Supporting system improvement and organizational culture change in Los Angeles County DCFS: A systems approach to understanding and learning from critical incidents

Diane Iglesias & Cynthia Wong-Blye
Los Angeles County Dept. of Children and Family Services

Michael Cull
University of Kentucky
Center for Innovation in Population Health

Our plan…

1. Describe ways a better engineered system can support safe, effect, reliable care safe, effective, reliable care.
2. Discuss specific team-based strategies to support a safety culture and improve reliability and effectiveness.
3. Highlight LA County's efforts to advance a safety culture
4. Describe how a system can use the SSIT to learn and improve


CULTURE
EATS
STRATEGY
FOR
LUNCH
PETER DRUCKER

Safety Science to inform a Safety Culture

An organizational culture that:

1. Acknowledges the **high-risk nature of an organization's** activities and the determination to achieve **consistently safe operations**
2. Promotes a **blame-free environment** where individuals are able to report errors or near misses **without fear of reprimand or punishment**
3. Encourages **collaboration across ranks and disciplines** to seek solutions to problems
4. Commits **resources** to safety concerns

Agency for Healthcare Research and Quality (2019)

Safety Culture in Child Welfare

Leaders in a safety culture:

- Strive to balance **systems** and **individual accountability**; and
- Value open communication, transparency, and continuous learning and improvement.

Teams in a safety culture

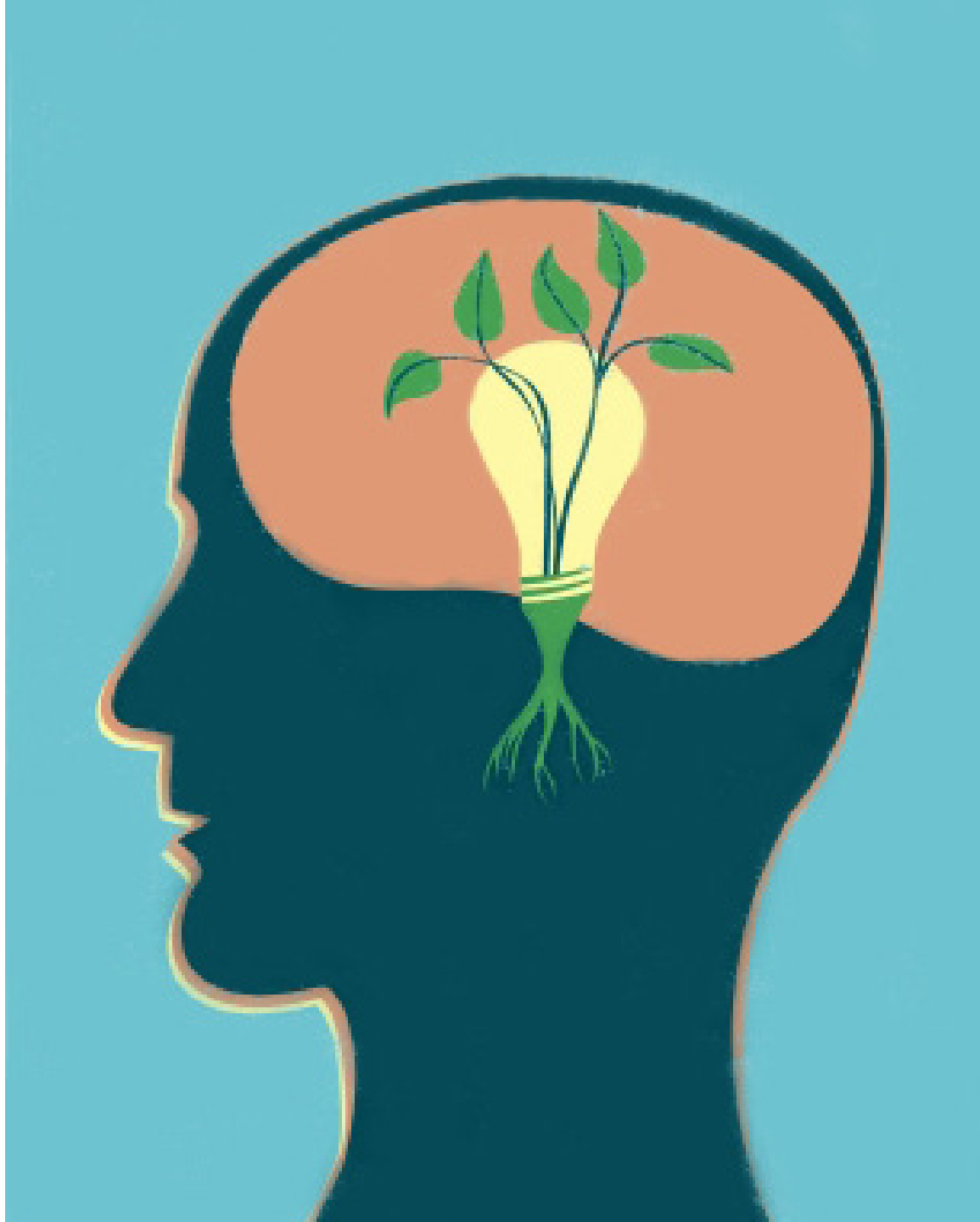
- Monitor themselves, their colleagues, and their system for stress
- Anticipate and respond to unexpected events as a unit


Good Choice
Bad Choice


Oops!

Cognitive Bias

- Fundamental attribution error
- Confirmation bias
- Selective attention
- Hindsight Bias
- Severity Bias



Three Levels of Stress Response

Positive

Brief increases in heart rate.

Mild elevations in stress hormone levels

Tolerable

Serious, temporary stress responses,

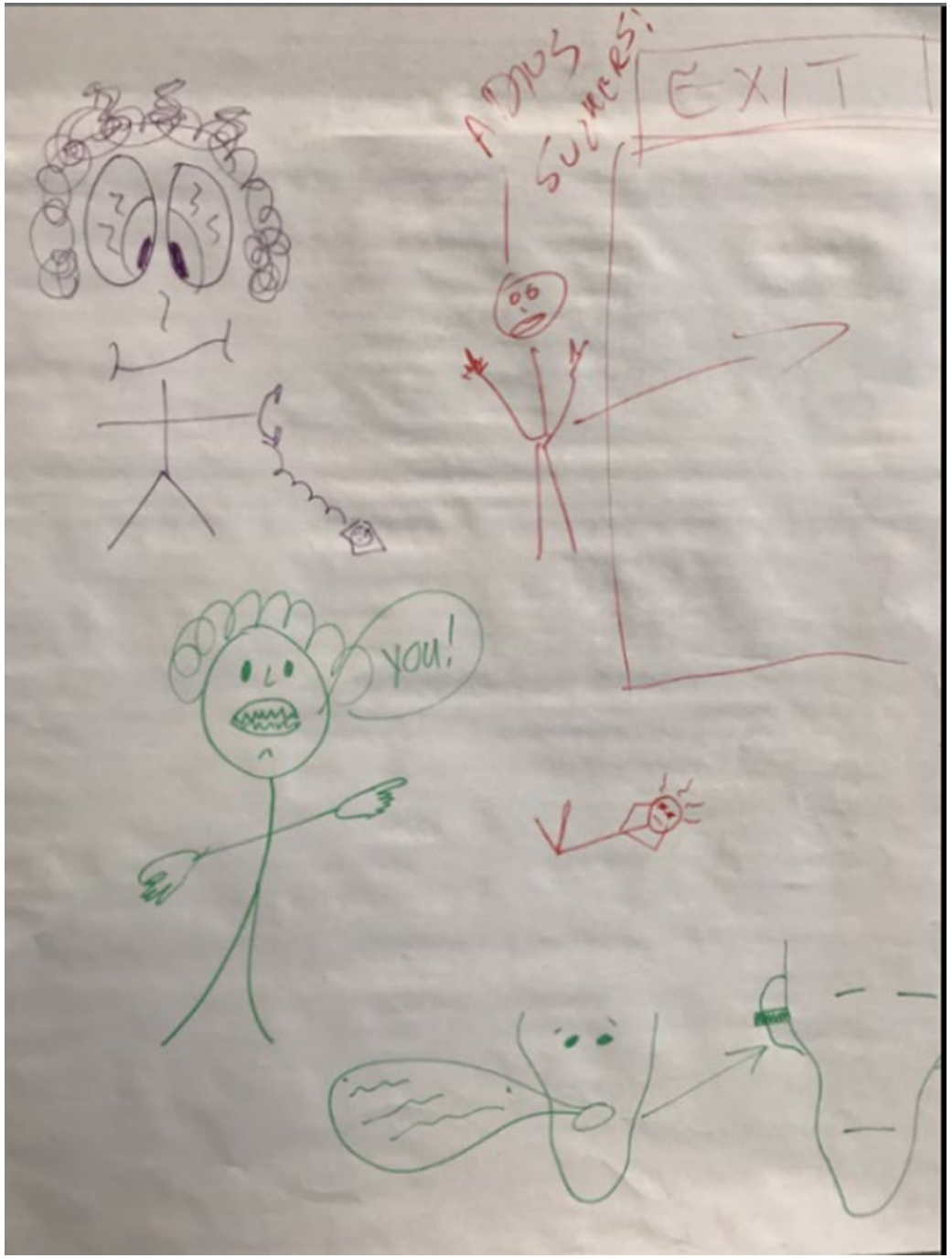
Buffered by ***supportive relationships.***

