed upon process for those children and youth who will be receiving mental health services at the hubs.

DMH anticipates being able to bill Medicaid for some of the specialty mental health services its staff will provide to the children and youth referred to the Medical Hub. DMH will work to obtain Medi-Cal certification of the hubs in order to bill for these services. Certification means that the space allows a billing Medi-Cal provider to provide a patient with services and that visit is able to draw down reimbursement from Medicaid. The space must meet the Federal and State Criteria for a space where a

certified provider is able to work. The certification will be done by DMH based on a set of standard elements that must be in the clinical setting. The certification process can take three to six months from the date of the certification request. However, both billable and non-billable services can be provided during the certification process. Panic buttons are required at the point service delivery begins. This is a Department and Union requirement.

Staff

On January 13, 2015, this Board authorized DMH to hire six Psychiatric Social Workers and one supervisor to augment services at the Medical Hubs. On March 2, 2015, DMH hired a Mental Health Clinical Supervisor who will monitor and manage the work of the Psychiatric Social Workers. The recruitment for these social workers is ongoing. Fifteen candidates have been interviewed thus far and DMH intends to make selections and extend offers before June 30, 2015.

Cost: The cost (i.e. salary and employee benefits) of the six Psychiatric Social Worker items and the Mental Health Clinical Supervisors is 825,000. DMH will request in Final Changes that that these permanent items be added to its FY 2015-16 budget. DMH has current authority to hire to fill the six social worker positions. The source of funding, additional costs and potential for revenue offset is discussed in the CEO's report on the Recommended Budget for FY 2015-16.

Training

DMH will train its staff in several areas to ensure that the newly hired Psychiatric Social Workers are prepared to provide effective services. The social workers will be trained in several areas including, screening and assessment, essential DMH data systems, trauma, crisis assessment, documentation, and screening tools. The training dates have yet to be determined but will occur with a sufficient amount of lead time to allow staff at the MLK Hub to absorb the training before the launch date.

Next Steps

- Timely install necessary computers equipment at each hub
- Commence the Medi-Cal certification process
- Hire all staff ensuring that MLK Hub is staffed before launch date
- Train all staff ensuring that MLK Hub staff is trained before launch

III. Public Health Nurses Staffing and Staffing Plan

Staff

Conceptual Methodology

The conceptual design of Phase I identified a need for five additional PHNs to handle the increased number of joint visits - two assigned to the DCFS Compton Office and three assigned to its Vermont Corridor Office. The conceptual design recommended that Emergency Response PHN units be established. This is a sound plan in that this replicates the Emergency Response model used for CSWs.

The estimated need for five additional PHNs was based on data provided by DCFS reflecting the number of referrals for FY 2013-14 involving children under two years of age. The DCFS data reflected the following FY 2013-14 data on referrals involving children under two:

- 6,345 referrals received by the Phase I offices,
- 1,750 of the 6,345 referrals involved a child under two,
- 111 (7%) of the 1,750 referrals involving a child under two received a joint visit, and
- 1,639 (93%) of the 1,750 referrals of a child under two did not receive a joint visit.

The conceptual design recommended five additional PHNs for the Phase I offices to meet the need. Please refer to the CEO's original report dated January 12, 2015 for a detailed analysis of the projected need. The conceptual design does not appear to account for, among other things, the additional 453 referrals received during nights and weekends that are handled by the Emergency Response Command Post for families in the catchment area of the Phase I Offices. For this and other reasons identified below, OCP supports the recommendation that the staffing levels for Phase I be increased.

Determination of Additional Need

The conceptual design called for the creation of an Emergency Response (ER) PHN Unit. The success of this model depends on having a sufficient number of PHNs available day in and day out to conduct visits and to also have time in the office to complete follow-up and link families to services. After analyzing the data and comparing it to the realities of everyday practice with workgroup members, it appears that the initial estimated need for five PHNs seems appropriate as a mathematical proposition, but too conservative to implement a staffing plan.

A review and assessment of the data is the starting point of the staffing analysis. Next, logistical and operational issues must inform a staffing plan – a plan which, in this case, points to a need for additional PHNs. This DCFS staffing plan must address the following:

1) The need for PHNs (like CSWs) to have days when they are not conducting investigations (i.e. being on rotation) allowing them time in the office to conduct follow-up and link families to services;

2) The need to have PHNs available to respond to referrals received after hours and weekends; and

3) The need to have an adequate number of PHNs available during those times where referrals are received simultaneously rather than in a series.

As such, DCFS recommends that the five PHN items approved by the Board be supplemented with nine additional PHNs assigned to the Phase I offices; plus six additional PHNs assigned to the DCFS Emergency Response Command Post (ERCP) operation (to handle nights and weekends); plus two PHN Supervisors to manage the new PHNs in the Phase I Regional offices and ERCP. The OCP supports this recommendation echoing the sentiments contained in the conceptual design – the true need will be unknown until Phase I is implemented and PHNs and CSWs start conducting joint visits. If during implementation it turns out that Phase I Offices are overstaffed, this positions DCFS to roll out Phase II sooner because trained staff can be redirected to Phase II Offices. The revised PHN staffing request is identified below.

Revised PHN Staffing Request

Table 1: PHN Staffing Plan

	Regional Office (Regular Hours)		Weekend/Afterhours	Total
	Compton	Vermont	ERCP	
Total PHN Need	9	7	6	22
PHN Transfers Into Phase I Offices	1	1	0	2
Pre-approved PHN Items	2	3	0	5
New PHN Ask	**6**	**3**	**6**	**15***

* (22 PHNs need - 2 transferred PHNs - 5 Pre-approved new hires = need for 15 additional PHNs)

Table 2: PHN Supervisor Staffing Plan

	Regional Office (Regular Hours)		Weekend/Afterhours	Total
	Compton	Vermont	ERCP	
Total PHNS Need	1	1	3	5
PHNS Transfers Into Phase I Offices	1	1	0	2
Pre-approved PHNS	.50	.50	0	1
New PHNS Ask	n/a	n/a	**2**	**2***

*(5 PHN Supervisors needed – 2 transferred supervisors – 1 pre-approved new hire = need for 2 additional supervisors)

PHNs assigned to ERCP for evenings, nights and weekends will support additional phases of the roll out of the joint visit initiative.

Once Phase I launches, much learning, tracking and adapting will occur. DCFS and DPH will gain a better understanding of what the actual need for PHNs will be. The learning from Phase I will be used to adjust or "true-up" the number of PHNs needed in Phase I offices and the ERCP as well as inform staffing needs for future phases of the joint visit initiative. If Phase I lessons learned reveal that Phase I has been over-resourced, then DCFS will determine the appropriate need and redirect PHN resources to Phase II offices.

Cost:

Previously approved costs – 6 staff, $965,000

- Five PHN and one PHN Supervisor item was previously approved for the Phase I Offices.
- The cost of the salary and benefits for these six items is $965,000.

Additional items requested – 17 staff, $2.75M

- Fifteen additional PHN items and two additional PHN Supervisor items requested.
- The cost of the salary and employee benefits for the 15 additional PHNs is $2.4M and $350k for the two additional PHN Supervisors.

Existing staff – 4 staff, $666k

- DCFS intends to devote four existing staff to the Phase I at a cost of $666,000 for salary and employee benefits.

