# COUNTY OF LOS ANGELES
# OFFICE OF CHILD PROTECTION

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December 8, 2017

To: Supervisor Sheila Kuehl, Chair
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Janice Hahn
Supervisor Kathryn Barger

From: Judge Michael Nash (Ret.)
Executive Director, Office of Child Protection

**THE 90-DAY PROGRESS REPORT ON THE CONSOLIDATION OF THE DEPARTMENT OF CHILDREN AND FAMILY SERVICES' PUBLIC HEALTH NURSE PROGRAM WITHIN THE DEPARTMENT OF PUBLIC HEALTH**

On September 13, 2016, the Board of Supervisors directed the Office of Child Protection (OCP), in collaboration with the Chief Executive Officer (CEO), Department of Children and Family Services (DCFS), Department of Public Health (DPH), and applicable unions, to consolidate the DCFS Public Health Nurse (PHN) program within DPH. With the purpose of building a PHN program that promotes and improves child well-being, health, and safety, the Board specifically directed the OCP to:

1. Engage all affected stakeholders, including, but not limited to, the CEO, DCFS, DPH, and the applicable unions, in discussions relating to the plan, progress, and desired outcomes of the consolidation
2. Direct the CEO to identify funding should any costs related to the transition accrue, to ensure cost neutrality for DPH
3. Determine, using both anecdotal and evidence-based practices and research, how to most effectively utilize the PHN program for the purposes of child welfare and safety, once it is transferred to DPH
4. Provide progress reports every 90 days on the efforts and outcomes relating to the consolidation

This is our fourth and final report-back on the consolidation efforts. As of July 1, 2017, the Department of Children and Family Services' Public Health Nursing program was consolidated into the Department of Public Health within the Children's Medical Services Branch, and became the Child Welfare Public Health Nurse Program (CWPHN). The

programs were consolidated "as is," with the expectation that the OCP would work post-consolidation with the other stakeholders to make recommendations for the best uses of Public Health Nurses in child welfare.

## BACKGROUND

In child welfare, ensuring the safety of children—in their family homes or in care—is of the utmost importance. If children are removed from their homes because of abuse or neglect, the County must safeguard their continuing good health and also help them and their caregivers with new or ongoing health challenges. For youth in the child welfare system, PHNs play an important part in carrying out that County responsibility, taking on multiple roles that include health care consultant, care coordinator, medical record manager, and advocate for a child's medical needs.

### Allowable PHN Activities

Monies used to fund PHNs have restrictions that prohibit PHNs from providing direct medical services to the children; in other words, they are unable to physically touch children.

According to Welfare and Institutions Code section 16501.3:

> *(a) . . .The purpose of the public health nursing program shall be to promote and enhance the physical, mental, dental, and developmental well-being of children in the child welfare system.*
>
> *(b) Under this program, counties shall use the services of a foster care public health nurse. The foster care public health nurse shall work with the appropriate child welfare services workers to coordinate health care services and serve as a liaison with health care professionals and other providers of health-related services. This shall include coordination with county mental health plans and local health jurisdictions, as appropriate. In order to fulfill these duties, the foster care public health nurse shall have access to the child's medical, dental, and mental health care information, in a manner that is consistent with all relevant privacy requirements.*
>
> *(c) The duties of a foster care public health nurse shall include, but need not be limited to, the following:*
>
> > *(1) Documenting that each child in foster care receives initial and followup health screenings that meet reasonable standards of medical practice.*
> >
> > *(2) Collecting health information and other relevant data on each foster child as available, receiving all collected information to determine appropriate referral and services, and expediting referrals to providers in the community*

*for early intervention services, specialty services, dental care, mental health services, and other health-related services necessary for the child.*

*(3) Participating in medical care planning and coordinating for the child. This may include, but is not limited to, assisting case workers in arranging for comprehensive health and mental health assessments, interpreting the results of health assessments or evaluations for the purpose of case planning and coordination, facilitating the acquisition of any necessary court authorizations for procedures or medications, monitoring and oversight of psychotropic medications, advocating for the health care needs of the child, and ensuring the creation of linkage among various providers of care.*

*(4) Providing followup contact to assess the child's progress in meeting treatment goals.*

*(5) At the request of and under the direction of a nonminor dependent, as described in subdivision (v) of Section 11400, assisting the nonminor dependent in accessing physical health and mental health care, coordinating the delivery of health and mental health care services, advocating for the health and mental health care that meets the needs of the nonminor dependent, assisting the nonminor dependent to make informed decisions about his or her health care by, at a minimum, providing educational materials, and assisting the nonminor dependent to assume responsibility for his or her ongoing physical and mental health care management.*

**PHN Service Areas**

Under the combined CWPHN program, there are four service categories for PHNs: Emergency Response, Continuing Services, Health Care Program Services for Children in Foster Care (HCPCFC), and Medical Hub services (as shown in Table 1).

| Table 1: PHN Service Areas | |
|---|---|
| FRONT-END SERVICES | **I. Emergency Response (which also includes the Children's Social Worker (CSW)–DPH Joint Visitation pilot)**<br>Emergency response nurses work with children's social workers to address the needs of children and youth reported through the hotline and requiring an Emergency Response investigation into reports of potential abuse or neglect. These investigations usually occur within the home. Since they are supposed to close within 30 days, no ongoing services are associated with this component.<br>• Under the CSW-PHN Joint Visitation Pilot, located within the Compton and Vermont Corridor offices, the PHNs must accompany the CSW when there is a child under two years of age involved.<br>• For all other regional offices, PHNs accompany CSWs upon request for visits where a medical issue is disclosed during the hotline call or is known to DCFS. |
| | **II. Continuing Services (Family Maintenance, Voluntary Family Reunification, Medically Fragile)**<br>These case-carrying nurses provide Continuing Services/Family Maintenance for children and families requiring ongoing monitoring and support while the child/youth remains in the home of a parent. |
| BACK-END SERVICES | **III. Health Care Program for Children in Foster Care (HCPCFC)** (court-supervised children in out-of-home placement)<br>These case-carrying nurses address the medical needs of the approximately 20,000 children and youth placed in foster care and/or juvenile hall. |
| COMBINED | **IV. Medical Hubs**<br>Nurses are stationed in seven Medical Hubs (Department of Health Services facilities) to coordinate referrals for children and youth involved in the child welfare system, and maintain the flow of relevant information between the medical hubs and referring social worker/nurse teams. These PHNs do not carry cases. |

With the exception of Compton and Vermont Corridor, the PHNs co-located in DCFS regional offices provide "front-end services" that include both Emergency Response services and Continuing Services caseloads.

In the Compton and Vermont Corridor regional offices, the CSW-PHN Joint Visitation pilot splits PHN duties among Emergency Response for children under two years old, Emergency Response for all others, and Continuing Services cases. The transfer of the DCFS PHN program into DPH did not change the PHN roles, and they have continued "as is."

## STAFFING CHANGES UNDER CONSOLIDATION

The Board of Supervisors adopted the Fiscal Year (FY) 2017–18 Final Budget on June 26, 2017, and the Supplemental Budget on September 26, 2017. These actions moved forward the consolidation of the DCFS PHN program into DPH effective July 1, 2017. Table 2 reflects staffing for the two departments and additional positions added to the CWPHN program as a result.

| Table 2: Staffing | DCFS | | | DPH | | | New Items | | |
|---|---|---|---|---|---|---|---|---|---|
| Title Description | Ordinance | Budgeted[1] | Vacant | Ordinance | Budgeted | Vacant | Ordinance | Budgeted | Vacant |
| Assistant Nursing Director | | | | | | | 1 | 1 | 1 |
| Nurse Manager | 1 | 1 | | 1 | 1 | | 1 | 1 | 1 |
| PHN Program Specialist | 1 | 1 | | | | | | | |
| PHN Assistant Program Specialist | | | | 1 | | 1 | | | |
| Nursing Instructor | | | | 2 | 2 | | 2 | 2 | |
| PHN Supervisor | 13 | 13 | 1 | 8 | 8 | | 1 | 1 | |
| PHN | 92 | 92 | 14 | 77 | 71 | 8 | 9 | 9 | 3 |
| ITC | 8 | 8 | 3 | 8 | 8 | | 5 | 5 | 5 |
| **TOTAL** | **115** | **115** | **18** | **97** | **90** | **9** | **19** | **19** | **10** |

[1]This includes the 17 PHNs and 3 PHN Supervisors for the CSW-PHN Joint Visitation pilot that DCFS agreed to fund for 2 years following consolidation.

As part of the Board actions:

- The DCFS PHN program (115 items) was transferred into DPH. Twenty of those items were assigned to the CSW-PHN Joint Visitation program pilot, which DCFS agreed to fund for up to two years following consolidation, pending the outside evaluation report and determination by the Board.
- Five positions were added to ensure the success of the combined program: one Assistant Nursing Director, two Nursing Instructors, one Nurse Manager, and one Secretary II.
- DPH identified the need for five new Intermediate Typist Clerk (ITC) positions (one clerical staff per Supervising PHN) to reduce the amount of time PHNs spend doing clerical-type duties and allow for the prioritization of key PHN services.
- State funding of $2.2 million was accepted by DPH to add nine PHNs and one PHN Supervisor for the monitoring of psychotropic medication and oversight activities to meet the requirements of Senate Bill No. 319.

Not included in Table 2 are any positions resulting from the FY 2017–18 State HCPCFC funding augmentation of $3.84 million outlined in the CEO's July 5, 2017 memo. (As of November 17, 2017, the funding allocation letter has not yet been issued.) With the inclusion of the enhanced federal match, the augmentation could total an estimated $15.4 million statewide. DPH is estimating that the County's share may equal an additional $5.2 million (state/federal) on top of its current $11.0 million allocation to help reduce caseload sizes for the HCPCFC program.

In sum, a total number of 172 PHNs are budgeted (both DCFS and DPH); of those, there are 19 vacancies (16 from the combined CWPHN program and 3 PHNs approved for psychotropic medication monitoring). The need for additional PHNs beyond those, including the consideration of staffing ratios for CSWs and PHNs, is subject to evaluation.

## BEST USE OF PHNs DETERMINATION

### Process

To determine the best use of PHNs in child welfare, we collected both quantitative and qualitative data by convening focus groups and workgroups that included representatives of the PHNs, PHN Supervisors, Nursing Managers, Children's Social Workers (CSWs), Supervising CSWs, Regional Administrators, other DCFS staff, other DPH staff, Medical Hub physicians, Board offices, the Alternate Public Defender, Children's Law Center, medical directors, and Service Employees International Union (SEIU) 721. Several relevant reports and recent legislative changes were also reviewed to help identify the key services needed from PHNs working in child welfare.

### Findings

*Relevant Legislative Changes*

Legislative changes resulting from two California Senate Bills created additional responsibilities for PHNs in psychotropic medication monitoring and services for transition-age youth (TAY).

- Senate Bill 319 (Chapter 535, Statutes of 2015) authorized the foster care public health nurse to monitor and oversee the child's use of psychotropic medications, receive health care and mental health care information, and required PHNs to assist non-minor dependents to make informed decisions about their health care.

- Senate Bill 238 (Chapter 534, Statutes of 2015) required the Judicial Council to amend and adopt the rules of court and revise the forms to be completed for the approval and oversight of orders for psychotropic medications for system-involved children to include PHN input.

*Current PHN Practices Working Well*

Based on the information gathered, the areas where the PHNs appear to offer the most value are:

- Consultations between CSWs and PHNs when acting on emergency response call allegations of medical neglect and specific health issues, and in explaining the child's various health-related conditions to CSWs in lay terms

- Explaining to the parent/caregiver their child's medical needs, how to read medical records, how to monitor and treat their child's common illnesses (such as asthma and diabetes), explaining the child's hospital discharge requirements and the benefits of certain health practices, and stressing the importance of following through with ongoing medication prescriptions and appointments

- Their role in psychotropic medication monitoring in meeting the Court's Psychotropic Medication Monitoring protocol and the monitoring requirements outlined by Senate Bill 319

*Current PHN Practices Needing Improvement*

Several challenges were identified by stakeholders, which included the following.

