

AGENDA

MEETING OF THE BOARD OF COMMISSIONERS

Chair: Sheila Kuehl

Thursday, September 24, 2020
1:30 PM

Meeting Location:

First 5 LA
750 N. Alameda Street
Los Angeles, CA 90012

(If you would like to speak to any item on the agenda, please complete a public comment form)

1. ACTION

Call to Order / Roll Call

2. INFORMATION

Review Program and Planning Committee Transcript from February 27, 2020

3. INFORMATION

2020 Indicators Report

Presenters: Kimberly Hall, Interim Director, Measurement, Learning & Evaluation; Agnieszka Rykaczewska, Evaluation and Learning; Manager, Measurement, Learning & Evaluation; Bryan Fahrback, Organizational Learning Specialist; Integration & Learning; Ofelia Medina, Senior Policy Strategies, Public Policy and Government Affairs; John Guevarra, Program Officer, Communities

4. Break

5. INFORMATION

Collaborative Efforts to Close the Infant and Maternal Mortality Gap in LA County: Request to Establish a Strategic Partnership with the Los Angeles County Department of Public Health to Support Evaluation of the African American Infant and Maternal Mortality Initiative in the Amount of \$400,000 over One Year

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COMMISSIONERS

Los Angeles County Supervisor	Jane Boeckmann	Yvette Martinez
Sheila Kuehl	Bobby Cagle	Romalis J. Taylor
<i>Chair</i>	Barbara Ferrer, Ph.D., M.P.H., M.Ed.	Keesha Woods
Judy Abdo		Marlene Zepeda, Ph.D.
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Presenters: Tara Ficek, Director, Health Systems; Deborah Allen, ScD, Deputy Director, Health Promotion, Los Angeles County Department of Public Health; Melissa Franklin, Pritzker Fellow; Brandi Sims, Program Officer, Family Supports

6. INFORMATION

Authorize First 5 LA to Receive Funds from First 5 California Commission for the Home Visiting Coordination Project, Approve Resolution # 2020-09 and Authorize First 5 LA Staff to an Execute Agreement in the Amount of \$199,560 (**WRITTEN ONLY**)

7. INFORMATION

Public Comment (for items not on the agenda)

8. ACTION

Adjournment



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MEETING OF FIRST 5 LOS ANGELES PROGRAM AND PLANNING
Thursday, February 27, 2020
750 North Alameda Street, First Floor
Los Angeles, California 90012

STENOGRAPHICALLY REPORTED BY:
HEATHERLYNN GONZALEZ
CSR #13646

1 Thursday, February 27, 2020; Los Angeles, California

2 1:32 p.m.

3 -oOo-

4 COMMISSIONER ZEPEDA: Okay. I think we need to --
5 I got the signal that we need to start, the high sign.
6 Okay.

7 Welcome, everybody, to -- I guess this is our
8 first of the year program and planning committee meeting.
9 So welcome. And let's go ahead and start with
10 introductions, and I'll start to my left.

11 COMMISSIONER HEGER: Astrid Heger.

12 COMMISSIONER ARAGON: Linda Aragon, Department of
13 Public Health.

14 COMMISSIONER ABDO: Judy Abdo. I'm on the board.

15 MR. HILDEBRAND: Alex Hildebrand, consultant with
16 Learning For Action.

17 MS. TITH: Good afternoon. Kaya Tith, First 5 LA.

18 MS. ALTMAYER: Christina Altmayer.

19 COMMISSIONER WOODS: Keesha Woods, Los Angeles
20 County Office of Education.

21 COMMISSIONER TILTON: Deanne Tilton, ICAN and
22 commission.

23 COMMISSIONER TAYLOR: Romalis Taylor,
24 commissioner.

25 MS. BELSHE: Kim Belshe' First 5 LA.

1 COMMISSIONER ZEPEDA: Let's start over here on the
2 left with our wonderful staff.

3 Speaker: (Inaudible), First 5 LA.

4 SECRETARY: Linda Vo, First 5 LA.

5 Speaker: Jean (inaudible), First 5 LA.

6 Speaker: (Inaudible).

7 Speaker: (Inaudible).

8 Speaker: Tara Ficek, First 5 LA.

9 COMMISSIONER ZEPEDA: Okay, Antoinette.

10 Speaker: Antoinette Andrews.

11 Speaker: (Inaudible), First 5 LA.

12 Speaker: Kara (inaudible), First 5 LA.

13 Speaker: Becca (inaudible).

14 Speaker: (Inaudible).

15 Speaker: (Inaudible).

16 Speaker: Raphael Gonzalez, First 5 LA.

17 Speaker: (Inaudible).

18 Speaker: Amado Ulloa, First 5 LA.

19 THE REPORTER: Heatherlynn Gonzalez.

20 COMMISSIONER GAREN: Wendy Garen, commissioner.

21 COMMISSIONER ZEPEDA: Welcome, everybody.

22 So let's go ahead to Item 2 and review the program
23 and planning committee meeting notes. If the commissioners
24 have any questions or comments about that?

25 Hearing none, let's go ahead and accept them as

1 is, and move onto Item 3, which is our strategic plan 2020
2 to 2028. I can't even believe that we're saying that.

3 And we have Christina Altmayer, Kim Hall, Kaya,
4 Alex will be presenting on our strategic plan. So welcome.

5 MS. TITH: Good afternoon, commissioners. Very
6 excited to be here today to present the first of our
7 implementation and learning approach for the 20-28
8 strategic plan. So as we shared, we're joined by Alex, our
9 strategy planning consultant from Learning For Action. And
10 Kim Hall and I will tag team in this presentation and also
11 open it to discussion at the end.

12 So as a reminder during the board of commissioners
13 meeting earlier this month, we provided a preview of the
14 year ahead for implementation planning and the priority
15 implementation issues for 2020. Today's discussion is a
16 continuation of that presentation where we will provide
17 further details of our implementation planning approach and
18 how we will use -- how we can use impact framework to help
19 prioritize and focus the implementation efforts being
20 developed. And we'll also provide a preview of the board's
21 guidance and decision making points throughout
22 implementation of the strategic plans once it's launched on
23 July 1st and preview the ongoing learning and reflection
24 activities that will inform periodic refinements of the
25 strategic plan.

1 Our pathway for systems change, which you've seen
2 numerous times, illustrates what First 5 LA's role and
3 contribution to systems change work is to achieve the north
4 star; that is, by 2028 all children enter kindergarten
5 ready to succeed in school and life. We believe that our
6 contribution to achieving the four results for children and
7 families in order to reach that north star is by
8 strengthening family serving child focused systems so that
9 they are accessible, they provide quality services and
10 experiences, are aligned and resources to be sustainable.

11 And our contribution to the long-term system
12 outcomes we'll advance is through implementing those four
13 strategic priorities outlined in the strategic plan. And
14 we'll do so through deploying policy change, practice
15 change, and will building. And this will be grounded in
16 our values and investment guidelines.

17 And we know that on this journey to our north star
18 is complex and it's not as simple as depicted in this
19 visual; that this journey can be winding, overlapping, and
20 multiple parallel roads leading to our north star. So to
21 help us navigate the complexity of our systems change work
22 and our progress and measure progress being made towards
23 our north star, we're developing the impact framework tool
24 as a way to measure progress to the north star. And as we
25 shared in previous board presentations on the impact

1 framework, it includes the different types of data and
2 indicators that we will monitor to track progress towards
3 our north star. These indicators include data for the
4 results for children and families that will help us gauge
5 how well family serving systems are working. It includes
6 data for the long-term systems outcomes we envision for
7 families serving child-focused systems and those early
8 markers for progress that we seek to achieve through
9 implementing the strategic priorities.

10 And then this slide here is a reminders, as the
11 systems change agent, our best contribution to
12 strengthening system is by deploying these systems change
13 approaches, policy change, practice change, and will
14 building, and that it's interlocking and requires pulling
15 all three levers in order to strengthen systems so that way
16 they work better for children and families.

17 With that context, we'll first share how the
18 elements of the pathway for systems change that we just
19 outlined will inform our approach for implementation
20 planning. Staff is currently in the planning process to
21 develop implementation strategies for the first three years
22 the implementation. This process will bring greater
23 clarity to our work to what we affirm, refine, and
24 prioritize.

25 Implementation planning is about prioritizing and

1 making choices. So this approach to this planning process
2 is focused on prioritizing those implementation strategies
3 and activities that will maximize our resources, both
4 financial and nonfinancial resources, and the impact in the
5 results we seek to see in young children and families.

6 So I'll provide an overview of the key planning
7 questions grounded in our pathway for systems change that
8 will help us identify those implementation strategies and
9 activities. And Kim will highlight how we can use the
10 impact framework to help us clarify and prioritize those
11 efforts.

12 So firstly, the top line question for
13 implementation planning is, how can First 5 LA develop an
14 integrated approach to implementing our strategic priority
15 and how will we sequence that work over the first three
16 years of implementation. So to address this for each of
17 the strategic priorities and its objective, there are
18 planning questions for each of the strategic plan elements.

19 Firstly, the four results for children and
20 families represents what we believe are the precondition
21 necessary to achieve our north star. So when we think
22 about implementation strategies, we are asking what results
23 will the objective advance. And in order to achieve the
24 result that the objective is advancing, we're also asking,
25 what's the primary system that First 5 LA will prioritize.

1 We know that there are an array of systems that serve
2 children and families, and implementation planning is
3 focusing on prioritizing what are those systems where First
4 5 LA can play a unique and differentiating role that
5 contributes to the result that we seek to see.

6 The primary system includes publicly-funded,
7 state, county, regional, municipal agencies, as well as
8 within organizations and systems include also formal and
9 informal networks at the community level.

10 And in order to strengthen the prioritize system
11 to advance our results for children and families, we're
12 asking what will be the approach as policy change, practice
13 change, will building that we'll deploy as well as the
14 tactics. And, lastly, how will implementation of the
15 objective align with our values and our investment
16 guidelines which is foundational to our work.

17 So now, I'll hand it over to Kim who will share
18 how the impact of the key impact framework questions that
19 will inform how we prioritize our implementation efforts.

20 MS. HALL: Good afternoon, commissioners.

21 So I'm going to build on the key planning question
22 that's Kaya just walked through to really demonstrate how
23 the impact framework is informing implementation planning.
24 So what we're really thinking about what these questions or
25 what they're going to allow us to do -- or answering the

1 questions will allow us to do is to make sure we're
2 aligning our implementation plan with the outcomes that we
3 seek. And we want to be really intentional about doing
4 that.

5 Secondly, we want to be explicit about how we're
6 going to measure the progress of what we're doing. So not
7 only do we want to tie our plan to outcomes, but we want to
8 say, how are we going to measure our progress towards those
9 outcomes.

10 So the first question is focused on the results,
11 and it asks which indicators for the results for children
12 and families will this objective target. So in other
13 words, for each of the efforts included in the plan, we
14 want to specify which of the ten result indicators we
15 believe it will impact. And for some of them, they may
16 impact more than one of those indicators. But we want to
17 be able to draw a clear line between the strategies we're
18 including in the plan and those indicators.

19 The second question builds on the identification
20 of the primary system, and it asks, which long-term system
21 outcomes will be prioritized for that system in order to
22 improve conditions for children and families. So here,
23 what we're really saying is that, for each primary system,
24 we want to identify which of the long-term system outcomes
25 are we going to target in first three years, which ones are

1 most important, how are we going to sequence. There may be
2 a need in some systems to address multiple long-term system
3 outcomes. But here we want to be really clear in the first
4 four years which of them. Not to say there's only one, but
5 we want to be able to name all of them.

6 And as I said previously, this is really a key
7 sustain because, by specifying the long-term system
8 outcome, not only are we saying which system do we want to
9 target, but what's the change that we're trying to make in
10 that system. And we can look to see whether or not the
11 strategies in our plan are really geared towards that
12 long-term system outcome.

13 The third question is focused on the early
14 milestone for those system changes, what we've been calling
15 the short-term markers of progress that we expect to see in
16 the first three years. So similar to specifying the
17 long-term system outcomes that we want to see, we also want
18 to be very intentional in terms of developing our strategy
19 that we're identifying what are the short-term changes that
20 we want to see. And this is going to be particularly
21 important for informing our accountability and our
22 learning, so we can start to look at, are those short-term
23 markers of progress being achieved; if not, why not. And
24 we can determine what kind of corrections or adjustments we
25 might want to make.

1 So I just want to say that, really taken together,
2 answering all three of these questions are going to allow
3 us to be clear about the changes that we're driving towards
4 and how we're going to measure our progress.

5 MS. TITH: Thank you, Kim.

6 So you just heard our approach and how we -- our
7 approach to implementation planning. And so we just wanted
8 to highlight a bright example through home visiting of how
9 this approach is being utilized in the planning process.

10 So as a reminder, one of First 5 LA strategic
11 priority is to improve, integrate, and expand systems of
12 early prevention, intervention, and learning to become
13 family centered, child focused, and promote equitable
14 outcomes. And one of the objectives for implementing this
15 strategic priority is through affirming the leadership role
16 First 5 LA can play in policy practice and system building
17 efforts that supports the development and expansion of a
18 system of voluntary home visiting system in LA County.

19 So how this implementation planning for this
20 objective look like? We believe that a coordinated
21 universal system of home visiting will connect families and
22 -- connect and link families and providers to the needed
23 resources across public systems, organizations, and the
24 informal and formal networks, thus achieving the best
25 result for children and families. And how we will measure

1 progress for that result is through the result indicator at
2 the rate of LA families who participate in home visiting
3 programs. And for this objective, we're prioritizing the
4 home visiting systems there which, include the providers --
5 providers, programs, and funders at the local and state
6 level. And we believe that this objective will advance all
7 four long-term system outcomes over the first three years,
8 which includes providing quality services that are
9 responsive to parents, families' needs and the priorities
10 of families and communities, and that a home visit -- the
11 home visiting system is sustainable by securing diversified
12 funding streams and partners, as well as a coordinated
13 referral pathway.

14 So an early marker of progress of implementing
15 this objective is demonstrating the evidence of capacity to
16 maximize -- maximize available revenue. And the system
17 change approaches we will deploy includes policy change,
18 changing administrative policies to ensure long-term
19 sustainability of the home visiting system, as well as
20 building the will of key stakeholders, funders, and
21 providers.

22 And lastly, implementation of this objective
23 aligns with First 5 LA's values of collaboration, learning,
24 integrity, diversity, equity, and inclusion through the use
25 of data, collaboration of diverse partners and

1 sustainability investment guidelines to create the
2 sustainable funding for home visiting system.

3 So this approach that we just highlighted will
4 help us prioritize and focus our implementation efforts so
5 that we will maximize our resources and impact in achieving
6 our results for young children and families. In this
7 section of the presentation, we will share how board
8 guidance and decision making throughout implementation will
9 further inform and guide implementation efforts.

10 Implementation is grounded in the policy direction set
11 forth in the refined strategic plan, and the implementation
12 of the strategic priorities and objectives will be
13 reflected through these implement -- set of implementation
14 actions.

15 So, firstly, the board approval process and
16 actions through our mid-year budget adjustments, our annual
17 budget development, and long-term financial plan informs
18 the financial resources for implementation. The
19 procurement and contract approval, whether that's through
20 our annual renewal process or through the monthly board
21 consent and action items, will provide an opportunity for
22 board to provide guidance on the -- and action on the
23 contracts and agreements that are being executed to
24 implement the work.

25 And, lastly, Proposition 10 requires that the

1 board hold a public hearing at least annually to review
2 First 5 LA's strategic plan. This annual public hearing is
3 another opportunity to share progress on implementation and
4 receive additional comments in alignment with Prop 10
5 requirements.

6 And so now, I'll hand it over to Kim who will
7 share how the impact framework can be invited through these
8 implementation actions.

9 MS. HALL: Thank you, Kaya.

10 So here we're going to highlight some of our
11 considerations about how board engagement that are focused
12 on the processes that Kaya just mentioned can be informed
13 or sort of framed in the context of the impact framework.
14 So really our aim is to embed elements of the impact
15 framework into some of our business processes, and then to
16 bring that information forward as the board is making
17 decisions to inform -- so you have that information to
18 inform your decisions.

19 So to be clear, I'm going to walk through some
20 questions that we haven't yet answered, but these are the
21 questions that we're contemplating. And our aim here is
22 really to share what our intent is and the direction that
23 we're going in so you guys can see the connection between
24 what's going to happen during implementation and how the
25 impact framework is going to play a role in that, with the

1 idea that the impact framework is not only going to be a
2 tool for measuring our progress, it's going to be a tool
3 for helping to make decisions along the way.

4 So in terms of budget decisions, we're thinking
5 through how we can connect information about the impact
6 framework to the budget so that we can really understand
7 where we're allocating resources in support of specific
8 outcomes. And those could be outcomes that are short-terms
9 markers of progress, long-term system outcomes, results.
10 But, ultimately, we really want to examine how the
11 allocation of our resources are related to our progress, so
12 we'll able to look at how much money are we spending on
13 these efforts. And then later, when we're seeing progress,
14 we can also think about what were the resources that were
15 required to achieve that progress.

16 So this is really involved, identifying the
17 connections between specific items that are in the budget
18 and the outcome indicators at the various levels so that
19 we're able to -- to understand the relative size of our
20 investment for specific outcomes and indicators.

21 In terms of procurement and contract approval,
22 there are two considerations that I want to highlight, only
23 one of which is on the slide. So our thinking is emergent.
24 And I want to talk first about the second one because it
25 relates to what I just said related to budget. So just as

1 I mentioned, we want to be able to tie specific budget
2 items to our outcomes and the indicators that we're working
3 towards. We also want to do that with new funding
4 opportunities as well as new contracts, so that when we're
5 coming to you all and talking about a new funding
6 opportunity, we're going to be able to point to
7 specifically which results and which long-term system
8 outcome and what are the short-term markers of progress
9 that those funding opportunities are driving towards. And
10 that can help inform you all's decision making about
11 whether those are investments that we want to make. And,
12 similarly, as new contracts are brought for approval, we'll
13 make those connections as well.

14 And then, finally, with the annual public hearing,
15 our intent is to report on the progress of our strategic
16 plan in a number of ways, one of which will be in terms of
17 the impact framework and the progress that we're making on
18 our indicators. However, one caveat I do want to make is
19 that, while we'll be looking at our indicators at these
20 annual public hearings and talking about the progress that
21 we're making, we want to do that while acknowledging that
22 we're not expecting to see changes in long-term system
23 outcomes and at the population level every single year.
24 Those might be things that have a longer time horizon. But
25 we will be gauging that. We'll be looking at our

1 short-term markers of progress, and, hopefully, that will
2 give us a sense that we're headed in the right direction.

3 So kind of taken altogether, what we're saying is
4 that, as we bring you information for decisions, we want to
5 be able to tie them back to the outcomes as well as the
6 outcome measures that are outlined in the impact framework.

7 MS. TITH: Thank you, Kim.

8 So what we've shared so far is, so what's our
9 implementation planning approach, what are those decision
10 making and board engagement parts with implementation. And
11 now we'll share, so what is that ongoing review and
12 refinement look like for implementation because we know
13 that implementation is a work in progress and be informed
14 through further review and reflection on what progress made
15 and implementation, what data is telling us through impact
16 framework, and what we're learning from the external
17 environment that will inform implementation.

18 So this review cycle we shared earlier during this
19 month's board of commissioners meeting is just a reminder
20 that this, while there will be ongoing learning and
21 reflections through our annual planning processes and those
22 -- through those implementation actions we just
23 highlighted, every three years there's -- we do plan to
24 engage the board and staff in a review and refinement cycle
25 of the strategic plan elements. And this could -- this

1 includes review and potential refinement of our strategic
2 priorities, objectives, and impact framework indicators
3 informed by what we're learning from our implementation
4 progress to date, what we're learning from the external
5 environment, as well as the indicators report that we are
6 planning to produce and have released in alignment with
7 these refinement cycles.

8 So to inform these refinements, there will be
9 ongoing learning and reflection activities which we'll
10 highlight here. So these activities include assessing
11 implementation progress using impact framework data, as
12 well as what we and our partners are learning from the
13 external context that may inform refinements. There will
14 also be plans to engage board and staff during the
15 refinement cycles. And these are example questions we will
16 be asking. Similar to how we went through the strategic
17 planning refinement process, we're planning that in a
18 periodic cycle, SPR4 light maybe. And so those -- the
19 questions will focus on, so what progress we're seeing,
20 what are we learning from implementation, and how do
21 changes in the external environment inform and impact
22 implementation.

23 And further refinements will be informed by the
24 input reflections and what we're hearing from our diverse
25 partners. These include what we're hearing from parents,

1 community members, grantee, county agencies, key
2 stakeholders, and others. Our partners can help us reflect
3 on what progress is being made and help us understand
4 what's happening in the environment that is contributing to
5 the progress or maybe hindering our progress. And so one
6 way an opportunity to engage our partners, which we shared
7 last year, is through our -- conducting the Center For
8 Effective Philanthropy surveys, which we continue to plan
9 to implement periodically through this process.

10 So with that, Kim, Alex and I and Christina are
11 happy to take any questions you have about our
12 implementation and learning approach for the plan.

13 Thank you.

14 COMMISSIONER ZEPEDA: Thank you very much for that
15 presentation and that overview. I know this has been a
16 long road, and we appreciate your thoughtfulness and the
17 care that you've taken in the development.

18 Commissioners, questions, comments?

19 COMMISSIONER WOODS: Three I have a question.

20 You guys may have covered this. But when we talk
21 about implementation planning approach, first off, I really
22 like the way that you broken it out between the planning
23 question and the impact question and how that's going to
24 help inform one side or the other.

25 When you're talking about your results indicators,

1 some of them for me were a little evasive, not really being
2 able to determine what the baseline was and what we're
3 trying to achieve. Now, I know we have our north star, we
4 have our strategic priorities. But how do we know that we
5 moved the needle on change if we don't know what the
6 baseline is? And some areas we can't quantify the
7 baseline. How do we know we're still effective?

8 And I think that's the part that I'm trying to
9 figure out if in my own mind as you're going through this:
10 How would I know that we are really in alignment to where
11 we want to be or do we need to tweak our direction? That's
12 a question. You don't have to answer me now, but --

13 MS. HALL: Well, I can provide somewhat of an
14 answer, provide a response to that question. So one of the
15 things that I can share is that we're in a process of
16 developing the first indicator report, which is,
17 essentially, going to provide the baseline for our ten
18 result indicators. We plan to release that report in early
19 summer with the launch of the new strategic plan. And I
20 want to say, a caveat with that is that we're going to be
21 providing a baseline based on the best information
22 available at this time.

23 You're exactly right that some of the indicators
24 are harder to measure. We don't have comprehensive data
25 that enables us to say exactly where the county is on every

1 one of those indicators. But what we will do is to talk
2 about where we are right now with that available data, and
3 that's something that we will continue to monitor over
4 time; not only what change did we see based on the data
5 that was available now, but as we develop new data, we'll
6 also start to -- we will continue to monitor that progress.

7 But there will be some changes. We -- and one
8 example of that is with the indicator that's focused on the
9 percentage of children enrolled in high quality ECE. Right
10 now, we're limited in terms of being able to report on that
11 indicator and we're relying primarily on data from QSLA,
12 our county's QRIS system. We know that only covers ten
13 percent of the licensed programs in the county. So we
14 don't know about -- and we don't know which of those other
15 programs are high quality. We don't know what percentage
16 of children are enrolled. But as we develop new data,
17 we'll have information about more of those programs and can
18 report a more accurate number.

19 I think it's a limitation. We understand that,
20 but we're going to do the best we can to sort of monitor
21 how things are changing over time.