Total staff devoted to Phase I and costs – 27 staff, $4.4M

- The total number of all staff (existing and new items) devoted to Phase I of the joint visit initiative is 27.

- The total cost of the salary and employee benefits of all staff working on the joint visit initiative for Phase I and the ERCP is $4.4M.

CEO will provide DCFS with ordinance items for this current budget year and for FY 2015-16. DCFS will ask that the permanent items be added to its budget once the total number of needed PHNs and PHN Supervisors is determined.

PHN and PHN Supervisor Staffing Plan

Table 3: Regional Office PHN Staffing Plan

Shift/Hours	Regional Office (Regular Hours)		Total
	Compton	Vermont	
Day (M-T) 7:00 am – 5:30 pm	5	4	**9***
Day (T-F) 7:00 am – 5:30 pm	4	3	**7***
Total			**16**

*** One supervisor assigned to each Phase I Regional Office.**

Table 4: ERCP PHN Staffing Plan

Shift/Hours	Emergency Response Command Post	Total
Day (F-M) 7:00 am – 5:30 pm	2*	**2**
Swing 1 (W-Sat) 4:00 pm – 2:30 am	2*	**2**
Swing 2 (Sat – Tu) 4:00pm – 2:30 am	2*	**2**
Total		**6**

*** One supervisor per shift. Each supervisor will be assigned additional duties to ensure they are fully engaged.**

Hiring Plan and Hiring Timeline

The OCP has been working with DCFS and DPH to coordinate efforts to implement a hiring plan and timeline. DCFS currently does not have a list of eligible PHN candidates from which it can hire PHNs. It takes approximately four months to promulgate a list. DPH has allowed DCFS to use DPH's recently promulgated list in order to expedite the hiring process. DCFS will use the DPH list to invite PHN candidates to apply for the PHN positions allocated to this joint visit initiative. Candidates hired from this list will conduct joint visits and form the PHN – ER units as envisioned in the conceptual design. In order to launch Phase I in July, the additional PHNs should be hired by no later than June 30, 2015. The milestones for the DCFS PHN hiring plan are listed below:

- By April 10, 2015 DCFS issued canvass letter,
- By April 20, 2015 DCFS will begin the interview process,
- By May 10, 2015, DCFS will make final selection of candidates, and
- By June 30, 2015, PHNs are hired and assigned to DCFS regional offices or ERCP.

Next Steps

- Implement PHN hiring plan for PHNs and PHN Supervisors
- Solicit volunteers to serve as Lead Workers to mentor ER PHN Units
- Solicit volunteers to supervise the ER PHN Units

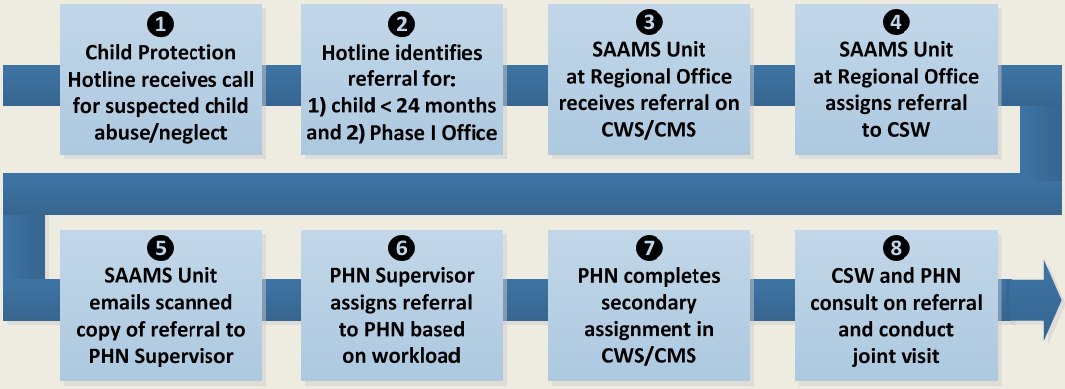
IV. Implementation Concerns and Solutions

The OCP has convened meetings with DCFS, DHS, DPH, and SEIU to work through identified implementation challenges in the following areas: 1) Operational issues associated with pairing PHNs and CSWs; and 2) Policy/Training.

CSW-PHN Pairing Protocol

Figure I on the next page provides a high level overview of a proposed conceptual design for assigning PHNs and CSWs to referrals and then pairing them for a joint visit.

Fig. I: Pairing of CSW and PHN



On February 19, 2015, DCFS held a meeting with PHNs regarding the joint visit initiative and the Phase I roll out. Out of that meeting came various concerns identified by PHN staff and SEIU. The questions that came out of that meeting generally fall into the seven categories identified in Table 5.

Table 5: Issues and Concerns

Issue	Concern
1. Scope of Practice	Ensuring proposed PHN duties under this initiative fall within their scope of practice and thereby are in compliance with the Nurse Practices Act
2. Process and Procedure	Identifying processes in the conceptual design that pose implementation challenges or that will have unintended consequences
3. Policy/Training	Identifying which PHNs will be trained and topics to include in the training
4. Hub Capacity	Assessing whether Hubs will have capacity to handle increased visits
5. Staffing Phase I	Assessing whether 5 additional PHN staff represented a realistic estimate
6. Technological Support	Identifying need for technological support for PHNs in the field conducting joint visits
7. Single Administration	Identifying the County entity appropriate for single administration of the PHN program

DCFS, DPH and DHS have developed solutions to many of the issues and questions posed by staff. For other issues, solutions are being developed. Other issues are outside the scope of this joint visit initiative

as they are more appropriate for bargaining between the County and labor. With respect to all pending issues, the OCP will continue to meet with DCFS, DPH and SEIU to identify solutions. Once solutions or responses have been developed for the identified barriers and concerns, DCFS and DPH will hold another staff meeting with PHNs, PHN Supervisors and CSWs to respond to their questions and share the progress made to date.

Next Steps

- Present the pairing protocol to the DCFS-SEIU labor meeting
- Hold follow-up meeting with PHN and PHN Supervisors to share plans to address issues and share final plan for the Phase I roll–out.

V. Policy and Training

Several policies and forms needed to implement Phase I are currently under development and review. The OCP intends to reconvene the policy workgroups to finalize the policies. Once finalized, the policies must be presented to SEIU representing CSWs before implementation. At or around the same time, DCFS and DPH must also preview the joint visit initiative with stakeholders including: the Dependency courts, attorneys representing parents and children, and community medical providers.

Policy

Work on developing the policies necessary for the joint visit initiative is well underway. The DCFS Policy Unit, in collaboration with DCFS regional staff from the Phase I Offices, and Public Health Nurses drafted a proposed policy document titled, *PHN and CSW Joint Visit on Emergency Response Referrals for Children Under 24 Months of Age*. Once finalized and approved, this FYI will serve as the policy basis of the joint visit initiative. A policy workgroup has been established to vet the document. The workgroup consists of both DCFS and DPH PHNs, SEIU, and the DCFS Policy and Training Unit.

The FYI, among other things, informs staff about the purposes of the joint visit initiative; that Phase I is limited to the Compton and Vermont Corridor Regional Offices; provides direction on what must be done during a joint visit; and outlines the duties and responsibilities of the PHN and the CSW.