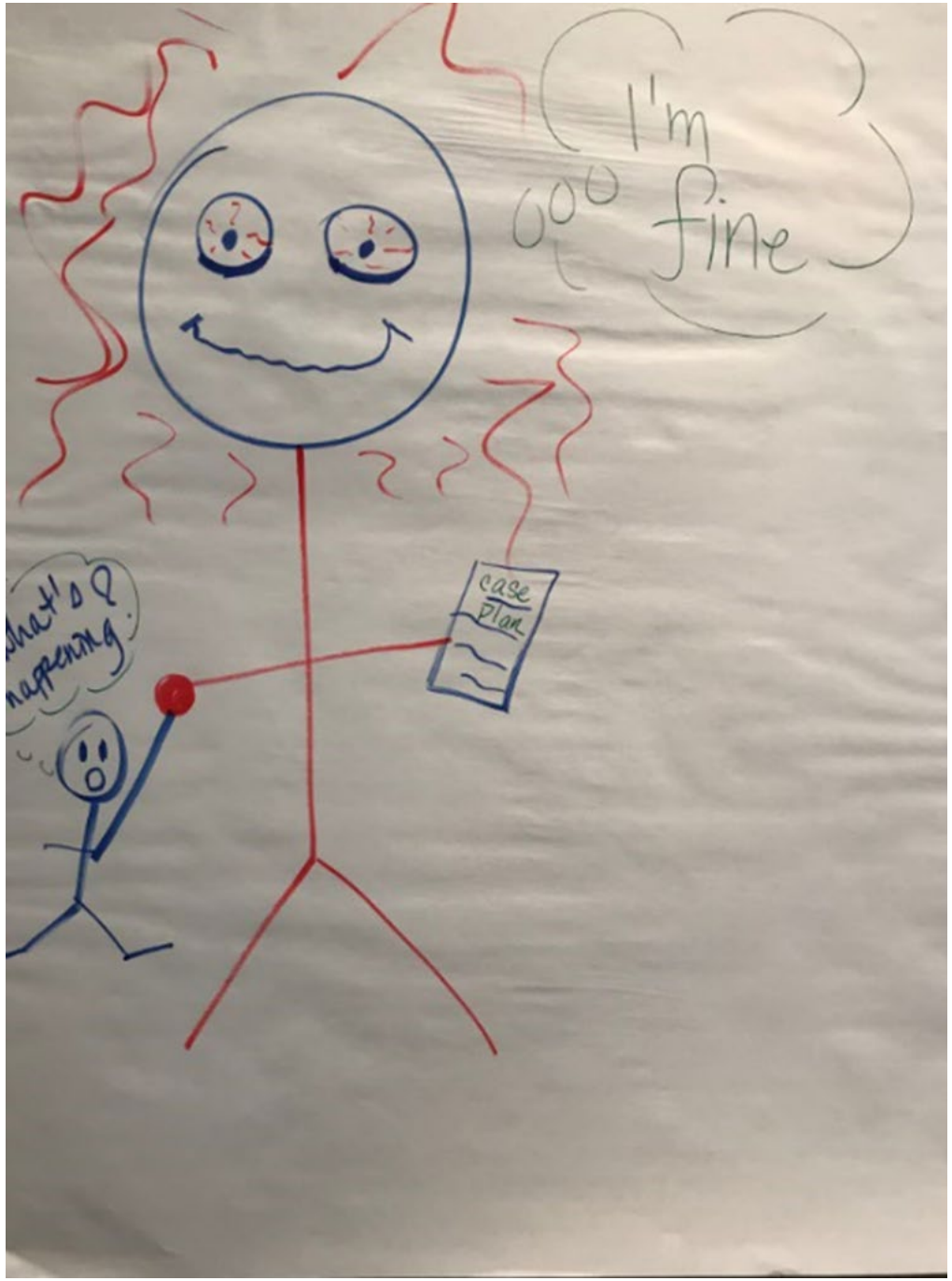
Toxic

Prolonged activation of stress response systems

In the absence of ***protective relationships.***

Harvard Center of the Developing Child

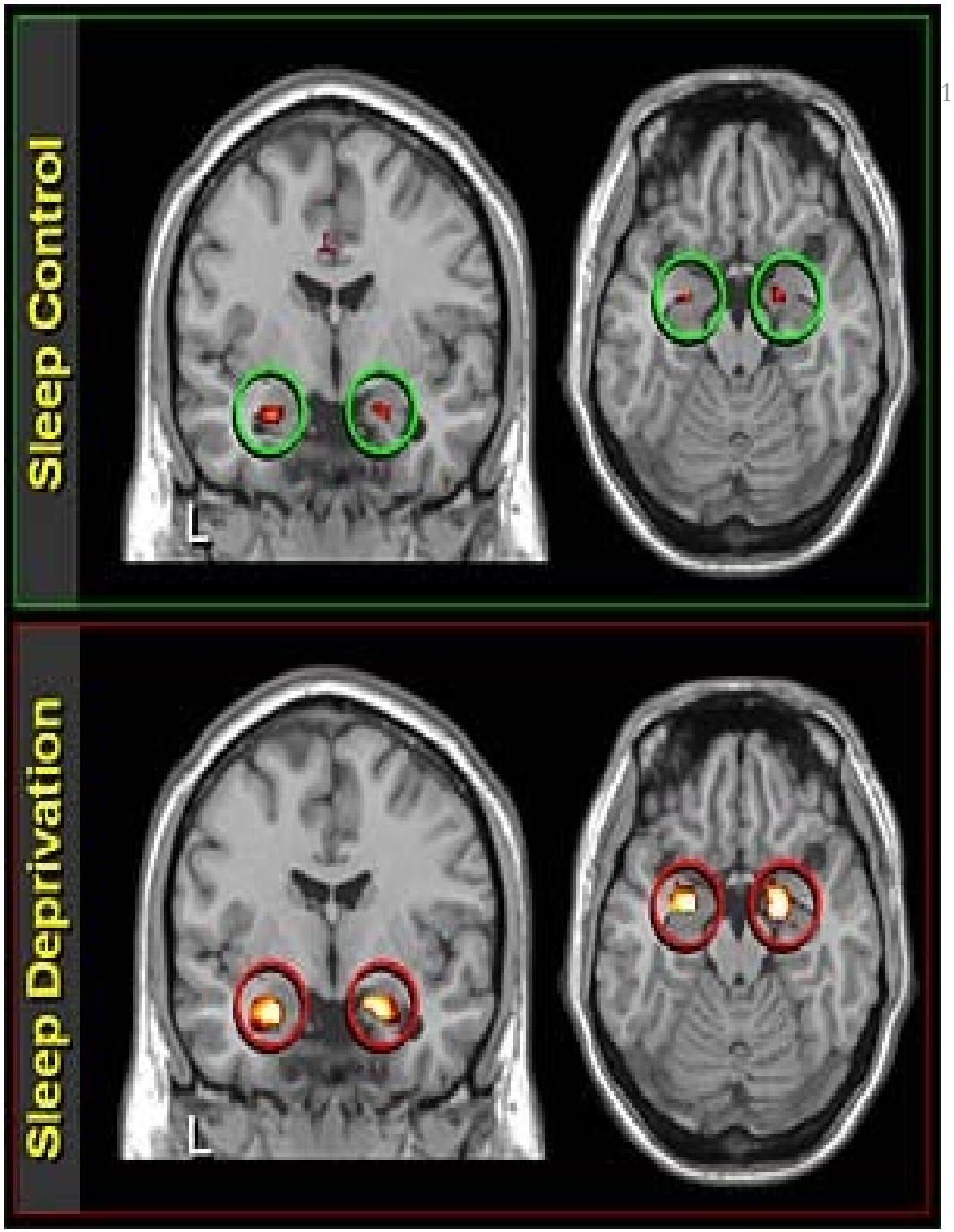

EXIT
you!