22 COMMISSIONER WOODS: Okay. Thank you.

23 COMMISSIONER ZEPEDA: Other questions, comments?

24 COMMISSIONER HEGER: I have a question.

25 COMMISSIONER ZEPEDA: Go ahead, Commissioner

1 Heger.

2 COMMISSIONER HEGER: You go first.

3 COMMISSIONER TAYLOR: No. No. You go ahead.

4 COMMISSIONER HEGER: I would really be interested
5 in looking and getting some information on recruitment and
6 retention of the families because it feels to me sometimes,
7 as I say around this table, that we're pushing the easy
8 button and that we're going in and doing home visitations
9 on families that are actually high functioning enough that
10 they can say yes. And I'm wondering if there is a place in
11 First 5 to think about looking at the higher risk, the --
12 and then comparing them to the easy button and then working
13 on developing a plan on how we would recruit and retain. I
14 mean, I think -- I think I see families -- I mean, what's
15 the carrot to get them to come back to my clinic, say, for
16 ongoing care when I realize that they're high risk? And it
17 would be really a neat thing to say, we're going to
18 identify the highest risk families and we're actually going
19 to figure out how to recruit them into home visitation and
20 do a comparison study with what we're doing in terms of the
21 families that are the easy button. I just think it would
22 be a really interesting dynamic to see that kind of impact
23 on those -- on the families. So that's -- that's one
24 thought.

25 What are we asking the providers of home

1 visitation to provide us as far as a recruitment retention
2 strategy for these various groups?

3 MS. ALTMAYER: Thank you. Really appreciate those
4 comments. We were actually just working on that yesterday.
5 So as we think about the home visiting system and think
6 about what we're calling short-term markers of progress,
7 Two of the ones we're thinking about: One is how are we
8 looking at the recruitment of families for specific target
9 populations where we know that we're not having an
10 appropriate distribution of them out of the population that
11 we serve. So, for example, African-American women, if we
12 think about the population of them countywide that would be
13 eligible for enrollment in home visiting versus as we think
14 about the system of existing services, how does their
15 participation compare with what we would hope to be the
16 target population. So one of the short-term markers of
17 progress that we're looking at is specifically identifying
18 increasing the enrollment of African-American women.

19 Similarly -- and this is building off the recent
20 Board of Supervisors' motion that was focused on
21 identifying whether homeless women and what are we doing to
22 enroll homeless women as well as substance -- substance
23 abusing women into home visiting services. And, Linda,
24 please jump in here. So we've been working really closely
25 with the Department of Public Health to think about, how do

1 we think about this on a nonprogrammatic basis, but a more
2 systemic basis and encouraging those.

3 So those are good examples, things like target
4 enrollment and retention, that we're envisioning that would
5 be identified as specific targets in these short-term
6 markers of progress.

7 So appreciate your comment. It's very aligned
8 with our thinking.

9 Linda, if there's anything you want to add.

10 COMMISSIONER ARAGON: I think also looking at the
11 home visiting system as a whole in terms of, what is the
12 best home visiting service or model that's for the
13 different populations because we know, just because it's
14 evidenced based, doesn't mean it's going to be appropriate
15 for the different target populations; and how are we being
16 much more thoughtful and intentional in looking at
17 different home visiting type models or creating a new home
18 visiting type model that could be much more responsive to
19 kind of emerging crisis needs of families and not just the
20 ones that curriculum based, nine-to-five during the day.

21 COMMISSIONER HEGER: See, I think it would be
22 really cool to create a unique project that really looks at
23 both of highest-risk families, certainly the single moms
24 that end up being homeless, but offering them as part of
25 the participation carrot, to give them things like free

1 child care, therapeutic day care for the little kids. And
2 this certainty goes back, as you know -- I won't mention
3 those four letters again today. But goes back to the idea
4 that we are going to deal with addiction and other kinds of
5 issues in a very supportive, but aggressive way and provide
6 them with the kind of services that they need.

7 So I'm just -- I think it's -- it would be cool.
8 I mean, you and I talked about this, too, and I think I
9 talked to your boss. The idea of creating -- the idea of
10 child abuse and neglect as a public health issue and how do
11 we address it in terms of homelessness and poverty, all
12 those good things. But I just think we have to come up
13 with some guidelines for recruitment and retention that are
14 creative, unique, colorful.

15 I think I could split my -- I bet you I could get
16 a lot of people to participate in our -- our health model
17 if you opened a beauty salon and a nail salon at the
18 clinic. But that's just my thinking.

19 COMMISSIONER ZEPEDA: Thank you for those
20 comments.

21 Commissioner Taylor.

22 COMMISSIONER TAYLOR: I'm kind of in line with
23 what both my colleagues have talked about, not only the
24 baseline issue, but the community level impact. Not
25 everything is related to a data set. Some of it is about

1 how people feel that they were being engaged before and
2 then after, and what was the outcome that they had and felt
3 was the system actually responding to them. Human level
4 stories is a very important indicators of whether or not
5 what you're doing something is having a true impact versus
6 a systems level indicator, two different entities working
7 at it and finding out that working together -- that they
8 had a greater impact working together. Those are just as
9 important as the community level impact.

10 So you want to look at and evaluate all of those
11 data capturing things which may not be a data but more of
12 an evaluation and an input kind of format that gets it --
13 that we know we're moving in the right direction.

14 The other thing is I want to talk about -- between
15 the first -- when you start and then you get to the third
16 year, I don't want to wait -- I know you're going to have
17 some kind of process you're going to talk about. I'm more
18 interested in hearing about that, because you need to be
19 capturing where are we, you know, what's going on so that
20 the wind is in your sails, right, so that you know that
21 you're sailing in the right direction. So for each of
22 these different elements, there may be different ways of
23 sampling that in order to determine that you're sailing in
24 the right direction.

25 So I like the fact and we need to reiterate it,

1 we're learning environment and we're learning. So there's
2 no pass/fail. It's how we improve as we move. And so that
3 has to be an element that we preach to ourselves, as well
4 as with our collaborative partners that we're about
5 constant improvement of what we're trying to do to reach
6 the ultimate goal. So I'm -- I'm just saying somewhere
7 we've got to do that or we'll get lost in that process.

8 COMMISSIONER ZEPEDA: Thank you.

9 Any other comments, commissioners? I have a few.

10 I just want to clarify when we use the term
11 "systems," we use the term "primary system," have we
12 operationalized that for our audience because I'm -- we
13 keep talking about systems change, systems change. What
14 systems are we talking about? How are we operationalizing
15 that? You used the term "primary system," and my head went
16 directly to pediatricians or the first source point of
17 contact with -- between a child and the system. Is that
18 what we're talking about? I think it would be helpful -- I
19 don't know, maybe we've talked about that before. I don't
20 recall that we have, but I may be wrong. But I think for
21 me that needs clarification. I think that probably would
22 need clarification in order to message what it is that
23 we're doing to the public.

24 Then I also noticed on the home visiting example
25 that one of the results was the number of families

1 participating. That bothered me. And the reason that
2 bothers me is because it is very superficial and it doesn't
3 tell you anything. And this goes back to Commissioner
4 Taylor's comment about what the process was to get the --
5 the number of families participating. And it's the process
6 that we want to change and intervene in. And without
7 knowing about that process, the number of people
8 participating doesn't really give you that information.
9 And this has been -- you know, Kim, I've criticized you
10 guys about this even before you were here that we need --

11 MS. BELSHE: I was here before that Kim and the
12 other Kim and the other Kim.

13 COMMISSIONER ZEPEDA: But anyway, you know what
14 I'm talking about, the idea -- and I've criticized First 5
15 California for this too. We need to kind of look under the
16 hood to see what it is that's going on in order to make
17 those changes and then also to see, possibly to
18 Commissioner Heger's concern, that we tend to look at the
19 low-hanging fruit all the time. She calls it the easy
20 button. I hadn't heard that term before. And that you see
21 that -- we do that with. We do that with QRIS, for
22 instance, because it's a path of least resistance, and then
23 it's the cost/benefit issue, blah, blah, blah.

24 But -- and we've had -- I think we've touched on
25 this topic before in terms of qualitative analysis what is

1 going on, focus on process as opposed to product, things of
2 that nature. So I just wanted to bring that up again. And
3 I really think it's important -- and Kim brought this up in
4 her comments, is that, when we're talking about child
5 growth and development, that a one-year or a two-year
6 result will not necessarily tell you what's going to
7 happen, that often there's a latency effect, often there's
8 unanticipated consequences associated that may be positive
9 and/or negative, and that we need to be mindful of that.
10 And that's always been my issue with First 5 -- the First
11 5s is that we kind of stop at five. And it's like, there's
12 life after age five -- that we may be affecting, but we
13 don't -- we don't know that.

14 So I think that needs to be borne in mind when
15 we're talking to each other and when we're talking to
16 funders about what to expect because these one and two-year
17 outcomes for young children, which we do that in research
18 all the time doesn't -- you know, we have a washout effect,
19 you know. That's been -- we've known about that washout
20 effect since the Head Start -- Early Head Start days. So I
21 think that that's really important to keep in mind as well.

22 Commissioner Garen.

23 COMMISSIONER GAREN: Your remarks got me thinking
24 I -- with results for children and families, the raw count
25 issue versus looking at triaging needs somehow and reaching

1 the most fragile families. It also made me think that
2 we're not -- this raw count doesn't get at the impact on
3 the children or families. It's just a, did it happen.
4 It's sort of like counting, did you go to training. Yes,
5 check, I went. Did it matter, is the lives of the families
6 somehow. And so I -- I'm interested in, did it matter to
7 the children.

8 There'd be systems related did it matters too.
9 Tracking, systems engagement that -- that occurred or
10 doesn't occur. But I -- I'm a little troubled by the
11 nature of, you know, units of service being delivered and
12 that that's somehow -- that's a very -- you know, it's sort
13 of compliance oriented as opposed to impact oriented. Or
14 it's the crudest measure of impact. It's like the
15 low-hanging fruit of impact is counting it. And I'd like
16 us to go a little deeper.

17 MS. HALL: I want to say a couple of things in
18 response to those comments. And I appreciate them, and
19 those are things that we have also talked about.

20 So one thing is just a reminder that the impact
21 framework, especially the results for children and
22 families, those indicators are intended to be counted over
23 a 30,000 foot view of where our children and families. And
24 there are things underneath that that are going to give us
25 more information about how we got there, And then things

1 beyond that, which I'll talk about, give us a sense of the
2 impact, did it make a difference.

3 And so in terms of, did it make a difference, one
4 of the measures that you guys are probably all familiar
5 with and one of the efforts we have underway is around the
6 use of the EDI and being able to assess kindergarten
7 readiness. It's not an indicator for the results for
8 children and families, but it is a measure that gets us
9 better at sort of being able to measure our north star.

10 COMMISSIONER GAREN: Broadly, but unrelated to
11 home visiting.

12 MS. HALL: Yes. Exactly. You're exactly right.

13 And one of the things that we have to prioritize
14 is just, what are all of the things that we can measure and
15 what can we evaluate. And so with the impact framework,
16 we're trying to take a really broad look. But that's not
17 the only look that we're taking. We're also doing specific
18 evaluations. We're currently doing an impact evaluation of
19 Welcome Baby where we are going to be able to look at
20 outcomes, not only at the end of the program and a year
21 later, but even after that. We're working with the
22 Children's Data Network so that we're able to link the data
23 on those children who participated to their outcomes in the
24 education system and the child welfare system and a number
25 of other areas.

1 So the impact framework will not be our only tool
2 for learning. It's a learning at a really high level so
3 that we can see on a population basis what's happening.
4 And we're going to be digging deeper in other areas.

5 One of the things that I'll just preview and we'll
6 probably -- I'm sure we'll talk to you about it another
7 time is one of our objectives in the new strategic plan is
8 to partner around data and evaluation efforts. And so
9 we're going to have to make some decisions around what are
10 the programs that we're going to be evaluating and what
11 kind of evaluations are we going to be doing, What are we
12 going to learn from those evaluations. So we'll be
13 bringing those to you as well. And I just wanted to share
14 that so you guys know the impact framework is not the end
15 all, be all, but it's our way to kind of keep our finger on
16 the pulse of what's happening at the population level
17 across the county. And we can completely agree that we
18 need to look under the hood.

19 COMMISSIONER HEGER: Let me ask one more question.

20 COMMISSIONER ZEPEDA: Sure.

21 COMMISSIONER HEGER: You know, in your comparison,
22 all right, so you're looking at impact and you're saying
23 this particular group had home visitations. So what's your
24 comparison group? Who are you comparing the outcomes to?
25 You're looking at outcome or impact, not just numbers,

1 which, you know, Commissioner Garen talked about. What's
2 your comparison group? Who are you comparing them -- those
3 who did not have?

4 MS. HALL: Yeah. So there will be recruitment
5 that happens within the hospitals. And for parents who opt
6 into the study, some of those will be randomized into a
7 treatment group and a control group, essentially. But
8 there will be some parents who opt out completely. And I
9 think that maybe you're wondering about that population
10 that chooses to opt out.

11 That's a reality. We can't mandate participation,
12 but we do plan to have a control group that we're going to
13 be comparing to.

14 COMMISSIONER HEGER: I guess that comes back to
15 what I'm saying about the highest needs group, you know,
16 because they could layer themselves out into their
17 comparison group so we can look spectacularly successful
18 because you have the group that probably would have done
19 okay without home visitation. I think that's the thing I'm
20 thinking about.

21 MS. ALTMAYER: But I think that's the challenge as
22 you think about voluntary services, is how do you create
23 incentives, whether we're talking about home visiting or
24 other programs, for those who need the program most to
25 solicit -- to actively and proactively engage and say yes.

1 Right? I mean, I think the challenges for home visiting
2 services to work, it's our belief that they have to be
3 voluntary, and that by creating a universal platform you're
4 destigmatizing the seeking of those services and supports.

5 So one of the reasons why looking at home visiting
6 engagement at a population level is monitoring whether or
7 not that system is being accessible and is being inviting
8 to families so that there is that yes to participation.

9 It's not the whole measure. Right? And I think as we're
10 thinking about our measurement approach, I often use the
11 phrase that we have to think about this as like a family of
12 measures. Right? Not -- there isn't one single measure
13 that's going to be able to tell us whether or not we're --
14 that's going to answer every question, but it's kind of
15 thinking of things at the population level, at the strategy
16 level, at the specific program level to say in complement
17 what story does this tell us about the impact that First 5
18 LA is funding.

19 COMMISSIONER TAYLOR: I think we need to make this
20 very human for the general population, because it's what
21 they think, not what we think and not what is academically
22 thought of by counting a number or a widget.

23 I sit on one of the advisory committees for home
24 visitation. And the first thing I asked them to do is, I
25 want to hear what a parent had to say about what we were

1 doing. And the stories that parents tell you about the
2 hope and the power that this service gave to them that they
3 didn't have when they walked in the door was very powerful,
4 very moving. And -- and their connection back to the
5 people that helped them, you should see how they elevated
6 the good work that these people were doing.

7 These are more -- that's why I'm talking about
8 community level impact. So we can't just measure how many,
9 but we need to understand what did it do, how did it help,
10 what did it help, and how the relationship between those.

11 Parents As Teachers, people started telling other
12 people, I got this and it helped me. And it opened the
13 door for more people wanting to get it because hey, my
14 friend got it. Oh, I need to go get it. And then it gets
15 rid of the stigma. It gets rid of the fact of the help.
16 So it's how we do business, as well as what they do. And
17 people and peers do a very effective job of saying the
18 story of what you're doing.

19 So we have to be very careful about when we go and
20 interject ourselves into the lives of people, that we're
21 truly respecting their thinking and their feelings. And
22 that's why I keep talking about community level impact
23 because I want to hear from the people that we serve,
24 whether they be high need or high risk in all our
25 strategies because we want to understand how it's affecting

1 them because that's the most powerful thing when we go and
2 talk to the legislature, saying, hey, I had a story from
3 this family, this is what happened and everything. That's
4 what they want to hear. Not five widgets or seven widgets
5 did we serve.

6 So we have to collect that for the statistical
7 data. However, we want to talk about what did that mean
8 ultimately when you drill down into the real world.

9 So I -- I hear what you're saying. I think we're
10 all saying the same thing but in different ways. But I
11 just want to make it more, you know, community level.

12 MS. BELSHE: And these have been terrific
13 comments. We'll be coming back over the course of the next
14 number of months with additional layers of complexity here.
15 As a systems change funder and advocate convener, et
16 cetera, by definition, we have invited upon ourselves a
17 very complex approach to evaluating impact. So I know that
18 it may feel like there's a dissonance between results
19 indicators that are very direct service oriented in terms
20 of numbers. But behind that are other layers around
21 systems change which will have indicators as well to help
22 inform the progress we're making.

23 So our goal is not just increasing numbers of
24 people enrolled. It's enrolling in systems that accessible
25 and sustainable and aligned, et cetera.

1 Second, we also consistently said, there's both
2 quantitative measures where we actually have data, and
3 there are also qualitative measure. The qualitative will
4 help inform the process, the how in the near-term. And
5 part of -- a really powerful part of the qualitative, as
6 you're saying, Commissioner Taylor, is the voice and lived
7 experience of families.

8 But we as a major funder and leader in systems
9 change, we've got to be able to do both. Because as a
10 former recovering bureaucrat, I can assure you the numbers
11 matter. The numbers matter. And elected officials may
12 want to hear from parents. Absolutely, they want to hear
13 from parents. And that gets -- that captures their
14 imagination. It helps them see a connection to issues that
15 their communities care about and something that maybe or is
16 pending before the legislature. But that's just getting an
17 issue in the door. It then starts going through
18 legislative processes and budget processes where the data
19 actually matters. So we've got to do both. I think that's
20 an expectation we hold for ourselves. It's not either/or;
21 it's both/and.

22 So today, we're not talking about that qualitative
23 piece. We're providing that kind of higher level framework
24 for how we are trying to connect for the board our approach
25 to planning and how that will look with the impact

1 framework. But there's a lot more under the hood, and
2 that's on for us to come back and engage the committee and
3 the board more fully.

4 We've got to be able to do both/and, and we need
5 to lead on both/and.

6 COMMISSIONER ZEPEDA: Any other comments or
7 questions, commissioners?

8 This is -- we're on a journey. I know that. And
9 I appreciate all the hard work that's going into this. And
10 nobody else is doing this stuff. What did I say at one
11 point? We're building the plane as we're flying the plane.
12 So we really do appreciate all your hard thinking on this.
13 And, of course, we'll be the watchdogs on you.

14 So thank you.

15 MS. BELSHE: Thought partners.

16 COMMISSIONER TAYLOR: I like that.

17 COMMISSIONER ZEPEDA: Thought partners.

18 All right. Thank you very much. Alex, are you
19 going to say anything to us?

20 MS. BELSHE: He's here as a resource.

21 COMMISSIONER ZEPEDA: Do you want to say anything
22 to us?

23 MR. HILDEBRAND: Only that's it's been very
24 gratifying to be a part of party to all of the very hard
25 thinking that has gone into this and, like you said, is

1 still unfolding. But I think we have the right brains
2 working on the right problems. You're a part of that as
3 well. So this organization is going through the challenge
4 it needs to go through right now.

5 COMMISSIONER ZEPEDA: Thank you for your help and
6 we appreciate it. So, again, thank you for the
7 presentation. And one step at a time going forward. Thank
8 you.

9 MS. BELSHE: I suggest we go to the next one.

10 COMMISSIONER ZEPEDA: We're going to go ahead then
11 to our next item and we'll break after that. So we're
12 moving onto Item 5.

13 MS. BELSHE: Becca and Marcy.

14 COMMISSIONER ZEPEDA: Is Becca here? Oh, there
15 she is.

16 MS. BELSHE: And Marcy who is making her first
17 appearance. Yea. Barb, get the cookie ready.

18 Speaker: I'm on it.

19 MS. PATTON: I've been thinking about that cookie
20 all day.

21 COMMISSIONER ZEPEDA: Okay. So we're moving on to
22 Item 5, population level developmental index, formerly
23 known as the KRAs, progress on implementation.

24 Becca Patton and Marcy Manker and just you two are
25 talking to us. And Christina is there to correct you if --

1 MS. ALTMAYER: Moral support.

2 MS. BELSHE: Moral support. No correction needed.

3 COMMISSIONER ZEPEDA: Okay. I'll keep my mouth
4 shut. Thank you.

5 MS. PATTON: Good afternoon, commissioners. I'm
6 Becca Patton with the early care and education team. And
7 we're here to talk today about our work on the Kindergarten
8 Readiness Assessment. So you're going to see and hear
9 throughout the presentation a change in our language. So
10 we're now referring to KRA as a population level
11 measurement of school readiness. This change is a more
12 accurate description of our initiative and this new
13 language is also reflected in our newly adopted strategic
14 plan.

15 So today we're going to discuss current
16 implementation of this population level measurement of
17 school readiness. We're also going to discuss how our
18 strategy has shifted to be more in line with our newly
19 adopted strategic plan. And, finally, we're going to
20 review a proposal for expansion into the Long Beach Unified
21 School District.

22 So now I'm going to hand it over to early care and
23 education senior program officer, Marcy Manker.

24 MS. MANKER: Thank you, Becca. Am I appropriately
25 leaned in? Okay. Great.

1 MS. BELSHE: You've been leaning in since you got
2 here.

3 MS. MANKER: Good afternoon, commissioners.

4 As Becca said, I'm the senior program officer for
5 early care and education. And as of next Tuesday, I will
6 have been here a full six months. So this is, of course,
7 my first opportunity to present to the board of
8 commissioners, and it's a real pleasure. When I get
9 excited, I tend to talk very quickly. So if you see Becca
10 kick me, don't be alarmed. You have full permission to do
11 so.

12 Before I begin I want to note changes on two sides
13 from the originally posted materials. On slide seven and
14 slide ten, we shifted some of the data collection
15 projections based on recently updated timeline from Long
16 Beach Unified. Originally, they were interested in doing
17 part of their data collection in spring and part of it next
18 fall. And we're now planning on doing the data collection
19 starting in the fall to allow for more planning time.

20 So as Becca said, our goals today are to provide
21 information on progress towards implementation of the
22 initiative form early known as the KRA initiative. I want
23 to first quickly review the background of this work and
24 progress made thus far before elaborating on some of the
25 lessons learned through implementation and how we plan to

1 apply these lessons going forward.

2 As the commission will recall, the initiative was
3 approved in October 2017. The goal of the initiative was
4 to expand the use of a population level measurement of
5 school readiness in the county. The early development
6 instrument or EDI was selected as the measurement tool. In
7 the past few years, First 5 LA has partnered with school
8 districts, cities, and community-based organizations to not
9 only collect EDI data, but to also make the data available
10 to community stakeholders through informed community
11 action. In the most recent fiscal year, the board
12 authorized over \$4 million in investments to support the
13 initiative across nine different communication.

14 In the 2020-2028 -- that's the first time I've
15 said that correctly -- strategic plan, First 5 LA
16 reaffirmed commitment to the expansion of the initiative,
17 particularly in Best Start geographies. This refined
18 strategic focus is called out in two objectives in
19 particular. First, we are committed to expanding the
20 adoption of a population level measurement to capture and
21 drive systems level change. And, second, we're committed
22 to advocating and supporting the use of a population level
23 measurement of school readiness to inform community action.

24 As you all know in the strategic plan, the second
25 priority calls out advancing this work in our Best Start

1 geographies based on our historic investments. With this
2 context, we want to next review implementation thus far and
3 share our best thinking around adjustments that may be made
4 to implementation in light of this new strategic focus and
5 lessons learned.

6 The EDI continues to be the tool we use as a
7 measure of school readiness in this work. As commissioners
8 will recall, the EDI is an internationally-normed
9 measurement -- normed measurement tool designed to provide
10 the community snapshot of child well-being and readiness
11 for school. The readiness data is measured across five
12 development areas: Communication skills, physical health
13 and well-being, language and cognitive, emotional maturity,
14 and social competence. Data is collected at least three
15 months into the school year and is based on teacher recall.
16 We know that these indicators of child well-being are
17 critical information in supporting communities and the
18 county in targeting resources and driving action.