PHN Assessment Tool

The PHN Assessment Tool is a form under development that PHNs will use when conducting a joint visit. Recently, the OCP and DCFS sought input on the form from County Counsel and the Nurse Directors from DPH and DHS. Out of this discussion came a recommendation to revise the form to ensure that a PHN's assessment will remain a clinical observation rather than a medical diagnosis. The Nursing Directors have indicated that the proposed PHN Assessment Tool does not call for the PHN to engage in activity that is beyond a PHN's scope of practice.

Next Steps

- Finalize the FYI and present the document to CSWs
- Finalize PHN Assessment Tool
- Communicate plan to stakeholders

Training

A comprehensive training plan is being developed to ensure that Public Health Nurses have the requisite skills to determine whether a child should be referred to the MLK Hub or other appropriate safety related action. The plan is being developed through a collaborative effort between the DCFS and DPH Training units. The Policy/Training Workgroup will re-convene in April to finalize the training plan.

The training plan incorporates a multi-level approach: didactic training, hands-on training, and shadowing. PHNs will be allowed to shadow Emergency Response CSWs in order to gain a better understanding of the type of work they do. Then PHNs will be sent to training. Training modules will take five days to complete and will include lectures, computer-based tutorials, information guides, and simulations. DCFS plans to train all newly hired PHNs, all PHNs in the Phase I offices and all PHN Supervisors in the Phase I offices. Each training cohort will consist of 24 participants. The training curriculum is divided into two components: didactic and practicum.

Table 6: Training Curriculum Components

Didactic	Practicum
▪ Core Practice Model Overview ▪ PHN/CSW Roles and Responsibilities ▪ Emergency Response (ER) Overview & Legal Authority ▪ Procedures for Conducting Joint Visits ▪ Field Safety Considerations ▪ Child Abuse Identification & Reporting Laws ▪ Medical/Health Documentation (including CWS/CMS contact entry)	▪ Scenario simulations where PHNs and CSWs will be able to gain an overall understanding of the joint visit process for the specific target population. ▪ Simulations will enable PHNs and CSWs to get insight into the type of skills that are necessary as well as obtain a perspective on what circumstances can be present during a joint visit.

Next Steps

- DCFS and DPH finalizing training manual and curriculum.
- Develop schedule to allow PHNs to shadow Emergency Response CSWs
- Develop training schedule for newly hired and existing PHNs assigned to Phase I Offices

VI. Measures and Outcomes

To understand the impact that Phase I has on the safety and well-being of children under 24 months, tracking various process and outcome measures is critical. Moreover, the results from Phase I will inform the adjustments required to achieve better results in subsequent phases. A data workgroup has been established. The Data Workgroup was tasked with creating the workflow process to capture data elements to be tracked and monitored during Phase I. Performance will be tracked during implementation of Phase I to ensure that services are provided to children and families; and to inform policy decisions that will impact future phases of the CSW-PHN Joint Visit Initiative as County-wide rollout continues. Most of the data elements are to be documented in CWS/CMS, and monthly activity reports (trends, impact) will be run to measure performance during Phase I.

A preliminary list of data elements that will be tracked and monitored during implementation of Phase I have been identified and categorized into three types of outcomes: (1) process; (2) child welfare; (3) health. These outcomes pertain only to those referrals that received a CSW-PHN pairing during the investigation.

Table 7: Performance and Outcomes Measures

Activity	Measure
Referrals Assigned to CSW and PHN	1. Total number of referrals that paired a CSW and PHN ▪ By time period (traditional business hours; afterhours) ▪ By referral type (Immediate Response, 5-day, etc.) ▪ By child's age (less than 24 months (focus child); siblings over 24 months) ▪ Type of allegation
Joint Visits	2. Total number of visits conducted by PHNs ▪ Number of initial visits that a CSW and PHN conducted together ▪ Number of initial visits conducted separately ▪ Number of joint visits conducted jointly 3. Number of children assessed by PHN (by age)
Hub Referrals by PHN	4. Number of Hub referrals by PHN for medical screening ▪ Number of Hub referral refusals (by parents) 5. Number of children screened at Medical Hub (by age) 6. Number of days that Hub screening occurred after joint CSW-PHN visit
Hub Appointment Management	7. Total number of appointments 8. Number of Hub appointment failures (by parents) ▪ Number of appointments rescheduled – Number of times rescheduled: 1, 2, 3, etc. – Reasons for rescheduling (parent request vs. Hub requests) ▪ Number of children that were not scheduled for an appointment within 72 hours of joint visit and the reasons (parent request vs. Hub unable to accommodate) ▪ Number of families that required (and received) transportation assistance
Child Welfare Related	*The following require a comparison of the baseline with Phase I outcomes by regional office* 9. Number of detentions 10. Impacts on ER referral closure timelines. Information on referrals open > than 30 days ▪ Number of children who required a Hub exam ▪ Number of children who received a Hub exam within 72 hours of joint CSW-PHN visit ▪ Impact of #8 above on referral closures (< 30 days vs. > 30 days) 11. Number of children returning to the system 12. Number of children with recurrence of maltreatment 13. Number of child fatalities, if any
Linkage with Health Care and Supportive Services	14. Number of PHN-generated community referrals 15. Number of children who were referred to services as a result of PHN-generated referrals ▪ Number who received/obtained services ▪ Number who were deemed ineligible by agency ▪ Number who declined services 16. Number of families already connected with Home Visitation and other community-based specialty (resource) services at the time of the referral 17. Number of families with an existing Medical Home (and at time of referral/case closure) ▪ Number with no identified Medical Home at time of referral ▪ Number with private provider as Medical Home at time of referral ▪ Number with DHS as Medical Home at time of referral

More work is required to identify additional measures indicative of health related outcomes for children. The OCP has reached out to DHS and to the Children's Data Network to help identify meaningful health

related measures that can be tracked through this joint visit initiative. As roll-out continues, data collection will improve and the metrics and outcomes initially chosen to be measured will likely change.

Next Steps

- Determine how to track requests for medical records and impact on disposition
- Continue to work on identifying health related outcomes and measures

Conclusion

Since January, much planning and work has taken already place to implement the CSW-PHN joint visit initiative. Each Department is working to implement its hiring plan, and the workgroups continue to meet to finalize policies, procedures and work through other logistical details. The Departments continue to work together to address intra-departmental operational changes. The OCP will provide a pre-implementation report on or before June 15, 2015 to keep this Board apprised of progress being made. The CEO will issue a separate report assessing the budget and operational changes, including personnel and capital improvements needed to implement the recommendations outlined in the Board reports issued by DHS on January 9, 2015 and CEO on January 12, 2015.

