COUNTY OF LOS ANGELES
OFFICE OF CHILD PROTECTION

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June 30, 2016

To: Supervisor Hilda L. Solis, Chair
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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:

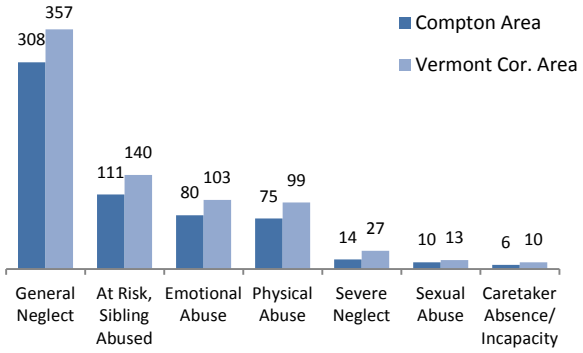
- CSW will be paired with a PHN during investigations of referrals that include a child, under 2 years of age.
- CSW will investigate, as usual; and continue to be responsible for all casework decisions.
- CSW will consult with PHN during investigation. PHN will be a secondary assignment to the referral.
- 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

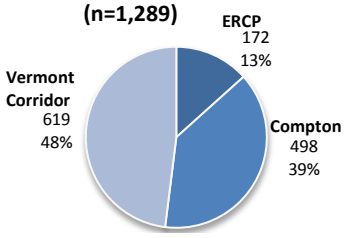
The data from August 2015 through February 2016 shows that the Child Protection Hotline received 1,289 referrals, with 1,353 allegations, across the Compton and Vermont Corridor Regional Offices that included a child under two years of age. Of the allegations made, 49% of the referrals were for general 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.

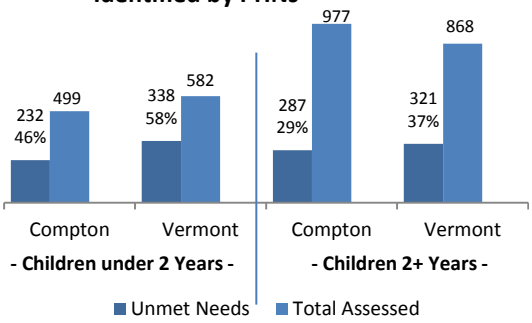
An added benefit of the PHNs interviewing and completing their non-clinical, health/safety assessment tool was the identification of unmet needs for the children, reflecting a public health perspective of improving the overall health of the family. The top three unmet needs identified for children under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

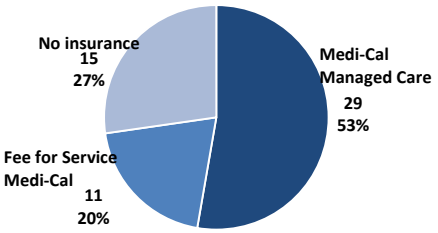
Of the children seen at the MLK Hub, 55 children were surveyed about their medical insurance coverage. The MLK Hub found that 53% were enrolled in Medi-Cal Managed Care, 20% in Fee for Service Medi-Cal,

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

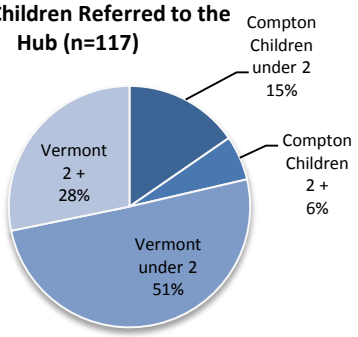
DCFS records show PHNs referred 117 children for medical assessments, while the MLK Hub reported receipt of 126 referrals. A manual reconciliation of the records between DCFS and DHS showed a match between 82 of the referrals reported by the Hub and DCFS. Of the 35 referrals from DCFS not included in 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.