19 To date we have worked with nine different
20 communication and organizations to collect readiness data
21 representing. Data representing 12,826 students has been
22 collected. This number puts us at ten percent saturation
23 countywide. The next slide represents a detailed breakdown
24 of implementation to date and projections to the end of
25 this fiscal year.

1 So there are a few details I would like to
2 highlight for commissioners here. First, projected
3 saturation. By the end of this fiscal year, we'll have
4 data representing an additional almost 9,000 students.
5 With expansion to Long Beach by the end of next fiscal, we
6 will be at least 18 percent saturation of LA County
7 kindergartens. We anticipate returning to the board in the
8 next few months for approval to expand in other districts
9 and can anticipate this overall projected countywide
10 saturation to grow.

11 The other detail in which we'd like to expand
12 further is alignment with Best Start geographies. Through
13 out current partnerships, six of the nine EDI initiatives
14 have at least partial overlap with Best Start geographies.
15 As we consider our approach to implementation and expansion
16 of the initiative, there are opportunities for alignments
17 with in both strategic priority areas. First, how do we
18 expand strategically to capture a critical amount of data
19 for all of our Best Start geographies; and second, where we
20 already have EDI data available, how might we better
21 connect and align stakeholders across the community to
22 inform community action.

23 Okay. To address the first question, how/where
24 might we expand strategically. This map is a visualization
25 of the current alignment of Best Start geographies and EDI

1 data collection. As you can see, communities where there
2 are no EDI data being collected are Panorama City,
3 Northeast San Fernando Valley, Lancaster, and Palmdale.
4 There is also only partial overlap in the east LA,
5 southeast LA, South El Monte/El Monte areas. As we
6 consider future expansion of this work, we believe these
7 communities should be, as Becca likes to say, first among
8 equals, and should be targeted first.

9 To address the question of how we may better
10 inform community action in current and future initiatives,
11 it's useful to consider the example of the El Monte Best
12 Start geography. Three local school districts selected
13 data in 2018: El Monte, Mountain View, and Rosemead. This
14 year, the goal of the initiative has been to develop the
15 appropriate relationships and structures to use the EDI
16 data in this area to target resources and drive local
17 action. Stakeholders from across these communities,
18 including representatives from the districts, officials
19 from all three cities, communities-based organizations, and
20 specific city departments meet in a workgroup to establish
21 ways to make EDI data available and actionable to the
22 community at large, with the goal of eventually driving
23 local policy priorities and using data to target resources.

24 Current projects of this convening include
25 developing a day of the young child event for local

1 policymakers, hosting parent cafe model to train parent
2 leaders and developing a community EDI report to make
3 information accessible to community members.

4 Local elected officials have also shown interest
5 in the data, and we see strong potential for electeds in
6 these communities to become future champions of using EDI
7 data to inform and support, using city resources to support
8 early childhood. While this partnership is still in its
9 early stage, we have learned that engagement from multiple
10 stakeholders in a given community with both the data and
11 each other is an important step in ensuring collection
12 drives community action.

13 So this transitions us to our recommendation for
14 action today: A new strategic partnership with Long Beach
15 Unified School District. A strategic partnership in Long
16 Beach represents an opportunity to not only expand in the
17 Best Start geography, but also engage multiple stakeholders
18 through cross-agency collaboration.

19 The district expects to collect data representing
20 about half of the kindergarten population by the end of
21 fiscal year -- next fiscal year. As stated previously,
22 this would take our countywide saturation to about 18
23 percent.

24 What is perhaps more exciting than the increase
25 saturation in the county is that this opportunity is a

1 result of partnership across our organization and is
2 uniquely positioned to build on learnings from communities
3 like El Monte. The communities and community relations
4 team, in addition to others, worked along side the ECE team
5 to engage stakeholders across Long Beach in advocacy to
6 adopt EDI. This internal team is currently collaborating
7 to determine having a structure implementation in Long
8 Beach to capture and expand the energy around EDI that
9 exists across community stakeholders.

10 Long Beach is positioned to become a proof of
11 concept of how EDI can inform systems level change. There's
12 already support across the city, including the mayor's
13 office, the school district, and the health department.
14 Commitment to this work extends to the City's ECE strategic
15 plan and all children five collaborative which call EDI as
16 an essential component of the ECE strategy in Long Beach.

17 While not a formal partner currently, the Best
18 Start partnership is also aware of the benefit of using EDI
19 data to support community action planning and has expressed
20 interest in participating in this process. We believe
21 these conditions in Long Beach will make the use of EDI
22 uniquely effective, and we look forward to applying lessons
23 learned from this partnership to current and future EDI
24 projects.

25 The engagement of municipal and community

1 stakeholders in both El Monte and Long Beach gives us an
2 opportunity to evaluate how we may better align in our
3 existing projects. We look forward to evaluating these
4 learnings in partnership with our internal integration and
5 learning team and applying these learnings to project
6 implementation.

7 As we indicated, there's several communities where
8 data will be available for at least a portion of a given
9 Best Start geography. And as we prepare for our work next
10 year, we are determining how we may involve stakeholders
11 across a given community to collaborate, build
12 relationships, and target resources based on shared data.

13 An example of this work is in Compton where our
14 communities teams and ECE team have been working together
15 to find natural alignment points in existing community work
16 as opportunities to disseminate data across the community
17 to engage multiple stakeholders.

18 As stated earlier, as we prepare for next year,
19 we're also looking to expand in geographies with Best Start
20 overlap that do not currently have EDI data. Specifically,
21 we would like to pursue expansion in Palmdale and
22 Lancaster. We're also looking to engage other districts --
23 the other districts that serve El Monte and south El Monte
24 area.

25 MS. PATTON: So for immediate next, step you will

1 have before you in the next commission meeting a proposal
2 to -- for target expansion with the refined approach for
3 engaging multiple stakeholders. There will be a strategic
4 partnership to start with Long Beach Unified School
5 District.

6 So with that, we'll open it up to questions.

7 COMMISSIONER ZEPEDA: Thank you.

8 Commissioner Garen.

9 COMMISSIONER GAREN: I'm curious why they're
10 proposing 56 percent to be surveyed and why not go all in.

11 MS. MANKER: It just starts when I start talking.
12 That's amazing.

13 I think that's a capacity issue right now. I
14 think that would be eventually interested in going all in.
15 They wanted to phase in.

16 Go ahead.

17 MS. ALTMAYER: I was just going to say. The
18 experience with school districts is, this is a lift for the
19 school district. Teachers have to be trained on how to
20 administer the tool, they need to figure out the protocols
21 and the processes. So it's a big lean in for a school
22 district to go all in in --

23 COMMISSIONER GAREN: So they're not doing this
24 testing before you begin. It's a new -- brand new at every
25 school.

1 MS. ALTMAYER: Not in every school. Santa Monica,
2 which Judy can speak to, has had a long history of doing
3 this work. But the ones that we're bringing forward are
4 new schools.

5 COMMISSIONER ZEPEDA: Commissioner Abdo.

6 COMMISSIONER ABDO: Yes, Santa Monica has been
7 doing this a long time, but we did start in a smaller way
8 than we are doing it now, and that was using just some
9 schools. And I think -- I -- this is my recollection of
10 the data that was collected at the beginning. I think that
11 it was not nearly as valid as what we're seeing now because
12 teachers were doing this for the first time and trying to
13 answer questions about children that -- that they hadn't --
14 they'd known them for three months, but they -- they might
15 not have had the full understanding of where the question
16 was going.

17 And so I think, as it goes along, the data becomes
18 much more appropriate and valid, even though it's totally
19 subjective. And -- and that's one of the issues with this
20 particular program, is it's individual teachers saying
21 things or answering questions about children without having
22 any sort of established test, shall we say, to know exactly
23 how to answer that.

24 So if you are a teacher -- kindergarten teacher
25 with 24 kids, 20 kids, whatever number it is, in one school

1 you may be seeing a very different thing than you're --
2 than another teacher at another school is seeing. And it's
3 hard to -- to be sort of -- to step back and answer the
4 questions in -- in a way that is consistent with that other
5 teacher or that other school. I -- I think that that's
6 just part of the way this program works.

7 My other question -- my question, though, is, why
8 the change in the name? And I'm totally, totally not
9 understanding what this new name is supposed to mean. I
10 didn't like the first name either, but I'm just wondering.

11 COMMISSIONER ZEPEDA: KRA to PLDI.

12 MS. PATTON: It's not great for being simple, but
13 it's really great for being very precise and accurate. So
14 we wanted to ensure that we were really communicating that
15 this is population, it's not an individual child
16 measurement; that we're looking at school readiness, not
17 necessarily kindergarten readiness; and that this isn't
18 necessarily an assessment because it's not necessarily an
19 evaluative tool for the individual child.

20 But I hear the feedback around the mouthful of
21 words.

22 COMMISSIONER ABDO: I don't think anybody, just
23 seeing those words strung together at the beginning, would
24 understand at all what we're talking about, and that
25 includes me. I looked at that phrase and I thought, what?

1 So maybe there's a nickname.

2 MS. PATTON: Yes. Yes. And I think that that --
3 this change in language is more about our precision
4 internally and with each other and not necessarily
5 something we will use publicly or externally all that much.

6 COMMISSIONER ABDO: Thank you.

7 COMMISSIONER ZEPEDA: Commissioner Heger.

8 COMMISSIONER HEGER: Is there an incentive to --
9 as a teacher to skew the -- your statements to making the
10 kids more needy or less needy of more services?

11 MS. PATTON: Not inherently because there isn't
12 necessarily resource flow tied to individual answers. The
13 idea is that, at the population level, we do want to drive
14 community action, but we want to drive community action for
15 services for children before they enter school.

16 COMMISSIONER HEGER: I hear that.

17 MS. PATTON: So we want to -- so it wouldn't
18 necessarily -- I mean, there's a little bit of inherent
19 bias of, you want more prepared children coming into your
20 kindergarten classroom, but there's not necessarily
21 resource flow happening within the school district based on
22 results.

23 COMMISSIONER HEGER: I'm just saying, if I'm
24 writing a grant for Long Beach, I'm in the school district
25 there and I know that there's either foundation funds or

1 state fund or so forth. If I can show that the kids in my
2 school are excessively needy of better preschool services,
3 then my grant starts out with -- first line says the
4 children in our schools X, Y, and Z are so many standard
5 deviations below what would be expected or what we're
6 seeing at the schools. So I'm just saying that there's a
7 certain -- certain incentive to make yourself more needy.

8 MS. ALTMAYER: And potentially incentive to --
9 when you think about mapping this data on a countywide
10 comparison, this was an issue that certainly we addressed
11 in Orange County that there could be a bias to overstate,
12 right, if you're trying to say one school district in
13 comparison.

14 So I certainly hear, and I certainly think that's
15 a limitation of any type of qualitative assessment, right?

16 So there are a number of different school
17 readiness assessment instruments that are out there. And I
18 think all of them have the bias. And I think it has to be
19 acknowledged.

20 That being said, as Commissioner Abdo indicated,
21 over time I think the accuracy of the EDI data has improved
22 significantly because the training is more specific and
23 more directed guiding teachers with how do you answer a
24 questions. So the whole -- the instrument is a series of
25 questions that teachers are answering reflective of their

1 engagement with that individual child. Because the data is
2 never reported on an individual child basis, it's always
3 either aggregated at a school district or community basis,
4 it does try and -- it's not intended to be used to say,
5 this individual child needs X, Y, or Z.

6 It's always mapped just exclusively at a community level.
7 It mitigates of some of that bias.

8 I think we would be disingenuous if we said
9 there's no bias. There's always a bias in any of these
10 instruments. There's efforts that are made throughout the
11 training to mitigate the influence of that bias in
12 producing the results.

13 COMMISSIONER HEGER: I think some of the control
14 issues are looking at the access to various services for
15 the -- for that school district for the kids as a whole.
16 For example, if you're going to compare San Marino to, you
17 know, to -- something in SPA 6 where there's minimal access
18 or sadly -- sadly to a lot of preschools that are elegant
19 and educational. I mean, if you look at factors that
20 contribute -- I'm not just thinking about controls. I'm
21 just thinking about writing this grant.

22 Christina.

23 MS. ALTMAYER: I think it's a concern. I mean, I
24 appreciate that there certainly could be where there would
25 be incentives to -- there's a diversity of -- because

1 individual teachers are completing this as opposed to being
2 centrally administered. You have so many diverse
3 participants that it may mitigate some of that bias. I
4 think that's -- you know, I'm -- there's both pro -- is it
5 one teacher that's doing the entire data collection for the
6 entire school district. It's diversified down at the
7 teacher level.

8 So each individual teacher is probably bringing
9 some bias. Are they bringing the same bias? Probably not.
10 But I think you're pointing out that it's got -- that this
11 ongoing training is critical to get the uniformity within
12 the results to the degree possible.

13 COMMISSIONER ZEPEDA: Commissioner Abdo had a
14 question.

15 COMMISSIONER ABDO: A comment.

16 COMMISSIONER ZEPEDA: Oh, comment.

17 COMMISSIONER ABDO: I think that's a really
18 important point. And I just want to point out one example
19 that was early in Santa Monica, and that there are the
20 physical -- physically ready questions, and the -- the
21 teacher's expectation for what that is may be really
22 different in one place than in another place. But then one
23 of the -- the learnings is supposed to be, well, are there
24 enough parks, are there enough activity related things
25 available to these children, which there may or may not be.

1 But the question really gets to, are the children getting
2 the experience of the physical activity, whether or not
3 there's a million parks available if they're not going to
4 them or if they're not, you know, in -- in classes that
5 preschools sometimes present, then they're not going to --
6 they're not going to make the expectation of the teachers.

7 So I -- and I think that that was an early on bias
8 that is being addressed along the way, and it gets better
9 and better. But at the -- at the beginning, I think it was
10 a real difference in class and in what people's
11 expectations of readiness really were.

12 COMMISSIONER ZEPEDA: Did you have a comment or
13 question? Other comments or questions?

14 Okay. I have some. Does Neil Hillson know that
15 you changed the name of this thing?

16 MS. PATTON: I don't have that much power.

17 COMMISSIONER ZEPEDA: No. I can appreciate why
18 you changed it, but I agree with Commissioner Abdo that
19 it's a mouthful and people are not going to know what it
20 means.

21 I'd like to touch on something that Commissioner
22 Abdo brought up but in a much more larger philosophical
23 way, and that is the orientation of a school district to
24 children. Is this being used for transitional
25 kindergarten?

1 MS. ALTMAYER: We just have it in kindergarten
2 classroom. I don't think we have it in TK classrooms.

3 COMMISSIONER ZEPEDA: That would be important to
4 know because TK, because they're younger.

5 MS. PATTON: Exactly.

6 COMMISSIONER ZEPEDA: So that would be important
7 to know.

8 But the bigger philosophical question I think is
9 the issue that many of our elementary school teachers do
10 not have a child development background. And so,
11 therefore, their expectations are based on the kind of
12 training on what I call C and I, curriculum and
13 instruction, focused on discrete learning, things like
14 that, and not necessarily on differentiated development in
15 young children. And so that's -- that is both of a
16 challenge, but it also presents an opportunity, because one
17 of the things that we've been talking about is this notion
18 of alignment. And so this would be an opportunity to -- to
19 talk about that with the districts. And so it's -- it's a
20 big lift for sure, but I think we need to do that. I think
21 there's a lot of mechanisms like ESSA talks about that. So
22 that's -- that's a piece.

23 But I also think and I'm going to -- you know, I'm
24 a broken record on this issue. On the dual language
25 learner issue, if the teacher doesn't know the child's

1 language, the child is quiet and stays in the corner, and
2 they'll be rated very poorly. Sometimes they're rated as
3 discipline problems because they don't understand what the
4 hell is going on. So that's a concern. And I know that
5 the UCLA group is supposed to be talking about
6 disaggregating the data and all that stuff, but I think
7 that's a continuing concern that I have since the bulk of
8 the population of young children that you're going to go in
9 to see and being assessed are going to be children who come
10 from homes where English is not the primary language.

11 So that's a concern -- an ongoing concern that I
12 have had with this measure. That's my little editorial.

13 We do have a request to speak from Kathy Shriner
14 on this topic.

15 MS. SHRINER: Thank you very much. So many of you
16 know me. I'm Kathy Shriner. I'm a community member of
17 Best Start Panorama City and Neighbors out in San Fernando
18 Valley. And I'm kind of a little agitated because I've
19 been talking to Christina since the LAUSD expanded their
20 district west rather than north. And, you know, in terms
21 of equity, in terms of usefulness to our Best Start
22 community, that has not been done. In your list of
23 followups, you mentioned we were not included but we were
24 not one of the bullet points that you put in this for
25 following up. And it won't be easy because I can tell you

1 one thing I did early on to just research and understand
2 the elementary schools in our distribution, is the Panorama
3 City and Neighbors is -- the elementary schools are almost
4 divided in half between the northeast and northwest
5 districts, which is stupid because we're all east of the
6 405. But it just has something to do with LAUSD logic. So
7 if we're talking about expansion, it may need to be focused
8 more on the individual schools than, you know, that
9 breakdown.

10 And I'm sure I could get more school board member
11 to be active about this. When I found out about the -- the
12 change, it was already agendized to the LA school board.
13 And I thought about making a comment and going to our rep,
14 but it turns out it was a big day for her on something else
15 and she wouldn't have followed through. And I haven't gone
16 to her since then because I didn't want to stir up too much
17 trouble because LAUSD maybe wasn't going to be able to do
18 more things.

19 So we really feel left out. And -- and just on
20 the points Marlene raised, I was wondering about the TK as
21 well because I'm really wondering one of the things this
22 may show is the difference between the students that come
23 from TK and that come from preschool, because for all the
24 reasons that Marlene and I both know about the workforce
25 and about the teachers that get dumped down into TK and

1 aren't not necessarily well equipped to be working with
2 young children. You know, I worry about that. It's so easy
3 for the parents to sign up for TK that don't even consider
4 alternatives, especially Hispanic population. So I don't
5 kind of know how that will go, but I'm very concerned about
6 that.

7 And then, as I say, the equity issue has now come
8 up a few times. The situation we are in -- in the region
9 three is, we are within the City of Los Angeles and within
10 LA Unified School District. So it's much harder for First
11 5 to work with us than work in El Monte or Long Beach where
12 you have discrete systems and discrete governments. So I
13 just want to wave the equity flag that we don't get left
14 out.

15 COMMISSIONER ZEPEDA: Thank you, Kathy.

16 Okay. Thank you for the presentation, Becca.
17 Marcy, welcome to the game. And we'll go ahead and take a
18 ten-minute break. Thank you.

19 (A brief break.)

20 COMMISSIONER ZEPEDA: Okay. If we can start
21 making our way back to our seats. Nobody's paying
22 attention.

23 We're going to move on to Item 6. Moving on to
24 Item 6 on home visitor compensation and turnover analysis.
25 We have Diana, Christine, Sharlene, and then Barbara is

1 just hanging in there.

2 MS. DUBRANSKI: Observing.

3 COMMISSIONER ZEPEDA: Thank you.

4 MS. CAREAGA: Thank you. So, welcome,
5 commissioners, staff, and guests.

6 I'm Diana Careaga. I'm happy here to be
7 presenting the results for the compensation and turnover
8 study to, along with my colleagues here today. So your
9 PowerPoint materials listed one of the presenters as Mara
10 Harrington who is VP of Center for Nonprofit Management.
11 But I wanted to note we did make a change and we have
12 Christine Newkirk here with us to help present. She's the
13 strategist at CNM and she had the luck of having to dive in
14 to calculate and assess all of the data. So be sure to
15 pass any methodology study questions to her.

16 And I also have here Sharlene Gonzalian who is a
17 student director at Los Angeles Best Babies Network. She
18 has been in this effort with us for the past ten years. So
19 she'll be sharing some observations and highlights about
20 workforce retention in the field,

21 So as background for this study, we know that
22 recruitment and retention of high quality home visiting
23 staff is of utmost importance. They play a critical role
24 in home visiting program success given their work directly
25 with children and families. The best practices work group

1 of the home visitation consortium identified this as a type
2 of study that was a need to look at workforce retention,
3 the compensation, turnover factors. So given the
4 importance of this issue for First 5 LA, this study was
5 taken on with a countywide lens for all programs for home
6 visiting in the county.

7 And, again, the study was conducted to identify
8 and increase our understanding regarding the variation in
9 compensation across the seven home visiting program models
10 in Los Angeles or the primary larger ones and to better
11 understand the factors leading to turnover, retention.

12 So as you know, the December 2016 Board of
13 Supervisors' motion requested multiple county departments,
14 First 5 LA and others, to develop a plan to coordinate to
15 expand access for high-quality home visiting programs to
16 serve more families. In the board report that was released
17 in July 2018 really called out four areas as you see here
18 on this slide as key to realizing the optimal system of
19 support in Los Angeles: So the coordination, data,
20 workforce, and funding.

21 And the study really takes a deeper look at the
22 aspects of the workforce, and in particular the key
23 components of compensation and turnover assisting a
24 highly-qualified workforce.

25 With that, I'm going to pass it over to Christine

1 to dive into the study.

2 MS. NEWKIRK: Thank you, Dianna, for the
3 introduction.

4 So as Dianna mentioned, members of the home
5 visiting consortium learned over time that recruitment and
6 retention of quality staff in home visiting programs can be
7 challenging for a myriad of reasons. To better understand
8 patterns of recruitment and retention, First 5 LA
9 contracted this compensation and turnover study to compare
10 salary ranges for key home visiting roles to market rates
11 and to identify factors contributing to turnover and
12 retention in home visiting programs.

13 The more closely examined compensation as a
14 possible factor underlying turnover and retention, this
15 study measures home visiting compensation rates against
16 market rates, all program rates, and program specific
17 rates. And all of those data are available in the full
18 report, which you may have seen.

19 To better understand the role of employee benefits
20 in staff turnover and retention, we engaged program staff
21 in listening sessions to hear about current and recommended
22 benefits. These benefits included time off policies,
23 reimbursements, merit increases and perks that ease the
24 financial and emotional cost of the work.

25 The study was conducted in 2019. The compensation

1 data were collected between April and June 2019. And we
2 completed final data collection in July. So the
3 compensation rates reported here are considered to be
4 reflective of July 2019.

5 The collection and analysis of turnover data was
6 completed in August 2019. And the recommendations and
7 report were finalized in November 2019.

8 A majority of First 5 LA-funded programs
9 participated. Organizations managing First 5 LA-funded
10 programs participated, including Welcome Baby, Healthy
11 Families American and Parents as Teachers. We had 100
12 percent participation from Nurse-Family Partnership and
13 Healthy Start, which was easy to get because there's one of
14 each.

15 We had less participation from Partnerships For
16 Families and Early Head Start, probably because they're not
17 funded by First 5 LA. And note that we did not invite
18 Momma's Neighborhood providers to participate because the
19 program was in its earlier stages.

20 We also had strong representation of both home
21 visitors and home visiting managers and supervisors in our
22 turnover studying listening sessions.

23 And just to note, I mentioned earlier that we
24 measured home visiting compensation ranges against market
25 rates. These market rates from drawn from the Center for

1 Nonprofit Management's 2018 Southern California Nonprofit
2 Compensation and Benefits Report. This report details
3 compensation practices among nonprofit social work
4 providers across LA County, and includes reports for job
5 titles and job title families congruent with the home
6 visiting program roles of interest in this study. And if
7 anyone would like to see that, I have a hard copy of this
8 compensation study here with me today.

9 So I will now quickly review the main findings of
10 the compensation study. A note on methodology for the
11 methodologists in the room. We collected from
12 participating organizations actual annual compensation for
13 all currently employed home visiting program staff. In
14 order to compare home visiting salary ranges to market
15 rates, we looked at job descriptions for each of those
16 individuals to sort home visiting staff into job title
17 families. This allowed to us compare apples to apples and
18 not get bogged down in people's actual job titles, which
19 could be assigned inconsistently. The four job title
20 categories that we will discuss today are home visitor,
21 home visiting program manager, home visiting clinical
22 supervisor, and director of programs. The full report,
23 however, includes salary ranges for additional titles
24 because we know, for example, Welcome Baby has some
25 additional roles in their home visiting program model.