I'm fine
case Plan

Interplay of Stress and Fatigue

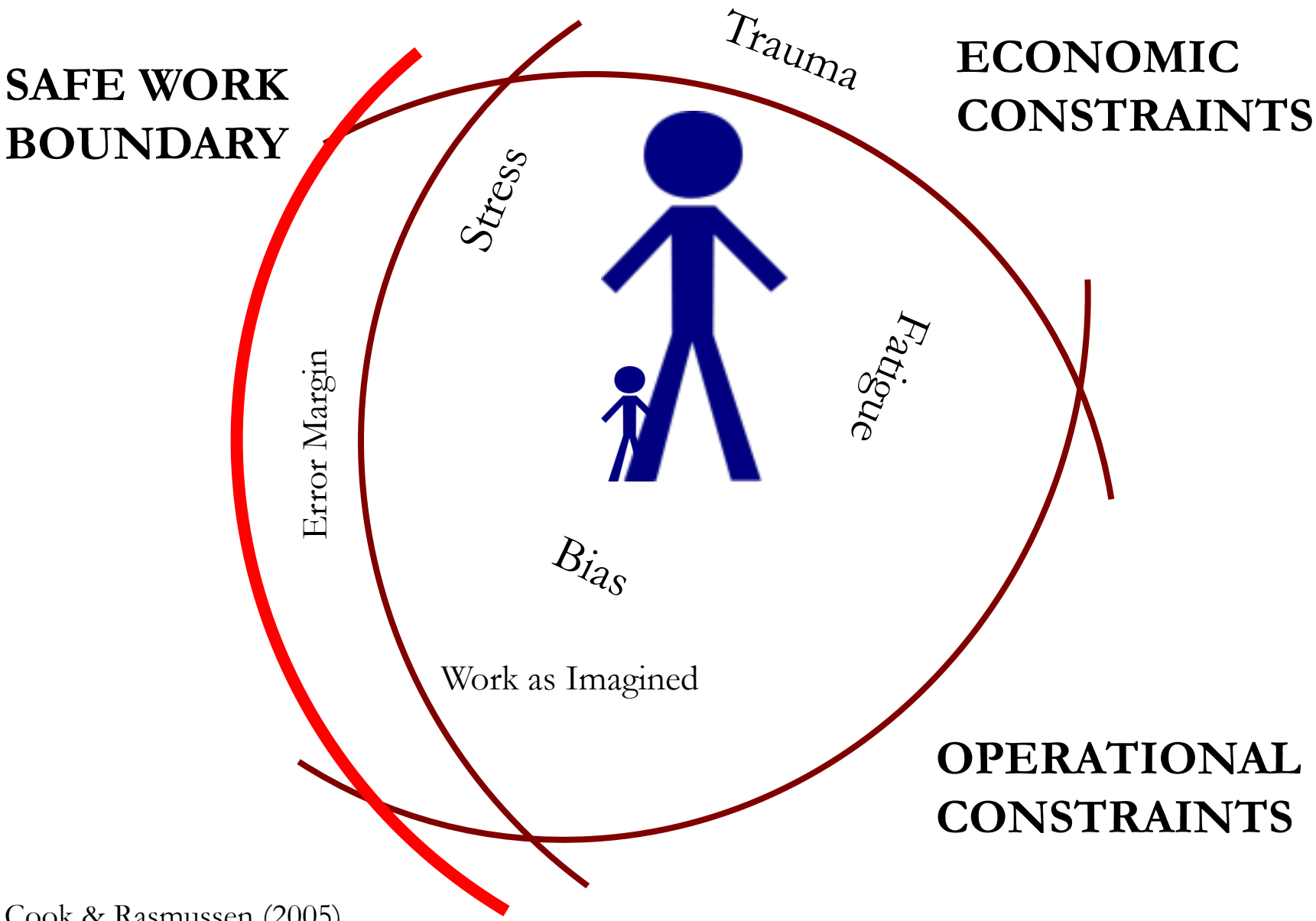
"The emotional centers of the brain were over 60 percent more reactive under conditions of sleep deprivation than in subjects who had obtained a normal night of sleep,"

Walker et. al., *Current Biology, October 2014*

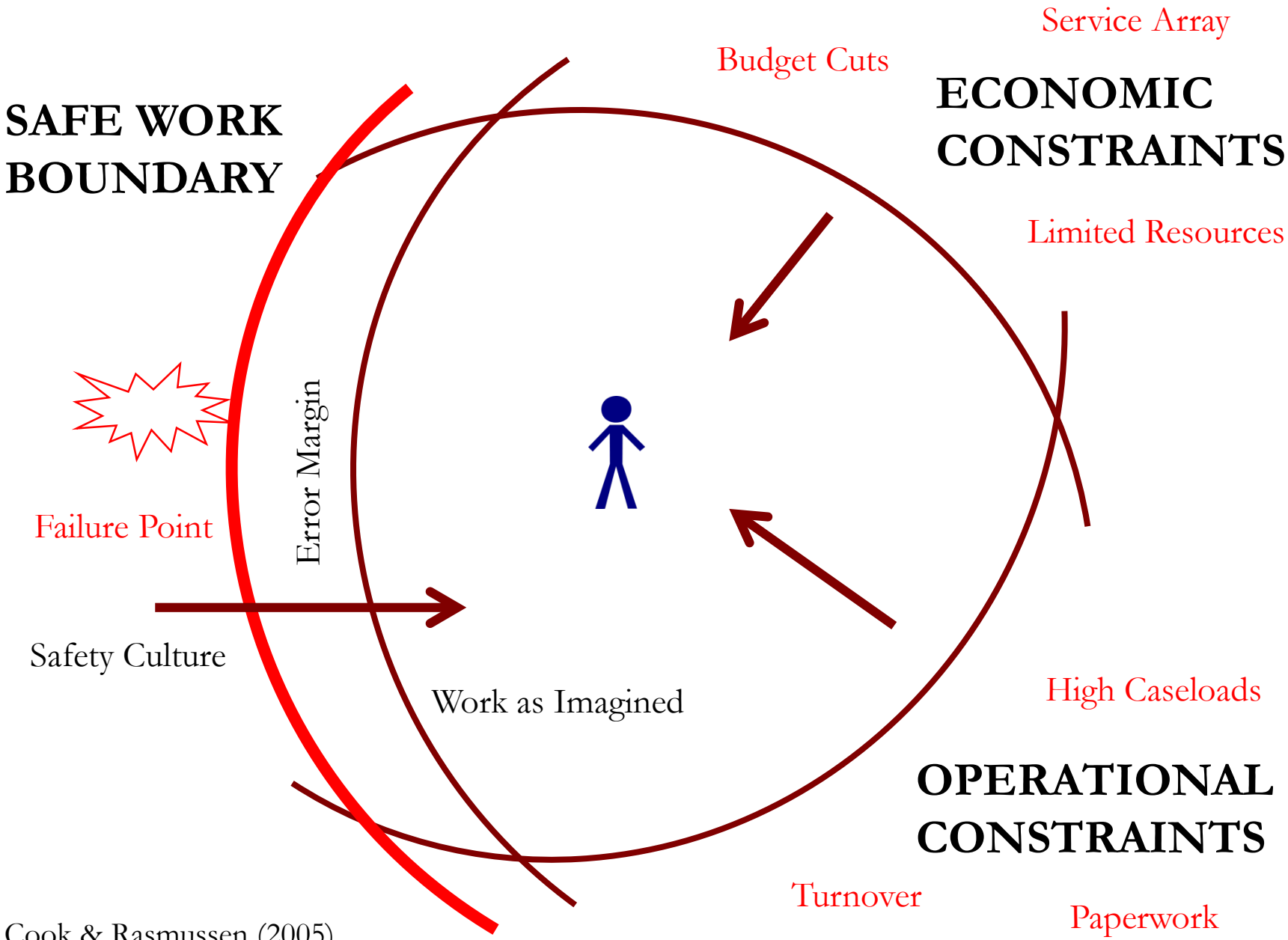



TAKE CARE
TAKE CARE
TAKE CARE
SUBWAY KEEP OFF

Resilience as a property of the system…



Cook & Rasmussen (2005)