- Staffing realignment is needed to optimize the use of PHNs.
  - PHN workloads are high and vacancies are not being filled, adversely affecting productivity and increasing overtime usage.
  - Additional clerical support is needed for obtaining records and inputting information into the database.
  - The Medical Hub PHNs' role needs to be clearly defined, as their functions vary by Hub and not all services are related to the CWPHN requirements (Attachment I).
  - PHNs provide non-child–specific trainings, pulling them away from services that directly benefit the CSW, child, and caregiver.

- Rules are confusing with regard to when PHNs can visit a child's home and why some PHNs can visit on their own without being accompanied by a CSW.

- Delays with acquiring medical records affect the ability of DCFS to close referrals in a timely manner.
  - Medical providers have 30 days to respond after their receipt of a signed authorization request to provide records under the Health Insurance Portability and Accountability Act (HIPAA).
  - Medical records received are sometimes incomplete, and additional requests must be made to obtain the child's full record.

- The Health and Education Passport (HEP) system is not being kept up to date because of insufficient staffing for the amount of data entry required and the time it takes to access the information.

- Insufficient PHN resources support transition-age youth (TAY).

- Service gaps caused by changes in placement and a lack of communication around those placement changes must be eliminated when a child has ongoing medical needs.

- There is confusion among CSWs as to the role of PHNs in the regional offices. There is likewise confusion among PHNs on how to best support CSWs and the children they serve.

*Outside Evaluation of the CSW-PHN Joint Visitation Project Pilot*

On February 21, 2017, the County entered into a no-cost agreement with the University of Southern California's Children's Data Network (CDN) for the evaluation of the CSW-PHN Joint Visitation Project pilot. This pilot, which paired a PHN with a social worker to "improve and enhance DCFS' investigative processes" and to help prevent child maltreatment, was approved by the Board on January 13, 2015. To conduct this evaluation, CDN reviewed data from calendar year 2016 for the two pilot offices in Compton and the Vermont Corridor. Data from the Wateridge office was also reviewed to provide a comparison group, as clients served in all three offices were similar with respect to age, sex, and prior family involvement with DCFS.

The evaluation (see Attachment II) assessed changes in child safety after the joint pilot visit occurred by following the participating children for four months after their referrals were closed. It concluded that:

> *The primary goal of the program recommended by the Blue Ribbon Commission was to improve child safety. Looking four months out, this analysis shows that participation in the pilot project did not reduce subsequent child welfare referrals, case openings, or out-of-home placements—key indicators of child safety.*
>
> *Anyone who works in the child welfare system understands that the families it serves face complex challenges, often with very limited personal, financial and social resources. The systems in place to help these families are equally complicated, particularly in a large metropolitan area like Los Angeles County with its multiple jurisdictions, organizational silos, and complex service delivery systems. There is little evidence that this program, taken on its own, without consideration of simultaneous internal reform efforts or external changes in community service or support systems, had the desired effect on child safety. While there were very likely benefits for the families served as a result of the hard work of the staff, their efforts were undertaken in the context of a large system where many things needed to change at once in order to achieve measurable differences in child safety.*

**Key PHN Services Identified**

Within the child welfare system, the CSWs hold the main responsibility to protect children from situations of abuse, neglect, and maltreatment; determine the appropriate child-

welfare service needs for the child and the family; and focus on ensuring the social, emotional, physical, and psychological well-being of the children under the County's care. PHNs are one of the vital partners available to assist CSWs in ensuring that the child's medical, mental, dental, and developmental needs are being met by the child welfare system.

The key PHN services shown in Table 3 were identified as critical because they address vital aspects of physical safety and well-being for the child, meet important changes in the law, and support the needs of the CSW.

| **Table 3: Key Identified PHN Services in Child Welfare** |
|---|
| • Consult with CSWs on medical questions during an investigation or when working with a child. |
| • Go on visits with CSWs or on their own, as requested or needed. |
| • Help CSWs and family/caregivers understand the child's medical records. |
| • Offer advice to parents or caregivers on how to meet the medical needs of the children in their care. |
| • Help monitor the administration of psychotropic medications. |
| • Work with TAY to ensure that they are able to make informed decisions regarding their medical needs. |
| • Maintain some continuity and ongoing contact with the families they work with that is not conditional on placement status or service delivery phase. |
| • Oversee the acquisition of medical records for CSWs, and also the timely data entry of medical information and notes into the HEP. |

## Recommendations for the Best Use of PHNs Moving Forward

1. PHNs should continue to provide the key services identified in Table 3 that are currently effective, which include consulting with CSWs when they have medical questions, helping CSWs and family/caregivers understand the child's medical record, offering advice to parents/caregivers on how to meet the medical needs of children in their care, and monitoring psychotropic medication use by foster youth under the court's protocol and the requirements of Senate Bill 319.

2. In light of the evaluation findings from Children's Data Network, eliminate the CSW-PHN Joint Visitation Pilot, reallocate these PHNs based on business needs, consider staffing needs, and ask the CEO to determine if a permanent funding stream is needed for these positions.

    - The termination of this pilot does not affect joint visits conducted for identified medical issues per DCFS policy; the unmet needs of families will continue to be addressed through the implementation of the County's prevention plan, *Paving the Road to Safety for Our Children: A Prevention Plan for Los Angeles County,* released in June 2017.

3. If it is determined that a home visit by a PHN is warranted, whether to help stabilize a placement or because of medical necessity, PHNs need to be able to visit a home either on their own or with a CSW. DPH, DCFS, and PHN representatives should re-evaluate DPH's policy (mandating that CSWs accompany PHNs when visiting a home) to determine if the basis for the policy is still valid and reflects best practices.

4. CWPHN clerical staff should obtain all available medical records for the CSWs. The PHNs and their clerical staff should be granted access to systems such as the Los Angeles Network for Enhanced Services (LANES), the Department of Health Services' Online Real-time Centralized Health Information Database (ORCHID), the Integrated Behavioral Health Information System (IBHIS), and/or other applicable systems, as allowed by law, to obtain the information necessary for PHNs to fulfill their duties.[1] However, until this access is provided, collecting medical records should be done by ITCs, with PHN input and oversight, to speed up the process.

5. Clerical staff at an appropriate level (to be determined) should enter data into the HEP[2], including any prescription information, to expedite data entry. PHNs should review the entries for accuracy and add their nursing notes into the system in easy-to-understand language.

6. PHNs should work with all TAY to help them make informed decisions about their health care once they leave the system. Medical Hub PHNs and case-carrying PHNs with TAY in their caseloads should always offer to explain the youth's medical records and discuss their health needs, including reproductive health information. In addition, a PHN should be available part-time at the DCFS Youth Development Services division to meet with TAY when needed.

7. DPH and DCFS should develop a program to allow the same PHN to provide services to the child as the child moves through the system, from the front end to the back end, to improve continuity of care. This program could be designed after a previously successful DCFS pilot that tested this service model but was discontinued because DPH was unable to claim the work provided by their PHNs for HCPCFC funding. We understand that audit concerns by the State Department of Health Care Services exist around the braiding of DCFS and HCPCFC funds for PHN services. Therefore, DPH should seek approval for a waiver and/or agreement to allow HCPCFC funding flexibility to enable HCPCFC-funded PHNs to serve all child welfare populations.

[1] The foster care public health nurse shall have access to the child's medical, dental, and mental health care information, in a manner consistent with all relevant privacy requirements, as allowed under Civil Code §56.103 and Welfare and Institutions Code §§ 5328.04 and 16501.3.

[2] Child Health and Disability Prevention Program letter #17-05, states, "The PHN, Social Worker, and/or clerical support update the Child Welfare Services/Case Management System Health and Education Passport, including prescribed medications."

- In the interim, DPH and DCFS should develop a protocol to ensure that PHNs know when a referral is closed and a case is opened so that communication and continuity of care is maintained during case transitions.

8. Nursing Instructors hired as part of the DCFS PHN consolidation into DPH should provide generic PHN trainings for non-child–specific issues.

9. Medical Hub PHN duties should be refocused to meet CWPHN program responsibilities, including those key services identified in Table 3 (page 9 of this document) that can be provided in the Hubs.

10. More home visitation services are needed within the County to help strengthen families that come into contact with the child welfare system, as identified in the County's Prevention Plan. DPH is currently working on a design to expand and maximize the home visitation services available countywide. CWPHN program staff should be used to help identify those families who would benefit most from voluntary home visitation services. These PHNs could provide referral services, baseline assessments, or some home visits to these families to help address their underlying needs.

**CONCLUSION**

It is clear that PHNs provide a wide array of essential services that help the child welfare system perform better as a whole. To maximize this partnership between DCFS and DPH, CSWs and PHNs need to be clear about their responsibilities within this system, have mutual respect for each other's roles, and know who is assigned to their cases. Ultimately, the best use of PHNs will depend on the interactions between the CSWs and PHNs and the continued support of their departments to set the right conditions for their success.

Unless we hear otherwise from your Board by January 8, 2018, we will move forward with implementing the recommendations. If you have any questions, please contact me at (213) 893-1152 or by e-mail at mnash@ocp.lacounty.gov, or your staff may contact Karen Herberts at (213) 893-2466 or by email at kherberts@ocp.lacounty.gov.

MN:CDM
KMH:eih

Attachments (2)

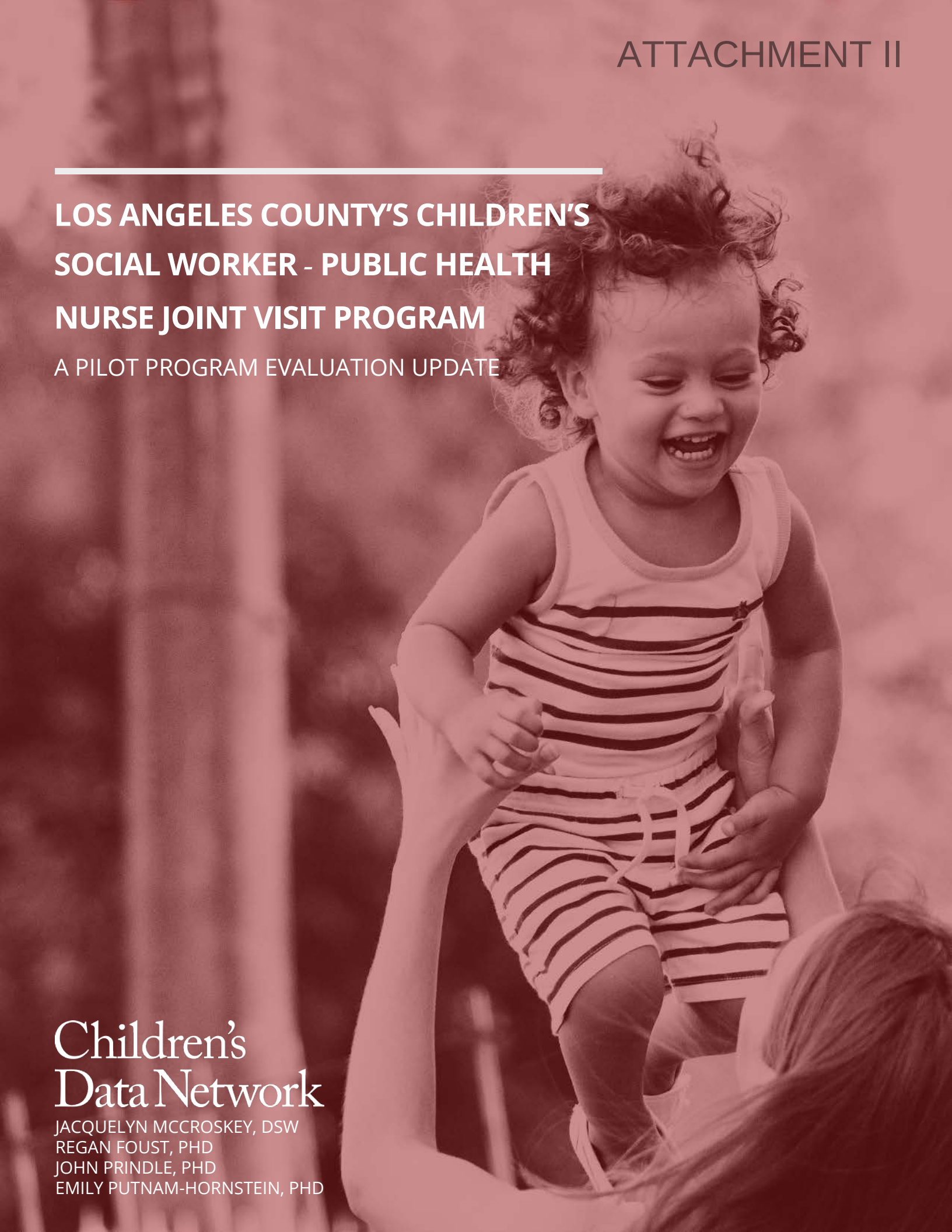
c: Chief Executive Office
Executive Office, Board of Supervisors
County Counsel
Children and Family Services
Public Health
Health Services