1 So for the results, I will now review the salary
2 range comparisons looking at home visitors. Home visiting
3 program home visitors were grouped into the social work
4 specialist job title family. That social work specialist
5 job title family coming from the Southern California
6 Compensation and Benefits Survey. This job title family
7 includes caseworkers, personal service coordinators,
8 counselors, and coaches all with job responsibilities very
9 similar to home visitors.

10 Here in this figure, you see the 25th, 50th, and
11 75th percentile salary range values for the social work
12 specialist, social work specialist staff level, which are
13 the two market comparisons, and the home visitor role.
14 Note that the median salary for home visitors is below the
15 median for the two comparison job title families.

16 Moving on to home visiting program manager, here
17 you see the 25th, 50th, and 75th percentile salary range
18 values for the comparison job title, which is social
19 services manager and for our home visiting program
20 managers. Again, note the home visiting program range is
21 lower than the comparison range.

22 The home visiting program clinical supervisor role
23 is the only one in which we found there to be a pretty
24 comparable range between the home visiting programs and the
25 market comparison. We see more parity there.

1 And then, finally, looking at home visiting
2 program directors. Again, with similar to the home
3 visitors and the program managers, the median salary for
4 home visiting program directors is lower than the median
5 for the comparison job title.

6 And now I will quickly introduce the main findings
7 of the turnover study. We asked for each of the
8 individuals included in the study for how long have they
9 been in their current role. And from that, we were able to
10 calculate average tenure by program model. When looking at
11 tenure by program model, we see that tenure across programs
12 is relatively low, even for programs with the longest
13 number of operating years. So this confirms the sort of
14 anecdotal evidence that led to, you know, initiating this
15 study in the first place; that within these programs, you
16 know, people don't stay very long in their position.

17 We also as part of the study, we took advantage of
18 the opportunity to estimate the cost of turnover, replacing
19 a staff person every time they leave. And when looking at
20 monetary cost of turnover in home visiting programs, we
21 found that these costs are significant. And these are
22 conservative estimates as well compared to some of the
23 methodologies that people use to calculate the cost of
24 turnover in an organization. These turnover costs include
25 the salaries of the home visitors and home visiting staff

1 who have been hired and are receiving salary but are not
2 yet fully trained and, therefore, not able to take on their
3 caseload yet. It also includes that cost of training new
4 staff, if it's a direct cost to the program, and the total
5 number of staff hours among all staff associated with
6 training and bringing on, integrating a new staff member.
7 So we estimated hours and then used salary -- average
8 salary to calculate those costs.

9 So in response to the question, why do home
10 visiting staff leave their positions or what makes it
11 difficult to stay, we heard feedback related to the
12 following: The physical work environment, including the
13 fact that home visitors themselves are often working out of
14 their own vehicles. The caseload and workload, and that
15 includes the burden of scheduling appointments at times
16 that are convenient for families while also making sure
17 that within the flow of your workday, you've made time to
18 do all of the -- you know, the reporting within the
19 reporting window. The emotional and psychological aspects
20 are costs of doing this work. The home visiting team
21 dynamic, so within that small team itself, but also
22 organizational culture and the degree to which home
23 visiting staff feel that the larger organization truly
24 understands what makes home visiting unique, challenging,
25 rewarding, and important to the overall organization

1 mission. And then formal benefits or lack of formal
2 benefits.

3 So in conclusion, our listening sessions and
4 consultation with nonprofit compensation and benefit
5 experts, as well as our own compensation and benefits study
6 findings and CNMs own expertise produced the following
7 recommendations for improving retention in these programs:
8 Developing a template of salary step ranges adopting a
9 shared policy and practice guide for home visiting program
10 salary assignments. Identifying all job requirements in
11 determining pay ranges rather than just deferring to a job
12 title, but really looking at what within an organization,
13 each individual staff member is actually being asked to do
14 because that varies, accounting for additional outside
15 factors influencing compensation rates in Southern
16 California, including the mandatory increase in minimum
17 wage and how that's hitting different organizations
18 differently, but then also the broader context around, you
19 know, problem facing everybody of stagnant wages against
20 rapidly rising housing costs and rapidly increasing cost of
21 living. Providing mental health benefits to home visitors
22 outside of the reflective supervision they receive. Again,
23 referring back to the sort of emotional and psychological
24 cost of doing this work. Providing reimbursements for
25 costs incurred by home visitors because they are often

1 working out in the field, working from coffee shops, et
2 cetera. So they incur additional costs as part of their
3 job. Car care stipends ends and providing more defined
4 concrete opportunities for advancement -- or formalizing
5 that, particularly for the home visitors so that they can
6 see the pathway to advancement within their own
7 organization or within this field.

8 And with that, I will hand this back over to
9 Sharlene. Thank you.

10 MS. GONZALIAN: Thank you so much, commissioners.
11 My name is Sharlene. I'm with LA Best Babies Network. LA
12 Best Babies Network is enthusiastically unfortunately the
13 oversight entity for the First 5 LA-funded home visiting
14 program, so that includes Welcome Baby, HFA and Pat
15 1.50.42}. We roughly over the last seven years have
16 trained over 700 staff member that has been doing this work
17 as funded by First 5. We currently have about 450 active
18 staff members across the 14 Welcome Baby sites in the 26
19 HFA and Pat sites that are funded by First 5.

20 And some of the challenges that we've run to in
21 terms of workforce and compensation is very early on. When
22 we started the expansion about six, six and a half years
23 ago, we saw a lot of jumping. There's a clear difference
24 between the pay when a hospital holds the contract as
25 opposed to when a CBO. So unfortunately, there's a lot of

1 conversation between our home visitors, our nurses, even
2 our managers and clinical supervisors in terms of pay. So
3 the home visitors, parent coaches, parent coach
4 supervisors, and nurses are generally paid at a much higher
5 rate at hospitals as opposed to their partners at a CBO who
6 are, essentially, doing the same work.

7 So that has definitely caused some challenges in
8 terms of retention at a site. But what's nice is, they
9 keep it within the network. Everyone really likes the
10 work. So they're jumping ship and just jumping to another
11 program, but they're not necessarily leaving the field or
12 leaving the program. Quite often what they're doing is
13 trying to find a site that's closer to their home and also
14 has a higher pay rate.

15 Additionally, on top of that, what we're seeing
16 is, we have a lot of staff, as Christine talked about, you
17 notice the average was -- the expansion was for Welcome
18 Baby has been about six years and the average employment
19 was 4.6 years. What we see a lot with our home visitors as
20 well is ongoing education. So we have a number of home
21 visitors also that are now going after their MSWs and MFTs
22 and are looking for further growth opportunities.

23 So what does that mean as a home visitor that when
24 technically the MFT or MSW is not a requirement but it
25 actually what we're finding is it's absolutely an asset in

1 the home visiting world, what does that mean in terms of
2 compensation and really kind of hitting the ceiling effect
3 where they don't have anywhere to go after that. And
4 necessarily private practice isn't where they want to go.
5 Their heart is still in home visiting. So what does that
6 look like. And there is that internal struggle as well for
7 our home visitors.

8 Additionally, on top of that, a lot of our home
9 visitors have very similar backgrounds to our clients.
10 They're coming from the same community. That have very
11 similar high risk or have experienced high risk adverse
12 childhood experiences. So what does that mean for us? On
13 the flip side what we're also seeing because of the success
14 of our programs, we have a handful of our clients or past
15 clients who are now our own home visitors. So there is
16 this little bit of a cycle that's going now that we have
17 expanded over the last six years, but there's still an
18 opportunity for growth.

19 So what does that mean when Christine also alluded
20 to the mental health piece. So we do provide training.
21 Every home visitor has to go through 180 hours worth of
22 training over 28 topics. There's weekly individual and
23 group, but there's many aspects beyond this when you're
24 able to go into a home and really put your own self aside,
25 as you all know, to ensure that you're providing

1 trauma-informed care. So what does that mean for the home
2 visitor that has that same background?

3 And then we're expanding. As a county, we have
4 expanded exponentially with DPH, DMH, DPSS adding more home
5 visitors. When we look at this whole collective impact in
6 terms of Welcome Baby, HFA, and Pat, we're now looking at
7 nearly 750 home visitors that are doing the work. And
8 they're all talking to each other, because, essentially,
9 it's the same 26 community-based organizations in the
10 hospitals. And there's differences between the pay even
11 between programs.

12 So what I mean by that, for CBO sometimes, they
13 don't want to pay any higher because another program at the
14 same site, they're trying to keep it equitable. So what
15 does that mean for the site who is receiving the money from
16 the funder but essentially is saying, we're choosing not to
17 give our home visitors more money because we want to make
18 sure outreach staff from a totally different program is
19 paid the same.

20 So these are just the highlight of some of the
21 anecdotal challenges that comes in terms of working with
22 staff, what we hear. But ultimately what we're seeing is,
23 folks are also sticking around because they believe in the
24 work, but also they want to be heard in terms of what's
25 happening because we're seeing that higher need. We know

1 through the data work group that only about five percent of
2 clients that actually need the services are getting it.
3 And if we just continue -- want to continue expanding the
4 workforce and the pay needs to be further built out as
5 well.

6 Thank you.

7 MS. CAREAGA: So for next steps, what do we do
8 with all this information? So one of the things that First
9 LA is doing is really looking at how this will inform our
10 contract renewals and our compensation for home visitors.
11 As Sharlene mentioned, it's anecdotal but very real that
12 this is a factor in retaining a qualified workforce. And
13 as you saw from the slides, the ranges were below, I think
14 particularly and the home visitors and supervisors.

15 So we have been looking at that data internally,
16 comparing it to current actual salary levels for home
17 visitors, and coming up with guidelines to help bring some
18 more equity and alignment to market rate where possible.
19 And so we've been working on that.

20 And I think also just ongoing monitoring of the
21 workforce retention. So as an example, the best practices
22 has expressed interest. And there are some agencies, as
23 Sharlene mentioned, that have high tenure, such as Welcome
24 Baby. What are they doing that's different that's really
25 engaging and retaining the staff? So maybe diving into

1 some of those organizations that have been able to retain
2 staff over a long term to identify some best practices and
3 learnings to share with other organizations.

4 And then, finally, our efforts continue to coordinate
5 and to align with other funders within this home visiting
6 system to really address workforce retention efforts along
7 compensation.

8 So with that, we want to open it up to your
9 questions. And thank you.

10 COMMISSIONER ZEPEDA: Thank you for that
11 presentation. It's very sobering actually presentation.

12 So questions or comments, commissioners, regarding
13 this sobering information?

14 Deanne.

15 COMMISSIONER TILTON: Thank you very much for
16 adding the depth and texture to this home visiting program
17 and issue because the numbers are hard to come by when you
18 say just five percent of the families that need home
19 visiting services are receiving them.

20 I have a couple of questions. First of all, when
21 you're talking about the overview of home visiting, are you
22 talking about across the board when you're giving your
23 statements about the supervision and management of the home
24 visitors? Are you just on the First 5 LA funded?

25 MS. HALL: That's referring specifically to

1 Welcome Baby, HFA as funded by First 5 LA.

2 COMMISSIONER TILTON: Only Welcome Baby -- and how
3 many did you say, 700 and --

4 MS. GONZALIAN: We've trained roughly about 750
5 staff over the last six years. Actively right now, there's
6 about 450, but I think it should be noted that earlier this
7 year, probably in March or April, there was a shift of
8 First 5 LA staff that went over to DPH staff in the
9 expansion. So those staff are still active and are
10 considered part of that larger training. So all in all,
11 actually, if you take the entire effort or the entire
12 network is closer to about 800 active staff member between
13 the funding sources.

14 COMMISSIONER TILTON: Okay. And so I'm struck
15 with the challenge of being a home visitor. And we can
16 talk about the -- the more high risk families or we can
17 talk about the neighborhoods and the type of program.
18 There's a big difference historically between Healthy
19 Families America and Nurse Family Partnerships, the
20 training level, the -- Healthy Families really started out
21 as just neighbors going over and saying, I'm your home
22 visitor. And I think in Hawaii where it started there was
23 some concern about some -- some of the families were --
24 where the home visitor would come over after -- after a
25 party and knock the door down and say, hey, I'm here to

1 monitor your -- your parenting skills. But it's -- it's
2 evolved so enormously.

3 So I -- I'm -- I'm focusing again on what it's
4 like to be a home visitor in each of these programs. And
5 so I guess my question is, what kind of -- we're making
6 recommendations for different kinds of support or
7 considerations for more equity in pay, but what kind of --
8 what kind of connections and support services are there for
9 these home visitors on an ongoing basis? I mean, they're
10 going out and they're trying to do their best and doing
11 wonderful things to make a difference. I'm totally on
12 board with that. But it's hard. So what -- what is there
13 for them across the board in terms of, I need -- you know,
14 I need to talk to somebody about this, or this family
15 really needs some help in this area and I need to be
16 connected with that medical or -- or social or economic
17 resource?

18 MS. CAREAGA: I'd like to start on and then I'll
19 pass it to Sharlene to add on.

20 So I think, Commissioner Tilton, you did kind of
21 identify the evolution of training and support for home
22 visitor and really valuing that work. The national model
23 really only requires a few key topics and then there's two
24 weeks worth of training for HFA. However here, because
25 we're really focused on quality and supporting, the

1 training that's provided and coordinated by Los Angeles
2 Best Baby's network is over 150 hours worth. It has really
3 ongoing touch points at the organizational level and
4 monitoring the fidelity to ensure that they're getting
5 reflective supervision, which is an identified practice to
6 help prevent burnout, support the staff when working with
7 families.

8 So in terms of connections, I mean, one, I think
9 there's connections that they may be able to make with one
10 another informally with other home visitors, given the
11 sheer number. There's also organizational practices. So I
12 think it's looking at what organizations are really able to
13 offer the level of support that's not just a reflective
14 supervision, that it's not counseling, but linking them to
15 the services that they need to be able to do this work.
16 And I think that probably varies from organization to
17 organization. Perhaps the one -- that's another question
18 to look at, say retain some other staff longer may be doing
19 a better job.

20 But I'm going to pass to Sharlene if you want to
21 add.

22 MS. GONZALIAN: Absolutely. I think one of the
23 other things to note is that these models all have
24 different hiring requirements for the home visitors. So
25 Pat and HFA don't -- minimum requirement is a high school

1 degree while Welcome Baby is a baccalaureate degree. And
2 many times what we see on the Welcome Baby side is staff
3 growing and getting their master's in terms of an MSW and
4 MFT. We've noticed differences in the retainment of
5 information as well between staff because we evaluate wait
6 all of that on our end in terms of the training evaluation
7 of the different programs and what they're able to retain
8 and how they're able to implement it into their daily work.
9 So there is a difference in terms of that.

10 To further build on Deanne mentioned the core
11 training that we have. We have what we lovingly call our
12 cohort trainings -- we're now actually just started our
13 17th one in the last six years -- where we take 28 topics
14 and we spread them over two and a half months. And every
15 new staff member that comes in is required to go over these
16 28 topics regardless of what program they're a part of, So
17 HFA, Pat, or Welcome Baby. As long as you're a part of
18 this network, you come in and you get trained.

19 Those topics range for -- from anything such as
20 bonding and attachment and empathetic parent/child
21 communication, brain development, trauma-informed care. It
22 could also include maternal depression, using the different
23 tools such as PHQ9, ASQ3 three milestones, all those sorts
24 of things. So, in essence, they're required to go through
25 all of these trainings before they start seeing clients.

1 On top of that, some of the other things that we
2 monitor for fidelity are observations and shadowing. So
3 they're required to observe their peers and not only at
4 their site, but other sites as well. There are ongoing
5 shadowing opportunities. Every manager and supervisor is
6 require to shadow their staff at least once per quarter
7 just for competency.

8 And then LA Best Babies Network, aside from the
9 cohort training, also provides ongoing support and
10 technical assistance, case consultations. We luckily have
11 full access to the database. So anytime there's a
12 situation in terms of cases that needs consulting, we get a
13 phone call and we take care of it with the staff member and
14 the -- the manager. On top of that, we provide ongoing
15 continuing education, roughly about -- so we have, I would
16 say in the fiscal year, about 24 additional continuing
17 education hours per staff member on various topics.
18 Besides themselves also take onus on doing in-services and
19 staff development based off of what their own needs are as
20 well.

21 The one slight difference I will say is Welcome
22 Baby has a lot more licensed MFTs and MSWs in the
23 supervisor role. I think that's really been helpful in
24 terms of the clinical supervision and the clinical
25 assistance that's given to staff members. The HFA and Pat

1 managers and supervisors tend to be master's prepared, but
2 don't necessarily tend to be licensed for social work and
3 MFT. So that may constitute to some sort of difference in
4 support that's provided. However, each program is required
5 to follow their model in terms of supervisor-to-employee
6 ratio, which is generally somewhere between one through
7 four or, one to five.

8 MS. DUBRANSKY: I'll just add that when you -- as
9 we've built this system over time, we've obviously studies
10 how home visiting is done in other localities across the
11 country. And the work that Los Angeles Best Babies Network
12 does is an anomaly in that most systems across the country
13 do not have this level of support. And, you know, I think
14 Sharlene is being quite humble. These agencies call LABBN
15 on a daily basis when they are having a challenge with the
16 quality of service, how -- how taking care of the home
17 visitors and the program, making connections to services
18 that families need. They are critical in convening home
19 visitors so that they can demand things, like for example,
20 when we use the data out of this database which is a
21 tremendously large database in context of the databases we
22 have available in this county, to tell the Department of
23 Mental Health, we have many more women who are showing
24 signs of depression and other mental health concerns than
25 we can find them spaces, and having the Department of

1 Mental Health say, it's not an availability issue. We have
2 availability. We're saying, okay, it's an access issue.
3 And then LABBN is the partner that they have to train home
4 visitors on how to navigate the Department of Mental
5 Health's services, as well as just really assess whether or
6 not they really need an intensive mental health services
7 versus some other need like a social support. They call
8 that mental health first aid at the Department of Mental
9 Health.

10 So when we -- often in our board meetings, we'll
11 say, can we get home visitors, too, you know, maybe give
12 materials on, you know, safe sleeping or whatever that may
13 be. Every time we want something from this workforce, it's
14 LABBN who actually makes that happen in a uniform and high
15 quality way. And I just want to point out that it's not
16 something that exists in other systems that we're able to
17 study.

18 COMMISSIONER TILTON: Excellent. Thank you.

19 COMMISSIONER ZEPEDA: Commissioner Abdo.

20 COMMISSIONER ABDO: Your training sounds
21 fantastic, and it's -- it sounds very comprehensive. And
22 I'm wondering if there is any way for them to get college
23 credit for that training so that, for those who are moving
24 forward on their educational path, that they get units. It
25 can help with future jobs or those jobs. But it can also

1 help in salary if you have more units and you have a salary
2 schedule that -- that rewards units, then it helps.

3 MS. GONZALIAN: Absolutely. We've actually done
4 quite a few letters of support for staff members who
5 perhaps were going after their bachelor's or their
6 master's, just providing documentation or -- essentially,
7 like a transcript of all the trainings that they've
8 completed with us. We have a very large database where
9 we're able to track every single training. Every single
10 staff member has down whether they're inactive or inactive.
11 And we get quite a few requests over the years.

12 Additionally, all our trainings do get continuing
13 education units -- professional continuing education units.
14 So all our nurses, LCSWs and MFTs and CHESS (phonetic)
15 units are provided roughly between six to eight units per
16 training for full-day training I should say.

17 MS. DUBRANSKY: We also in LA County right now
18 have an innovation that was brought about by CCRC, our
19 partner -- one of our partner agencies and in their
20 relationship to the Antelope Valley Community College have
21 applied to the State and received a grant to develop an
22 apprenticeship program around home visiting, which is very
23 exciting. So that will allow them to compensate people
24 while they're in school and establish essentially kind of
25 internships via that model. So they're in the process of

1 continuing to garner all the funds they need to fully
2 implement the -- the program they proposed to the State.
3 And it's going to be a great learning opportunity for all
4 of us about how we can recruit via community college
5 programs.

6 COMMISSIONER ZEPEDA: Other questions or comments?

7 Commissioner Taylor.

8 COMMISSIONER TAYLOR: Are we going -- one of the
9 recommendations to incentivize higher education and
10 development should they choose to do so? In other words,
11 if you're going to school, support them in some way of --
12 of cost sharing or cost reduction so that they can do that,
13 as well as salary elevation because, if they go up and get
14 a greater knowledge and they're more effective, as you have
15 said, in doing their work, then we should say, there's a
16 relationship between the salary and the elevation of their
17 knowledge, as well as the cost support to get that
18 knowledge.

19 MS. CAREAGA: I think on our end for First 5 LA,
20 we're definitely looking at the salary piece and how we can
21 help reform this, particularly those that are on the lower
22 end. I think, in looking at our analysis, we looked at the
23 lowest paid home visitor we have \$15.90 an hour. And that
24 will be minimum wage in July. So, again, it's looking at,
25 how do we bring some of that up to be more equitable. We

1 have a number of findings identified in the report that I
2 think are done at the organizational level. So it's really
3 promoting some of these findings, finding out what are some
4 of these organizations that are retaining them, what are
5 they doing successfully to help promote the awareness of
6 what organizations can do in terms of educational pathways
7 for their staff.

8 COMMISSIONER TAYLOR: Because if they're making
9 \$15 an hour and they're going back to junior college, as
10 you mentioned, or even getting their bachelor's or even
11 getting their master's, we need to incentivize that to let
12 them know that we totally support their effort to elevate
13 their own knowledge.

14 MS. GONZALIAN: I like to also mention that many
15 of the organizations do have some kind of stipend program
16 for continuing education, along with fairly flexible in
17 terms of accommodation of hours. We've had multiple staff
18 that, let's say if they were getting their hours, needed to
19 go down to 80 percent. And the funders have been more than
20 supportive in that sense. The team somehow figures out a
21 way.

22 What's really nice is actually I know all the
23 hospitals -- all the Welcome Baby hospitals do offer their
24 sites some kind of stipend. The CBOs also have something
25 very similar. It may not necessarily be the same amount,

1 but there's still opportunities there.

2 The other thing I just wanted to point out is, one
3 of the chief -- one of the main things that I keep hearing
4 from managers and supervisors, especially from our
5 community-based organizations, is this concept of, we know
6 our funder might support the -- what our home visitors
7 should be paid, but on an organizational level, we're not
8 sure how quickly we can make that change because of the
9 comparable rates to other programs, so that internal
10 struggle that exists. So even though the opportunity that
11 the money and the funding is there for the home visitor,
12 what does that mean for the rest of the staff. And it
13 seems like it's an internal. It's not necessarily a funder
14 challenge, per se, but it's an internal organizational
15 issue. And I actually just got this question asked this
16 morning of what can the funder do to help us internally as
17 well to determine pay across other programs even though
18 it's from different funding sources. So there was this
19 whole bigger picture, like, what does this mean for our
20 entire organization. So that's something I think that
21 really needs to be taken into consideration in this process
22 as well.

23 COMMISSIONER TAYLOR: Sometimes a shared
24 incentivizing process where we elevate the organization as
25 well as the staff by getting them to partner with them on

1 that shared responsibility will elevate the organization to
2 rethink its position.

3 COMMISSIONER ZEPEDA: Other questions or comments?

4 I have a -- I'm going to channel Commissioner
5 Woods because she's -- she had to leave. I was shocked at
6 the Early Head Start retention. Do you have any ideas
7 about why that was the case?

8 And the reason I bring it up is that Head Start
9 will become a zero-to-three program. It is becoming a
10 zero-to-three program, and much of those services are
11 delivered by home visitors because we don't have enough
12 center-based for babies. So that's alarming.

13 Do you have any hypotheses about that?

14 MS. CAREAGA: I think to keep in consideration, we
15 only had four out of 22 sites participate. So that may be
16 skewed. We don't know. They are decentralized so it was
17 harder to engage and have them participate.