Cook & Rasmussen (2005)

Three Interrelated Strategies

1. Organizational Assessment
2. Tools for Teams
3. Systems-focused Improvement

Cull, Rzepnicki, O'Day, & Epstein (2013)

LA’s Journey

LA by the numbers

- 21 regional officers
- 225,000 hotline calls
- 36,000 children/youth served
- 18,000 in out of home care
- 9,400 in relative care
- 28 full-time dependency court rooms
- 10,000,000 people
- 4,000 square miles
- 2,000,000 children under 18
- 9,400 DCFS employees
- 4,500 social workers

2011 - The fear-based years

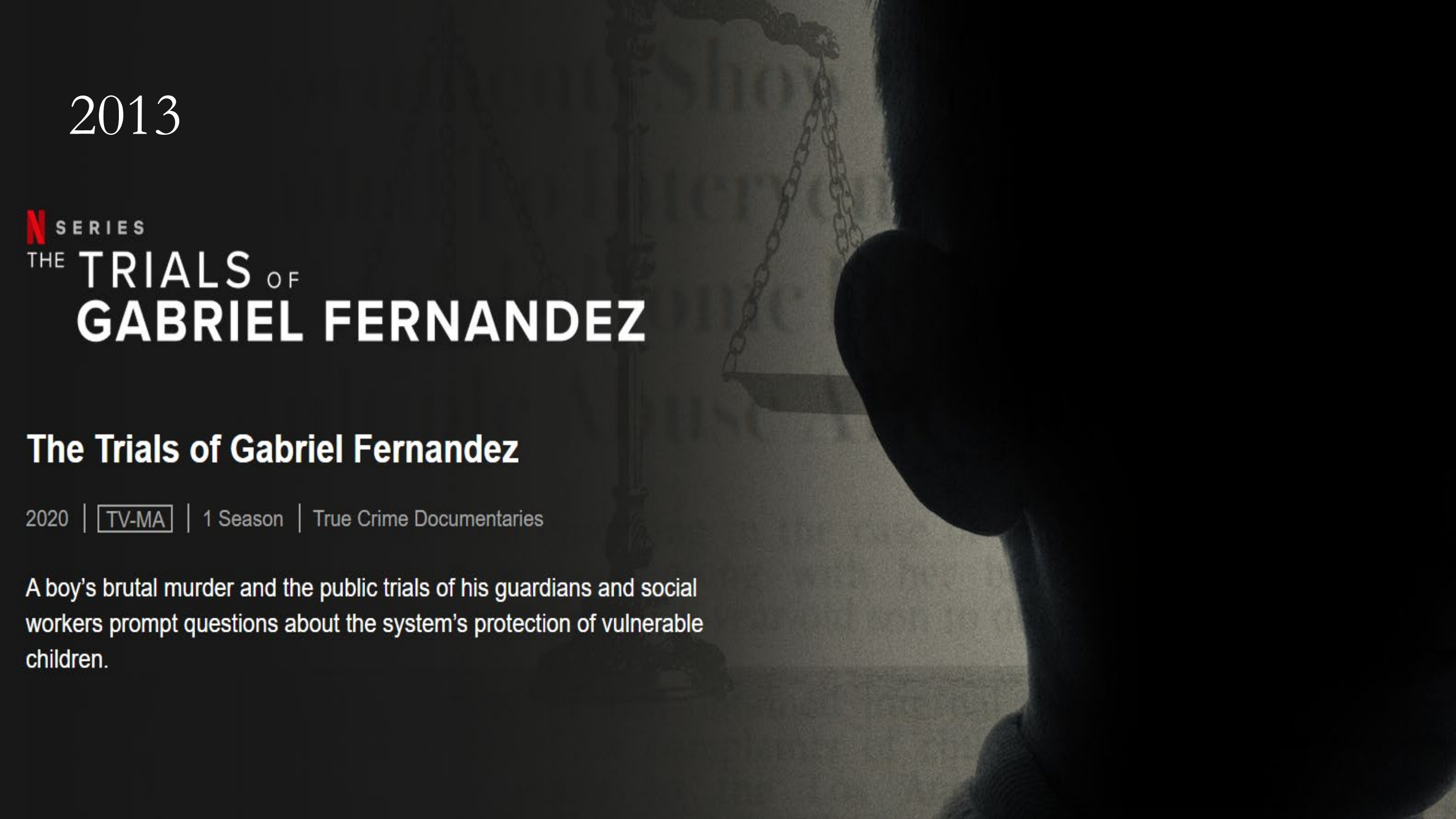
CSIU

- Deconstruct the fatality
- Make systemic recommendations
- Attorney/client privilege
- Recommendations shelved

CI/CF

- Deconstruct entire case
- Indemnified case practice deficiencies
- Referred to IA for discipline
- No systemic recommendations

2013



The Trials of Gabriel Fernandez

2020 | TV-MA | 1 Season | True Crime Documentaries

A boy's brutal murder and the public trials of his guardians and social workers prompt questions about the system's protection of vulnerable children.

Reforms after 2013

- Blue Ribbon Commission
- Office of Child Protection
- DCFS Child Fatality Redesign
- Invest LA

The National Partnership for Child Safety

NPCS is a national quality improvement (QI) collaborative with the mission *to improve child safety and prevent child maltreatment-related fatalities by strengthening families and promoting innovations in child protection*. Central to this work is the introduction of principles from the sciences of safety, improvement, and implementation.

Goals of the Collaborative

Casey Family Programs has partnered with Chapin Hall at the University of Chicago (Chapin Hall) to provide technical assistance in support of the NPCS's mission. The three activities that support the collaboratives goals are:

- Creating a national, member-directed, collaborative where child welfare jurisdictions can share standardized data on critical incidents (e.g., deaths, near deaths);
- Using a systems approach to understanding and learning from critical incidents to anchor broader system improvement and organizational culture change; and
- Assessing organizational culture and using a related set of team-based strategies and tactics to improve system safety, reliability, and effectiveness.

Participating Jurisdictions

- Connecticut
- Franklin County, OH
- Georgia
- Hamilton County, OH
- Indiana
- Los Angeles County, CA
- New Hampshire
- New Jersey
- New York City
- Santa Clara County, CA
- South Carolina
- Tennessee
- Vermont
- Wisconsin

Invest LA is a comprehensive initiative to promote system improvements in safety, permanency and well-being for children.

INVESTMENT AREAS

STRENGTHENING CHILDREN, YOUTH AND FAMILIES

We believe all children and youth deserve a place to call home and our families have access to high quality, universally available and timely services delivered with respect and integrity.

WORKFORCE EXCELLENCE

We believe our community deserves a highly skilled, culturally competent, trained and supported workforce to improve outcomes.

COMMUNITY AND CROSS SECTOR PARTNERSHIP

We believe in the shared commitment and collective impact of public and private organizations and community members to ensure children are safer, families are healthier, and communities are stronger and more supportive places for all to thrive.

FOUNDATIONAL PI

PREVENTION & AFTERCARE

Preventing traumatic experiences by strengthening the protective capacity of the family through comprehensive, integrated continuum of strength-based, family-centered and community-oriented resources.