County of Los Angeles

CHIEF EXECUTIVE OFFICE

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SACHI A. HAMAI
Interim Chief Executive Officer

June 19, 2015

To: Mayor Michael D. Antonovich
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Don Knabe

From: Sachi A. Hamai
Interim Chief Executive Officer

CHILDREN'S SOCIAL WORKER (CSW) – PUBLIC HEALTH NURSE (PHN) JOINT VISIT INITIATIVE – PRE-IMPLEMENTATION STATUS REPORT

On April 13, 2015, the Office of Child Protection (OCP) provided your Board with a plan to implement Phase I of the CSW-PHN Joint Visit Initiative in response to the Board's January 13, 2015 motion. The plan stated that Phase I will launch by July 1, 2015 at the Martin Luther King, Jr. Outpatient Center (MLK Hub) and the Department of Children and Family Services (DCFS) Compton and Vermont Corridor Regional Offices. During July, recently hired DCFS PHNs will begin training and joint visits will commence later in the month. The OCP has been working closely with DCFS, Health Services (DHS), Mental Health (DMH), Public Health (DPH), and the Service Employees International Union (SEIU) representing PHNs to ensure all essential factors are in place before the launch date.

This report provides an update on the medical hub augmentation, as it relates to the MLK Hub, and as approved by this Board on January 13, 2015. This report also includes updates from DCFS and DPH on necessary pre-implementation activities related to conducting the CSW-PHN joint visits.

Martin Luther King, Jr. Hub

Expanding Capacity for Additional Medical Screenings

DHS is working on several operational changes to expand capacity at the MLK Hub. By July 1, 2015, the MLK Hub will extend evening hours Monday through Thursday from 8:00 a.m. to 8:00 p.m., and on Friday from 8:00 a.m. to 4:30 p.m. To streamline the referral process for PHNs to refer children to the MLK Hub, DHS and DCFS have finalized a streamlined version of the referral form and are making necessary changes to electronically process the form. Both Departments fully expect that the revised form will be fully operational with electronic processing capability by July 1, 2015.

The MLK Hub is currently working to hire two Medical Case Workers. For children referred to the MLK Hub, Medical Case Workers will follow-up on missed appointments, and referred children and families will have their care coordinated.

Co-locating Mental Health Services

DMH has been working, in collaboration with DHS, to implement a plan to co-locate mental health staff at the MLK Hub. DMH has hired two of the three staff (a Mental Health Clinical Supervisor and a Psychiatric Social Worker) that will be housed at the MLK hub. Efforts to hire a second Psychiatric Social Worker are ongoing. Space for the staff has been identified by DHS. On May 15, 2015, a fire clearance for the MLK Hub was obtained, and an application to request Medi-Cal certification has been initiated. Finally, DMH is in the process of obtaining the necessary hardware to support the DMH Integrated Behavioral Health Information System, and installing a DMH server in order for DMH staff at the MLK Hub to access DMH's electronic health record system.

CSW-PHN Joint Visits

Presently, DCFS and DPH have finalized procedures and forms necessary to implement the CSW-PHN joint visits, including the PHN Assessment Tool and the joint visit protocol. DCFS is hiring PHNs, and DPH has developed a training curriculum. Both Departments have agreed to a joint training plan. Additionally, DCFS continues to work on developing a system to track outputs and outcomes. The following updates relate to policy, training, and hiring of staff.

Policy and Procedures

A PHN Assessment Tool has been developed in collaboration with the Nursing Directors of DHS and DPH, PHNs and management staff at DCFS and DPH, the OCP, and County Counsel. Moreover, the Nursing Directors have established that the information gathered through the completion of the tool falls within the scope of nursing practice.

The DCFS Policy Section, in consultation with DCFS regional staff from the Compton and Vermont Corridor Regional Offices and DCFS and DPH PHNs, have drafted a protocol document specifically for the Compton and Vermont Corridor Regional Offices and the Emergency Response Command Post (ERCP). The DCFS Policy Section will develop a website where the PHN-CSW Joint Visit Initiative Phase I protocol will be accessible for staff at those offices. The protocol will pertain to the Phase I offices only and to those ERCP cases mapped to Compton and Vermont Corridor. Once countywide rollout of the PHN-CSW Joint Visit Initiative is complete, countywide policy changes will take place.

Training

A comprehensive and specialized training curriculum has been jointly developed by DCFS and DPH to ensure PHNs have the skills to implement the joint visits. The training curriculum was developed through a collaborative effort between the DCFS and DPH Training Units, as well as with DCFS and DPH PHNs and PHN-Supervisors. The DPH training will focus on the requisite skills needed for PHNs to complete the PHN Assessment Tool during the joint visit with the CSW. The DCFS training unit will provide PHNs with a foundational overview of the Emergency Response (ER) unit at DCFS regional offices, child abuse reporting laws and practical application of the Child Welfare Services/Case Management System.

Staffing PHNs

Current staffing levels at the regional offices participating in Phase I include 14 staff dedicated to the initiative, comprised of volunteer PHN transfers and new hires. To date, DCFS staffed both the Compton and Vermont Corridor regional offices (four PHNs at Compton; five PHNs at Vermont Corridor; one Supervisor PHN at each office; one lead PHN at each office). For the ERCP, DCFS has one Nurse Manager and is identifying additional PHN staff. DCFS will continue recruitment efforts to identify additional staff for the ERCP, which will handle investigations during afterhours and on

weekends. Recruitment efforts will be ongoing to identify staff for regional offices in subsequent phases as the Countywide rollout continues.

Labor-Management Meetings

While efforts are underway to implement this initiative, labor has presented questions and concerns raised by staff. During early implementation efforts, OCP held several meetings with SEIU and invited them to the implementation planning table with all other involved Departments. DCFS and SEIU engaged in an initial meet and consult on February 19, 2015, and the final meet and consult is scheduled for June 23, 2015.

Once the CSW-PHN Joint Visit Initiative launches, the OCP will be providing the Board with a status update after 90 days to report on progress, including outputs and outcomes. If you have any questions, please contact Fesia Davenport at (213) 974-1186, or by email at fdavenport@ceo.lacounty.gov.

SAH:FD
VD:ljp

c: Executive Office, Board of Supervisors
Children and Family Services
County Counsel
Health Services
Mental Health
Public Health

CSW-PHN Joint Visit Initiative Status June 2015 Progress Report.bm

COUNTY OF LOS ANGELES
OFFICE OF CHILD PROTECTION

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JUDGE MICHAEL NASH (RET.)
EXECUTIVE DIRECTOR

June 30, 2016

To: Supervisor Hilda L. Solis, Chair
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: Judge Michael Nash (Ret.)
Executive Director

CHILDREN'S SOCIAL WORKER (CSW) – PUBLIC HEALTH NURSE (PHN) JOINT VISIT INITIATIVE – REPORT

On January 13, 2015, the Board adopted the motion to implement the recommendations from the Chief Executive Officer's report of January 12, 2015, regarding the pairing of a PHN with a CSW when conducting abuse and neglect investigations for all children under 24 months of age.

On June 19, 2015, the Office of Child Protection (OCP) provided the Board with a pre-implementation status report on the first phase of the CSW-PHN Joint Visit Initiative. It outlined the work done with the Departments of Children and Family Service (DCFS), Health Services (DHS), Mental Health (DMH), and Public Health (DPH), and the Service Employees International Union (SEIU) representing PHNs to ensure essential factors were in place, including: policy and procedures, PHN staffing and supervision, training of PHNs, and data collection.