| CURRENT PUBLIC HEALTH NURSE SERVICE INTERVENTIONS | |
|---|---|
| **ER, Continuing Services, and HCPCFC PHN** | **HUB PHNs** |
| **Consultations**<br>• Consultations—initial and follow-up consults with CSW, SCSW, MD, or PHN on child<br>**Health Assessment/Documentation**<br>• Physical/dental exam—obtain records, assess for missing information, follow-up, and review<br>• Medical home—assess if medical home; if none, refer to nearby providers<br>• Immunization records—obtain immunization records, provide education to caregiver on need<br>• Health and Education Passport (HEP)—create or update HEP with current medical/dental/psychological/developmental information received<br>• Home/office/hospital/school visit—consultation to determine if visit is warranted for a child with any medical, developmental, psycho-social, chronic-disease, specialized case management, or recurring medical issues (for the CSW-PHN Joint Visitation pilot, the determination is based on age). During the visit, assess each child (visual head-to-toe), safety, home environment (if applicable), and any unmet needs. Provide resources and education to the family and child as needed.<br>• Hospitalization—if child is hospitalized, PHN contacts the hospital weekly for updates on child's health status and to assist with discharge planning.<br>• JV-220 / PMA—PHN reviews information and contacts the CSW and provider if JV-220 is not current<br>• F-Rates/AAP-Rates—Determination of rates or training on rates<br>• DCFS 561 (a-health care provider, b-dental care provider, or c-mental health provider) forms reviewed and assessed<br>• PM160—review billing form for medical information<br>• Referrals—referrals to specialty providers and community partners to address child's health care needs<br>**Health Education/Training**<br>• Education—assess the family's and child's needs, research, and provide verbal and/or written education to assist with the follow-up of disease process, treatment, resources, etc., to ensure understanding and for preventative measures<br>• Training—Training provided can be child-specific or disease/treatment-focused, and provided to CSW, caregivers, and the community regarding disease, treatment, and nutrition<br>**Communication**<br>• Communication—emails, phone, faxes, or in-person communications<br>**Meetings**<br>• Collaboration—participate and prepare for DCFS Multidisciplinary Assessment Team, critical-incident, Child/Family Team meetings that are scheduled and formal with a written summary plan from coordinator<br>• Meeting—non-child –specific meetings; e.g., administrative, unit meetings<br>**Reports**<br>• N2N Report—report from nurse to nurse when a case is transferred<br>• Critical incident—follow-up<br>• Critical fatality—follow-up | **Hub Appointment Preparation**<br>• CWS/CMS—review to determine referral/case status; CWS/PHN assignment re placement<br>• Health and Education Passport—research, retrieve, review, print, and attach to e-mHub<br>• CSW/PHN—contact to request additional information<br>• DCFS 561—review document<br>• CAIR—retrieve, review, and/or print immunization records<br>• Medical records—retrieve, review, and attach to e-mHub<br>• PHN assessment tool—retrieve, review, and attach to e-mHub<br>• Consultations—consult with Hub providers and/or caregivers<br>**e-mHub Review**<br>• Status review—lab results, scheduled appointments, and appointment compliance<br>**Miscellaneous**<br>• Birth records—request records<br>• HIV consent—obtain, retrieve, or request copy<br>• Form 179—request parental consent and authorization for medical care and release of educational records form<br>• Regional Center—follow-up as needed<br>• Medical coverage/benefits—follow-up as needed<br>• 4158 authorization—retrieve (General Medical Care) from CSW (court order) |

ATTACHMENT II

# LOS ANGELES COUNTY'S CHILDREN'S SOCIAL WORKER - PUBLIC HEALTH NURSE JOINT VISIT PROGRAM

A PILOT PROGRAM EVALUATION UPDATE



Children's Data Network

JACQUELYN MCCROSKEY, DSW
REGAN FOUST, PHD
JOHN PRINDLE, PHD
EMILY PUTNAM-HORNSTEIN, PHD

## LOS ANGELES COUNTY'S CHILDREN'S SOCIAL WORKER – PUBLIC HEALTH NURSE JOINT VISIT PROGRAM: A PILOT PROGRAM EVALUATION UPDATE

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John Prindle, PhD
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### ACKNOWLEDGEMENTS

We wish to acknowledge collaborating colleagues at the LA County Departments of Children and Family Services, Health Services, Mental Health, and Public Health, the Los Angeles County Office of Child Protection (OCP) and the Children's Data Network at the USC Suzanne Dworak-Peck School of Social Work; Regan Foust and Jonathan Hoonhout managed the project and report production and Rose Bridges designed the report.

Finally, we wish to thank Armando Jimenez and First 5 LA, as well as Jeannine Balfour and the Conrad N. Hilton Foundation, for investments in generating new knowledge through administrative data.

### PROJECT OVERVIEW

The Children's Data Network (CDN) is a university, agency, and community collaborative focused on the integration and application of data to inform programs and policies for children and their families. The CDN receives essential infrastructure funding from First 5 LA and the Conrad N. Hilton Foundation, additional project support from the Robert Wood Johnson Foundation, the Laura and John Arnold Foundation, and the California Department of Social Services, and operates in partnership with the California Child Welfare Indicators Project at UC Berkeley.

## INTRODUCTION

On June 13, 2015, the Los Angeles County Board of Supervisors directed the Chief Executive Officer (CEO) and Directors of the Departments of Children and Family Services (DCFS), Health Services (DHS), Mental Health (DMH), and Public Health [DPH] to implement a pilot project that would pair Children's Social Workers (CSW) with Public Health Nurses (PHN) when conducting maltreatment investigations for families with children under two years old. A little over a year later, on June 30, 2016, the Office of Child Protection (OCP) issued the first status report on the program including data describing the first seven months of program operation, August 2015 through February 2016. The following update, developed by the Children's Data Network (CDN) at the University of Southern California's Suzanne Dworak-Peck School of Social Work,[1] extends the evaluation timeframe for the CSW-PHN Joint Visit Program, including descriptive data and initial data on program outcomes during calendar year 2016.

## BACKGROUND

The final report of Los Angeles County's Blue Ribbon Commission on Child Safety (Blue Ribbon Commission on Child Safety 2014) included two recommendations designed to leverage the county's health system to help prevent child maltreatment. The Commission recommended that "the skills and expertise of Public Health Nurses should be used to improve and enhance DCFS's investigative processes" by pairing PHNs with CSWs when conducting child neglect or abuse investigation for infants under 12 months old. This recommendation was based on data showing that very young children were more likely to be re-referred to the DCFS child protection hotline, and Commission discussion about improving child safety through timely information about the developmental, medical, and mental health issues that may be involved. The Commission also recommended expanding the population of young children eligible to receive medical assessment and services through the established County-wide system of Medical Hubs by including those whose families were under investigation due to allegations of abuse or neglect as well as the smaller number of children who were detained by child protective services subsequent to an investigation. A decision was later made to expand the age range of eligible children so that families with children under age two referred to the DCFS child protection hotline with an allegation of child abuse or neglect, and determined to require an investigation, should receive a joint visit from a CSW-PHN team.

[1] Data were shared with the CDN in accordance with a Delegated Authority Agreement between OCP and CDN for no cost services to provide evaluation support and technical assistance.

The overall emphasis of the BRC was on creating a roadmap for a more integrated and effective multi-departmental system designed to assure child safety, breaking down the silos that get in the way of coordinated and effective responses to complicated family situations. The conceptual design for implementation of the CSW-PHN joint visit program was developed by the CEO and executive managers from affected department (DCFS, DHS, DMH, and DPH) and approved by the Board on January 13, 2015. This design recommended that the program be phased in, beginning with pilot testing in one region of the County. The recommendation was to start with two DCFS offices in South LA -- Compton and Vermont Corridor -- and the Martin Luther King Jr. Outpatient Center (MLK Medical Hub).

## PROGRAM ELEMENTS

Key elements of the CSW-PHN Joint Visit program[2] conceptual design included:

- CSW will be paired with a PHN during investigations of referrals that include a child under 24 months 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 bio-psychosocial 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 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 the 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.

[2] As outlined in the OCP's June 30, 2016 status report.

As a matter of general practice, CSWs refer some children to the local Medical Hub for forensic evaluation in order to receive information from a medical provider with specialized training in detecting and treating injuries from child abuse. Because this program was designed to expand timely access to medical consultation and services, the PHNs were asked to complete an observational assessment tool, The Child Welfare Public Health Nurse Assessment Tool[3]; they can also refer observed children to the MLK Medical Hub for additional screening if, in their opinion, it is medically necessary. While both CSWs and PHNs have responsibilities for referrals and service linkages, it is clear from this outline that CSWs take the lead on casework, identifying safety concerns and unmet needs, while PHNs serve in a secondary capacity assessing and identifying unmet health, parenting, and supportive service needs.

One of the key operational challenges facing the implementation team was that there were two existing groups of PHNs, each of which had applicable skills and experience. While both groups provided similar non-clinical coordination and consultation services to support CSWs, the nurses employed by DCFS could provide coordination and consultation services to non-detained children subject to an investigation, while the nurses working for DPH could only serve children who had been detained and placed in out-of-home settings. Given the ability of DCFS PHNs to work with non-detained children, it was determined that this program should be expanded to support the new pilot project. Fifteen new PHNs and 1 new PHN supervisor were hired to augment an existing staff of 2 PHNs and 2 PHN supervisors.[4] In total, there were 17 PHNs and 3 PHN supervisors involved in the project. Although these nurses would not able to provide clinical services to children as part of the joint visit – a significant limitation in the program's design – they could provide support and consultation to CSWs, assessing needs and offering service referrals and resources to families who were under investigation. In its initial report on the CSW-PHN joint visit program, the OCP recommended consolidation of the two groups of PHNs under the management of a single department. The Board of Supervisors agreed that continuity of care and service effectiveness would be improved under the leadership of a single department. As a result, both groups now report to DPH.

[3] Los Angeles County Department of Children and Family Services. (04/15/2016). See Appendix I.

[4] Eight PHNs were hired for the Compton Regional Office, 6 for Vermont Corridor, plus a PHN and PHN Supervisor for the Emergency Response Command Post. Staffing considerations at each office account for the differences in the number of new staff positions.