BR SCI

Integrating understand developme effects of t resiliency, a apply them both at the and systen

SAFETY CULTURE

Applying safety sciences as learned from other disciplines to move from a culture of blame to one of accountability, to learn from undesirable outcomes, and to address systemic issues to improve outcomes.

SAFETY CULTURE

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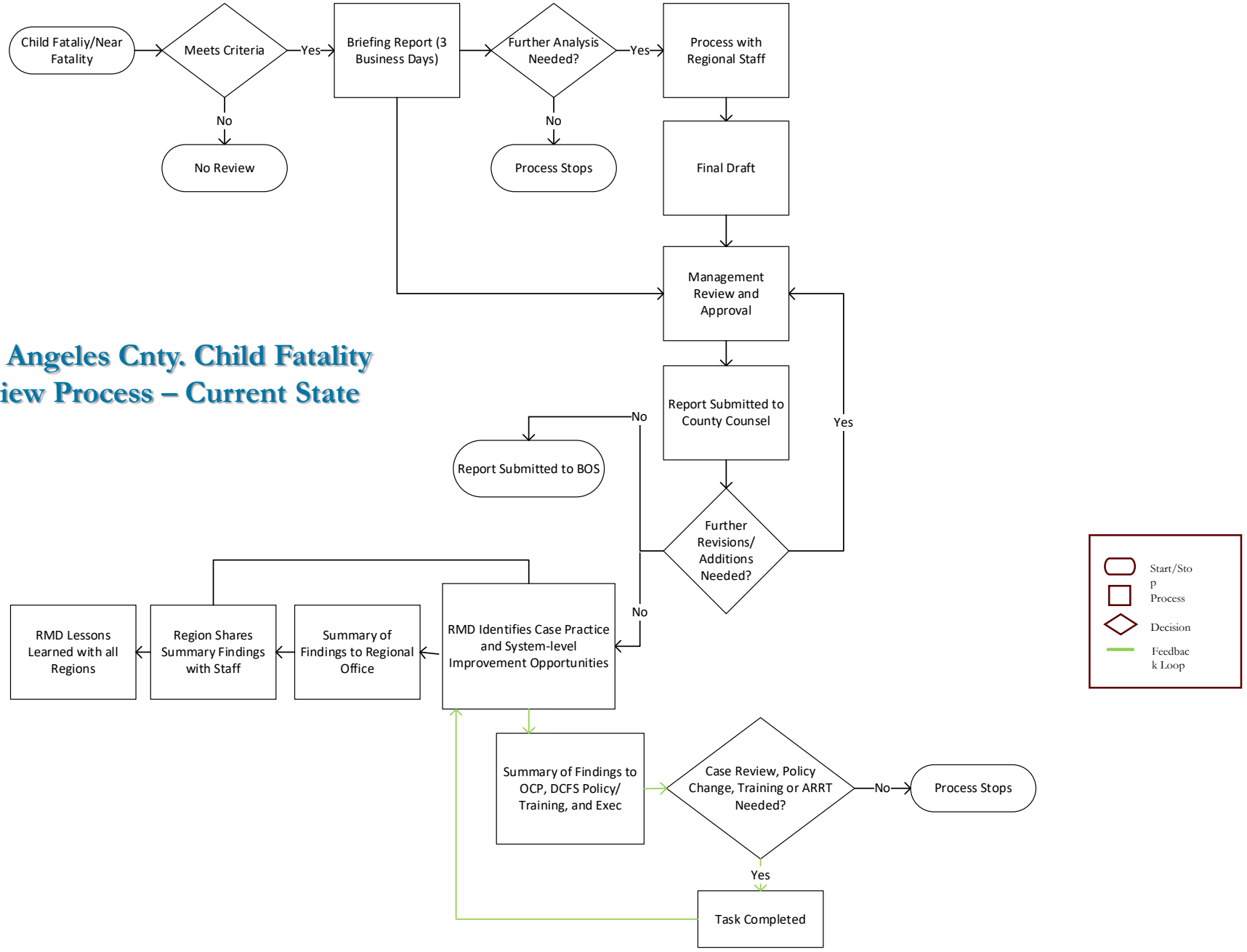
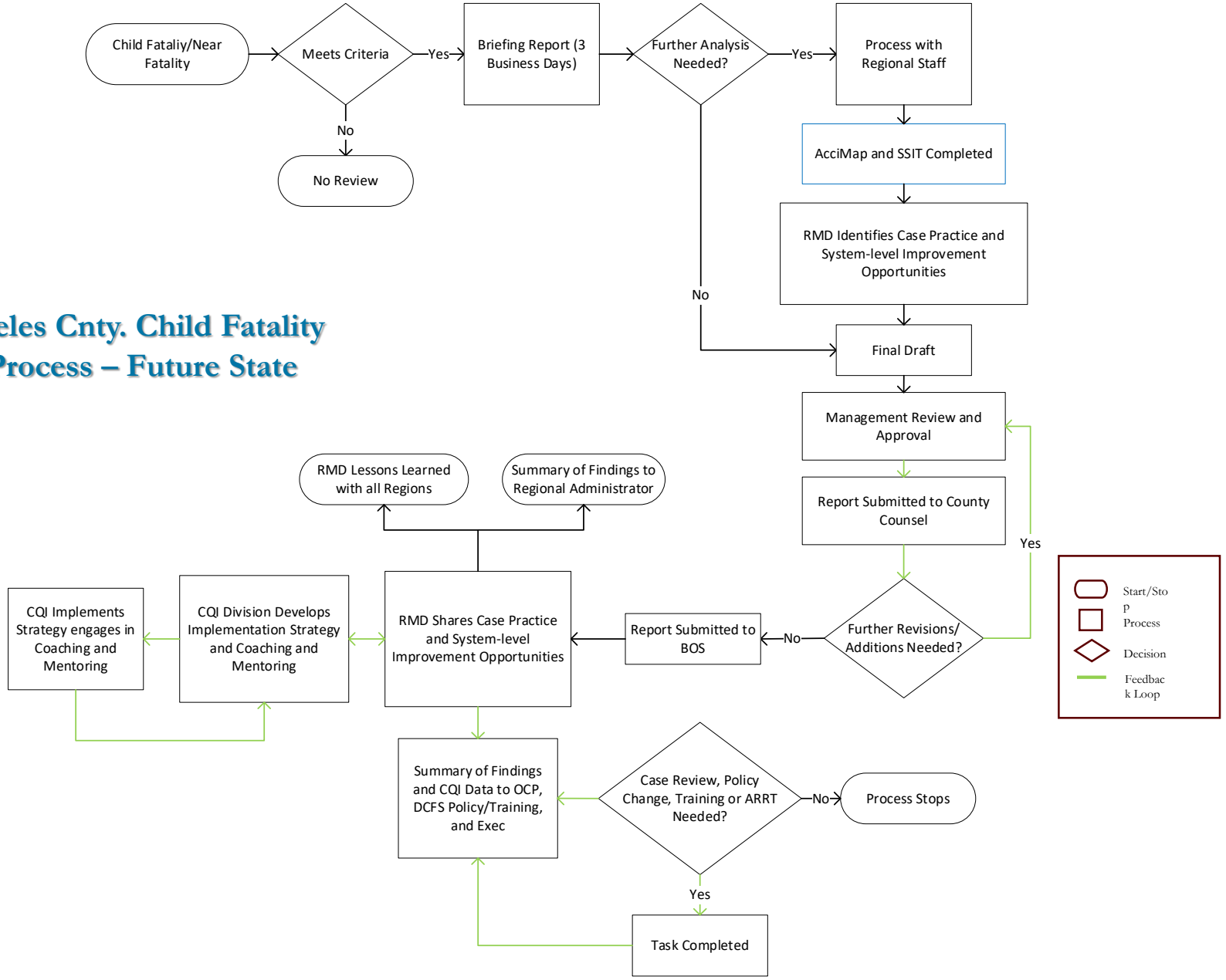
CULTURE OF EQUITY

Addressing racial and sexual orientation disproportionality which leads to increases in placement disruptions, emotional issues, hospitalizations, congregate care placements, and homelessness.