The CSW-PHN Joint Visit Initiative launched on August 3, 2015, at the DHS Martin Luther King, Jr. Outpatient Center and the DCFS Compton and Vermont Corridor Regional Offices. The conclusions and recommendations in this report, Attachment I, are based on data that was collected from August 2015 through February 2016 from DCFS, DHS, and DMH, along with several meetings convened by OCP with the staff involved in the Initiative, other representatives from the involved Departments, SEIU, and other entities. This report has been shared with the Directors of the involved Departments prior to submission to the Board.

In summary, while the joint visits occurred for 97% of the referred children under 2 years of age, there is no clear data to indicate whether or not this initiative helped to improve the safety of these children. What the data showed was frequent referrals for health

needs and the identification of a significant number of families in need of health insurance.

Since implementation of the program demonstrated more of an impact on early intervention instead of safety, a decision needs to be made whether this is a sufficient basis to continue this program. Based on the findings from the evaluation of the Initiative, the OCP recommends:

1) Termination of this pilot program.

2) Enhanced training for CSWs on recognition of signs necessitating the need for further evaluation by a PHN or other medical professional.

3) Further discussions amongst the appropriate entities as to how PHNs can be more efficiently and effectively utilized within existing resources.

4) The DCFS PHNs and DPH PNHs should be consolidated under DPH.

The OCP will continue to work with DCFS, DPH, DHS and DMH to further explore the best and most effective use of PHNs in child welfare to improve safety outcomes, as well as ensure linkages for needed services are made. The OCP will report back to the Board on the any proposed program.

If you have any questions, please contact me at (213) 893-1152 or via email at mnash@ocp.lacounty.gov, or your staff may contact Karen Herberts at (213) 893-2466 or via email at kherberts@ocp.lacounty.gov.

MN:CDM:KMH

Attachment

c: Executive Office, Board of Supervisors
Chief Executive Office
Children and Family Services
County Counsel
Health Services
Mental Health
Public Health

Background

On June 10, 2014, the Board of Supervisors (Board) adopted the final recommendations of the Blue Ribbon Commission for Child Protection (BRCCP) entitled, "The Road to Safety for Our Children." The BRCCP noted that medical or developmental issues may be symptoms of child abuse or neglect, and that when those signs are missed or not addressed, the risk of repeat abuse, serious injury, or even death increases. Thus, included in the report was a recommendation to utilize the skills and expertise of Public Health Nurses (PHNs) with the Department of Children and Family Services' (DCFS) Children's Social Worker (CSW) when conducting child abuse or neglect investigations of all children from birth to at least age one, and referring children whose cases are under investigation for further screening at a Department of Health Services (DHS) Medical Hub, in order to improve safety.

On January 13, 2015, the Board approved a motion directing the Chief Executive Officer (CEO) and Department Directors of DCFS, DHS, Mental Health (DMH), and Public Health (DPH) to implement the recommendations contained within the CEO's report dated January 12, 2015, for the actionable items related to pairing a PHN and a CSW when conducting abuse and neglect investigations for all children under 24 months of age. The CEO's report proposed a conceptual design of how PHNs could be paired with CSWs to conduct joint visits, identify resource issues, and recommend a phased-in approach starting with one medical hub, Martin Luther King, Jr. Outpatient Center (MLK Hub), and two DCFS Regional Offices, Compton and Vermont Corridor, to test the model.

PHNs from the DCFS and DPH programs already co-located in the 19 DCFS Regional Offices were considered for this pilot. They both provided similar consultative and coordination-type, non-clinical services to CSWs. Whereas, the DCFS PHNs could provide services to non-detained children subject to an investigation, the DPH PHNs funding limited their services to only detained children placed in out-of-home care. Therefore, to meet the anticipated staffing needs of this pilot, an additional 15 DCFS PHNs and one PHN Supervisor were hired (8 for Compton, 6 for Vermont Corridor, and a PHN and PHN Supervisor for the Emergency Response Command Post (ERCP)), with existing staff consisting of two PHNs and two PHN Supervisors completing the team.

A PHN Assessment Tool was developed for the PHNs to use when assessing and providing their professional observations on the children seen during the course of the investigation. The Tool was designed in collaboration with the Nursing Directors of DHS and DPH, PHNs and management staff at DCFS and DPH, Office of Child Protection (OCP), and County Counsel. In addition, a comprehensive and specialized training curriculum was jointly developed by DCFS and DPH to ensure the PHNs had the skills to implement the joint CSW PHN visits and complete the PHN Assessment Tool.

CSW - PHN joint visit program design includes the following:

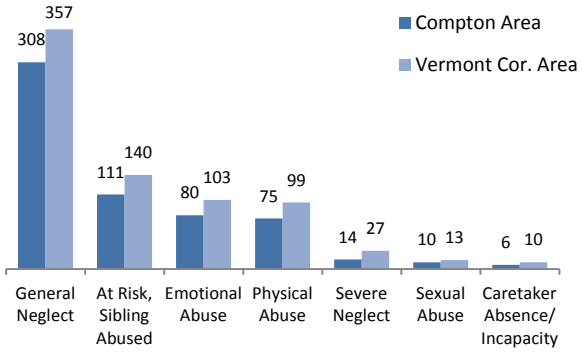
- CSW will be paired with a PHN during investigations of referrals that include a child, under 2 years of age.
- CSW will investigate, as usual; and continue to be responsible for all casework decisions.
- CSW will consult with PHN during investigation. PHN will be a secondary assignment to the referral.
- PHN will visit to observe child(ren), interview parents, and conduct biopsychosocial and environmental assessments utilizing the PHN Assessment Tool, to:
    - Identify unmet needs
    - Provide advice on parenting and child development
    - Provide linkages to services to address the unmet needs
- PHN will determine medical necessity for additional medical screen. If medically-necessary, PHN will refer children to MLK Hub.
    - Consenting parents will transport child(ren) to Hub within 72 hours
    - Hub clinician will determine additional forensic/treatment needs AND obtain parental consent to proceed
    - Hub clinician will enter outcomes into e-mHub within 48 hours
- PHN will retrieve Hub outcomes and provide to CSW.

On August 3, 2015, Phase I of the CSW and PHN joint visitation initiative began in the Compton and Vermont Regional Offices, with medical services provided at the MLK Hub. This report reviews the Initiative's data from August 2015 through February 2016, assesses the Initiative's alignment with its original safety intent and makes recommendations for next steps.

Referrals to DCFS Child Protection Hotline

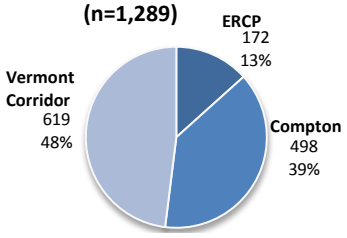
The data from August 2015 through February 2016 shows that the Child Protection Hotline received 1,289 referrals, with 1,353 allegations, across the Compton and Vermont Corridor Regional Offices that included a child under two years of age. Of the allegations made, 49% of the referrals were for general neglect and 28% of the referrals included some form of abuse, (i.e., emotional, physical, and/or sexual). (Fig. 1).

Fig. 1: Hotline Allegations for Children Under 2 Years



The Compton Office received 498 of these referrals, 619 of the referrals were for the Vermont Corridor Office, and 172 of the referrals were received after-hours and directed to the Emergency Response Command Post (ERCP). Although the ERCP began immediate response joint visits with one PHN in January 20, 2016, only six joint visits occurred during this reporting period and were not included in this report. (Fig. 2).