18 There is a study that just came out nationally
19 from the Urban Institute around home visiting and workforce
20 development. And I will say that a lot of the trends
21 nationally are the same: Very low retention, high
22 turnover. So it's not a problem local to LA. I think it's
23 national.

24 So I think it's very important to think about what
25 are those factors that retain them or -- again, do they

1 have a pathway, does it compensate. There's probably more
2 than one, but those would be my guesses.

3 COMMISSIONER ZEPEDA: Barb and I have had that
4 this conversation as a former higher ed person. There is
5 no career path that says, home visitation, I'm going to go
6 major in home visitation. That doesn't happen. It's
7 either an -- and what you find are the social work types
8 primarily involved with home visitation, and then they need
9 all the training on child development because they've had
10 one lecture on attachment. And then have you the child
11 development people who don't know about home visitation as
12 a viable alternative for a career path, and they don't
13 necessarily have the family psychology piece that the
14 social workers have. So there is this real kind of -- it's
15 even though home visitation in some form or fashion has
16 been a long around for a long time, it's not viewed as a
17 career pathway.

18 So -- so there is this need -- and maybe you've
19 got to talk to the PEACH people. You can talk to them
20 about this. Because I know San Diego State had a
21 certificate in home visitation. I don't know of any home
22 visitation in higher education here in LA. I may -- you
23 know, there may be. So that we're having to do all this
24 patchwork stuff.

25 Anyway, I could go on and on, but I won't. But there

1 is a role for higher ed here and -- and it merits some
2 exploration.

3 MS. DUBRANSKY: There's also a new -- I've noticed
4 a new major emerging called child and family life. I teach
5 MSWs, and I have child and family life students coming in.
6 So they're getting some developmental education and they're
7 able to cross reference into social program so they can get
8 the ecological model piece of it. So that's been a
9 curiosity too. It would be great for us to look into what
10 could that mean for home visiting as well.

11 COMMISSIONER ABDO: If one of the models is to
12 employ people who have been home visited or have been
13 clients of the county in some way or another, it seems to
14 me that we need to push harder on how you enter the field
15 and what it takes, you know, if there's a certificate in
16 community college level. And then -- then some kind of a
17 program at the more BA level, if there's a -- sort of a
18 ladder to move up, it would be really good because there
19 are many people who need jobs who have been clients and
20 sort of learned while they were being served who could --
21 could be doing this work with some more training.

22 MS. DUBRANSKY: Yeah. So as you all know, we've
23 had two funding streams come from the State into home
24 visiting from Calworks as well as from the general -- the
25 general fund of the Governor's budget. What that -- in the

1 State looking at its interest in funding home visiting, one
2 of the things they did is, they turned to First 5
3 California and said, what's your role in this. This is
4 early childhood. So the First 5 California commission has
5 invested in two ways. They're looking at giving planning
6 grants across the state so that counties can look at how to
7 build their system out. They're also investing in a
8 workforce study. And one of the things they're looking for
9 and we've made sure that they've been aware of the Urban
10 Institute work that just came out which has been really
11 important, as well as obviously we've shared our own
12 results with them. And they're looking at just that
13 because we didn't go so far in our study to go into career
14 pathways. And they will take the study further and will
15 look at it on a statewide basis. And, of course, we'll be
16 sharing data as we can to support that work.

17 MS. GONZALIAN: I can also mention Brandy Sims
18 through the -- so I help facilitate the African-American
19 home visiting engagement work group for the First 5 LA
20 funded home visiting programs. It's been really great to
21 have home visitors actually come together and explore what
22 needs to be done to engage our African-American clients
23 even more.

24 One of the things we just launched, actually, with
25 the help of Brandy's initiative and she got a really nice

1 sample size, about 300 -- I think it's close to 350, 360
2 home visitors that responded to that survey was around the
3 engagement work with African-American families, but also
4 what was their career pathway into where they are. So that
5 actually that rich data is sitting there, but it's a lot of
6 work to go through and there's a lot of qualitative piece
7 into that as well. So that's actually fresh, hot off the
8 press in some sense, and it is available for analysis,
9 which we'll be working on in the next couple of months.

10 And then also I want to highlight the work that
11 Deanna has done with The best Practice workgroup with the
12 consortium, but the consortium has the -- the best
13 practices work has done a lot of surveys with our existing
14 CBOs in terms of taking on interns. So what does it look
15 like for home visiting interns to come on and the liability
16 piece and the opportunity piece and all -- the contracting
17 piece and all of that. And then through the best practices
18 workgroup, we've actually made a couple of connections with
19 universities and we're kind of on, like, heavy rotation for
20 presentations right now, especially with the ECE and child
21 and family life degrees. So that -- that work has -- was
22 started with the initiative that Deanna took with the best
23 practices workgroup as well.

24 COMMISSIONER ZEPEDA: Thank you for that.

25 Any other questions or comments from

1 commissioners? We do have a --

2 COMMISSIONER TAYLOR: I just have one thing. I
3 would be very interested in, once you do the analysis of
4 that information, what is the outcome, if you can come back
5 and share that with us.

6 COMMISSIONER ZEPEDA: We do have a request to
7 speak from Kathy on this item. Kathy Shriner.

8 MS. SHRINER: Thank you. Thank you. I was just
9 so pleased to see this on the agenda because it's been a
10 big problem in region 3, if you want to just take -- the
11 valley. Very -- from quite a while ago because I would
12 hear anecdotally about, oh, we lost a bunch of staff
13 because they were able to get higher salaries. And just
14 most critically, I was in a meeting on a different purpose
15 and found out that one of the agencies had lost virtually a
16 whole team of home visitors and were starting from scratch
17 therefore because they won't have productive people for
18 whatever number of months it is that they're going through
19 the Best Babies Network.

20 And so it does seem that a way of bringing pay
21 equity is probably very important, but also raising the
22 floor, you know. And -- and as Marlene knows, I've been
23 very involved in ECE work for a number of years and there's
24 a lot of parallels, you know, to what's going on. And
25 especially that interest -- issue of the agencies, CBOs not

1 feeling like they can raise the ECE people without some of
2 the other people. So at least -- you know, just to know
3 that it's similar.

4 And then would I just wonder on the contrast
5 between Welcome Baby and some of the other programs,
6 Welcome Baby is light touch. They don't spend a lot of
7 time with each family; whereas, the select home visiting
8 is either three or five years maximum depending on the
9 family's needs. So that might be draining in a different
10 way. So just raise that.

11 And then something that's come up in DCFS kinds of
12 coordination with other agencies, something that in one of
13 our exercises came out that the home visitors don't have
14 much opportunity to connect with the caseworkers if a
15 family is under DCFS. And maybe that's something to focus
16 on as well because there's just so much information that
17 could be exchanged that would make both parties work more
18 productive.

19 I just bring that up because it's come across to
20 me.

21 COMMISSIONER ZEPEDA: Thank you, Kathy, for those
22 comments.

23 Thank you, panel, for your presentation. And we
24 look forward to hearing how things are coming along as we
25 move forward. Thank you.

1 And I think that concludes our meeting. We don't
2 have to have a motion for adjournment, do we? No, we
3 don't. We never have. You can go home now.

4 (At 3:54 PM the meeting was adjourned.)

5
6 C E R T I F I C A T E
7

8 I, Heatherlynn Gonzalez, a Certified Shorthand
9 Reporter for the State of California, License
10 Number 13646, do hereby attest that:

11 The preceding is a true and accurate transcription
12 of the meeting of the organization named herein;

13 The meeting was taken down stenographically and
14 transcribed into English under my supervision and
15 authority;

16 I have no interest, financial or otherwise, in any
17 of the parties, issues, or individuals who are involved in
18 this organization.

19 Attested to on this 10th day of March 2020.

20
21 Heatherlynn Gonzalez

22 CERTIFIED SHORTHAND REPORTER

23 FOR THE STATE OF CALIFORNIA
24
25

FIRST 5 LA

SUBJECT:

Impact Framework: Inaugural Indicator Report

BACKGROUND – WHERE WE’VE BEEN:

First 5 LA has been developing the Impact Framework (IF), which reflects an innovative approach to monitoring our progress towards our North Star. Throughout this period, First 5 LA staff have engaged the Board during various stages of the development process. Staff have:

- Presented the proposed Indicators for Results for Children & Families (June 2019)
- Conducted 1:1 briefings with several Commissioners on the Indicators (Summer/Fall 2019)
- Presented the revised Indicators for Results for Children & Families (September 2019)
- Presented the revised Contextual Indicators (October 2019)
- Presented the approach to using the Impact Framework during Implementation Planning and Implementation (Winter 2020)

WHERE WE ARE:

First 5 LA is proud to release the inaugural Impact Framework Indicator Report, titled *Pathway to Progress: Indicators of Child Well-being in Los Angeles County* (Attachment 1). The report leverages population and subgroup data related to the 10 Result Indicators and 20 Contextual Indicators to document the most recent conditions of L.A. County children and families. Additionally, the report shares the Impact Framework and how we will measure the progress of our 2020-2028 Strategic Plan, encouraging buy-in and adoption of the Impact Framework indicators.

The findings of the report can inform First 5 LA staff, commissioners and key partners in our work on early childhood issues, including County departments, grantees, and contractors, to (1) align efforts to improve conditions for children and families with a focus on issues of diversity, equity, and inclusion (DEI), (2) make policy, funding and planning decisions informed by these conditions, (3) increase champion and stakeholder awareness of specific findings and issues, and (4) develop contract/project specific metrics informed by current data.

This report was a collaborative effort, gathering and incorporating input from staff from across the organization, First 5 LA Commissioners and external partner organizations.

Report Content

The core contents of the report are an overview of the Impact Framework, a summary of key findings, and two-to-six pages of findings for each indicator. When data allows, analysis by race or ethnicity, socioeconomic status and geography is also provided. This disaggregated data can help First 5 LA and its partners to see more clearly where inequities exist to guide efforts to eliminate disparities.

The report elevated several areas with negative findings, including in areas of publicly-funded early care and education (Result Indicator #2), early identification and intervention (Result Indicator #3), and CPS involvement (Result Indicator #5), where we will have to reverse these conditions to see improvements. A few areas showed positive trends, such as Result Indicator #6 on Family Engagement with Child; however, even in these instances, the data demonstrated issues of equity and access. Finally, in many instances, there was not sufficient data to make any broader conclusion about the conditions of children and families, such as in Result Indicator #1 on High Quality Early Care and Education.

Challenges and Lessons Learned

As this report is the first of its kind created by First 5 LA, staff encountered and have reflected on challenges and lessons we've learned along the way. We anticipate that these challenges will be with us throughout our journey on the Pathway to Systems Change so we recognize the importance of finding a way forward guided by our organizational values. Key challenges and the connection to our organizational values are highlighted below:

- An inherent challenge of the Impact Framework as a tool for measuring progress, or any systems change effort, is measuring change in complex systems. In spite of this, and consistent with our organizational value of Integrity we are leaning into the need to hold ourselves accountable to progress. There is much to learn about the systems that serve children and families and how to best measure the ways in which they are becoming more responsive. We will learn as we go, while also being explicit about and holding ourselves accountable for the results we seek.
- Another inevitable challenge is that we are starting with less than perfect indicators. Our indicator selection criteria prioritized indicators that were related to our work AND had available data. A consequence of this is that we don't always have indicators directly related to some of our work because there wasn't sufficient data available. Another consequence is that as we gain further clarity on First 5 LA's strategic direction through our Implementation Plan, new or more prominent areas of focus call for additional indicators. As a learning organization we were committed to getting started somewhere and anticipated then and now that the Impact Framework will continue to evolve as we go based on the availability of new and better data and as our strategy shifts and takes shape over time.
- A significant challenge given our organizational commitment to addressing issues of Diversity, Equity and Inclusion (DEI) is the limited disaggregated data available for many of our indicators. Disaggregated data allows us to understand and highlight where inequities exist, develop targeted strategies to address these inequities and monitor our progress in eliminating them. As we lean into our DEI value increasing the availability, and ultimately the use, of disaggregated data is a high priority.
- The final challenge was right-sizing the report length and tone. With 30 indicators combined between the Result and Contextual indicators we wanted to keep the length of the report manageable. Not only was this a challenge given the variety of ways we wanted to present indicator data—current status, trend and disaggregated by race/ethnicity, geographic areas, and income, but it also limited the amount of context we could provide to explain the findings. Because of this we opted to maintain a factual tone in terms of presenting data primarily combined with some critical insights about the current context. Striking this balance was only possible through collaboration with internal and external content experts. And we plan to continue this collaboration as we make sense and use this data.

In our effort to overcome these challenges, staff learned that engaging both internal and external partners to provide additional context and input on the framing of indicators and the presentation of data is necessary to tell the most complete story possible and plant the seed for future conversations focused on working together to address data limitations.

DISCUSSION:

The purpose of today's discussion at the Special Meeting of the Board/ Program and Planning Committee is to introduce the report and demonstrate how the findings are informing our efforts to improve conditions for young children and families in Los Angeles County. We are also eager to hear from Commissioners about any additional information or future discussions they would like to have related to the report as well feedback about how we can use the report and other potential users.

NEXT STEPS – WHERE WE'RE GOING:

Now that the report has been finalized we are turning our attention to dissemination and using the findings. Dissemination efforts aimed at First 5 LA staff and Commissioners are underway, and we are fine tuning plans to share the report with our grantees, contractors and other partners.

Sensemaking is another major next step in the process. So, while in some ways sensemaking, or making meaning of findings highlighted in the report, is a component of using the report we also see it as an essential precursor. Sensemaking will involve the convening of stakeholders, including those with diverse perspectives, to discuss findings, share insights, build common understanding, identify implications and generate recommendations.

Along with dissemination and sensemaking, report use is central to where we are going. Staff is in the process of finalizing initial use goals that articulate what we want to accomplish through using the report. We have also identified the Priority Users for which these Use Goals are intended. We will soon begin developing and executing strategies to achieve these goals in ways that that align and are integrated into other efforts. We look forward to engaging Commissioners along this journey.



IMPACT FRAMEWORK: INAUGURAL INDICATOR REPORT

.....

Kimberly Hall, MLE
Agnieszka Rykaczewska, MLE
Bryan Fahrbach, I&L
Ofelia Medina, PPGA
John Guevarra, Communities



1. Where We've Been

- Impact Framework as a tool to track progress
- Previous board engagements

2. Where We Are Now

- Orientation to the inaugural Impact Framework Report
- Key report findings
- Reflections on our goals and challenges
- Connecting findings to First 5 LA's efforts

3. Where We Are Going

- Dissemination, sensemaking and report use

**Where
We've Been**



Our Pathway for Systems Change



By 2028, all children in L.A. County will enter kindergarten ready to succeed in school and life.

We Want Systems To Be

- Accessible
- Quality
- Aligned
- Sustainable

Results for Children and Families

- Families optimize their child's development.
- Children receive early developmental supports and services.
- Children are safe from abuse, neglect, and other trauma.
- Children have high-quality early care and education experiences.

We Change Systems By

- Policy change
- Practice change
- Will building

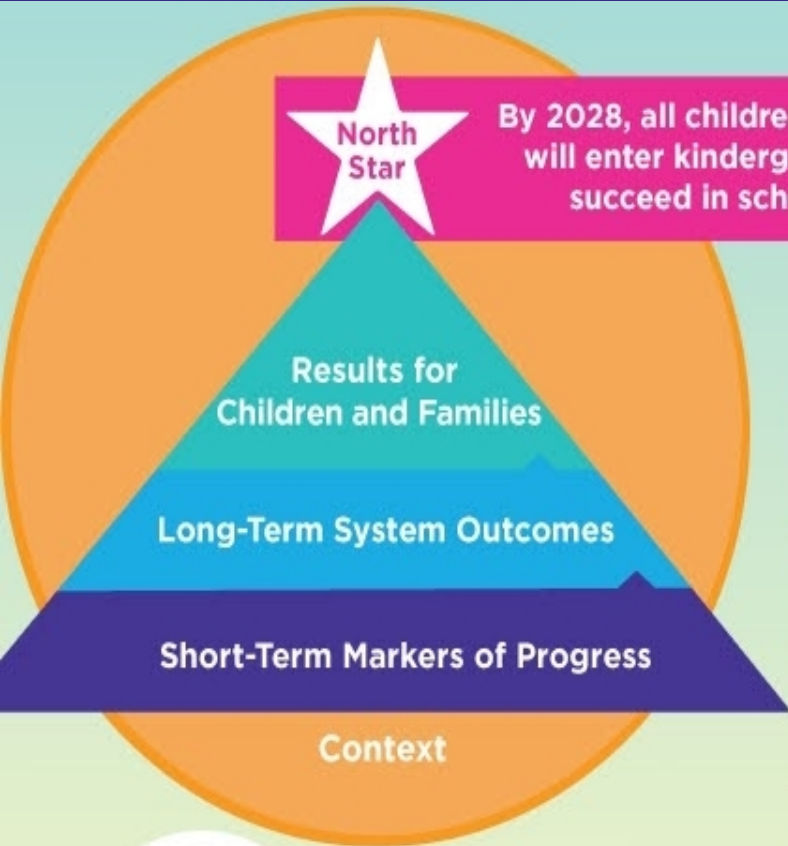
Our Strategic Priorities

- Strengthen public & community systems
- Advance & build on community experience
- Expand influence & impact with data
- Optimize our effectiveness

Our Values

- Collaboration
- Integrity
- Learning
- Diversity, Equity and Inclusion

North Star
 By 2028, all children in L.A. County will enter kindergarten ready to succeed in school and life.



Types of Indicators	What They Are	How We Will Use Them
Results for Children and Families	The child and family conditions that reflect progress toward the North Star	To gauge how well systems are working for children and families
Long-Term System Outcomes	The improvements needed in systems so that they work for children and families	To measure the progress of our systems change strategies
Short-Term Markers of Progress	The early improvements in systems expected from our strategies	To guide course-correction and serve as early markers of progress
Context	Conditions within L.A. County which inform our work	To understand the context and inform our objectives



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Long Term System Outcomes

Systems By

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Short Term Markers of Progress

Our Values

- Collaboration
- Integrity
- Learning
- Diversity, Equity and Inclusion

Our Investment Guidelines

- Equity
- Sustainability
- Partnership
- Prevention
- Systems Change
- Evidence and Innovation

Our Pathway for Systems Change



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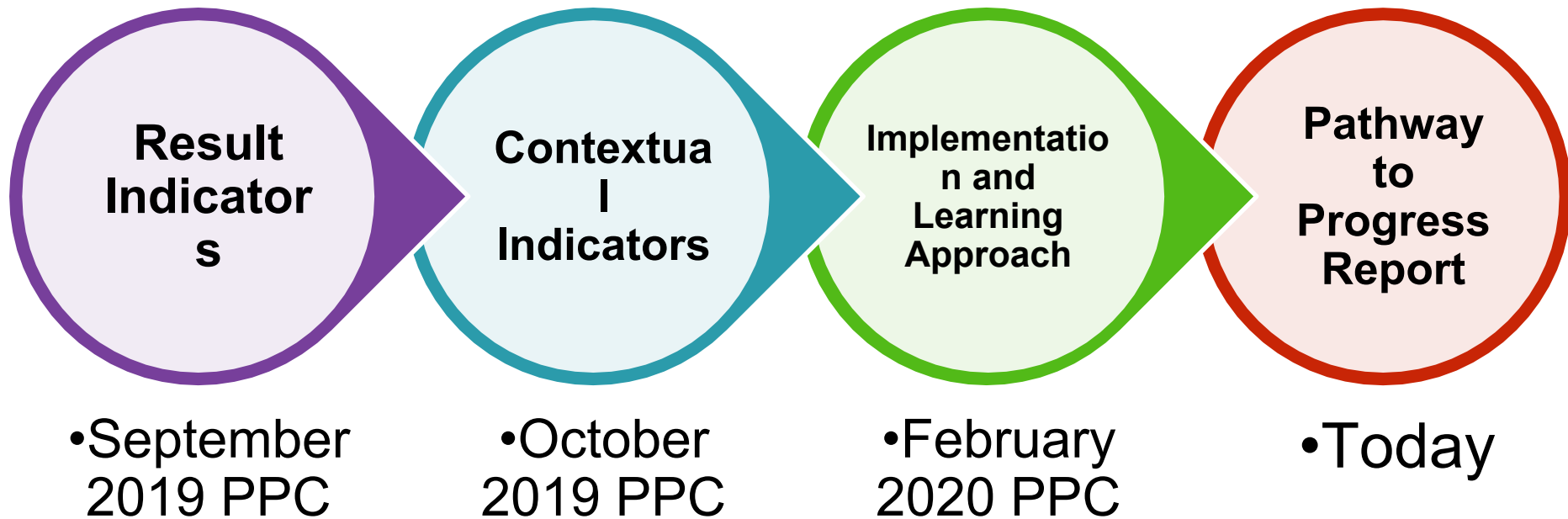
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Short Term Markers of Progress


Context

Our Values

- Collaboration
- Integrity
- Learning
- Diversity, Equity and Inclusion







Share the Impact Framework and how we will measure the progress of our Strategic Plan

Document the conditions of L.A. County children and families prior to the launch of the 2020-2028 Strategic Plan

Encourage use of indicator data internally and externally

Provide a resource with population and subgroup data

F5LA Staff

**Board of
Commissioners**

**Grantees and
Contractors**

Data Partners

**County
Partners**

**Advocacy
Partners**

Municipalities

Funders

Business

Media

**Higher
Education**

**Best Start
Networks**

Audiences Engaged During Report Development

F5LA Staff

**Board of
Commissioners**

**Grantees and
Contractors**

Data Partners

**County
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Municipalities

Funders

Business

Media

**Higher
Education**

**Best Start
Networks**

What
information
is provided
for each
indicator?

- Indicator Description
- Importance of the Indicator
- Current Context
- Findings
 - ✓ Most recent year
 - ✓ Trends
 - ✓ Race/Ethnicity Detail
 - ✓ Socioeconomic Status Detail
 - ✓ Geographic Detail
 - ✓ Charts
- Data Notes and Limitations

Result Indicator	Trend	Equity	Access	Overall
1. High-Quality ECE	●	●	●	●
2. Publicly Funded ECE	●	●	●	●
3. Early Intervention Services	●	●	●	●
4. Average Age of Students in Special Education	●	●	●	●
5. CPS Involvement	●	●	●	●
6. Family Engagement With Child	●	●	●	●
7. Home Visiting Participation	●	●	●	●
8. Safety Net Program Eligibility	●	●	●	●
9. Social Support	●	●	●	●
10. Access to Parks	●	●	●	●



Key:

- Mostly positive
- Mixed or modestly good
- Mostly negative
- Unknown

Key Findings for the Result Indicators

Title	Trend	Equity	Access	Overall
1. High-Quality ECE	●	●	●	●
2. Publicly Funded ECE	●	●	●	●
3. Early Intervention Services	●	●	●	●
4. Average Age of Students in Special Education	●	●	●	●
5. CPS Involvement	●	●	●	●
6. Family Engagement With Child	●	●	●	●
7. Home Visiting Participation	●	●	●	●
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Questions?