Los Angeles Cnty. Child Fatality Review Process – Current State

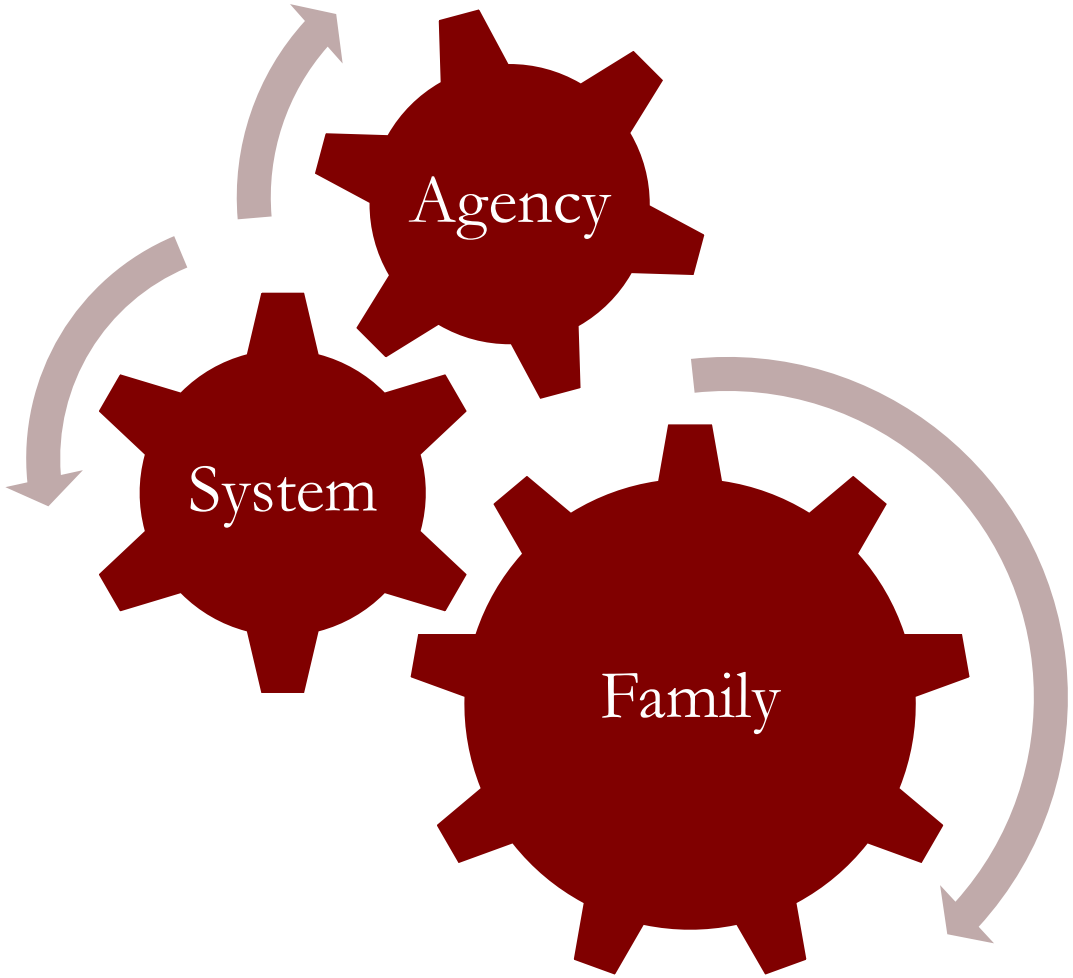


Los Angeles Cnty. Child Fatality Review Process – Future State

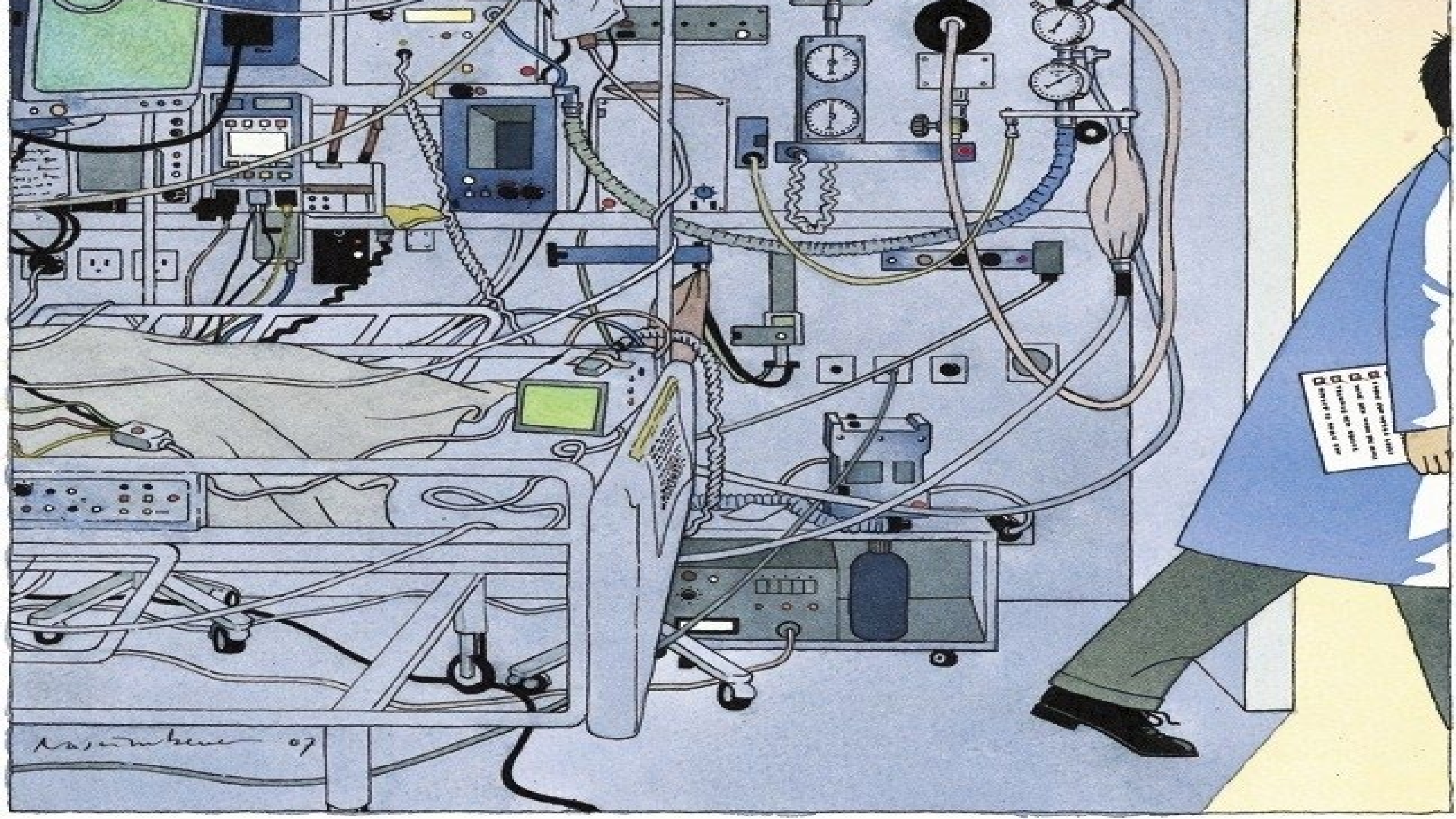


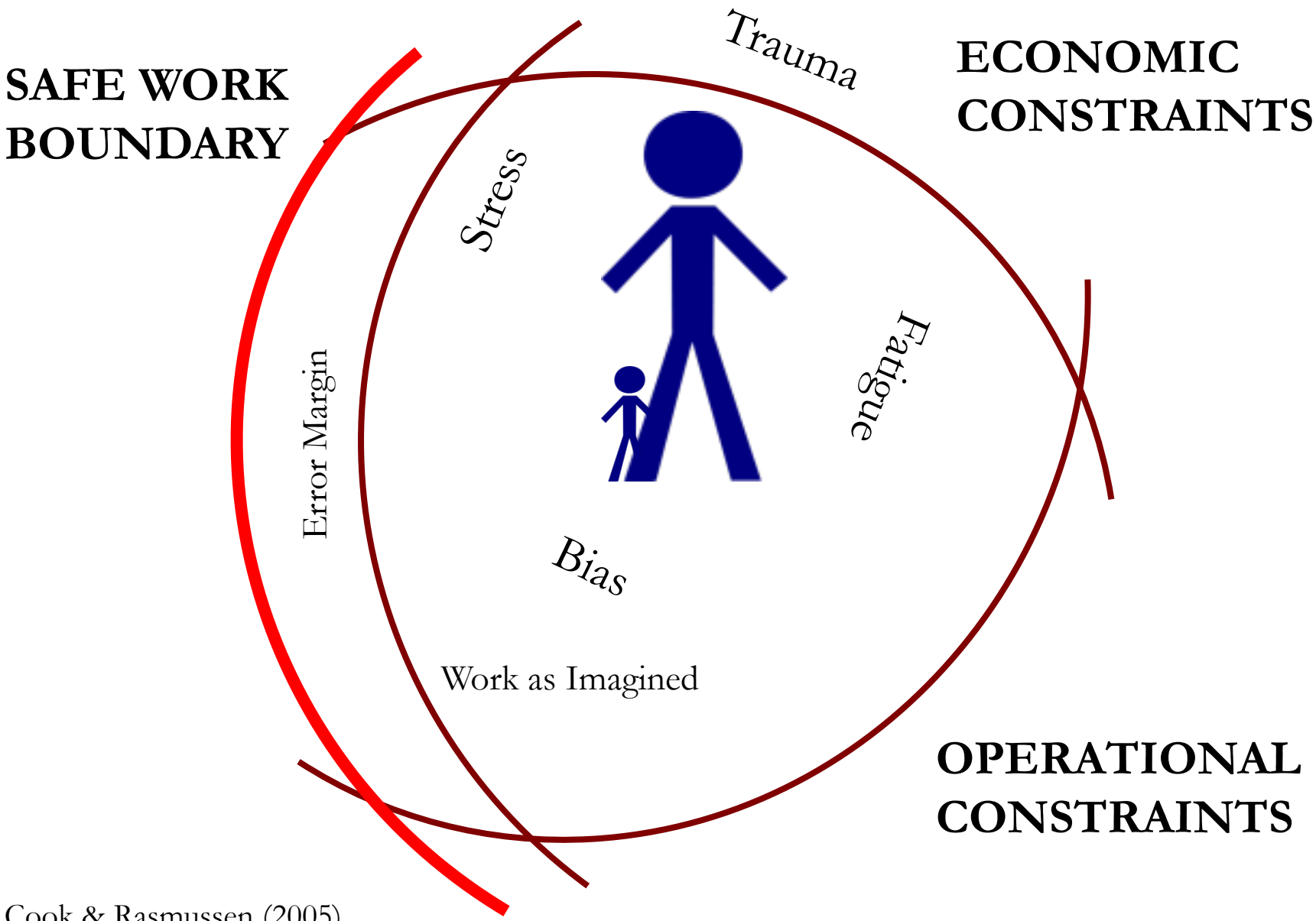
System Improvement with the Safe System Improvement Tool (SSIT)

Systems-Theoretical Approach




User experience
Design