Fig. 2: Aug 2015 - Feb 2016 Referrals Compton and Vermont Corridor (n=1,289)



Reduction of Removal Rates, Cases Opened, and Referrals Closed

During this time period, the number of children removed from their families, cases opened, and referrals closed were significantly reduced from the same period of the prior year. However, it is unclear how much of the changes were a direct result of pairing a CSW with a PHN for joint visits during an investigation of a child under 2 years of age. During this same timeframe, DCFS implemented several key initiatives such as the push to hire more CSWs to reduce caseloads, the Countywide rollout of Core Practice Model,

Table 1: Removal Rates for Compton and Vermont Involving a Child Under 2 Years

	2014-2015				2015-2016			
Month	Not Removed	Removed	Total # of Children	% Children Removed	Not Removed	Removed	Total # of Children	% Children Removed
Aug	168	33	201	16.4%	155	11	166	6.6%
Sep	195	24	219	11.0%	208	20	228	8.8%
Oct	198	33	231	14.3%	222	23	245	9.4%
Nov	161	20	181	11.0%	185	11	196	5.6%
Dec	177	25	202	12.4%	203	23	226	10.2%
Jan	159	25	184	13.6%	189	14	203	6.9%
Feb	175	24	199	12.1%	196	28	224	12.5%
Total	**1,233**	**184**	**1,417**	**13.0%**	**1,358**	**130**	**1,488**	**8.7%**

Table 2: Cases Opened for Compton and Vermont Involving a Child Under 2 Years

	2014-2015				2015-2016			
Month	Case Not Opened	Case Opened	Total # of Children	% Children	Case Not Opened	Case Opened	Total # of Children	% Children
Aug	151	50	201	24.9%	210	70	280	25.0%
Sep	165	54	219	24.7%	206	43	249	17.3%
Oct	164	67	231	29.0%	184	37	221	16.7%
Nov	143	38	181	21.0%	179	28	207	13.5%
Dec	149	53	202	26.2%	104	30	134	22.4%
Jan	134	50	184	27.2%	145	25	170	14.7%
Feb	145	54	199	27.1%	154	34	188	18.1%
Total	**1,051**	**366**	**1,417**	**25.8%**	**1,182**	**267**	**1,449**	**18.4%**

and the creation of the 2015-16 Director's Strike Team to assist Emergency Response CSWs with case closures. These efforts very likely affected changes in these data, so it is difficult to determine the impact of this pilot on this data.

Table 3: # of Days from Referral Received Date to Closure Involving a Child Under 2 Yrs

	2014-2015	2015-2016
Month	Avg. # of Days	Avg. # of Days
Aug	88	79
Sep	84	82
Oct	88	82
Nov	90	72
Dec	92	62
Jan	91	51
Feb	84	38

CSW and PHN Joint Visitation and Linkages

During Phase I of this Initiative, CSWs and PHNs have done well in meeting the recommendation to jointly conduct investigations of child abuse or neglect for children from birth up to age 2. Of the 1,117 referrals for a child under 2 received by the Compton and Vermont Corridor Offices, the PHNs accompanied the CSWs on 97% of those visits.

Table 4: CSW-PHN Joint Visits & MLK Hub Referrals: Aug 2015-Feb 2016

	Number by Office		Total
Measures	**Compton**	**Vermont**	**Both Offices**
DCFS Referrals for Children Under 2 Yrs	498	619	**1,117**
Children Under 2 Yrs Assessed by PHN	499	582	**1,081**
CSW-PHN Joint Visits	635	672	**1,307**
Percent of Joint Visits Conducted	127.5%	115.5%	**121%**
Children Under 2 Years			
Children Ref. by PHN to Hub for Screening	18	59	**77**
Percent of Children Ref. by PHN to Hub	3.6%	10.1%	**7.1%**
Children Ref. by CSW for Forensic Eval.	41	68	**109**
Children 2+ Years			
Children 2+ Years Assessed by PHN	977	868	**1,845**
Children Ref. by PHN to Hub for Screening	7	33	**40**
Percent of Children Ref. by PHN to Hub	0.7%	3.8%	**2.1%**
Children Ref. by CSW for Forensic Eval.	70	71	**141**

For the 1,081 children under age 2 assessed, a total of 1,307 (121% of referrals) joint visits occurred through the investigative process, which also included interviews of the siblings of the referred child. The difference between referral assessments and joint visits is an indication that occasionally multiple joint visits occurred for the same family. There are several reasons that could account for the additional visits, such as the child may have not been available on initial visit, a follow-up visit was indicated, or additional visits were needed to assess all the siblings of the child in question. In total, the PHNs met with 2,926 children, with 1,081 (37%) under age 2 and 1,845 (63%) age 2 or older.

Of the 1,117 Hotline calls, the CSWs referred 109 children under age 2 and 141 siblings aged 2 and older to the MLK Hub for forensic evaluations; the PHNs referred 77 children under age 2 and 40 siblings aged 2 and older to the MLK Hub for medical screenings.

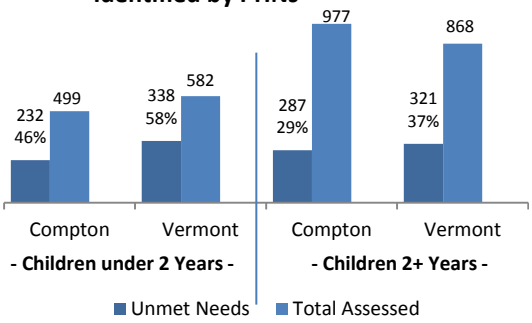
An added benefit of the PHNs interviewing and completing their non-clinical, health/safety assessment tool was the identification of unmet needs for the children, reflecting a public health perspective of improving the overall health of the family. The top three unmet needs identified for children under age 2

Table 5: PHN Identification of Unmet Needs by Age Group – Aug. 2015 - Feb. 2016

Children Under 2 Years Assessed by PHN				***Children 2 Years and Over Assessed by PHN***			
Children with Unmet Needs			**570**	Children with Unmet Needs			**608**
Identified Unmet Needs	**Compton**	**Vermont**	**Total**	**Identified Unmet Needs**	**Compton**	**Vermont**	**Total**
Parent Education	**71**	**256**	327	Parent Education	62	**256**	318
Medical Evaluation	48	162	210	Medical Evaluation	96	162	258
Co-Sleeping/Unsafe Sleeping	53	80	133	Dental	**131**	109	240
Immunizations	40	35	75	Co-Sleeping/Unsafe Sleeping	24	35	59
Dental	32	33	65	Immunizations	27	20	47
Nutrition	27	14	41	Developmental/Speech Impair.	32	13	45
Developmental/Speech Impair.	9	15	24	Insurance Coverage	14	12	26
Insurance Coverage	14	9	23	Nutrition	15	9	24
Homeless	12	8	20	Homeless	10	8	18
No primary medical doctor	5	11	16	Psychosocial/Behavioral	5	10	15
Medical Supplies/Equipment	4	2	6	Vision	12	0	12
Psychosocial/Behavioral	3	2	5	No primary medical doctor	3	9	12
Vision	0	1	1	Medical Supplies/Equipment	2	1	3
Other	10	13	13	Other	8	3	11
Total Unmet Needs	328	631	959	Total Unmet Needs	441	647	1,088

were: 1) parent education (34%), 2) medical evaluation (22%), and 3) co-sleeping/unsafe sleeping (14%). The PHNs found that 53% (570) of children under 2 years and 33% (608) for children 2 years and older were identified as having unmet needs. Of note, PHNs from the Vermont Corridor Office identified a higher percentage of unmet needs for their children in both age groups (45% vs. 35%).