Highlight two findings from the report



Share examples of how we're connecting the implementation plan and our work to report findings



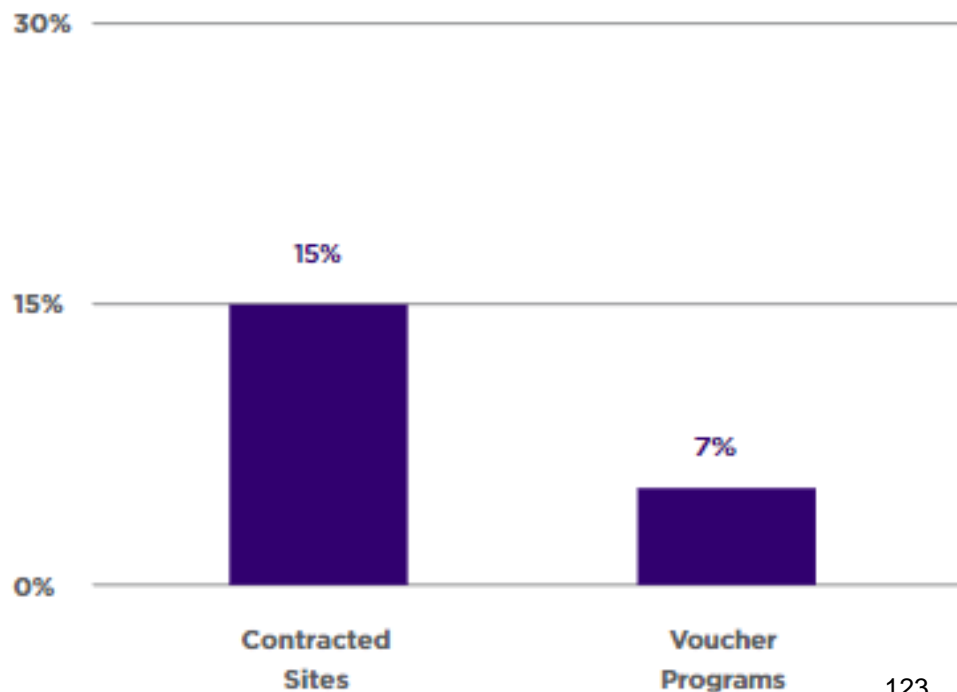
Provide an opportunity to reflect and discuss.



**Using Results
Indicators in
Implementation
Planning**

ENROLLMENT OF ELIGIBLE CHILDREN IN PUBLICLY FUNDED ECE IS LIMITED

Percentage of Eligible Los Angeles County Children Enrolled in Publicly Funded Early Care and Education Programs by Type, 2019



123

Objective 1.4

Advocate for policy change that aligns and enhances the eligibility and program requirements of publicly funded preschool.

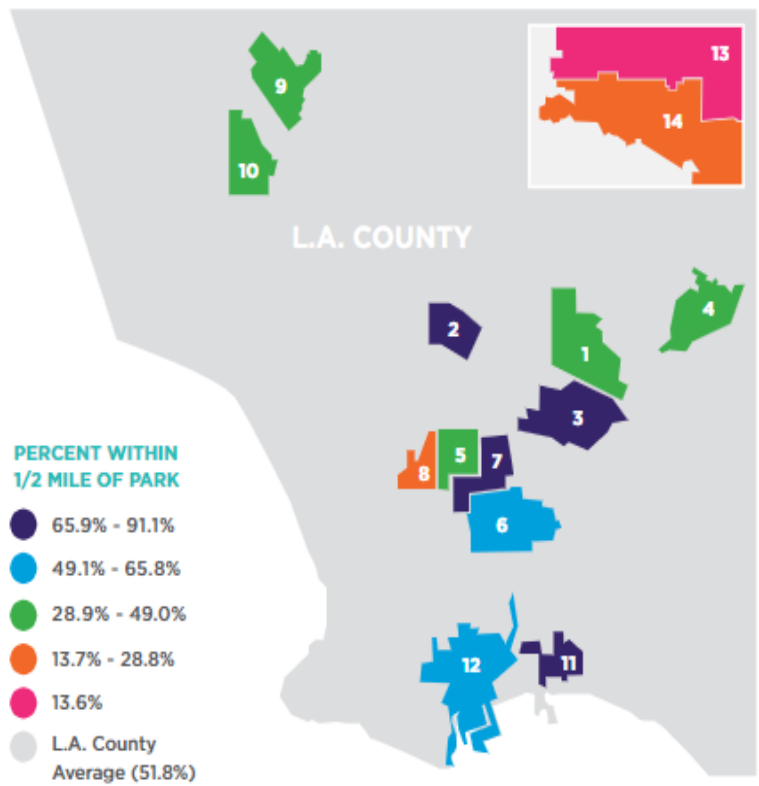
Long Term System Outcome:
Accessible

- What are your reactions to this finding about access to Publicly-funded ECE?
- Do you have any observations or questions about the connections between this finding and our work?

Substantial variation in park access depending on community

Percentage of Los Angeles County Children from Birth Through Age 5 Who Live Within One-Half Mile of a Park or Open Space by Best Start Geography, 2019

REGION 1	
1 East LA	43.5%
2 Metro LA	77.4%
3 Southeast LA	76.8%
4 South El Monte/El Monte	42.9%
REGION 2	
5 Broadway-Manchester	46.5%
6 Compton	59.0%
7 Watts-Willowbrook	83.8%
8 West Athens	28.8%
REGION 3	
9 Northeast Valley Communities	49.0%
10 Panorama City & Neighbors	48.4%
REGION 4	
11 Central Long Beach	91.1%
12 Wilmington	65.8%
REGION 5	
13 Lancaster	13.6%
14 Palmdale	23.7%



Objective 2.4
Optimize policy, partnership, and advocacy opportunities in transportation, food and **open space** and elevate early childhood considerations in environmental health and related community-identified priorities.

Long Term System Outcome:
Accessible

Short Term Marker of Progress

By June 30, 2023, increase amount of Measure A (parks and open space) funding distributed within Best Start geographies.

- What are your reactions to this finding about Access to Parks?
- Do you have any observations or questions about the connections between this finding and our work?



Dissemination

Sensemaking

Report Use

Are there any additional issues or findings related to the Pathway to Progress Indicator Report that you would like to learn about?



Thank you!



**Pathway
to Progress:**

Indicators
of Young Child
Well-Being in
Los Angeles
County

LETTER FROM THE EXECUTIVE DIRECTOR

There is a common saying: “If you’re not outraged, you’re not paying attention.” This is true today in many arenas, and not the least of which in the inequities that First 5 LA has documented in this report — our inaugural Impact Framework Indicators Report — where children of color repeatedly face a more challenging path to success in school and life. Born of our Impact Framework, which charts how we will measure progress on our 2020-28 Strategic Plan, this report is the physical manifestation of our “paying attention.” And, for many indicators, “outrage” will be a natural and just reaction.

As a systems change leader and funder, First 5 LA is focused on paying attention — and taking action. The report raises important questions about why certain things are happening — such as disparities in child outcomes — and what we can do to change them. It compels us to dig into the key metrics of child and family well-being, including disaggregated data, to examine the systemic issues that are holding inequitable conditions and outcomes for children in place, and to identify what First 5 LA’s contribution can be to strengthen child- and family-serving systems.

This report also sets a baseline to measure our progress; however, that baseline will be complicated by the global pandemic that we are currently living through. The indicators in this report represent the pre-COVID-19 world, and while inequities remain vast and troubling, hard-fought positive trends are emerging in some of the data. Post-COVID-19, we anticipate markedly different results. Young families are among the most vulnerable to the impacts of the pandemic, with many struggling with job losses, constrained early care opportunities, and limited access to social supports, which all contribute to an unprecedented level of family stress.

To be sure, the pandemic is testing the resiliency of our systems and our families. We have much work to do. We come to this work with deeply-held motivation for a just, safe and equitable future for our children; with confidence that progress is possible when our advocacy is informed by solid data and families’ diverse experiences; and with a commitment to partner with those who share our aspirations for young children.

We invite our partners to join us on this journey to our North Star, where all children in L.A. County will enter kindergarten ready to succeed in school and life.



Kim Belshé
Executive Director

First 5 LA Board of Commissioners

Sheila Kuehl,
Commission Chair

Judy Abdo,
Commission Vice Chair

Barbara Ferrer
Astrid Heppenstall Heger
Yvette Martinez
Johnthan E. Sherin
Romalis J. Taylor
Keesha Woods
Marlene Zepeda

Ex-Officio

Bobby D. Cagle
Wendy Garen
Karla Pleitéz Howell
Deanne Tilton Durfee

Alternates

Linda Aragon
Helen Berberian
Victor Manalo
Terry Ogawa
Carol Sigala
Sylvia S. Swilley
Christopher Thompson
Arturo Valdez



ABOUT FIRST 5 LA

In the first five years of a child's life, a million new neural connections form every second, making every second count.

Armed with this knowledge, First 5 LA — an independent public agency — works to support the safe and healthy development of young children so that by 2028, all children in L.A. County will enter kindergarten ready to succeed in school and life.

We partner with communities, organizations and other county agencies to support parents in achieving this goal. As a systems change agent, we believe we can help family-serving systems work better for children and their families by collaborating with public and community partners.

Defining the Early Childhood System

The early childhood system comprises the organizations, both public and private, that partner with parents and families to provide services and supports for children from birth to kindergarten entry. These services and supports span the sectors of physical and mental health, early learning and development, and family leadership and engagement.



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DEMOGRAPHIC SNAPSHOT

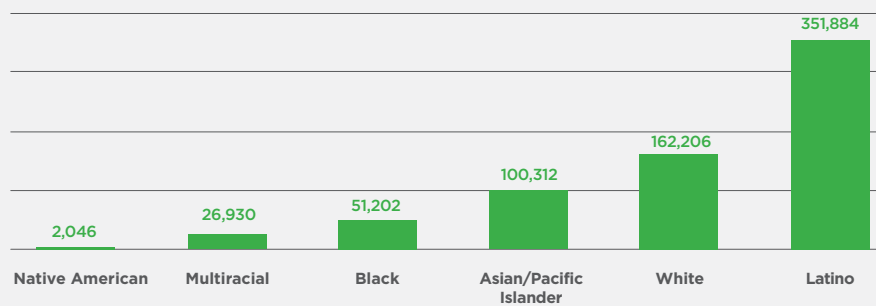
Young Children and Their Families in Los Angeles County

694,580
CHILDREN
from birth through age 5
LIVE IN L.A. COUNTY

7%
OF ALL L.A. COUNTY
RESIDENTS ARE
children from
birth through age 5

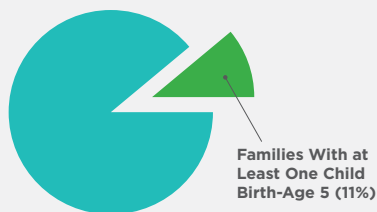
ABOUT HALF OF ALL L.A. COUNTY'S YOUNG CHILDREN ARE LATINO

Count of L.A. County Children from Birth Through Age 5 by Race/Ethnicity



1 IN 9 L.A. COUNTY HOUSEHOLDS ARE FAMILIES WITH YOUNG CHILDREN

Percentage of all L.A. County Households that are Families with at Least One Child from Birth Through Age Five

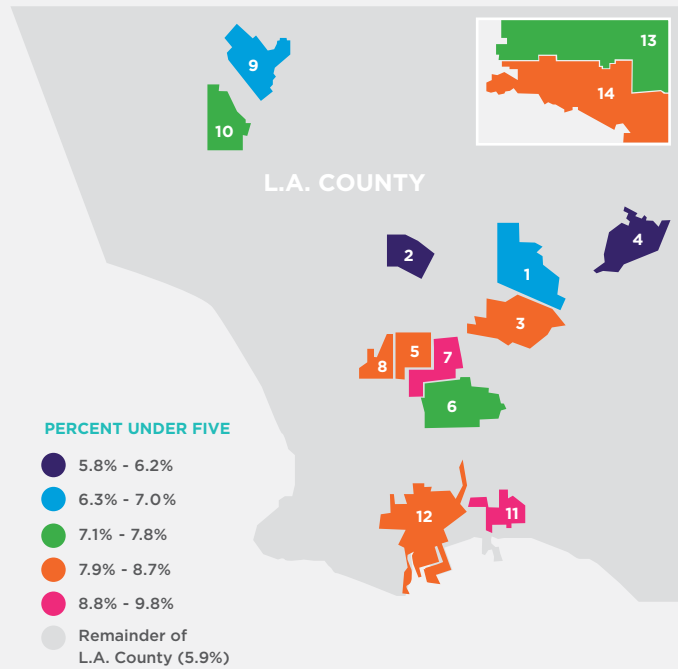


355,029
FAMILIES WITH
AT LEAST
**one child from
birth through age 5**
RESIDE IN
L.A. COUNTY

DEPENDING ON THE *BEST START* GEOGRAPHY, YOUNG CHILDREN COMPRISE FROM 6 TO 10 PERCENT OF THE TOTAL POPULATION

Number and Percentage of Population That are Children from Birth Through Age 4 by *Best Start* Geography

	Number of Children Birth Through Age 4	Percent of Total Population that are Children Birth Through Age 4
REGION 1		
1 East LA	9,887	7.0%
2 Metro LA	6,691	5.8%
3 Southeast LA	14,202	8.2%
4 South El Monte/El Monte	6,358	6.2%
REGION 2		
5 Broadway-Manchester	7,548	8.7%
6 Compton	10,739	7.7%
7 Watts-Willowbrook	8,399	9.8%
8 West Athens	3,732	8.2%
REGION 3		
9 Northeast Valley Communities	9,225	7.0%
10 Panorama City & Neighbors	12,925	7.8%
REGION 4		
11 Central Long Beach	9,474	9.2%
12 Wilmington	5,456	8.6%
REGION 5		
13 Lancaster	12,491	7.7%
14 Palmdale	14,851	8.2%
L.A. County Overall	631,911	6.3%
Remainder of L.A. County	499,483	5.9%



Data for the *Best Start* geographies are not inclusive of 5-year-old children.

SOURCES, NOTES, AND DATA LIMITATIONS

- See page 24 for a description of First 5 LA investment in *Best Start* geographies.
- Count of children from birth through age 5 (2020), racial/ethnic detail (2020), and projections (2020-2060): California Department of Finance, Demographic Research Unit, Projections, Tables P-1 and P-2 (The ethnic category Latino is of any race; the remaining racial categories are all non-Latino.)
- Count and percent of families with children from birth through age 5 (2018): U.S. Census Bureau, American Community Survey, 2018, 1-Year Estimates, Table S1101
- Count and percent of children from birth through age 4 by *Best Start* geography: U.S. Census Bureau, American Community Survey, 2017, 5-year Estimates, Table S0101; analysis conducted by Advancement Project (Data for the *Best Start* geographies are not inclusive of 5-year-old children.)

EXECUTIVE SUMMARY

First 5 LA is pleased to share the Pathway to Progress report with our community of partners. This report acts as the baseline for assessing progress on the implementation of our 2020-2028 Strategic Plan. As such, the indicators presented in this report are forward-looking, providing critical information to guide our work in the years to come.

As summarized briefly in this Executive Summary and presented in detail in the body of the report, the baseline findings for several indicators show progress in recent years. Yet, the findings also reveal systemic inequities, with most indicators showing that a higher proportion of children and families of color face more challenging circumstances than the countywide averages. Identifying and addressing the structures that perpetuate these inequities is a key driver behind our systems change work. Together with our partners, we will work to build momentum where we see progress and implement real and lasting change where we see gaps.

Complicating this work is the dramatic impact that the global coronavirus pandemic is having on many families with young children. It is important to note that the data in this report reflect “pre-COVID-19” conditions; the “post-COVID-19” context is likely to look markedly different. Going forward, the impact of the pandemic on the data will increase the challenge of measuring the progress made on improving conditions for children and families.

INDICATORS OVERVIEW

The Results Indicators presented in this report are aligned with the Strategic Plan’s Results for Children and Families, which capture First 5 LA’s desired future for children and families (see page 18). The 10 Results Indicators capture population-level changes in conditions for children and families and they will be used to gauge how well systems are working for children and families.

The Contextual Indicators presented in this report capture conditions within L.A. County that impact First 5 LA’s work. They are used to understand the context and to tailor strategies to L.A. County’s young children and their families. The findings of the 20 Contextual Indicators are summarized on the following pages within four categories: Child Characteristics, Maternal Characteristics, Family Resources and Community Characteristics.

As described in the Introduction and Impact Framework Overview, two additional sets of indicators — Long-term System Outcomes and Short-term Markers of Progress — are currently in development and not presented in this report.

RESULTS INDICATORS: FINDINGS AT-A-GLANCE

Key:	Trend	Equity	Access	Overall
	Definite or emerging positive trend	Equitable conditions	Many positively supported (or minimally negatively affected)	Mostly positive
	Flat or no discernable trend	Modest disadvantage or mixed	Some positively supported (or modestly negatively affected)	Mixed or modestly good
	Definite or emerging negative trend	Substantial disadvantage	Not many positively supported (or many negatively affected)	Mostly negative
	Unknown	Unknown	Unknown	Unknown

Title	Description	Trend	Equity	Access	Overall
1. High-Quality ECE	Increased rate of L.A. County children birth through age 5 enrolled in a high-quality early learning and care program				
2. Publicly Funded ECE	Increased rate of income-eligible L.A. County children birth through age 5 enrolled in publicly funded early learning and care programs				
3. Early Intervention Services	Increased rate of L.A. County children birth through age 5 with a developmental delay participating in early intervention services				
4. Average Age of Students in Special Education	Decreased average age of L.A. County children entering special education services				
5. CPS Involvement	Decreased rate of L.A. County children with Child Protective Services involvement at any point during the first 5 years of life				
6. Family Engagement With Child	Increased rate of L.A. County families with children birth through age 5 who read, tell stories, sing, play music, or teach letters, words, or numbers to their child daily				
7. Home Visiting Participation	Increased rate of L.A. County families who participate in home visiting programs at any point prenatally through age 5				
8. Safety Net Program Eligibility	Increased rate of eligible L.A. County families with children prenatal through age 5 participating in safety net programs				
9. Social Support	Increased rate of L.A. County families with children birth through age 5 who report having one or more people to talk to in times of need				
10. Access to Parks	Increased rate of L.A. County families with children birth through age 5 that have access to parks and open spaces				

In the table above, each indicator was assessed according to the following:

TREND:

Are systems or conditions improving, worsening or unchanged for all children in L.A. County?

EQUITY:

Do children or families of color have equitable conditions or are they at a modest or substantial disadvantage? Similarly, what does the data tell us about equity for children from low-income families or from certain communities?

ACCESS:

Are many children connected to a positive intervention or protected from a harmful or negative circumstance? Or is it a modest proportion or only a small proportion?

OVERALL:

Considering the three measures — trend, equity and access — how are children faring or systems performing overall?

Note: This visual summary is the high-level takeaway from the findings for each indicator; the indicator pages provide additional nuance and detail. Overlapping dots of two different colors signify that the indicator presents more than one dataset and those datasets have different results.

CONTEXTUAL INDICATORS: FINDINGS AT-A-GLANCE

CONTEXTUAL INDICATORS NO. 1 - 9

Child Characteristics

Indicators of children's well-being show significant inequities. Compared to their White or Asian/Pacific Islander peers, Black children are consistently more negatively affected. Latino children are also more negatively affected on most metrics. The association between these child indicators and the maternal, family and community indicators is strong, since children's well-being depends in large part of the well-being of their families and communities.

- The **birth rate** is declining in L.A. County for all race and ethnic groups.
- While the proportion of babies born at **low birth weight** remains flat, the **infant mortality** rate has increased. Babies born to **Black** mothers are disproportionately affected by low birth weight and have a higher mortality rate.
- **Preventable injuries** remain a problem, with no lasting improvement in 10 years of tracking. **Black** children were four times more likely to die of a preventable injury than children of other race or ethnic groups. **Drowning** was the most frequent cause of death, while **falls** were the most frequent cause of non-fatal injuries.
- Most children complete the recommended **well-child visits** and this rate has increased over time.
- Approximately 60 percent of young children living in low-income households have a **healthy weight**. Over a 16-year period, the proportion of overweight and obese children has gradually increased. Children of **Latina** mothers had the lowest proportion of healthy weight.
- Compared to six years ago, fewer students were **Dual Language Learners** when they entered kindergarten. The decline has been most significant among **Latino** children.
- Enrollment of young children in **special education** has been increasing, especially among **Latino** young children.
- Almost half of L.A. County's third grade students in public school met **literacy standards**, capping a steady upward five-year trend.

CONTEXTUAL INDICATORS NO. 10 - 14

Maternal Characteristics

While most mothers are doing well — getting prenatal and postpartum care, breastfeeding their infants, and not experiencing postpartum depression — Black and Latina mothers consistently experience poorer results on these measures.

- **Prenatal care** rates have been flat, and **mothers of color** have lower prenatal care rates than White mothers, but several **Best Start** geographies have shown improvement in rates.
- Fully nine out of 10 new mothers have a **postpartum check-up**. **Black** mothers and mothers in the **Antelope Valley** have slightly lower rates of postpartum check-ups.
- A quarter of new mothers experience **postpartum depression**, with **Black** and **Latina** mothers reporting higher rates of both prenatal and postpartum depression.

- While **breastfeeding** rates have increased over time and most mothers breastfeed at least part of the time at three months after the birth of their child, there is a drop off between breastfeeding at one week after birth (89 percent) compared to at three months after birth (71 percent). **Black** and **Latina** mothers report less breastfeeding.
- Half of mothers in L.A. County have **some college or a college degree** and nearly 85 percent have a **high school diploma** or higher.

CONTEXTUAL
INDICATORS
NO. 15 - 18

Family Characteristics

While most families of color do not experience poverty or food insecurity, there is a higher rate of poverty and food insecurity among families of color than other racial or ethnic groups.

- An analysis of the **assets a child has at birth** reveals inequities in resource access, with the children of White or Asian/Pacific Islander mothers more likely to start life with more assets than the children of Black and Latina mothers. All **Best Start** geographies have lower asset scores than the L.A. County average.
- Nearly 1 in 4 L.A. County young children live in **poverty**. Similarly, 1 in 4 lower-income families experience **food insecurity**. **Latino** families report higher rates of food insecurity, which could correlate with the lower rates of **healthy weight** among Latino young children.
- There were 30,543 young children experiencing **homelessness** for at least one month during 2019, representing a 6 percent increase over four years.

CONTEXTUAL
INDICATORS
NO. 19 - 20

Community Characteristics

The social and economic community characteristics that influence health and life expectancy vary widely within L.A. County. *Best Start* geographies are among the L.A. County communities that have a higher risk of poor outcomes.

- L.A. County has **community conditions** that are healthier than half of other California counties (50th percentile). Looking internally, all **Best Start** geographies have less healthy community conditions than the countywide average, with percentile scores ranging from six to 27, meaning that between 94 and 73 percent of other California communities have healthier conditions.
- In a majority of L.A. County zip codes, the **number of transit stops** is evenly matched to the number of families with children under age 6 in that zip code.

INTRODUCTION

First 5 LA is pleased to share the Pathway to Progress report with our community of partners. As the following pages describe, this report is an important tool for our agency. We also hope the content will be useful and inspiring for our partners working to support young children and their families in Los Angeles County.

WHY INDICATORS?

Indicators are **tools people can use to understand conditions in their communities** and to **measure progress** on issues of importance. They reveal whether things are getting better, worse, or staying the same. They also help communities **address inequities** by revealing disparities between different groups of people or neighborhoods in a region.

While indicators allow for high-level tracking of progress and the ability to develop hypotheses for why certain patterns are evident in the data, it is important to note that they do not allow for assessing the impact of particular programs, policies or practices. Despite this limitation, the indicators in this report help us understand the conditions of young children and their families in L.A. County. They also **set a baseline** to assess progress over time on the population-level results that First 5 LA and our partners are working towards within specific communities and across L.A. County.

WHY NOW?

Taking effect on July 1, 2020, the First 5 LA 2020-2028 Strategic Plan outlines how we will achieve our North Star through **“systems change”** – shifting the conditions that hold a problem in place. This includes improving **access** to resources and making sure that the systems that deliver those resources are **high quality, aligned, and sustainable**, and responsive to the needs of parents and children.

To gauge how well systems are working for children and families, and to help us assess how effective our strategies are, we developed the **Impact Framework**. The Impact Framework is a tool that identifies the data (indicators) we will use to measure our progress. The indicators contained in this report reflect an important first phase of this work, presenting the data for two of the four Impact Framework components: Results Indicators and Contextual Indicators. As the following pages describe, the Impact Framework is a work in progress.

WHO IS THIS REPORT FOR?