Additional challenges recognized during the process of program conceptualization and implementation included the need to: 1) augment capacity of the MLK Hub to meet increased demand; 2) create on-site access at the Hub for DMH staff who would provide crisis intervention and a bridge to community-based mental health treatment; 3) codify protocols and procedures to guide cross-departmental and cross-disciplinary collaboration; 4) provide training and cross-departmental support for both the direct service teams and their affiliated department support staff; 5) develop an assessment tool to be used by PHNs to collect medical and developmental information on children seen in joint visits; 6) establish a set of agreed-upon outcome measures and protocols for collecting different kinds of data by DHS, DMH, and DCFS; and 7) implement an electronic data system design that could track additional data elements unique to this project and not already captured or systematically recorded in California's SACWIS system (Statewide Automated Child Welfare Information System), the Child Welfare Services/Case Management System (CWS/CMS).

Thus, while the CSW-PHN joint visit pilot program began operating in two DCFS offices in August 2015, there were a number of large-scale system issues that were not fully resolved when the program began. Perhaps the most significant of these from the perspective of the Children's Data Network are different departmental approaches to data collection and reliance on manual data collection until well into 2016.

## RESEARCH METHODS

The Children's Data Network was asked to assist the OCP in analyzing existing data to: 1) extend evaluation of the CSW-PHN joint visit program past the first 7 months of operation covered in their initial status report[5]; 2) link program records with administrative data captured in CWS/CMS to assess child safety and well-being outcomes; and 3) provide information on a comparison group of DCFS families who were not included in the CSW-PHN joint visit pilot project. This report covers the 12 months of program operation during calendar year 2016. It draws on data collected by the CSW-PHN teams for all families who received joint visits, records from the MLK Medical Hub for families who received Hub referrals, and data available in CSW/CMS for families in South LA with young children who were referred, investigated, and may have received direct services from DCFS during 2016.

[5] August 3, 2015- February 2016. Office of Child Protection. (June 30, 2016). Children's Social Worker (CSW) – Public Health Nurse (PHN) Joint Visit Initiative report.

It should be noted that the start of any new program is often a difficult time for program evaluation as staff are hired, oriented, and take on new responsibilities. Calendar year 2016 was a particularly difficult year for data analysis because the key departments were keeping manual records during most of the year. An electronic data tracking log system was designed by DCFS and began operating in the fall of 2016. While some PHNs started inputting data into the electronic data tracking log system in October 2016 on a trial basis, all staff began to use the system for their primary data entry at the beginning of November. Reconciling the data collected by manual and electronic data systems proved to be especially difficult, further complicating the usual challenges of tracking a large number of referrals for families with complex problems during the child protective services investigation process. Since there was no shared "dictionary" of data elements collected by multiple players in DCFS Regional Offices, the Emergency Response Command Post (ERCP) and the MLK Hub, the CDN has done its best to align data from multiple sources. This report includes data on all cases served during 2016, but some tables focus on subsets of participating families drawn from manual records, assessment tools, or different service delivery sites, while others are based on linkage of administrative data.

The identification of specific performance and outcomes measures used to evaluate the CSW-PHN project was outlined in the CEO's conceptual project design[6] (CEO, April 13, 2015).[7] As is often the case for pilot projects designed to demonstrate new ways of working, these measures focus largely on program processes, and do not fully reflect discussions held by the BRC that were based on a somewhat broader conception of desired results. Specifically, the overall goal of the CSW-PHN joint visit program was to leverage collaboration between Los Angeles County's child protective services and health systems to increase child safety, while the secondary goal was to enhance child and family well-being. For the purposes of this study, reduced rates of subsequent referrals to child welfare, case openings, and out-of-home placements were used as indicators of child safety. Well-being is much more difficult to measure in the child welfare context, especially given the limitations of available data, but the CDN has been

[6] See Appendix II for a list of initial measures.

[7] Some of these measures were not tracked (or not able to be tracked) by the departments. Specific items that were not tracked are listed in Appendix II as follows: the number of Hub appointments rescheduled and clients requiring transportation assistance (#8 parts 1 and 3); the impact of Hub appointment failures on referral closures (#10 part 3); the number of child fatalities, if any; and the number of children who were referred to services as a result of PHN-generated referrals, but were deemed ineligible by agency or declined services (#15 parts 2 and 3).

able to use project data collected during the PHN assessment and information on referrals to describe some of the factors related to child well-being for children in the pilot project.

The CDN was also able to link pilot project records to administrative data in CWS/CMS to provide a preliminary assessment of child level safety outcomes. For the purposes of this study, reduced rates of subsequent referrals to child welfare, case openings, and out-of-home placements serve as indicators of child safety. We defined a "comparison group" of families with children under age two who were investigated during the same time frame but served by the Wateridge Office, a nearby DCFS Regional Office serving the same Service Planning Area (SPA 6).

## OVERVIEW OF FINDINGS

Almost 16,000 children (N=15,669) under 24 months of age were reported to the Los Angeles County child protective services hotline with allegations of abuse or neglect during calendar year 2016. About one in five (21%) of these referrals were handled by the Regional Offices in SPA 6: Compton (6%), Vermont Corridor (7%), and Wateridge (8%).

Records show that 94% of children seen in the Compton and Vermont Corridor offices who were eligible for a joint visit received one. Between January and September of 2016, CSW- PHN teams visited more than two-thirds (71%) of the families with young children investigated by the Compton and Vermont Corridor offices.[8] These visits also included assessment of the siblings of the referred child. The CSW-PHN teams met with a total of 3,591 children in these families, including both the very young children under age two and their older siblings; this included 1,690 children (47%) under age 2 and 1,901 children (53%) age 2 or older.

To assess changes in child safety following the joint visit, children under two years old with an initial child welfare referral in 2016 were followed for four months after case closing. Findings on re-referrals, case openings, and out-of-home placement are presented in Tables 10-12.[9] Preliminary analysis shows that there was no appreciable difference between families served by the Vermont and Compton offices and similar families served by the Wateridge (comparison) office. In fact, the Vermont (12.4%)

[8] All findings in this paragraph are based on manual data collected between January and September 2016.

[9] Note: Due to data limitations, it was not possible to limit the universe of individuals presented by office to only those who received the joint visitation. For that reason, all children with a referral in 2016 assigned to Vermont or Compton were considered part of the Intervention group. And, as data in Table 0 show, the vast majority of eligible children in these offices received joint visits.

and Compton (8.4%) offices had higher rates of subsequent referrals than the Wateridge office (7.8%).

In terms of improvements to the health and well-being of the children seen, about 12% of the pilot project children were referred to the MLK Hub.[10] CSWs referred 117 young children under age 2 and 148 older siblings for forensic evaluations; PHNs referred 93 children under age 2 and 86 older siblings for medical screening.

PHNs also assessed health and developmental histories of the children they saw, identifying indicators of possible abuse, neglect, and/or risk factors and subsequent need for follow-up. The PHNs found that 41% (699) of children under age two and 42% (793) of older siblings were identified as having unmet needs. The three top unmet needs for children under age two were: 1) limited parent knowledge (21%); 2) need for medical evaluation (17%); and 3) need for dental services (15%). PHNs from the Vermont Corridor Office documented a somewhat higher percentage of unmet needs among the children they saw (50% vs. 36%).

## DEMOGRAPHIC INFORMATION ON CHILDREN UNDER AGE 2 SERVED BY THE PILOT

Almost 16,000 Los Angeles County children under age two (15,669) were reported to child protective services during calendar year 2016. One fifth (21%) of those reports were handled by the three offices in this study: Compton (6%), Vermont Corridor (7%), and Wateridge (8%). See Table 0 for demographic information.[11] Records show that 94% of children seen in the Compton and Vermont Corridor offices who were eligible for a joint visit received one.

The children served by the three offices and by DCFS County-wide were similar with respect to age, sex, and prior family involvement with child protective services (CPS). However, the three program offices served a lower percentage of White children compared to their representation among the DCFS clientele across the county. Specifically, 11% of DCFS clients under age 2 were White, compared to 1% in the Vermont Corridor office and similarly low numbers in the Compton and Wateridge offices. In addition, Black children comprised a larger proportion and Latino children

[10] Note that there is a discrepancy between DCFS and DHS on the exact number of PHN referrals to the Hub due to differences in in data collection.

[11] Note: Only Compton and Vermont offices participated in the CSW-PHN Joint Visit Initiative; Wateridge is presented for comparison purposes

comprised a smaller proportion of the Vermont client population than the other two offices and LA County as a whole.

**TABLE 0: DEMOGRAPHICS FOR LA COUNTY DCFS CHILDREN UNDER TWO YEARS, BY AREA (JANUARY–DECEMBER 2016)**

| | Compton Corridor | | | Vermont Corridor | | | Wateridge | | LA County | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Eligible, and Received Joint Visit | Eligible, and Received Joint Visit | Total | Eligible, and Received Joint Visit | Eligible, and Received Joint Visit | Total | All | Total | All | Total |
| **Child Age in Months** | | | | | | | | | | |
| Infant | 187 | LNE | 19% | 201 | LNE | 19% | 226 | 19% | 2876 | 18% |
| 1-12 mos | 355 | 18 | 37% | 404 | 19 | 40% | 452 | 38% | 6158 | 39% |
| 13-24 mos | 396 | 38 | 43% | 385 | 41 | 40% | 524 | 44% | 6635 | 42% |
| **Sex** | | | | | | | | | | |
| Male | 479 | 36 | 52% | 499 | 37 | 51% | 620 | 52% | 8133 | 52% |
| Female | 456 | 27 | 48% | 489 | 24 | 49% | 578 | 48% | 7468 | 48% |
| **Race / ethnicity** | | | | | | | | | | |
| White | LNE | LNE | N/A | 12 | LNE | 1% | LNE | N/A | 1477 | 11% |
| Black | 268 | 21 | 34% | 464 | 35 | 54% | 345 | 35% | 2974 | 22% |
| Latino | 520 | 36 | 65% | 393 | 21 | 45% | 650 | 65% | 8694 | 64% |
| Asian/Pacific Islander | LNE | LNE | N/A | LNE | LNE | N/A | LNE | N/A | 345 | 3% |
| Other | LNE | LNE | N/A | LNE | LNE | N/A | LNE | N/A | 19 | 0% |
| **Prior Family Involvement with CPS** | | | | | | | | | | |
| Reports involving other children | 297 | 36 | 91% | 330 | 31 | 92% | 453 | 92% | 4960 | 91% |
| Other children placed in foster care | 26 | LNE | N/A | 26 | LNE | N/A | 42 | 8% | 474 | 9% |

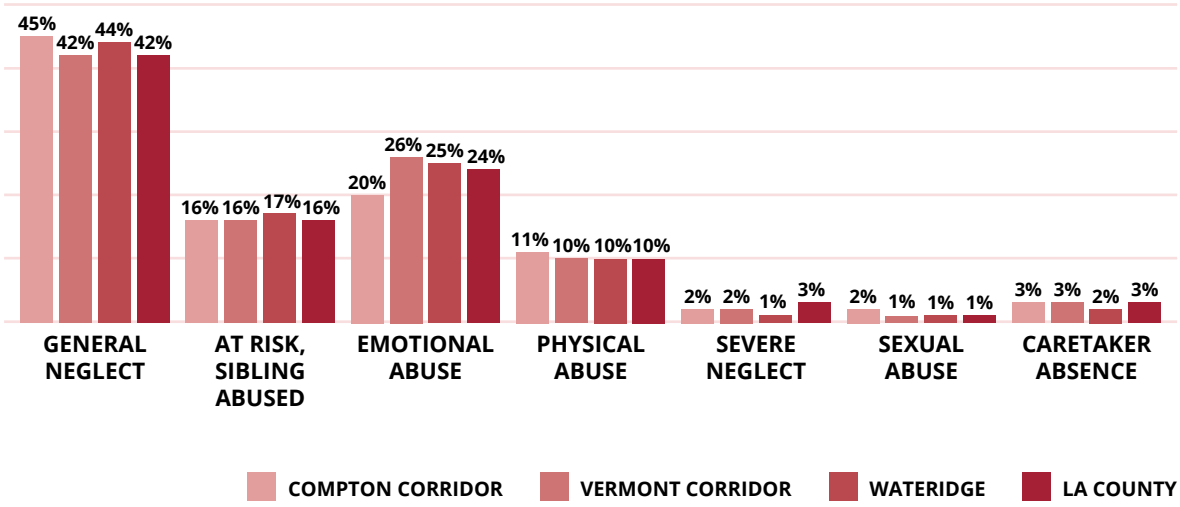
Methodological Notes:
1. LNE (i.e., Low Number Event) indicates that the cell is less than or equal to 10. N/A means Not Applicable.
2. Base data merged with CWS/CMS data to identify PHN records supplied by DCFS.
3. Received Visit totals calculated from base data using initial office.
4. Wateridge is divided into two offices (North and South). Values shown are the combined office sums.
5. Prior family involvement with CPS based on child IDs, which appear in the referrals for 2016. If another child was listed on this referral, that ID was checked against CWS/CMS for an earlier referral/placement. Similarly, prior foster care placement was established by querying client IDs of other children named on current 2016 referrals with complete CWS/CMS foster care histories.