Fig. 3: Children with Unmet Needs as Identified by PHNs



With over 40% (1,178) of the children assessed as having one or more identified unmet need, there is a significant need to provide linkages to programs and services to address them. Although providing these linkages are allowable activities under the funding currently being used, the use of the PHNs, in this context, to supply those linkages may not be a cost effective design, given their funding limitations on the number of staff and relatively high salaries. Other staffing options should be considered to supply the various linkages.

For the 570 children under age 2 with identified unmet needs, the PHNs provided a total of 1,908 referrals to services or programs. However, the requirement to complete an investigation within 30-days did not allow the PHNs enough time to build the relationships and trust with the families seen in other PHN programs, such as Nurse Family Partnerships. In meeting with staff involved in the initiative, the PHNs reported that although referrals or linkages for services were made, if the initial hotline referral was closed without opening a case prior to the families' scheduled appointments, there was no mechanism to follow-up and ensure the families kept their appointments.

Referral to Hub Services

Through this initiative, the PHNs refer to the MLK Hub when medically necessary to prevent illness/injury or promote the health of the child. The role of the MLK Hub physicians and nurses allows for the child to be medically screened in order to detect any condition requiring intervention and promote good health for the child through regular primary care. To help target the medical visits to areas of concern identified by the PHNs, the Hub received a copy of the PHN assessment form.

For the referrals made by the PHNs to the MLK Hub for medical screening of a child under age 2, seven categories were tracked (with multiple reasons allowed for each referral). The top three reasons cited most often for a referral to the MLK Hub were: 1) medical visits not being up-to-date (44%), 2) lack of a primary medical doctor (22%), and 3) being behind on immunizations (9%). The areas of possible child safety concerns were cited less often: developmental delays (8%), mental health (2%) and prenatal drug exposure (1%). (Table 6).

Table 6: Reasons Cited for PHN Referral for Medical Screening for Children Under 2 Years

Reason*	Compton	Vermont	Total	Percent
No Up-to-Date Medical Visit	12	60	72	44.2%
No Primary Medical Doctor	5	31	36	22.1%
Behind on Immunization	2	13	15	9.2%
Developmental Delay	1	12	13	8.0%
Mental Health	0	3	3	1.8%
Prenatal Drug Exposure	0	2	2	1.2%
Other Services	5	17	22	13.5%
Total	**25**	**138**	**163**	

*Includes data for 16 referrals later excluded during reconciliation as CSW referrals or referrals that occurred in March.

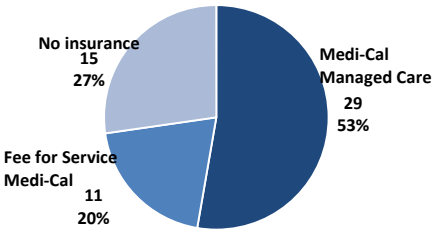
Of the children seen at the MLK Hub, 55 children were surveyed about their medical insurance coverage. The MLK Hub found that 53% were enrolled in Medi-Cal Managed Care, 20% in Fee for Service Medi-Cal,

and 27% had no health insurance coverage. As a result of visiting the Hub for services, 27% of families chose to receive their primary medical care at the Hub. (Table 7 and Figure 4).

Table 7: Did Family Choose Primary Care at Hub or Affiliate?

• **Had primary care elsewhere**		29	53%
– *Already had good primary care elsewhere*	*18*		
– *Has assigned primary MD elsewhere*	*11*		
• **Decided to visit Hub for primary care**		15	27%
– *Wants to change to Hub for primary care*	*12*		
– *Enrolled in primary care at Hub due to visit*	*3*		
• **To be determined at follow-up appt. at Hub**		2	4%
• **Declined primary care at Hub/not feasible**		9	16%
Total		55	100%

Fig. 4: Insurance Type (n=55)



In addition, the PHNs were able to refer their clients directly to the MLK Hub for mental health services. DMH staff co-located at the MLK Hub provided mental health services to 25 children referred through this Initiative, and six of these children, who were identified as needing additional services ,were further linked to specialty mental health services.

MLK Hub Assessments

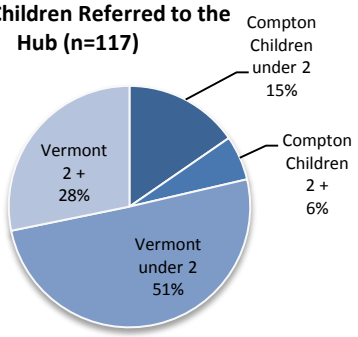
DCFS records show PHNs referred 117 children for medical assessments, while the MLK Hub reported receipt of 126 referrals. A manual reconciliation of the records between DCFS and DHS showed a match between 82 of the referrals reported by the Hub and DCFS. Of the 35 referrals from DCFS not included in the MLK Hub count, the majority of referrals (28) were not submitted as a PHN referred medical assessment, but instead as an initial medical exam to the MLK Hub or other Hubs. Of the 44 referrals received by the MLK Hub and not included in the DCFS count, the majority of the referrals (37) were submitted by CSWs instead of a PHN, or by the PHNs and not flagged as a referral from this pilot in DCFS' system. DCFS records also show the CSWs referred a total of 250 children for forensic exams. However, as the Compton and Vermont Corridor offices regularly submit forensic referrals to the MLK Hub, a notification process would have been needed in order for DHS to track the forensic referrals resulting from this pilot. These implementation issues highlighted the complexity of effectively sharing data electronically across departments, as well as the need for additional training to ensure the referrals are properly coded. (Tables 4 and 8).

Table 8: PHN Referred Medical Assessment Appointment Status

	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Total
MLK Hub PHN Referrals								
Medical Assessment Referrals	**13**	**26**	**34**	**10**	**15**	**17**	**11**	**126**
Completed MLK Hub visits	10	12	20	10	8	10	6	76
No shows and never completed	0	3	10	1	1	5	0	20
Unable to schedule/declined	2	8	3	0	1	1	1	16
Referrals completed Mar-16								14

Of the 126 children the MLK Hub scheduled for an assessment, 76 (60%) resulted in a completed visit by the end of the reporting period, and 36 (29%) never completed their visit due to not showing up to their scheduled appointments, Hub staff being unable to reach the parent/caregiver to schedule, or the parent/caregiver declining services. Several reasons could account for the roughly one-third of the referrals not completing their assessment, such as the family already had a primary health care provider or the referral had been closed and a case was not opened. However, it is concerning that 16% of the appointments for a PHN referred medical assessment were no shows, which means changes to the referral or follow-up process are needed to help ensure the child receives the assessment and also eliminate the unnecessary cost of a no show at the Hub.