The Pathway to Progress report is a tool for **First 5 LA leaders and staff** and our **many diverse partners**, including grantees, county agencies, elected officials, and others. We hope that the Impact Framework inspires excitement about the outcomes we wish to achieve in partnership with communities, organizations and countywide organizations.

WHAT CAN I EXPECT TO FIND IN THIS REPORT?

The next pages provide a more **detailed introduction to the Impact Framework** and its connection to the Strategic Plan and the indicators. This is followed by background to explain the different ways that **findings by geography** are shown in the maps. The main body of this report consists of **two-to-six pages of findings for each indicator**. Each indicator spread provides at minimum the latest year of data available and usually several years prior. When data allow, **analysis by race or ethnicity**, age, socio-economic status and geography is also provided. The **methods section** provides background on data collection and analysis when needed. If available, **supplemental tables** at the back of the report provide additional detail that was not included on the main indicator pages.

WHAT MIGHT BE MISSING?

The Result and Contextual indicators presented in this report are **not an exhaustive list** of important measures of early childhood; there are additional indicators that may also measure early childhood systems functioning or the well-being of young children and their families. Or there may be alternative ways to measure the indicators we have included. As noted above, our measurement work is ongoing, and the indicators may evolve over time.

The data shown in this report are **proxies** for what we want to measure. A proxy is a substitute or **alternative way of measuring** a condition when we do not have data that would allow for a direct measure. For example, in absence of direct data

that would tell us that children with developmental delays are getting identified as early as possible, we calculate the average age of children in special education. If the average age declines, we can infer that children are being identified earlier. While more limited than a direct measure, proxy measures are valuable tools for understanding the populations we serve and for tracking progress.

Advancing diversity, equity and inclusion is a core value of First 5 LA. That value is reflected in our commitment to present **information by subgroups**, including race or ethnicity, age, income status or geography. However, due to data limitations, it is not always possible to show these subgroups, nor all the subgroups we would like. When subgroup information is missing or appears incomplete (e.g., findings for only certain race/ethnic groups are presented), it means the **data was not available** at this time or not reliable when broken out by subgroup. For the subgroup data that is available, the intent is to maintain consistency with respect to racial and ethnic categories, age ranges, and other definitions; however, the features of each dataset place limitations on the ability to do so in all cases.

WHAT'S NEXT?

We look forward to **working collaboratively** with parents and our many partners — including community members, grantees, county agencies, elected officials and others — to address inequities and close gaps in family-serving systems so that all children in L.A. County will enter kindergarten ready to succeed in school and life. Implementing our Strategic Plan through systems change involves **policy change, practice change** and **will-building**. Some of these needed changes will be small, but others will require profound shifts in the systems supporting children and families. This is an ambitious agenda that we cannot tackle alone.

An important step in implementing this agenda is to engage in **“sensemaking”** — the convening of partners to discuss findings, share insights, build common understanding, identify implications and generate recommendations. We will use this **collaborative** process to better understand the data contained in this report.

The process of sensemaking will **shine a light** on many areas of progress but also many areas of entrenched inequity that impede children’s optimal development. This awareness emphasizes the importance of posing **questions** about how to ensure systems are equitable, accessible, high quality, aligned and sustainable. To guide this inquiry, we will begin with the following questions, with the understanding that additional questions may arise:

- What is the data telling us about how well young children and their families are supported in L.A. County? Are conditions improving? Are conditions equitable?
- What system improvements are needed to increase equity and reduce the disparities highlighted in the data?
- How can systems become more accessible in a way that would help improve conditions for children and families in L.A. County?
- How can we improve the quality of systems to drive results for children and families in L.A. County?
- What do the findings say about the need for alignment and coordination across family-serving sectors?
- How can we leverage and increase funding for systems to bridge gaps in supports for children and families?
- How should we adjust our strategies to be responsive to the context of L.A. County?
- Finally, what is the data not telling us? What more do we need to know in order to make progress?

The indicators in this report set our baseline for how we will measure progress on our Strategic Plan. The next step is **interpreting and acting** on these findings. To that end, the process of sensemaking with our partners will be a critical component of First 5 LA’s **continuous quality improvement** approach to systems change. It will inform the strategies we adopt to implement the Strategic Plan and to address inequities and gaps in family-serving systems. Our commitment to ongoing measurement will enable us to review the efficacy of those strategies and make adjustments to **improve our impact**. We look forward to engaging in this process of learning, planning and acting with our families and many partners.

A Word About the Impact of the Coronavirus Pandemic

As of publication, the worldwide COVID-19 pandemic is continuing to unfold. Widespread stay-at-home orders are having an impact of profound proportions on many residents. Families with young children, particularly families of color, are among the most vulnerable to the impacts of the pandemic, with many struggling with decreased earnings, constrained early care opportunities, limited access to social supports, and systemic inequities in the health care system, all of which contribute to family stress.

The data in this report are “pre-COVID-19” which means we are likely to see very different results in subsequent editions of the report, particularly in metrics that track with economic conditions, such as increased poverty, food insecurity and homelessness, or intersect with the health care system, such as delayed well-child visits, missed prenatal and postpartum care visits, and increased maternal depression. Critical supports, like early intervention for developmental delays or child protective services, are also likely to show reductions. We are also finding that providers are being challenged as never before to find ways to deliver services such as virtual home visiting or trying to maintain quality early care experiences in a world of face masks and social distancing.

In short, systems and families are being stretched and tested in ways we can’t control or entirely predict. Time will tell what the data measuring these systems and family conditions will reveal, but it is clear that interpreting the data will require flexibility, patience and creativity as we seek to measure our progress.

IMPACT FRAMEWORK OVERVIEW

2020-2028 STRATEGIC PLAN

To understand the Impact Framework, it is first important to be introduced to the First 5 LA 2020-2028 Strategic Plan. Our **Pathway for Systems Change** graphic provides a visual representation of the major Strategic Plan components.

The Plan begins with our aspiration — what we call our **North Star**.



By 2028, all children in L.A. County will enter kindergarten ready to succeed in school and life.

The North Star represents the ultimate goal of all of First 5 LA's work. Additionally, we recognize that in order to reach the North Star, there are certain conditions for children and families that are necessary — we refer to these as our four **Results for Children and Families**:



Families have the resources, opportunities and relationships to optimize their child's development.



Children are safe from abuse, neglect and other trauma.



Children receive early and timely developmental supports and services.

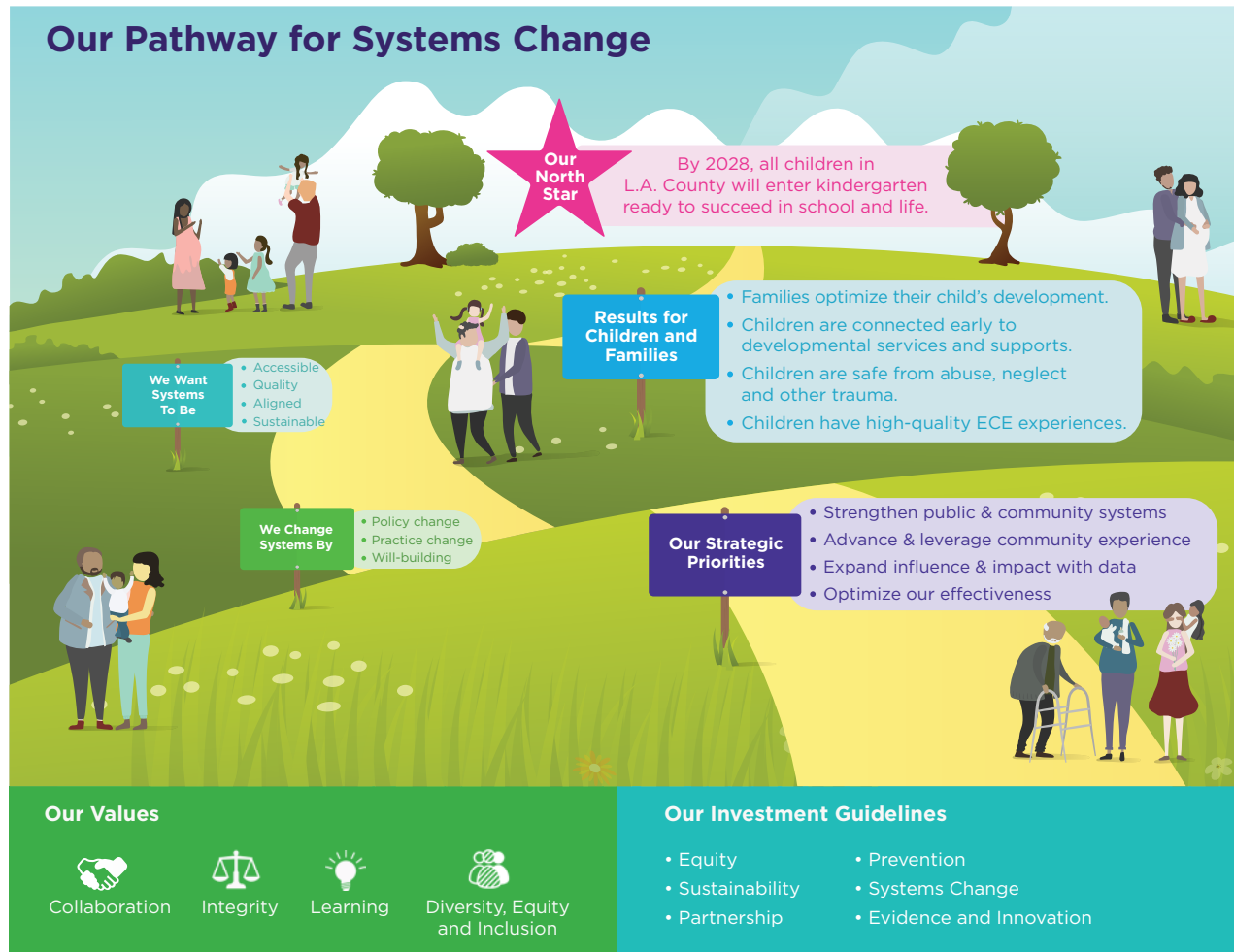


Children have high-quality early care and education experiences.

For these four Results for Children and Families to be met, systems that serve children and families require certain characteristics — they must be **accessible, quality, aligned** and **sustainable**. These are our **Long-term System Outcomes**. First 5 LA contributes to these long-term system outcomes through **policy change, practice change** and **will-building** in alignment with our **Strategic Priorities**:

- Strengthen public and community systems.
- Advance and build on community experiences.
- Expand influence and impact with data.
- Optimize our effectiveness.

All of our activities are supported by our **core values** — collaboration, integrity, learning, and diversity, equity and inclusion – and our **investment guidelines** — equity, sustainability, partnership, prevention, systems change, and evidence and innovation.



IMPACT FRAMEWORK PURPOSE

Given the complexity of systems change work, we needed a way to measure our progress toward our North Star. Our solution was to develop the Impact Framework. This tool identifies data we will monitor to:

- Gauge how well systems are working for children and families.
- Assess the effectiveness of our systems change strategies.
- Guide course corrections.
- Understand our context and inform our strategies.

Additionally, we will use this data to help tell First 5 LA's story and ensure we remain responsive to the needs of children prenatal through age 5 in L.A. County.

IMPACT FRAMEWORK INDICATORS

The Impact Framework contains **four different types of indicators** — or data — that we will monitor over time. Three of the four types of indicators monitor the outcomes we are seeking as a result of our work and the fourth provides contextual information on young children and their families.

Results Indicators

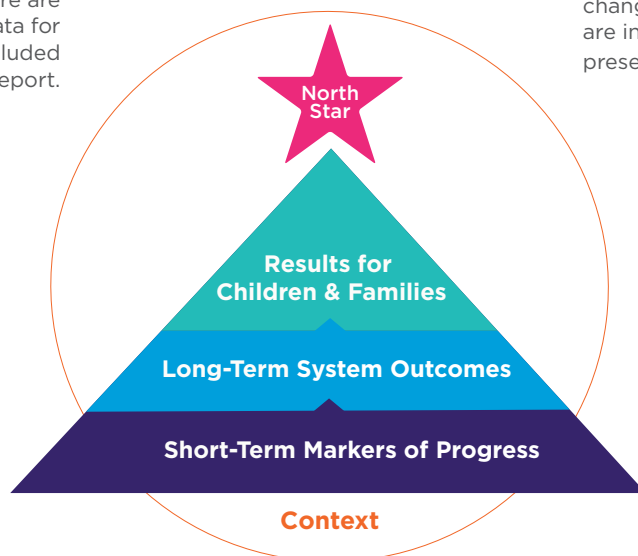
Indicators that are aligned with the Results for Children and Families and capture population-level changes in conditions for children and families.

These indicators will be used to gauge how well systems are working for children and families. There are 10 Results Indicators; data for these indicators are included in this report.

Long-Term System Outcomes

Indicators that capture the changes needed to improve the systems that serve children and families.

These indicators will be used to measure progress on our systems change strategies. These indicators are in development and not presented in this report.



Short-Term Markers of Progress

Indicators that are aligned with our Strategic Priorities and capture early changes in systems and key milestones.

These indicators will be used to gauge the progress we expect from our strategies and guide course-corrections, if needed. These indicators are in development and not presented in this report.

Contextual Indicators

Indicators that capture conditions within L.A. County that impact First 5 LA's work.

These indicators will be used to understand our context and to tailor our strategies to L.A. County's young children and their families. There are 20 Contextual Indicators; data for these indicators are included in this report.

Over time, as the context within which First 5 LA's work evolves, so may the indicators. Further, we anticipate that the ongoing implementation of our Impact Framework, including the development of the Long-Term System Outcomes and the Short-Term Markers of Progress, will lead to shifts among the indicators. For example, some Contextual Indicators may become measures in one of the other three categories of indicators.

Crosswalk to Four Results

The 10 Results Indicators were selected to measure progress on the four Results for Children and Families identified in the Strategic Plan. The relationships between the indicators and Results are not necessarily one-to-one; a single indicator may capture progress for more than one Result for Children and Families. For example, the High-Quality Early Care and Education indicator measures progress related to three different Results: Children have high-quality early care and education experiences; Children receive early and timely developmental supports and services; and Families have the resources, opportunities and relationships to optimize their child's development.

The table below shows how each Result Indicator corresponds with the four Results for Children and Families.

The icons in the matrix are used throughout the Results Indicators section of the report to help users identify for each Result Indicator the associated Results for Children and Families.



Contextual Indicators Domains

The 20 Contextual Indicators selected capture the conditions of children and families within four topical domains: Child Characteristics, Maternal Characteristics, Family Resources and Community Characteristics. The matrix below shows where each Contextual Indicator falls within the domains. The domain colors displayed below are repeated within the Contextual Indicators section to help users orient within the section.

CHILD CHARACTERISTICS

1. Birth Rate
 2. Infant Mortality Rate
 3. Low Birth Weight
 4. Well-Child Visits
 5. Preventable Injuries
 6. Healthy Weight
 7. Dual Language Learners
 8. Special Education Enrollment
 9. Third Grade Literacy
-

MATERNAL CHARACTERISTICS

10. Prenatal Care
 11. Postpartum Care
 12. Maternal Depression
 13. Breastfeeding
 14. Educational Attainment
-

FAMILY RESOURCES

15. Assets at Birth
 16. Children Living in Poverty
 17. Food Insecurity
 18. Children Experiencing Homelessness
-

COMMUNITY CHARACTERISTICS

19. California Healthy Places Index
 20. Access to Transit
-



GUIDE TO INTERPRETING THE MAPS

GEOGRAPHIC DATA VISUALIZATION METHODS

The maps are sorted using “hot-to-cold” color schemes, where the “hot” colors (such as magenta or orange) are applied to the communities facing the greatest challenge or impact, and the “cold” colors (such as green or blue) are applied to the communities facing less severe challenges or impacts.

The maps use a method of grouping the findings called Jenks (natural breaks). With Jenks, the divisions that separate the data into groups — or cut points — are based on natural groupings inherent in the dataset. The cut points maximize the differences between the groups and minimize wide variation within a group. Because the cut points are optimized for each dataset, the groupings and ranges of values in each grouping will vary from indicator to indicator.

The *Best Start* geographies are not depicted to scale in the majority of the maps. Lancaster and Palmdale appear as insets and smaller relative to the other *Best Start* geographies when, in reality, they are larger. This format enhances readability by allowing the smaller *Best Start* geographies to be enlarged. It also omits areas that do not contain *Best Start* geographies, including some coastal areas and a large area between Region 5 and the remaining regions. To view a scale version of the *Best Start* geographies, see Third Grade Literacy (page 90), where the *Best Start* boundaries overlay school district boundaries.

First 5 LA's *Best Start* Investment

Through *Best Start*, First 5 LA invests in 14 geographic areas that have faced historic disenfranchisement and oppression through political, economic, social and/or environmental factors that aggravate chronic family stressors such as violence and poverty. The goal of the *Best Start* networks is to catalyze, strengthen and elevate innovative approaches that improve the lives of children prenatal through age 5.

In 2018, First 5 LA grouped these 14 communities into five regions to maximize resources and strengthen systems change efforts. This regional grouping offers several advantages for communities: it provides more opportunities for leveraging and mobilizing resources than might be possible in a single *Best Start* geography, it increases opportunities to build collective power and achieve systems-level outcomes, and it invites cross-community learning and dialogue. Within the regional structure, First 5 LA continues to emphasize the importance of local customization that considers each community's uniqueness and honors the lived experiences of parents, residents and organizations at a local level.

GEOGRAPHIC AREAS

Best Start Geographies

Whenever available, the maps in the report show findings by *Best Start* geography and either the remainder of L.A. County (the areas outside the *Best Start* boundaries) or the overall county average (all areas, including *Best Start* geographies). The map tables are sorted by *Best Start* region and then alphabetically by *Best Start* geography within each region. The First 5 LA *Best Start* regions are as follows:

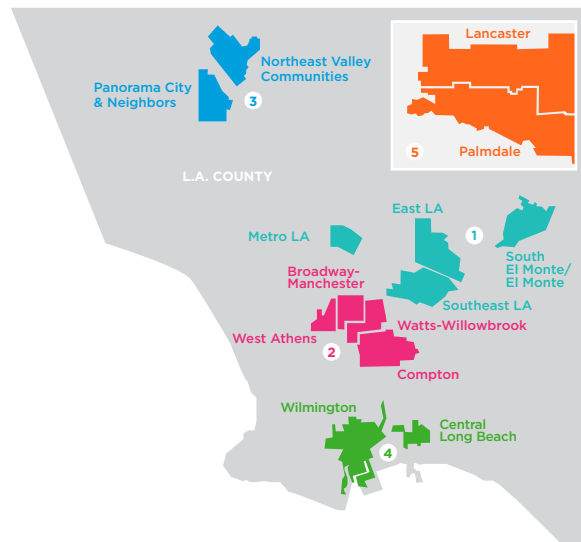
- REGION 1**
East LA
Metro LA
Southeast LA
South El Monte/El Monte

- REGION 2**
Broadway-Manchester
Compton
Watts-Willowbrook
West Athens

- REGION 3**
Northeast Valley Communities
Panorama City & Neighbors

- REGION 4**
Central Long Beach
Wilmington

- REGION 5**
Lancaster
Palmdale



Service Planning Areas

When data by *Best Start* geography is not available, the data is shown by Service Planning Area. A Service Planning Area (SPA) is a region within Los Angeles County that was created by the Los Angeles County Department of Public Health (DPH) to allow the DPH to develop and provide more relevant public health and clinical services targeted to the specific health needs of the residents in these different areas. When data by *Best Start* geography is not available, but data is available by SPA, the map shows the findings by SPA with *Best Start* boundaries overlaid.

- REGION 1**
Antelope Valley

- REGION 2**
San Fernando Valley

- REGION 3**
San Gabriel Valley

- REGION 4**
Metro

- REGION 5**
West

- REGION 6**
South

- REGION 7**
East

- REGION 8**
South Bay (including Santa Catalina Island)



Zip Codes

In rare cases, the maps show the data by postal zip codes with *Best Start* boundaries overlaid.



RESULTS INDICATORS

FOUR RESULTS FOR CHILDREN AND FAMILIES



FAMILY RESOURCES

Families have the resources, opportunities and relationships to optimize their child's development



EARLY INTERVENTION

Children receive early and timely developmental supports and services



CHILD SAFETY

Children are safe from abuse, neglect and other trauma



EARLY LEARNING

Children have high-quality early care and education experiences



1. High-Quality Early Care and Education	●	●	●
2. Publicly Funded Early Care and Education	●		●
3. Early Intervention Services		●	●
4. Average Age of Children in Special Education		●	●
5. Child Protective Services Involvement			●
6. Family Engagement With Child	●		
7. Home Visiting Participation	●		●
8. Participation in Safety Net Programs	●		●
9. Social Support	●		●
10. Access to Parks	●		

High-Quality Early Care and Education

RESULT INDICATOR 1

FAMILY RESOURCES



EARLY INTERVENTION



EARLY LEARNING



FOR MOST L.A. COUNTY CHILDREN, EARLY CARE PROGRAM QUALITY IS UNKNOWN

This indicator captures the proportion of Los Angeles County young children (from infants through preschool age) who are enrolled in early care and education (ECE) programs that have been quality-rated by Quality Start Los Angeles (QSLA). Also presented is the proportion of programs that are rated high-quality (Tier 3, 4 or 5) or rising quality (Tier 1 or 2). All quality-rated programs must meet minimum levels of quality as required by

state statutes; Programs rated high-quality engage in practices beyond the minimum requirements.

Why is it Important?

A large body of evidence suggests that having high-quality early care and education (ECE) experiences prior to kindergarten entry contributes to later school success. In addition to improving specific academic skills, such as reading, language development and numeracy skills, high-quality ECE experiences promote socio-emotional development through structured play, physical and motor development, and the building of positive relationships with teachers, caregivers and peers.

Current Context

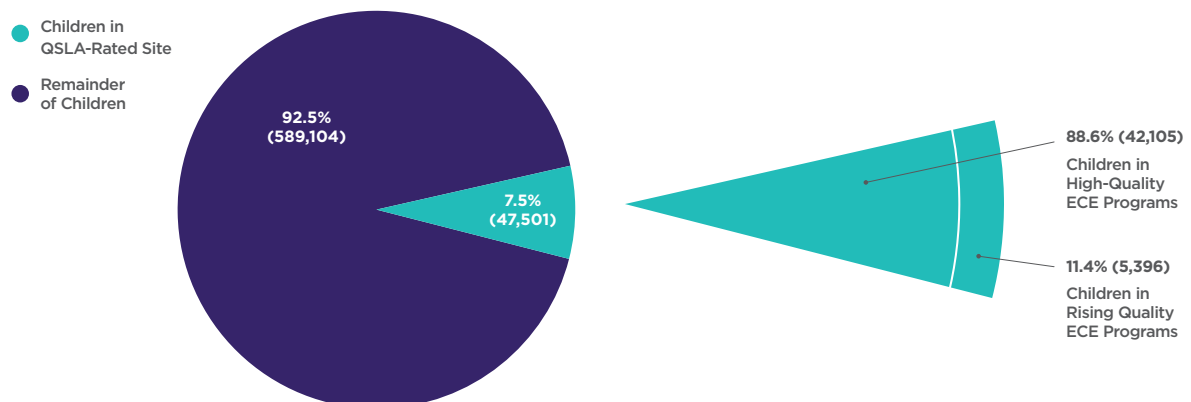
Several contextual considerations can help interpret the data shown in this indicator. First, it is important to note that many children are served in informal settings that are not quality-rated, such as care provided by a family member or babysitter, but they may be considered quality care. Second, cost can be a barrier to becoming a high-quality rated site, particularly for family childcare home settings that may not have the resources to invest in professional development and child development degrees or purchase costly materials. Third, the variation in participation in high-quality ECE by race/ethnicity may reflect the fact that QSLA intentionally seeks to combat entrenched inequity by working with ECE programs that serve families of color that may not have had equal access to high-quality care. Finally, the data shows results prior to the onset of the coronavirus pandemic. Results in subsequent years will likely show fewer quality-rated sites, and therefore fewer children enrolled in high-quality rated ECE, owing to challenges associated with how measurement tools can be successfully implemented in a virus-constrained atmosphere (e.g., mask wearing and physical distancing).