# REFERRALS, REMOVALS AND CASE OPENINGS

### REFERRALS TO DCFS CHILD PROTECTION HOTLINE.

The Child Protection Hotline received 21,964 allegations involving a child under two years of age across LA County; 1,319 were served by the Compton Office, 1,452 by the Vermont Corridor Office, and 1,676 by the Wateridge Office. Of the allegations made, nearly half were for general neglect and one third included some form of abuse, (i.e., emotional, physical, and/or sexual) (Fig. 1). No differences in the distribution of allegations were observed between offices participating in the pilot program and DCFS county DCFS totals (as indicated by CWS/CMS).

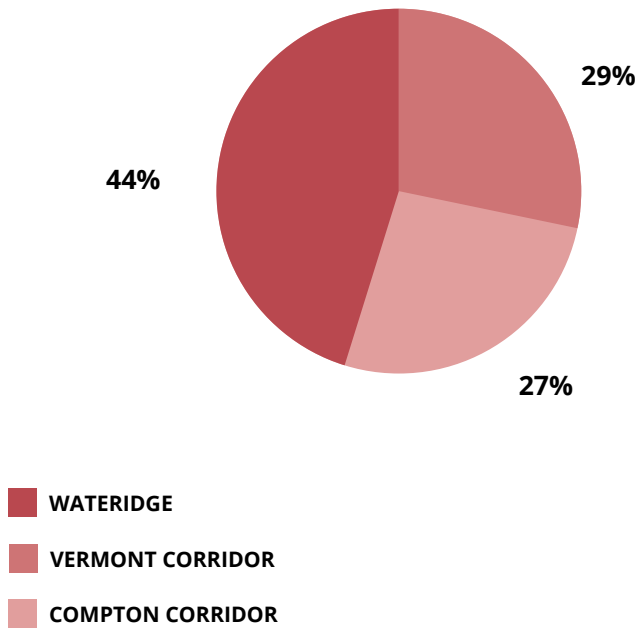
**FIGURE 1: HOTLINE ALLEGATIONS FOR CHILDREN UNDER 2 YEARS, BY AREA (JANUARY–DECEMBER 2016)**




Methodological Notes:
1. Base data merged with CWS/CMS and Office data from UC Berkeley.
2. Calculations based on total number of unique client IDs for children under 2.
3. Allegations are child-focused.
4. Each child may have more than one allegation.

In calendar year 2016, the Compton Office received 769 referrals for families with children under age 2, the Vermont Corridor Office received 814, and the Wateridge office received 1,247 (Fig. 2). County-wide, 1503 referrals were received after-hours and directed to ERCP.

**FIGURE 2: REFERRALS (JANUARY–DECEMBER 2016) (N=2,830)**



## REMOVAL RATES, CASES OPENED, AND REFERRALS CLOSED.

The 2016 rate of removal for the Compton and Vermont Corridor Offices (14.9%), while lower than the comparable Wateridge Office (17.6%), was higher than the rate for most of the time period covered by the previous pilot project evaluation (i.e., August through December 2015): 8.3%.[12]

### TABLE 1: REMOVAL RATES FOR COMPTON AND VERMONT VS. WATERIDGE OFFICES INVOLVING A CHILD UNDER 2 YEARS (JANUARY–DECEMBER 2016)

| | Compton and Vermont | | | | Wateridge | | | |
|---|---|---|---|---|---|---|---|---|
| | Not Removed | Removed | Total # of Children | % of Children Removed | Not Removed | Removed | Total # of Children | % of Children Removed |
| **Month** | | | | | | | | |
| January | 135 | 25 | 160 | 15.6% | 75 | 25 | 100 | 25.0% |
| February | 117 | 27 | 144 | 18.8% | 85 | 25 | 110 | 22.7% |
| March | 116 | 19 | 135 | 14.1% | 71 | 21 | 92 | 22.8% |
| April | 153 | 16 | 169 | 9.5% | 115 | 30 | 145 | 20.7% |
| May | 119 | 22 | 141 | 15.6% | 88 | 21 | 109 | 19.3% |
| June | 103 | 17 | 120 | 14.2% | 95 | 19 | 114 | 16.7% |
| July | 118 | 20 | 138 | 14.5% | 82 | 14 | 96 | 14.6% |
| August | 110 | 30 | 140 | 21.4% | 86 | 17 | 103 | 16.5% |
| September | 102 | 24 | 126 | 19.0% | 86 | 11 | 97 | 11.3% |
| October | 106 | 17 | 123 | 13.8% | 104 | 16 | 120 | 13.3% |
| November | 82 | 14 | 96 | 14.6% | 77 | 11 | 88 | 12.5% |
| December | 92 | 5 | 97 | 5.2% | 69 | 10 | 79 | 12.7% |
| **Total** | 1353 | 236 | 1589 | 14.9% | 1033 | 220 | 1253 | 17.6% |

Methodological Notes:
1. CWS/CMS ucb_ref data used to calculate 2016 data. Initial office was defined using ucb_office.
2. Removals were identified by merging the resulting file with ucb_fc.

[12] OCP, June 30, 2016

Similarly, rates of case openings in 2016 for the Compton and Vermont Corridor Offices (24.2%), while lower than the comparable Wateridge Office (29.6%) during 2016, were higher than the initial 2015 rate of 19.1% reported by the OCP for August through December 2015 (OCP, 2016).

## TABLE 2: CASES OPENED FOR COMPTON AND VERMONT OFFICES VS. WATERIDGE INVOLVING A CHILD UNDER 2 YEARS (JANUARY–DECEMBER 2016)

| | Compton and Vermont | | | | Wateridge | | | |
|---|---|---|---|---|---|---|---|---|
| | Case Not Opened | Case Opened | Total # of Children | % of Children with Cases Opened | Case Not Opened | Case Opened | Total # of Children | % of Children with Cases Opened |
| **Month** | | | | | | | | |
| January | 118 | 42 | 160 | 26.3% | 71 | 29 | 100 | 29.0% |
| February | 98 | 47 | 145 | 32.4% | 78 | 32 | 110 | 29.1% |
| March | 107 | 28 | 135 | 20.7% | 64 | 28 | 92 | 30.4% |
| April | 141 | 28 | 169 | 16.6% | 100 | 45 | 145 | 31.0% |
| May | 110 | 31 | 141 | 22.0% | 71 | 38 | 109 | 34.9% |
| June | 84 | 35 | 119 | 29.4% | 76 | 36 | 112 | 32.1% |
| July | 106 | 31 | 137 | 22.6% | 66 | 29 | 95 | 30.5% |
| August | 101 | 38 | 139 | 27.3% | 72 | 29 | 101 | 28.7% |
| September | 91 | 34 | 125 | 27.2% | 68 | 28 | 96 | 29.2% |
| October | 91 | 31 | 122 | 25.4% | 82 | 36 | 118 | 30.5% |
| November | 74 | 22 | 96 | 22.9% | 66 | 21 | 87 | 24.1% |
| December | 78 | 16 | 94 | 17.0% | 61 | 17 | 78 | 21.8% |
| **Total** | 1199 | 383 | 1582 | 24.2% | 875 | 368 | 1243 | 29.6% |

Methodological Notes:
1. CWS/CMS ucb_ref data used to calculate 2016 data. Initial office was defined using Ucb_office.
2. Cases were identified by merging the resulting file with ucb_case_svc_comp.

In aggregate, the average number of days from referral received to referral closure for children under 2 years old in the Compton and Vermont offices in 2016 was lower than the average rate previously documented in the OCP report for August through December 2015 (42 vs. 75.4 days).

### TABLE 3: NUMBER OF DAYS FROM REFERRAL RECEIVED TO CLOSE INVOLVING A CHILD UNDER 2 YEARS (JANUARY–DECEMBER 2016)

| Month | Average Number of Days |
|---|---|
| January | 55.1 |
| February | 60.9 |
| March | 50.7 |
| April | 59.1 |
| May | 55.4 |
| June | 47.6 |
| July | 42.6 |
| August | 37.3 |
| September | 47.3 |
| October | 42.6 |
| November | 37.6 |
| December | 45.4 |

## CHILD AND FAMILY WELL-BEING

### CSW AND PHN JOINT VISITATION AND LINKAGES.

Based on manual data tracking, PHNs accompanied CSWs on 832 joint visits, which means that 71% of referrals for a child under 2 received by the Compton and Vermont Corridor Offices between January and September 2016 received a joint visit, and 49.2% of associated children under age 2 assessed received a joint visit). In total, the PHNs met with 3,591 children; 1,690 (47%) under age 2 and 1,901 (53%) age 2 or older.

Of the 1,172 referrals received by the hotline and determined to fit criteria for the pilot project, the CSWs referred 117 children under age 2 and 148 siblings over age 2 to the MLK Hub for forensic evaluations. The PHNs referred 93 children under age 2 and 86 siblings over age 2 to the MLK Hub for medical screenings.[13]

[13] Note that there is a discrepancy between DCFS and DHS on the exact number of PHN referrals to the Hub due to differences in in data collection.

## TABLE 4: CSW-PHN JOINT VISITS & MLK HUB REFERRALS (JANUARY–SEPTEMBER 2016)

| | Compton | Vermont | Total |
|---|---|---|---|
| **Measures** | | | |
| DCFS Referrals for Children Under 2 Years | 556 | 616 | 1172 |
| Children Under 2 Years Assessed by PHN | 941 | 749 | 1690 |
| CSW-PHN Joint Visits | 448 | 384 | 832 |
| Percent of Joint Visits Conducted | 47.6% | 51.3% | 49.2% |
| **Children Under 2 Years** | | | |
| Children Referred by PHN to Hub for Screening | 47 | 46 | 93 |
| Percent of Children Referred by PHN to Hub | 5.0% | 6.1% | 5.5% |
| Children Referred by CSW for Forensic Evaluation | 56 | 61 | 117 |
| **Children 2+ Years** | | | |
| Children 2+ Years Assessed by PHN | 1163 | 738 | 1901 |
| Children Referred by PHN to Hub for Screening | 57 | 29 | 86 |
| Percent of Children Referred by PHN to Hub | 4.9% | 3.9% | 4.5% |
| Children Referred by CSW for Forensic Evaluation | 79 | 69 | 148 |

An added benefit of the PHN interviews and completion of the assessment tool was the identification of unmet needs for the children, reflecting a public health perspective of improving the overall health and well-being of the children and the family, as a whole. The PHNs found that 41% (699) of children under 2 years and 42% (793) of children over age 2 years had unmet needs. The top three unmet needs identified for children under age 2 were: 1) limited knowledge of the parents (21%); 2) medical evaluation (17%); and 3) dental care (15%).