Fig. 5: Children Referred to the Hub (n=117)



In addition to the training needs mentioned above, a need to increase consistency between Offices was noted. As mentioned earlier, the data also reflects differences in the number of referrals between the Compton and Vermont Corridor Offices. Figure 3 shows that PHNs from the Vermont Corridor Office identified 45% of their children as having unmet needs, while the Compton Office identified 35% of their children as having unmet needs. Figure 5 shows that of the 117 children referred to the MLK Hub for medical assessments, approximately 79% were referred from the Vermont Corridor Office and 21% were referred from the Compton Office. Although assessments were individualized and some fluctuation in percentages would be expected, the variance seems to indicate that further training to create greater consistency across the Offices would be beneficial.

Staffing

The original premise behind the creation of this joint visitation program was that the inclusion of medical professionals (i.e., PHNs and Hub staff) during investigations would improve the decision-making process and safety of the children being assessed. For this program, the strengths that the PHNs add are unable to be fully utilized, as the PHNs are not allowed, under their funding stream restrictions, to provide clinical services during a visit. The funding streams used for these PHNs require that they only provide non-clinical, consultation, medical care planning, or care coordination services, with neither a DCFS PHN nor a DPH PHN able to physically touch a child or provide direct patient care during a visit. If it is determined that the function of the PHN should change to fully utilize their medical skills, other funding avenues would need to be identified.

To help determine the number of PHNs initially needed for this pilot, the May 14, 2015, Board memo "Public Health Nurse Staffing Models" discussed three staffing options for consideration. The Compton Office was staffed with nine PHNs, which was option three of the model, with an estimated cost of $25 million if implemented Countywide. The Vermont Corridor Office was staffed in-between options two and three with seven PHNs, with an estimated cost of $19.6 million if implemented Countywide.

Table 9 reflects the staffing levels of PHNs and the number of assessments completed. The Compton Office was staffed for an anticipated caseload of 31 children per month, yet their actual average caseload was only 24 children. The Vermont Corridor Office was staffed for an anticipated caseload of 40 children a month, yet their actual average caseload was only 30 children. Although the number of children assessed each month was below the thresholds originally envisioned for this level of staffing, the majority of non-joint visits occurred when the referrals to the Vermont Corridor Office were at some of the highest levels. (Table 10).

Table 9: Average Number of Child Assessments Completed by PHNs per Month

Office	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Totals
Compton (9 PHNs)								
Total No. of Children	188	246	288	192	159	181	222	1,476
Assessments Per PHN	21	27	32	21	18	20	25	164
Vermont Corridor (7 PHNs)								
Number of Children	161	251	249	206	193	199	191	1,450
Assessments Per PHN	23	36	36	29	28	28	27	207

Table 10: Number of Assessments for Referral for Forensic Evaluation

Office	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Totals
Compton (9 PHNs)								
Referrals for Child <2yr	86	72	90	57	63	64	66	**498**
CSW Forensic Referral	7	10	6	2	1	8	7	**41**
PHN Input in Referral	7	9	6	2	1	8	7	**40**
Vermont Corridor (7 PHNs)								
Referrals for Child <2yr	103	92	94	76	82	93	79	**619**
CSW Forensic Referral	17	20	5	6	8	5	7	**68**
PHN Input in Referral	5	5	1	6	7	4	7	**35**

While much of the time the PHN staffing levels appeared to be high, the numbers indicate that the staffing levels in the Vermont Corridor Office were not sufficient during periods of high demand for a PHN to accompany the CSW on a joint visit. With an estimated cost of $19.6 million to implement the Vermont Corridor's staffing option Countywide, the ability to leverage other available PHNs to alleviate the overflow and provide coverage when needed would allow other staffing options to be considered for this program.

Conclusion

The original concept of having a PHN join the CSW during their investigation was to increase safety through the inclusion of a health professional for additional assessment. While the joint visits occurred for 97% of the referred children under 2 years of age, there is no clear data to indicate whether or not this initiative helped to improve the safety of these children. At best, meetings with participants in the program anecdotally suggest rare situations where the PHNs may have impacted safety.

What the data showed was frequent referrals for health needs, such as: 1) educating parents on health issues; 2) medical evaluations; 3) co-sleeping/unsafe sleeping; 4) dental services; and 5) immunizations. The MLK Hub identified a significant number of families without health insurance (27% of the 55 children sampled), and provided medical services to those families and referred them to DPSS for Medi-Cal coverage.

Other issues identified through this initiative were: 1) the need for electronic data sharing to improve the ability to track people referred between DCFS and DHS for care coordination; 2) training to promote consistent practices and reduce the disparity of referrals between the involved DCFS Offices; 3) the use of other staff to supply the referrals, instead of high level PHNs; 4) the short time-frame to close hotline referrals did not allow the PHNs time to build the relationship with the family or follow-up with the families for whom health care referrals were made; 5) the high percentage (29%) of children that did not show-up for scheduled appointments or were not able to be scheduled and/or declined service at the Hub; and 6) the cost to replicate the program Countywide and the inability to leverage staff as needed to meet the demands of the program.

Since implementation of the program demonstrated more of an impact on early intervention instead of safety, a decision needs to be made whether this is a sufficient basis to continue this program. Based on the information received, both quantitative and qualitative, the OCP recommends this program should end. Although there are holistic benefits to families with the PHNs making referrals to the Hub and other entities, much of this can be done by the CSW. In addition, enhanced training should be provided to the CSWs, which would include possible medical signs (e.g., size and weight of child that would trigger the request for a PHN (joint) visit). Given that funding resources limit the number of available PHNs, rather than going out on every case, the PHNs should only go out on Hotline calls when a medical issue is identified or when the CSW feels a medical-based observation may be warranted.

As there is demonstrated value in having PHNs involved in child welfare in some capacity, the OCP is recommending exploration of a more global approach at how PHNs can be more effectively utilized within the limited resources. That would include exploring how the monitoring and oversight of psychiatric medications and identified best practices could fit into the overarching plan for PHNs.

In addition, there is consensus that the DCFS PHNs and DPH PNHs need to be consolidated under one department. Consolidation would: 1) provide the children with continuity of care from the PHNs prior to

opening a case through case closure, instead of being divided between DCFS PHNs at the front end and DPH PHNs at the back; 2) eliminate service delays which occurred when the DPH PHNs were not aware when cases were opened; 3) consistency in trainings received by the PHNs, which differs between departments; and 4) provide possible operational efficiencies. DPH was chosen as the department in which to consolidate the PHN program as: 1) the PHNs' focus is in public health regardless of the target population being served; 2) DPH hosts regular, on-going training for their PHNs; 3) DPH has a direct link to many of the resources the PHNs need for their jobs, such as environmental health, substance abuse programs, and Nurse Family Partnership; and 4) DPH provides increased access to medical consultation resources, such as Nursing Directors. Also, several of the issues identified during implementation could be resolved for any future program design, including more easily sharing data electronically between the Hubs and PHNs; trainings already offered by DPH; and more easily leveraging staff, who are under one department. Therefore, it is recommended that the PHNs be consolidated under DPH.

The OCP will continue to work with DCFS, DPH, DHS and DMH to further explore the best and most effective use of PHNs in child welfare to improve safety outcomes, as well as ensure linkages for needed services are made. The OCP will report back to the Board on the any proposed program.