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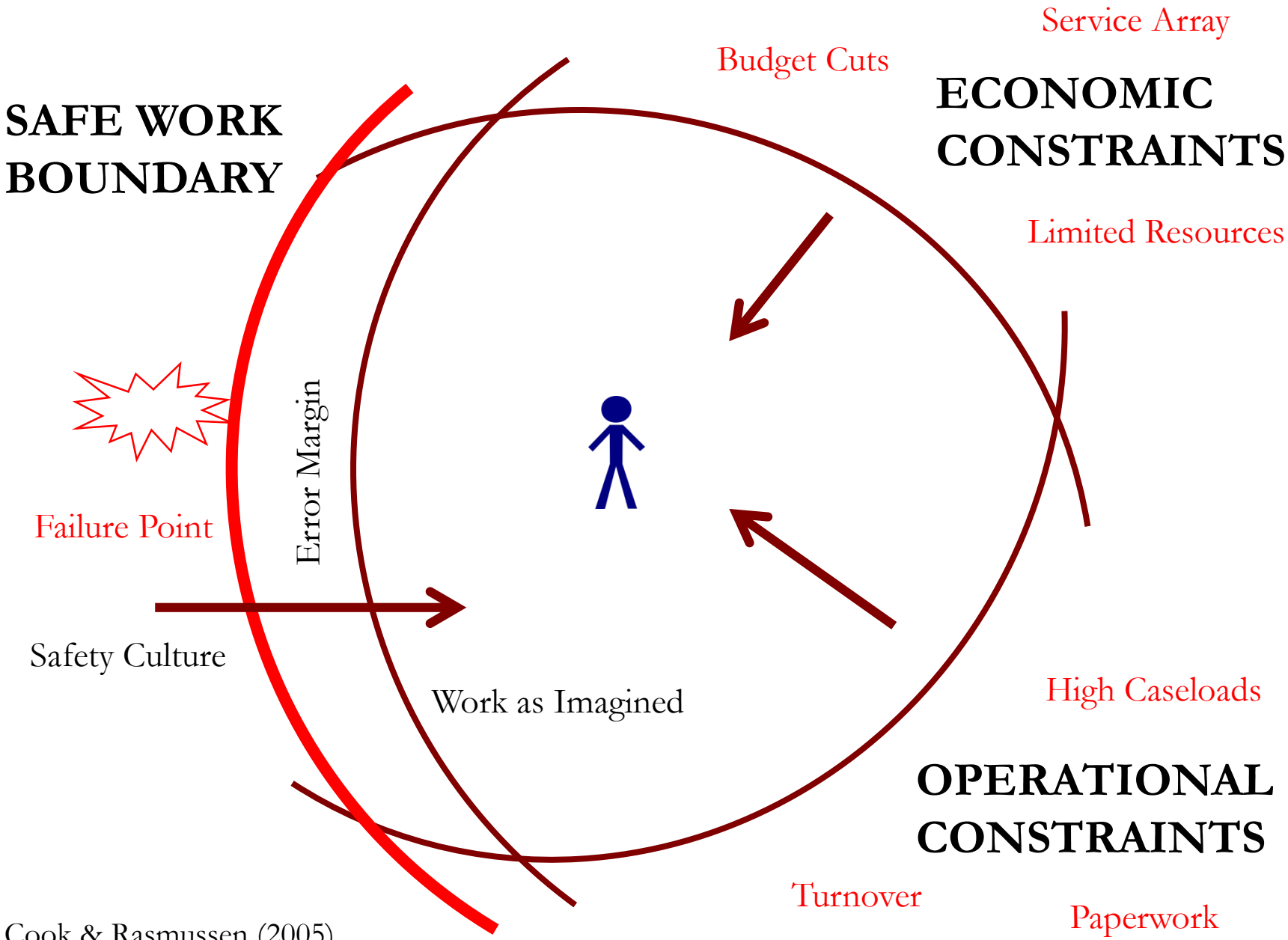


Cook & Rasmussen (2005)

Incident Review Steps:

- Review the Record– identify possible Key Findings
- Contextualize– debrief professionals, explore Local Rationality, learn the system factors affecting the case
- Identify if Key Findings were reasonably proximal to the outcome.
- Score the SSIT items
- Identify each Key Finding's Recurrence Risk