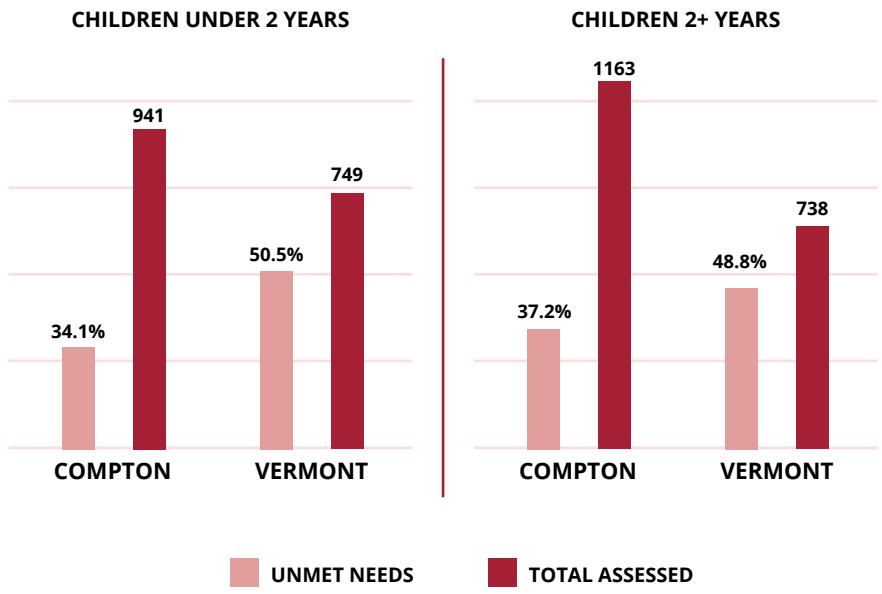
## TABLE 5: PHN IDENTIFICATION OF UNMET NEEDS BY AGE GROUP (JANUARY - SEPTEMBER 2016)

| | Children Under 2 Years Assessed by PHN | | | Children 2 Years and Over Assessed by PHN | | |
|---|---|---|---|---|---|---|
| | Children with Unmet Needs | | 699 | Children with Unmet Needs | | 793 |
| | Compton | Vermont | Total | Compton | Vermont | Total |
| **Identified Unmet Need** | | | | | | |
| Knowledge Deficit | 171 | 184 | 355 | 172 | 168 | 340 |
| Needs Med Eval | 105 | 154 | 259 | 159 | 146 | 305 |
| Dental | 78 | 47 | 125 | 228 | 137 | 365 |
| Educational | 59 | 204 | 263 | 79 | 165 | 244 |
| Co-sleeping | 97 | 142 | 239 | 44 | 56 | 100 |
| Immunizations | 39 | 42 | 81 | 29 | 14 | 43 |
| Nutritional | 25 | LNE | N/A | 40 | 17 | 57 |
| Other | 19 | 26 | 45 | 23 | 23 | 46 |
| No Primary Medical Doctor | 24 | 10 | 34 | 14 | LNE | N/A |
| Needs Spec Care | 11 | 12 | 23 | 26 | LNE | N/A |
| Homeless | 19 | LNE | N/A | 25 | 10 | 35 |
| Psychosocial | 27 | LNE | N/A | 30 | 11 | 41 |
| Insurance Coverage | 22 | 13 | 35 | 18 | 11 | 29 |
| Phys/Speech Impairment | LNE | LNE | N/A | LNE | LNE | N/A |
| Developmental | LNE | 16 | N/A | 15 | LNE | N/A |
| Family Planning | 20 | LNE | N/A | LNE | LNE | N/A |
| Needs Emergent Med Attn | LNE | LNE | N/A | LNE | LNE | N/A |
| Vision | LNE | LNE | N/A | 13 | LNE | N/A |
| Needs Med Supplies | LNE | LNE | N/A | LNE | LNE | N/A |
| Pregnant Teen | LNE | LNE | N/A | LNE | LNE | N/A |
| Parenting Teen | LNE | LNE | N/A | LNE | LNE | N/A |
| **Total Unmet Needs** | **740** | **883** | **1,623** | **935** | **794** | **1,729** |

Methodological Notes:
1. LNE (i.e., Low Number Event) indicates that the cell is less than or equal to 10. N/A means Not Applicable.
2. Data presented is at a child-level, with each row considered a unique child.
3. Figured reflect all children in each age range with unmet need indicated.

In Figure 3, PHNs from the Vermont Corridor Office documented a higher percentage of unmet needs among the children and families served by their office (50% vs. 36%).

**FIGURE 3: CHILDREN WITH UNMET NEEDS AS IDENTIFIED BY PHNS (DCFS/PHN RECORDS) (JANUARY–SEPTEMBER 2016)**




Methodological Notes:
Calculated using PHN RPT file, flag variable based on num_unmet_needs.

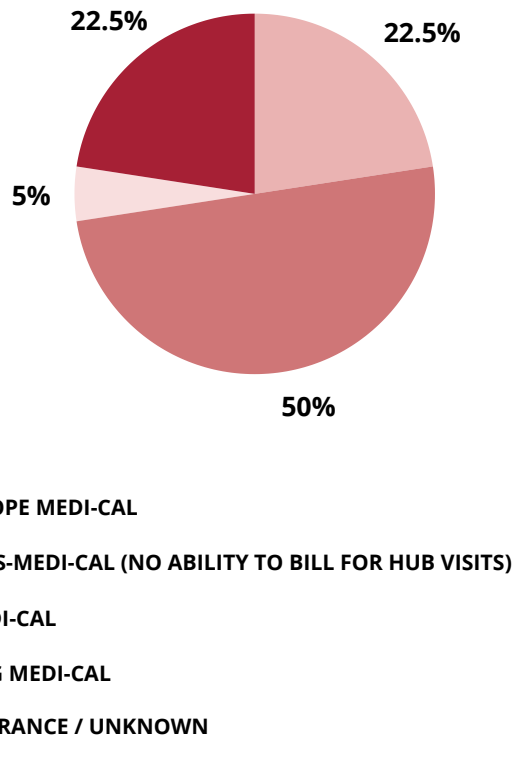
For the 1,492 children with identified unmet needs, the PHNs provided a total of 3,565 referrals to services or programs. With 42% (1,492) of the children assessed as having one or more unmet need, there is clearly a significant need to provide linkages to programs and services. The assessment instrument includes recommended next steps, but data are not currently available to track follow-through by PHNs, CSWs, and/or DMH and MLK staff. Responsibility for follow-up on service referrals and unmet family needs is an area of confusion and uncertainty in the County system overall. Not only are there a number of different County departments and community partners who might be called upon to address different kinds of family needs, but there also are regional differences in terms of community-based access to different kinds of support, services,

and resources. Further development of the County's child maltreatment prevention initiative may help to clarify the most effective options for assuring that family needs are met in a timely and effective way (OCP, June 30, 2017).

## 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.

### FIGURE 4: INSURANCE TYPE (ALL CHILDREN LISTED IN DCFS/PHN DATASET) (JANUARY–SEPTEMBER 2016)



According to the Department of Health Services, Medical Hubs System Data Report (June 2, 2017), of the 62 children seen at the Hub between December 2015 and December 2016, 31 (50%) had non-DHS Medi-Cal, 14 (22.5%) had no insurance reported, and 14 (22.5%) had Full Scope Medi-Cal. Since there were no DHS Medi-Cal patients, the patients seen with Full Scope Medi-Cal are the only patient visits that are billable.

According to the DCSF CWS/CMS system, the TOTAL number of families with an existing Medical Home (and at time of referral/case closure) since this initiative began is 3,149, yet the TOTAL number of families with DHS as Medical Home at time of referral/case closure is 69. One thing to note is that only patients with DHS Medi-Cal managed care, Full Scope Medi-Cal, or Emergency Medi-Cal may utilize DHS Hubs (or DHS clinics) as a medical home.

Fifty-six families visited the Hub between January and December 2016.[14] The vast majority (39 families, 70%) already had primary care in the community, and 7 (13%) chose to receive their primary medical care at the Hub as a result of visiting the Hub. Ten were in other situations, either not having access to primary care, PCP assignment was in progress, or information was not available.

According to the Department of Health Services, Medical Hubs System Data Report (June 2, 2017), the LAC Medical Hubs System overall is making a concerted effort to offer medical home services to more patients. This will increase as the Medical Hub System is expanded.

[14] According to the LW_Data for PHN Referred Medical Assessment file.

## MLK HUB ASSESSMENTS

From December 1, 2015 to December 31, 2016 (Department of Health Services, Medical Hubs System, June 2, 2017), the MLK Medical Hub received a total of 121 referrals for PHN-referred Medical Assessments. A total of 62 visits were completed during this period. A total of 33 patients were never scheduled, i.e., the caregiver could not be reached after multiple attempts or declined services. A total of 27 appointments did not show up and were never completed.

Of the 121 referrals, 3 were determined to be more appropriate as initial medical exams and 8 as forensic examinations after triage by Hub staff. The completed visits (62) include those completed as initial medical or forensic exam visits.

### TABLE 8: PHN REFERRED MEDICAL ASSESSMENT APPOINTMENT STATUS (DECEMBER 2015 - DECEMBER 2016)

| | Dec. 2015 | Jan. 2016 | Feb. 2016 | Mar. 2016 | Apr. 2016 | May 2016 | June 2016 | July 2016 | Aug. 2016 | Sep. 2016 | Oct. 2016 | Nov. 2016 | Dec. 2016 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Hub referrals by PHN | 13 | 16 | 12 | 20 | 0 | 9 | 5 | 4 | 8 | 4 | 24 | 4 | 12 | 121 |
| Children seen at Hub | 12 | 10 | 11 | 13 | 0 | 8 | 2 | 1 | 3 | 0 | 1 | 0 | 1 | 62 |
| Refusals by parent | 0 | 1 | 0 | 5 | 0 | 0 | 1 | 0 | 0 | 0 | 4 | 1 | 0 | 12 |
| Unable to schedule | 1 | 0 | 1 | 2 | 0 | 1 | 0 | 2 | 3 | 2 | 4 | 0 | 5 | 21 |
| No show and never completed visit | 1 | 5 | 0 | 0 | 0 | 0 | 2 | 1 | 2 | 2 | 5 | 3 | 6 | 27 |

According to the Department of Health Services, Medical Hubs System Data Report (June 2, 2017), all patients were offered appointments within 72 hours **of contact with the caregiver** (initial contact may often take several days), however in many cases appointments were scheduled further out due to caregiver availability/preference or Hub availability. Acute forensic appointments take precedence at the Hubs, and may have impacted immediate availability. The Hub also gave priority to those PHN referrals that indicated a specific medical concern rather than a missed immunization or wellness check.

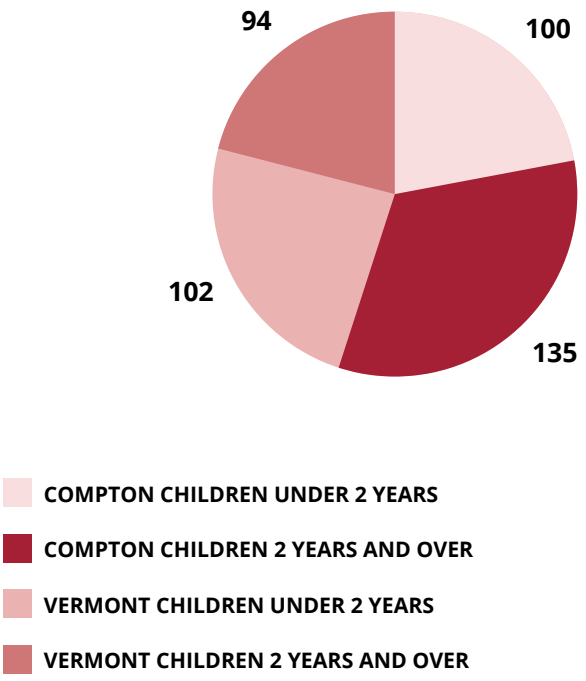
### TABLE 8a. TIME TO SCHEDULED AND COMPLETED APPOINTMENTS (DECEMBER 2015 – DECEMBER 2016)

| | Number of days between referral and initally scheduled appointmnet* | | Number of days between referral and completed appointment* | |
|---|---|---|---|---|
| | # | % | # | % |
| 0–3 days | 4 | 6.5% | 4 | 6.5% |
| 4–7 days | 6 | 9.7% | 4 | 6.5% |
| 8–14 days | 22 | 35.5% | 15 | 24.2% |
| 15–21 days | 11 | 17.7% | 9 | 14.5% |
| 22–30 days | 8 | 12.9% | 10 | 16.1% |
| 31+ days | 11 | 17.7% | 20 | 32.2% |
| **Total** | 62 | 100.0% | 62 | 100.0% |

* Includes the referrals submitted in December 2015 for patients seen in Jan/Feb 2016

Figure 3 shows that PHNs from the Vermont Corridor Office identified 50% of children as having unmet needs, while the Compton Office identified 36% of children as having unmet needs. Figure 5, however, shows that Compton Office referrals accounted for 55% of the 431 children referred to the MLK Hub between January and September 2016.

**FIGURE 5: CHILDREN REFERRED TO THE HUB (JANUARY–SEPTEMBER 2016)**



### STAFFING AND ASSESSMENTS COMPLETED

Table 9 reflects the staffing levels of PHNs and the number of child assessments completed. Average caseloads for January through September 2016 in the Compton and Vermont Offices were 30 and 35 children, respectively.

### TABLE 9: AVERAGE NUMBER OF CHILD ASSESSMENTS COMPLETED BY PHNS PER MONTH (JANUARY–SEPTEMBER 2016)

| | Jan. | Feb. | Mar. | Apr. | May | June | July | Aug. | Sept. | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| **Compton (# PHNs)** | 8 | 7 | 2 | 11 | 9 | 8 | 8 | 8 | 8 | 69 |
| Total # of Children | 206 | 213 | 5 | 299 | 332 | 256 | 318 | 338 | 236 | 2203 |
| Assessments Per PHN | 25.8 | 30.4 | 2.5 | 27.2 | 36.9 | 32.0 | 39.8 | 42.3 | 29.5 | 31.9 |
| **Vermont (# PHNs)** | 5 | 5 | 6 | 5 | 1 | 2 | 8 | 7 | 6 | 45 |
| Total # of Children | 139 | 166 | 130 | 178 | 63 | 28 | 248 | 269 | 293 | 1514 |
| Assessments Per PHN | 27.8 | 33.2 | 21.7 | 35.6 | 63.0 | 14.0 | 31.0 | 38.4 | 48.8 | 33.6 |

Methodological Notes:
1. Number of assessments per PHN is calculated using simple average.
2. PHN RPT was used to count unique PHN names and rows per PHN.

## CHILD SAFETY OUTCOMES

The overall goal of the CSW-PHN joint visit program was to leverage collaboration between Los Angeles County's child protective services and health systems to increase child safety, and, secondarily to enhance child and family well-being. For the purposes of this study, reduced rates of subsequent referrals to child welfare, case openings, and out-of-home placements were used as indicators of child safety. Children under two years old with an initial child welfare referral in 2016 and identified for investigation in the two pilot offices were followed for four months post-case closing, and re-referrals, case openings, and out-of-home placement activities were documented. Preliminary analysis shows that there was no appreciable difference in the percentage of re-referrals between the pilot offices in the Vermont Corridor and Compton Regional Offices and the comparison Wateridge Regional Office. In fact, the Vermont and Compton offices

had somewhat higher rates of subsequent referrals than the Wateridge office. The findings are presented in Tables 10-12.[15]

## TABLE 10: CHILDREN WITH AND WITHOUT 4-MONTH FOLLOW-UP REFERRALS IN VERMONT, COMPTON, AND WATERIDGE OFFICES

| | Vermont (n=659) | | | | Compton (n=628) | | | | Wateridge (n=1,003) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | No Follow-up | | Follow-up Referral | | No Follow-up | | Follow-up Referral | | No Follow-up | | Follow-up Referral | |
| | # | % | # | % | # | % | # | % | # | % | # | % |
| **Number of Children** | 577 | 87.6% | 82 | **12.4%** | 575 | 91.6% | 53 | **8.4%** | 925 | 92.2% | 78 | **7.8%** |
| **Age** | | | | | | | | | | | | |
| 0–6 months | 146 | 85.4% | 25 | 14.6% | 150 | 91.5% | 14 | 8.5% | 217 | 95.2% | 11 | 4.8% |
| 6–12 months | 244 | 88.1% | 33 | 11.9% | 217 | 89.3% | 26 | 10.7% | 359 | 89.3% | 43 | 10.7% |
| 12–24 months | 187 | 88.6% | 24 | 11.4% | 208 | 94.1% | 13 | 5.9% | 349 | 93.6% | 24 | 6.4% |
| **Race / ethnicity** | | | | | | | | | | | | |
| White | LNE | N/A | LNE | N/A | LNE | N/A | LNE | N/A | LNE | N/A | LNE | N/A |
| Black | 253 | 83.8% | 49 | 16.2% | 156 | 89.7% | 18 | 10.3% | 251 | 90.9% | 25 | 9.1% |
| Latino | 235 | 89.7% | 27 | 10.3% | 313 | 91.8% | 28 | 8.2% | 499 | 90.9% | 50 | 9.1% |
| Asian/Pac Islander | LNE | N/A | LNE | N/A | LNE | N/A | LNE | N/A | LNE | N/A | LNE | N/A |
| Other | LNE | N/A | LNE | N/A | LNE | N/A | LNE | N/A | LNE | N/A | LNE | N/A |
| **Sex** | | | | | | | | | | | | |
| Male | 281 | 87.3% | 41 | 12.7% | 293 | 88.8% | 37 | 11.2% | 478 | 92.8% | 37 | 7.2% |
| Female | 293 | 87.7% | 41 | 12.3% | 279 | 94.6% | 16 | 5.4% | 443 | 91.5% | 41 | 8.5% |

Methodological Notes:
1. Data from referral and office tables of CWS/CMS.
2. Referral in 2016 and closed by end of February 2017, all children under 2 at time of referral.
3. Missing values for Race and Gender exist and are not included in counts.

[15] Note: Due to data limitations, it was not possible to limit the universe of individuals presented by office to only those who received the joint visitation. For that reason, all children with a referral in 2016 assigned to Vermont or Compton were considered part of the Intervention group. And, as data in Table 0 show, the vast majority of eligible children in these offices received joint visits.

## TABLE 11: CHILDREN WITH AND WITHOUT 4-MONTH FOLLOW-UP CASE OPENINGS IN VERMONT, COMPTON, AND WATERIDGE OFFICES

| | Vermont (n=659) | | | | Compton (n=628) | | | | Wateridge (n=1,003) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | No Follow-up | | Follow-up Referral | | No Follow-up | | Follow-up Referral | | No Follow-up | | Follow-up Referral | |
| | # | % | # | % | # | % | # | % | # | % | # | % |
| **Number of Children** | 636 | 96.5% | 23 | **3.5%** | 603 | 96.0% | 25 | **4.0%** | 978 | 97.5% | 25 | **2.5%** |
| **Age** | | | | | | | | | | | | |
| 0–6 months | 167 | 97.7% | LNE | N/A | 156 | 95.1% | LNE | N/A | 223 | 97.8% | LNE | N/A |
| 6–12 months | 267 | 96.4% | LNE | N/A | 233 | 95.9% | LNE | N/A | 389 | 96.8% | 13 | 3.2% |
| 12–24 months | 202 | 95.7% | LNE | N/A | 214 | 96.8% | LNE | N/A | 366 | 98.1% | LNE | N/A |
| **Race / ethnicity** | | | | | | | | | | | | |
| White | LNE | N/A | LNE | N/A | LNE | N/A | LNE | N/A | LNE | N/A | LNE | N/A |
| Black | 284 | 94.0% | 18 | 6.0% | 165 | 94.8% | LNE | N/A | LNE | N/A | LNE | N/A |
| Latino | 257 | 98.1% | LNE | N/A | 326 | 95.6% | 15 | 4.4% | 534 | 97.3% | 15 | 2.7% |
| Asian/Pac Islander | LNE | N/A | LNE | N/A | LNE | N/A | LNE | N/A | LNE | N/A | LNE | N/A |
| Other | LNE | N/A | LNE | N/A | LNE | N/A | LNE | N/A | LNE | N/A | LNE | N/A |
| **Sex** | | | | | | | | | | | | |
| Male | 313 | 97.2% | LNE | N/A | 314 | 95.2% | 16 | 4.8% | 503 | 97.7% | 12 | 2.3% |
| Female | 320 | 95.8% | 14 | 4.2% | 286 | 96.9% | LNE | N/A | 471 | 97.3% | 13 | 2.7% |

Methodological Notes:
1. Data from referral, office, and case services tables of CWS/CMS.
2. Referral in 2016 and closed by end of February 2017, all children under 2 at time of referral.
3. Missing values for Race and Gender exist and are not included in counts.

## TABLE 12: CHILDREN WITH AND WITHOUT 4-MONTH FOLLOW-UP OUT-OF-HOME PLACEMENTS IN VERMONT, COMPTON, AND WATERIDGE OFFICES

| | Vermont (n=659) | | | | Compton (n=628) | | | | Wateridge (n=1,003) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | No Follow-up | | Follow-up Referral | | No Follow-up | | Follow-up Referral | | No Follow-up | | Follow-up Referral | |
| | # | % | # | % | # | % | # | % | # | % | # | % |
| **Number of Children** | 592 | 89.8% | 67 | **10.2%** | 587 | 93.5% | 41 | **6.5%** | 923 | 92.0% | 80 | **8.0%** |
| **Age** | | | | | | | | | | | | |
| 0–6 months | 137 | 80.1% | 34 | 19.9% | 139 | 84.8% | 25 | 15.2% | 196 | 86.0% | 32 | 14.0% |
| 6–12 months | 253 | 92.3% | 24 | 8.7% | 235 | 96.7% | LNE | N/A | 369 | 91.8% | 33 | 8.2% |
| 12–24 months | 202 | 95.7% | LNE | N/A | 213 | 96.4% | LNE | N/A | 358 | 96.0% | 15 | 4.0% |
| **Race / ethnicity** | | | | | | | | | | | | |
| White | LNE | N/A | LNE | N/A | LNE | N/A | LNE | N/A | LNE | N/A | LNE | N/A |
| Black | 257 | 85.1% | 45 | 14.9% | 159 | 91.4% | 15 | 8.6% | 246 | 89.1% | 30 | 10.9% |
| Latino | 240 | 91.6% | 22 | 8.4% | 318 | 93.3% | 23 | 6.7% | 500 | 91.1% | 40 | 8.9% |
| Asian/Pac Islander | LNE | N/A | LNE | N/A | LNE | N/A | LNE | N/A | LNE | N/A | LNE | N/A |
| Other | LNE | N/A | LNE | N/A | LNE | N/A | LNE | N/A | LNE | N/A | LNE | N/A |
| **Sex** | | | | | | | | | | | | |
| Male | 292 | 90.7% | 30 | 9.3% | 306 | 92.7% | 24 | 7.3% | 472 | 91.7% | 43 | 8.3% |
| Female | 297 | 88.9% | 37 | 11.1% | 278 | 94.2% | 17 | 5.8% | 447 | 92.4% | 37 | 7.6% |

Methodological Notes:
1. Data from referral, office, and case services tables of CWS/CMS.
2. Referral in 2016 and closed by end of February 2017, all children under 2 at time of referral.
3. Missing values for Race and Gender exist and are not included in counts.