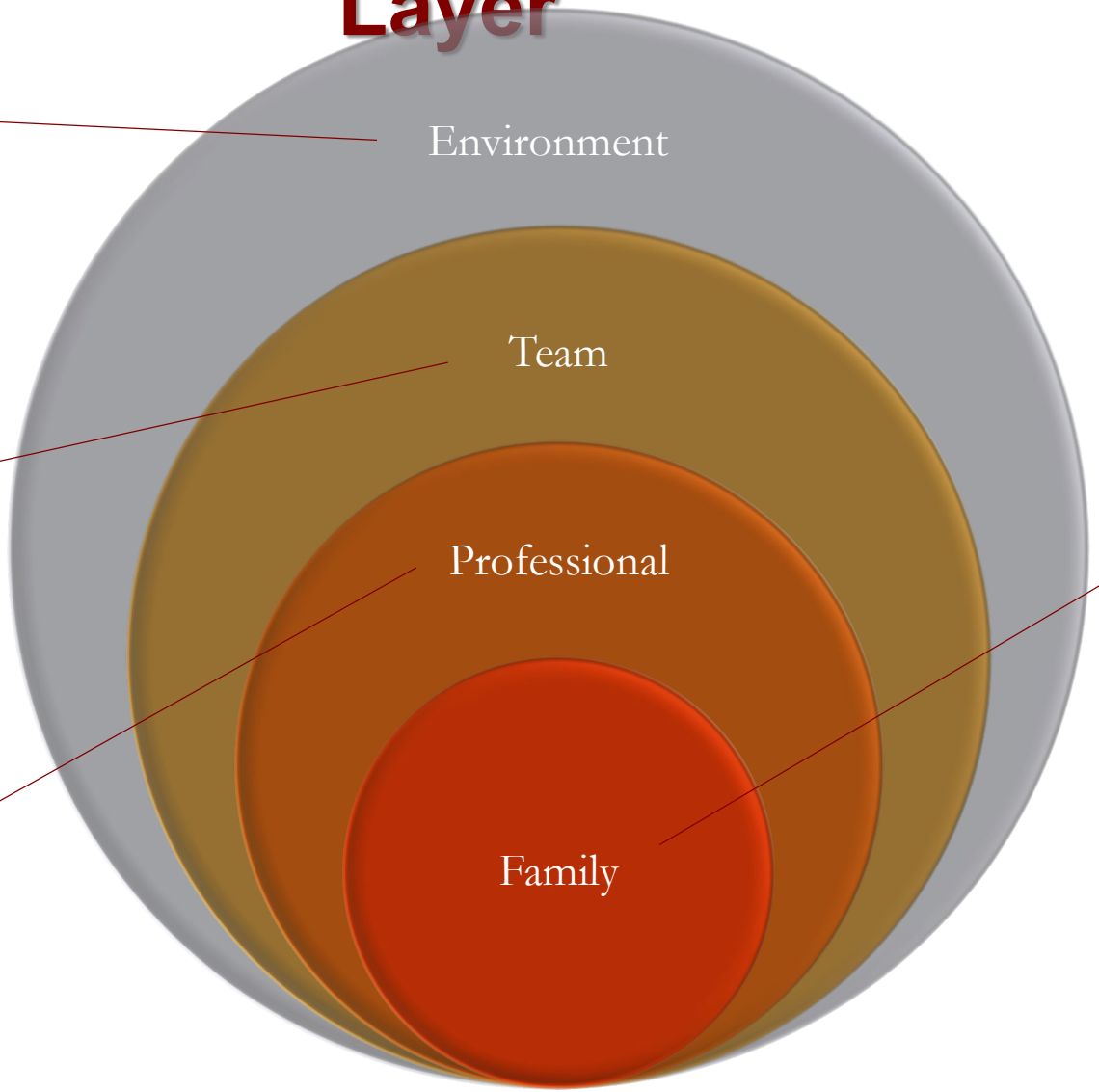
*When compiling data to share with Quality Improvement (QI) professionals, consider QI priority as established in the 2x2 grid.

Nested Domains – Seek the Systems Story Through Every Layer

ENVIRONMENT
Demand-Resource Mismatch
Technology/Equipment
Policies
Training
Service Array

TEAM
Teamwork/Coordination
Supervisory Support
Supervisory Knowledge Transfer
Production Pressure

PROFESSIONAL
Bias
Stress
Fatigue
Knowledge Base
Documentation
Evidence



CHILD/YOUTH
Medical/Physical
Developmental/
Intellectual
Mental Health

CAREGIVER
Family Conflict
Financial
Resources
Supervision
Developmental
Mental Health
Substance Use

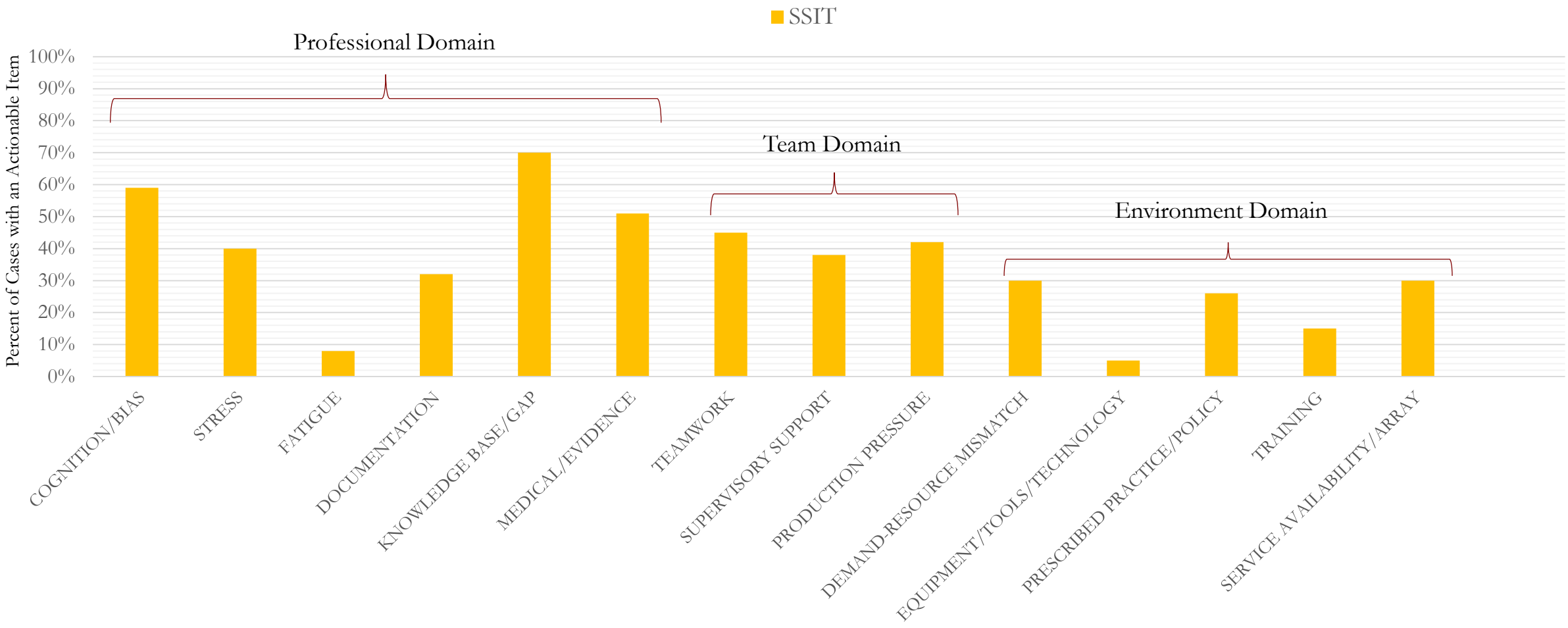
TEAMWORK/COORDINATION

Ineffective collaboration between two or more internal and/or external entities (e.g., agencies, people and teams).

Note: Ineffective teamwork between a supervisor and supervisee is captured under "Supervisory Support."

Questions to Consider	Ratings & Descriptions	
• What barriers existed in communicating with outside partners during this case? How often did you communicate? What barriers existed in internal communication while working this case?	0	No evidence of issue with teamwork/coordination.
	1	Evidence of latency (i.e., no known impact to case, but teamwork/coordination concerns were present).
	2	Teamwork/coordination impacted actions/decisions which affected safety and risk assessment or casework. Actions/decisions were not proximal to poor outcomes.
	3	Teamwork/coordination impacted actions/decisions and was proximal to poor outcomes for clients or staff.

SSIT Derived Outputs from 2018 TN Annual Report (n = 73)



Data taken from TN 2018 CDR Annual Reports. An average of 4.9 influences were identified per case in TN.

Thanks