## CHILD SAFETY OUTCOMES

The CSW-PHN joint visit program was designed to create a team approach to investigating allegations of child maltreatment for families with very young children under the age of two – the children most likely to experience repeat interactions with the child welfare system. In 2016, teams in the two pilot offices worked with more than 3,500 children and families, assessing risks, identifying unmet needs, making referrals to support a variety of family circumstances, and strengthening families by connecting them with needed support, services, and resources. Not surprisingly, the families reported to the DCFS hotline in 2016 and determined to require an investigation through the two DCFS offices in this pilot program had a complex array of unmet needs. Many parents lacked the information needed to fully understand their children's situation or where to go for help. Project data demonstrated that many of these families received helpful information and referrals through the pilot program that likely contributed to improved child and family well-being.

However, the primary goal of the program recommended by the Blue Ribbon Commission was to improve child safety. Looking four months out, this analysis shows that participation in the pilot project did not reduce subsequent child welfare referrals, case openings, or out-of-home placements – key indicators of child safety.

Anyone who works in the child welfare system understands that that the families it serves face complex challenges, often with very limited personal, financial and social resources. The systems in place to help these families are equally complicated, particularly in a large metropolitan area like Los Angeles County with its multiple jurisdictions, organizational silos, and complex service delivery systems. There is little evidence that this program, taken on its own, without consideration of simultaneous internal reform efforts or external changes in community service or support systems, had the desired effect on child safety. While there were very likely benefits for the families served as a result of the hard work of the staff, their efforts were undertaken in the context of a large system where many things needed to change at once in order to achieve measurable differences in child safety.

In the case of this pilot program, CSWs and PHNs were swimming against the tide. The requirement that PHNs only provide non-clinical case collaboration and consultation services limited their contribution to the teams; and gradual phasing in of new protocols and training processes may have challenged program implementation. Inadequate preparation for data sharing and electronic tracking of needed data also worked against the program in terms of documenting measurable changes in child safety outcomes. We applaud the many staff who worked tirelessly to help families, who were willing to test

new approaches, and share knowledge across multiple disciplines. The lessons learned from this pilot project will undoubtedly be useful as County government continues its efforts to integrate services and leverage collaboration between the multiple departments and community-based partners who play essential roles in strengthening families and keeping children safe and healthy.

## REFERENCES


Blue Ribbon Commission on Child Protection. (2014). The road to safety for our children. Retrieved from: ceo.lacounty.gov/pdf/brc/BRCCP_Final_Report_April_18_2014.pdf

Chief Executive Office. (April 13, 2015). Leveraging the county's health system to prevent child abuse and neglect.

Department of Children and Family Services. (May 4, 2016). PHN-CSW Joint Visit Initiative–Data report.

Department of Health Services, Medical Hubs System. (June 2, 2017). CSW-PHN Joint Visit Initiative Martin Luther King, Jr. Medical Hub Data: December 2015 – December 2016.

Office of Child Protection. (June 30, 2016). Children's Social Worker (CSW) – Public Health Nurse (PHN) Joint Visit Initiative report.

Office of Child Protection. (June 30, 2017). Paving the Road to Safety for Our Children: A Prevention Plan for Los Angeles County.


## APPENDICES

Appendix I. Child Welfare Public Health Nurse Assessment Tool
Appendix II. Performance and Outcomes Measures

# CHILD WELFARE PUBLIC HEALTH NURSE – ASSESSMENT TOOL
## Emergency Response – Joint Field Visit

SUBMIT

This checklist is a tool to guide the PHN's observations in reviewing specific criteria that identifies indicators of possible abuse, neglect, and/or risk factors during the initial joint field visit. Complete each section of this form and identify concerns. If no concern is found, please indicate in the shaded box provided.

| CHILD | DOB | PARENT / GUARDIAN CONSENT (*verbal*) ☐ Yes ☐No | DATE |
|---|---|---|---|
| REFERRAL ID | FOCUS CHILD ☐ Yes ☐No | AT-RISK CHILD ☐ Yes ☐No ☐ Unable for Visit | |
| CSW | PHONE | PHN | PHONE |
| Medical Insurance ☐ Yes ☐No | Type of Medical Insurance ☐ Medical ☐ Private (*Specify*) | | |
| Allegation Type | | | |

***All checked boxes in any assessment area must be explained in further detail in the comments section.***

| ASSESSMENT AREA | COMMENTS |
|---|---|
| **HEALTH HISTORY** | |
| Prenatal care ☐ YES ☐ NO<br>Where received _____ When received _____<br>☐ Birth complications *i.e. prematurity, HTN, Gestational diabetes*<br>Birth Weight: _____Birth Length: _____<br>Gestational Age: _____<br>Place of birth: _____<br>☐ Alcohol/smoking and/or drug use during pregnancy | |
| ☐ **Health History: Medical condition(s), allergies, hospitalizations, surgeries etc.**<br>☐ Parent/Guardian verbalizes awareness & knowledge of conditions<br>☐ Parent/Guardian verbalizes compliance with medical treatment or medication<br>**Medical Provider(s): _____**<br>**Medical Provider(s) phone number: _____**<br>**Last medical appointment date: _____**<br>**Next medical appointment date: _____**<br>**Dental Provider(s): _____**<br>**Dental Provider(s) phone number: _____**<br>**Last dental appointment date: _____**<br>**Next dental appointment date: _____** | |
| **DEVELOPMENTAL** (*for children under 24 months*) | |
| ☐ No developmental concern<br>**Area(s) of concern:**<br>☐ Head control ☐ Language<br>☐ Sitting ☐ Talking<br>☐ Standing ☐ Walking or climbing | |

| CHILD | PHN NAME | PHN SIGNATURE |
|---|---|---|
| | | |

| | |
|---|---|
| ☐ Crawling or cruising ☐ Fine and gross motor skills<br>☐ Observed lack of awareness of dev. stages and milestones<br>☐ Observed parenting skills/discipline techniques that are not age appropriate | |
| **ASSESSMENT AREA** | **COMMENTS** |
| **PHYSICAL** | |
| ☐ No physical concern<br>☐ **Observed Indicators for Possible Physical Abuse:** injuries (bruises, burns, lacerations, visible physical abnormalities, etc.)<br>☐ **Reported Sexual Abuse History** (suspected or actual)<br>☐ Observed Indicators for Possible Neglect:<br>☐ Lack of medical care ( illness or injury)<br>☐ Muscle tone limp or rigid<br>☐ Inadequate hygiene | |
| **NUTRITIONAL HISTORY** | |
| ☐ No nutritional concern/Age appropriate foods<br>☐ Feeding history/problems<br>☐ Breastfeeding/Formula/Food availability/Food preparation<br>☐ Elimination<br>☐ Imbalance nutrition, more or less than body requirements | |
| **PSYCHOSOCIAL** | |
| ☐ No psychosocial concern<br>☐ **Parental/Caregiver engagement**/ poor interaction/lack of bonding<br>☐ **Social interaction** concerns (smile, engagement vs. stranger/danger)<br>☐ **Sleeping** concerns<br>☐ **Eating** concerns | |
| **ENVIRONMENTAL FACTORS & BEHAVIORS** | |
| ☐ No environmental concern<br>☐ Indication of substance abuse (parent or child)<br>☐ Inappropriate sleeping arrangements (e.g. co-sleeping)<br>☐ Lack of food, clothing, diapers (basic needs)<br>☐ Parental needs unmet (e.g. lack of employment, transportation, health)<br>☐ Concerns noted in parent/guardian's physical and/or mental health status<br>☐ Limited access to care: transportation, health insurance<br>☐ Home safety issues observed:<br>**Concerns with any of the following areas:**<br>☐ Cleanliness ☐ Potential for Injury/poison<br>☐ Car seat ☐ Swimming pool<br>☐ Lead (Pb) ☐ Medication storage<br>☐ Smoking ☐ Secured windows/screens<br>☐ TV safety ☐ Pets<br>☐ Other | |
| **RECOMMENDED NEXT STEP(S)** | |
| ☐ No Further Action Required<br>☐ Additional Joint Visit Required<br>☐ Forensic exam<br>☐ Medical treatment/care for urgent issues<br>☐ Educational material to be provided<br>☐ Medical assessment<br>☐ HUB referral<br>☐ Primary Medical Doctor referral<br>☐ Community agency referrals<br>☐ Regional Center referral | |

| CHILD | PHN NAME | PHN SIGNATURE |
|---|---|---|
| | | |

| | |
|---|---|
| ☐ Translation / Interpreter Services Provided<br>Language: _____ | |

| PHN SIGNATURE & JOINT VISIT CERTIFICATION | | |
|---|---|---|
| **PHN NAME** | **PHN SIGNATURE** | **DATE** |
| | | |
| **JOINT VISIT CONDUCTED WITH CSW** (First Name, Last Name) | | |
| | | |

| CHILD | PHN NAME | PHN SIGNATURE |
|---|---|---|
| | | |

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<br>▪ By time period (traditional business hours; afterhours)<br>▪ By referral type (Immediate Response, 5-day, etc.)<br>▪ By child's age (less than 24 months (focus child); siblings over 24 months)<br>▪ Type of allegation |
| ***Joint Visits*** | 2. Total number of visits conducted by PHNs<br>▪ Number of initial visits that a CSW and PHN conducted together<br>▪ Number of initial visits conducted separately<br>▪ Number of joint visits conducted jointly<br>3. Number of children assessed by PHN (by age) |
| ***Hub Referrals by PHN*** | 4. Number of Hub referrals by PHN for medical screening<br>▪ Number of Hub referral refusals (by parents)<br>5. Number of children screened at Medical Hub (by age)<br>6. Number of days that Hub screening occurred after joint CSW-PHN visit |
| ***Hub Appointment Management*** | 7. Total number of appointments<br>8. Number of Hub appointment failures (by parents)<br>▪ Number of appointments rescheduled<br>– Number of times rescheduled: 1, 2, 3, etc.<br>– Reasons for rescheduling (parent request vs. Hub requests)<br>▪ 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)<br>▪ 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*<br>9. Number of detentions<br>10. Impacts on ER referral closure timelines. Information on referrals open > than 30 days<br>▪ Number of children who required a Hub exam<br>▪ Number of children who received a Hub exam within 72 hours of joint CSW-PHN visit<br>▪ Impact of #8 above on referral closures (< 30 days vs. > 30 days)<br>11. Number of children returning to the system<br>12. Number of children with recurrence of maltreatment<br>13. Number of child fatalities, if any |
| ***Linkage with Health Care and Supportive Services*** | 14. Number of PHN-generated community referrals<br>15. Number of children who were referred to services as a result of PHN-generated referrals<br>▪ Number who received/obtained services<br>▪ Number who were deemed ineligible by agency<br>▪ Number who declined services<br>16. Number of families already connected with Home Visitation and other community-based specialty (resource) services at the time of the referral<br>17. Number of families with an existing Medical Home (and at time of referral/case closure)<br>▪ Number with no identified Medical Home at time of referral<br>▪ Number with private provider as Medical Home at time of referral<br>▪ 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