MOST RECENT YEAR

In 2018-19, just 7.5 percent of Los Angeles County young children attended an ECE program that was quality-rated by QSLA. This is equivalent to 47,501 children in quality-rated programs. Of the children in these quality-rated programs, fully 88.6 percent were in high-quality programs and 11.4 percent were in a rising quality program.

PERCENTAGE OF YOUNG CHILDREN IN A QSLA-RATED PROGRAM IS LOW

Percentage of Los Angeles County Young Children Attending a QSLA-rated ECE Program and Percentage that are High-Quality or Rising Quality, 2018-19



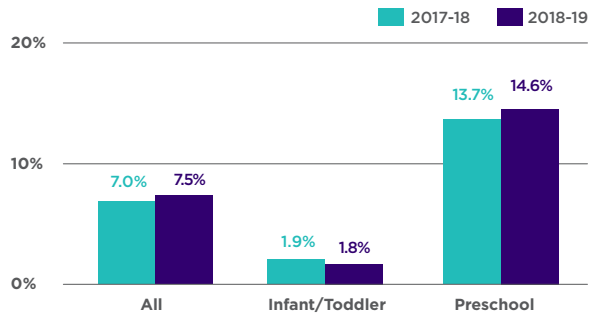
TREND

Overall, the proportion of children in QSLA-rated ECE programs increased slightly between 2017-18 and 2018-19, from 7.0 percent to 7.5 percent. The gain was driven by increases among programs serving preschool-age children. In 2018-19, among L.A. County preschool-age children, 14.6 percent attended a QSLA-rated program compared to 13.7 percent the prior year. Among infants and toddlers, slightly fewer attended QSLA-rated programs in 2018-19 compared to 2017-18.

The proportion of children in a high-quality program (rated Tier 3, 4 or 5) also increased between 2017-18 and 2018-19, from 5.7 percent of children to 6.6 percent. In 2018-19, 13.2 percent of preschool-age children attended a program rated high quality, compared to 11.7 percent in 2017-18. Similarly, more infants and toddlers were in high-quality programs in 2018-19 than in 2017-18.

PRESCHOOL CHILDREN IN QSLA-RATED ECE PROGRAMS INCREASED SLIGHTLY

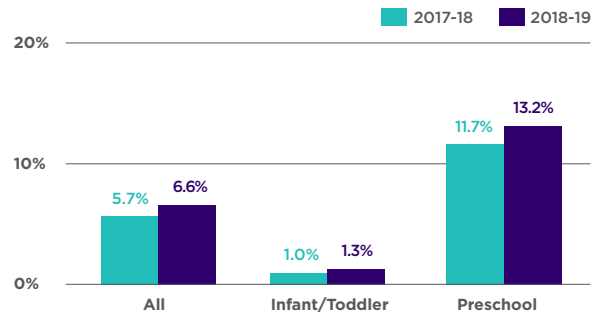
Percentage of Los Angeles County Infants, Toddlers and Preschool-Age Children in a QSLA-rated ECE Program, 2017-18 and 2018-19



Additional detail is provided in the Supplemental Tables.

PERCENTAGE OF CHILDREN IN HIGH-QUALITY ECE PROGRAMS GROWS

Percentage of Los Angeles County Infants, Toddlers and Preschool-Age Children in an ECE Program Rated High Quality (Tier 3, 4, or 5), 2017-18 and 2018-19



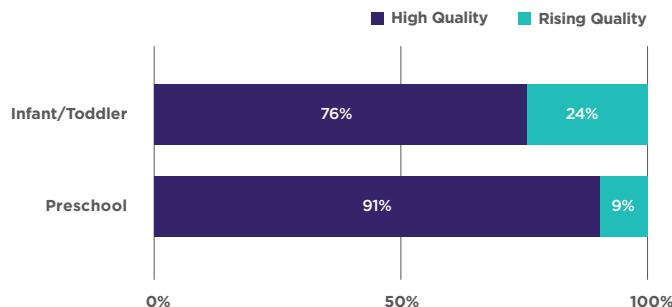
Additional detail is provided in the Supplemental Tables.

AGE DETAIL

Most of the children served by a QSLA-rated ECE program in 2018-19 were of preschool-age (87 percent), while 13 percent were infants or toddlers. Among those QSLA-rated programs, a greater proportion of preschoolers (91 percent) were in a high quality program than infants and toddlers (76 percent).

PRESCHOOLERS SOMEWHAT MORE LIKELY THAN INFANTS AND TODDLERS TO ATTEND AN ECE PROGRAM RATED HIGH-QUALITY

Percentage of Los Angeles County Young Children Participating in QSLA-Rated Programs by Quality Rating (High Quality or Rising Quality) and Age, 2018-19

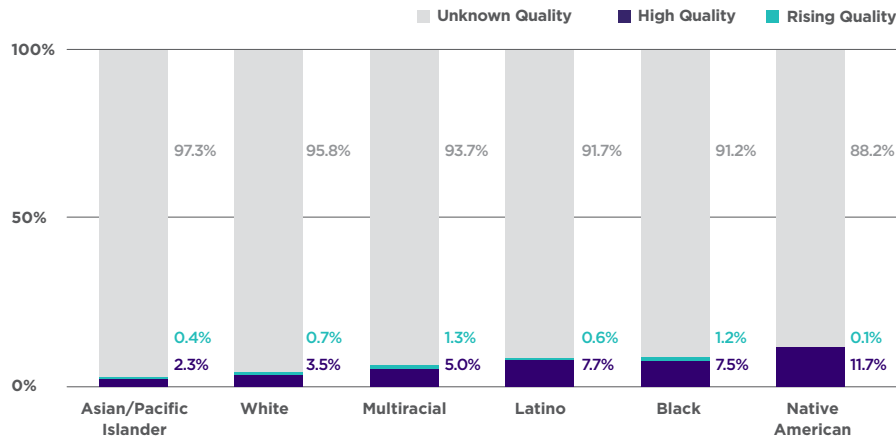


RACE/ETHNICITY DETAIL

While the number of Native American children participating in a QSLA-rated program is relatively small (194 in 2018-19), they have the highest rate of participation in care that has been rated by QSLA as high-quality; 11.7 percent of Native American children in Los Angeles County attend an ECE program that has been rated high-quality. Black children have the next highest rate, with 7.5 percent attending high-quality rated ECE and another 1.2 percent of Black children attending a rising-quality program. The quality of care is least known for Asian/Pacific Islander and White children.

1-IN-8 NATIVE AMERICAN CHILDREN ATTEND QUALITY-RATED ECE

Percentage of Los Angeles County Young Children Attending Programs Rated High Quality, Rising Quality, or Unknown Quality by Race or Ethnicity, 2018-19



Data can be interpreted according to the following example: 7.5 percent of Black young children in Los Angeles County attend ECE that has been rated high-quality. Additional detail by race and ethnicity is provided in the Supplemental Tables, including data for the year 2017-18.

DATA NOTES AND LIMITATIONS

QSLA is a voluntary quality rating and improvement system (QRIS) for early care and education programs in Los Angeles County. QSLA serves a wide range of programs in home-based and, most predominately, school- and center-based settings. Many QSLA programs receive public funding from sources such as Head Start, California State Preschool Program (CSPP) and vouchers. A limitation of this indicator is that the data reflects only quality rating information from QSLA, which is not representative of all high-quality ECE programs serving children. Further, due to data available, the denominator is all L.A. County young children, not just children enrolled in ECE or the children of families seeking ECE. As such, the measure is a conservative assessment of the reach of QSLA within the county since using a more constrained denominator would result in higher penetration rates. The denominator of “young children” includes children birth through age 4 plus one-quarter of 5-year-old children. One-quarter of 5-year-old children are included since children who have already turned 5 years old are not newly enrolled in ECE, but a child may turn 5 while in ECE and remain in the program. Therefore, the denominator approximates this circumstance by accounting for the smaller proportion of 5-year-old children in ECE programs. Infants and toddlers are defined as children from birth through age 2. Preschool-age children are defined as children from age 3 through 4, plus one-quarter of the total population of 5-year-old children. Rising-quality sites meet baseline quality measures as required by the State of California; high-quality sites engage in practices beyond the minimum requirements. The Methods section provides detail on the evaluation elements and scoring thresholds for high quality (Tier 3 and above) and rising quality (Tiers 1 and 2) designations.

Full Indicator Language: Increased rate of L.A. County children birth through age 5 enrolled in a high-quality early care and education program.

Source: Quality Start Los Angeles (QSLA), Quality Counts California (QCC) Common Data File; California Department of Finance, Demographic Research Unit, State and County Projections Dataset, Table P-3

Publicly Funded Early Care and Education

RESULT INDICATOR 2

FAMILY RESOURCES



EARLY LEARNING



LOW PARTICIPATION RATES POINT TO INSUFFICIENT SUPPLY OF PUBLICLY FUNDED EARLY CARE

This indicator provides an estimate of what proportion of income-eligible Los Angeles County children birth to age 5 are enrolled in publicly funded early care and education (ECE) programs. Income-eligible is defined as less than 85 percent of the State Median Income. The enrollment rate is calculated by dividing the number of children who participate in publicly funded early care and education by the number of children eligible for such services. The data reflect children in federal or state-funded ECE sites (referred to as contracted

sites) and children in an ECE setting supported by a voucher from CalWORKs or the Alternative Payment Voucher Program (referred to as voucher programs).

Why is it Important?

Participation in publicly funded ECE programs offers access to care for families with low income and improves financial stability for families in L.A. County. Research has established strong positive relationships between participation in subsidized ECE and family economic well-being, child school readiness, and later success in life, including future education, employment, and family outcomes, particularly for children from disadvantaged backgrounds.

Current Context

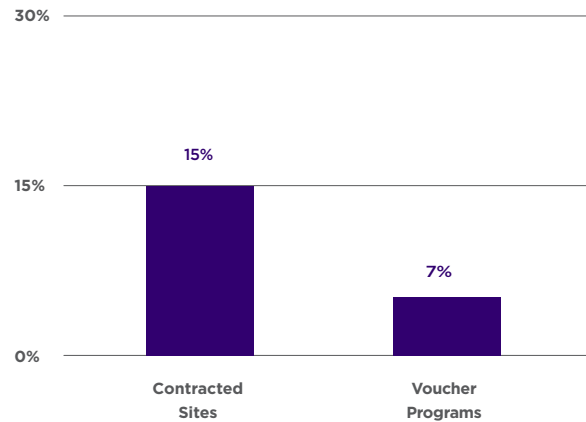
The participation rates shown in this indicator are heavily influenced by the lack of funding for spaces or vouchers, which leads to long waiting lists for a publicly funded space. The location of subsidized care can also be a barrier if it is not near home or work, or not accessible by transit. Many families that may not be eligible for subsidized care because their household income is above the eligibility threshold still struggle with affording care. While some families prefer informal care, such as a friend, family member or neighbor, other families may use these informal and less expensive options due to financial constraints.

MOST RECENT YEAR

In 2019, out of 455,581 children in L.A. County who were income-eligible for publicly funded early care and education programs, approximately one-quarter were enrolled in publicly funded ECE. Among these children, 15 percent were enrolled in contracted ECE sites and 7 percent received a voucher to pay for their ECE space.

ENROLLMENT OF ELIGIBLE CHILDREN IN PUBLICLY FUNDED ECE IS LIMITED

Percentage of Eligible Los Angeles County Children Enrolled in Publicly Funded Early Care and Education Programs by Type, 2019

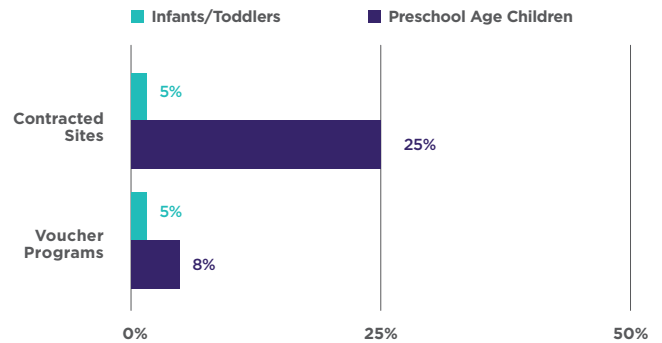


AGE DETAIL

Roughly one-third of all eligible preschool-age children participate in publicly funded ECE, including 25 percent of eligible preschool-age children enrolled in contracted sites and 8 percent enrolled in a voucher program. In contrast, 5 percent of eligible infants and toddlers are enrolled in a contracted site and 5 percent are enrolled in a voucher program.

FEWER INFANTS AND TODDLERS ARE ENROLLED IN PUBLICLY FUNDED ECE THAN PRESCHOOL-AGE CHILDREN

Percentage of Eligible Los Angeles County Children Enrolled in Publicly Funded Early Care and Education Programs by Age, 2019



DATA NOTES AND LIMITATIONS

Program data used in the numerator (the number of children enrolled in publicly funded ECE) is from 2019, while the total number of children eligible to participate in subsidized ECE, used in the denominator, is from 2016 data. A family is considered income-eligible if their household income is less than 85 percent of the State Median Income (SMI). In 2016, SMI was \$77,106 for a 4-person family; to be income-eligible, the family would have to have a household income of less than \$65,540. The enrollment rate is the proportion of all income-eligible children, although all income-eligible families may not seek childcare. It is possible for a child to be enrolled in a contracted site and a voucher program; as a consequence, there may be some duplication in the estimates of enrollment across the types of publicly funded ECE. Detail by race or ethnicity is not available at this time.

Full Indicator Language: Increased rate of income-eligible L.A. County children birth through age 5 enrolled in publicly funded early care and education programs.

Source: Early Learning Needs Assessment Tool from the American Institutes for Research (eligible children) and The Child Care Alliance of Los Angeles and Los Angeles County Office of Education (program enrollment)

Early Intervention Services

RESULT INDICATOR 3

EARLY INTERVENTION



CHILD SAFETY



EARLY INTERVENTION SERVICES DO NOT REACH ALL CHILDREN WITH DEVELOPMENTAL DELAYS

This indicator captures the proportion of California young children that have been identified with a developmental delay and have either an Individualized Family Service Plan (birth through age 2) or have an Individualized Education Plan (ages 3 through 5) through the Individuals with Disabilities Education Act (IDEA) Part C (Early Start) or Part B Section 619. The percentage of young children with an IFSP or IEP is used as a proxy for receipt of intervention

services. Two additional benchmarks are used to assess gaps and trends in children's connections to developmental supports: the estimated national prevalence rate of developmental delays in children and the percentage of first grade students receiving special education services.

Why is it Important?

Evidence demonstrates that the earlier developmental delays are identified and children receive services, the more effective an intervention can be in supporting optimal child development, potentially reducing a child’s need for long-term special education services. Despite this, literature on early identification suggests 12 to 16 percent of children in the United States have at least one developmental delay, yet as many as one-half of children will not be identified before they enter kindergarten.¹ Comparing the percentage of young children with an educational plan to this research-based prevalence rate, as well as to the percentage of first grade students receiving special education, sheds light on the gap between those children receiving services and those in need of developmental supports. It also provides important context for pinpointing barriers to identification and receipt of services, including strict eligibility criteria.

Current Context

The State of California codified its support for developmental screening when AB 1004 was signed into law in 2019. AB 1004 — the first piece of legislation sponsored by First 5 LA to become law — requires doctors to screen children enrolled in Medi-Cal for developmental delays using screening tools recommended by the American Academy of Pediatrics and at three specific times — 9 months, 18 months and 30 months. In July 2020, Children Now released a landscape analysis on Medi-Cal managed care performance for children, which reported variation in developmental screening rates across health plans. As AB 1004 is implemented, early identification rates are likely to increase over time.

¹ Mackrides, P. S., & Ryherd, S. J. (2011) Screening for developmental delay. American Academy of Family Physicians, 84 (5), 544-549

MOST RECENT YEAR

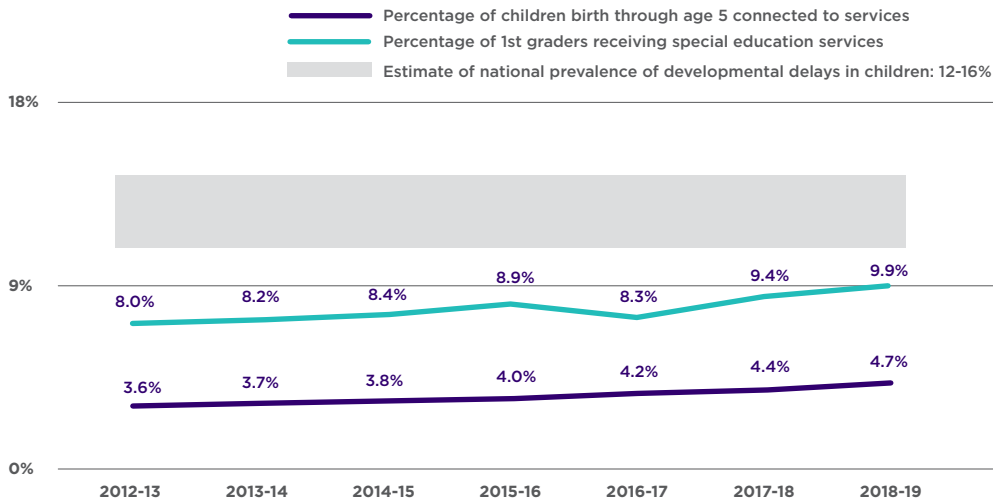
IDEA data from 2018-19 indicate that 136,631 California children from birth through age 5 were receiving early intervention services. This represents 4.7 percent of the 2.9 million young children in California. Two benchmarks suggest that young children may be underserved. First, the estimated United States prevalence rate for developmental delays in children of all ages is between 12 and 16 percent, which suggests an estimated 7 to 11 percent of young children in California are not identified and receiving needed services. Similarly, the rate of first grade children receiving special education services in California in 2018-19 was 9.9 percent, which suggests about 5 percent of young children are not connected to developmental supports until they enter school.

TREND

The rate of California children who receive early intervention services through IDEA has increased steadily over the last 7 years, from 3.6 percent in the 2012-13 school year to 4.7 percent in the 2018-19 school year.

SLOW, STEADY INCREASE IN EARLY IDENTIFICATION RATE OVER 7-YEAR PERIOD

Percentage of California Children Birth Through Age 5 Receiving Early Intervention Services Compared to Percentage of First Grade Students Receiving Special Education and Estimated Prevalence for Developmental Delays in Children, 2012-13 to 2018-19

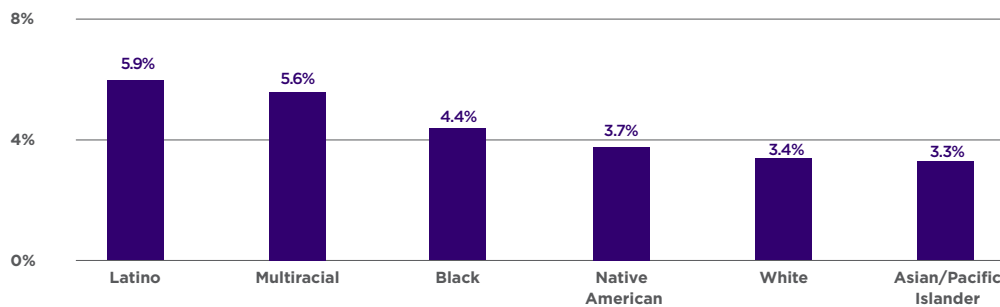


RACE/ETHNICITY DETAIL

Compared to their peers of other races/ethnicities, Latino children had the highest rate of early identification, at 5.9 percent of all Latino children from birth through age 5 in the 2018-19 school year. This is followed by a rate of 5.6 percent among multiracial young children and 4.4 percent among Black young children. White and Asian/Pacific Islander young children had the lowest rates of early identification, at 3.4 and 3.3 percent, respectively. Since 2012-13, the rate of identification for development delays has increased for all race and ethnic groups except White young children. Multiracial and Latino children showed the greatest increases in identification rates over this seven-year period.

A GREATER PROPORTION OF LATINO AND MULTIRACIAL YOUNG CHILDREN ARE IDENTIFIED EARLY

Percentage of California Children Birth Through Age 5 Receiving Early Intervention Services by Race/Ethnicity, 2018-19



Trend data by race/ethnicity are provided in the Supplemental Tables. The data display can be interpreted according to the following example: Out of all Latino children from birth through age 5, 5.9 percent are receiving intervention services.

DATA NOTES AND LIMITATIONS

Data is currently available only as a statewide indicator and not specific to L.A. County. The data presented reflects children enrolled in the Individuals with Disabilities Education Act (IDEA) Part C Early Intervention Program and Part B Section 619 Preschool Special Education Program. According to IDEA Part C, an Individualized Family Service Plan (IFSP) identifies the unique needs of the infant and toddler and the appropriate services to meet such needs. It must be developed within 45 calendar days of referral for early intervention services. At age 3, children still eligible for services transition to an Individualized Education Plan (IEP) Part B, Section 619. The two benchmarks used to assess gaps in young children's connection to developmental support have limitations. The national prevalence rate is for children of all ages (newborn to age 18), not the national or California prevalence rate for children from birth through age 5. The 9.9 percent of first grade students in special education may not capture all children with a developmental delay because additional children may be identified with developmental delays later in elementary school and many of these delays could have been identified during early childhood.

Full Indicator Language: Increased rate of L.A. County children birth through age 5 with a developmental delay participating in early intervention services.

Source: U.S. Department of Education IDEA Part B and C Annual Performance Reports (program enrollment); California Department of Finance Population Projections, Table P-3 (ages 0-5 denominator data); California Department of Education, DataQuest (1st grade students in special education); Children Now, Children's Medi-Cal Managed Care in California Counties, July 2020, www.childrennow.org (Current Context)

Average Age of Students in Special Education

RESULT INDICATOR 4

EARLY INTERVENTION



CHILD SAFETY



POSITIVE TREND TOWARD EARLIER IDENTIFICATION FOR SPECIAL EDUCATION

This indicator tracks the average age of Los Angeles County students enrolled in special education services for speech or language impairment (SLI). This analysis acts as a proxy for whether students are being identified prior to kindergarten entry. A lower average age over time signals that children may be receiving services earlier. SLI is the focus diagnosis because it typically can be identified before kindergarten entry.

Why is it Important?

Early identification of developmental delays and effective interventions supports a child's optimal development, increases success in school, reduces stress in the home, and increases parents' ability to provide for the intellectual, physical and emotional needs of their child. Conversely, when delays are identified late and children are not connected to services promptly, delays and family stress can compound and intensify.

MOST RECENT YEAR

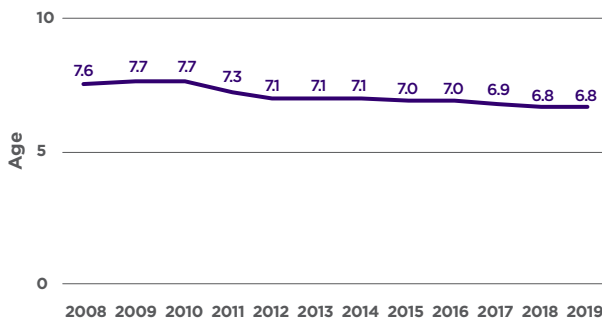
In 2018-19, the average age of L.A. County students enrolled in special education services for speech or language impairment (SLI) was 6.8 years old.

TREND

Since 2007-08, the average age of students enrolled in special education for SLI has fallen from 7.6 to 6.8 years old in 2018-19.

DECLINING AVERAGE AGE OF STUDENTS IDENTIFIED FOR SPECIAL EDUCATION

Average Age of Los Angeles County Students Enrolled in Special Education for Speech or Language Impairment, 2007-08 – 2018-19

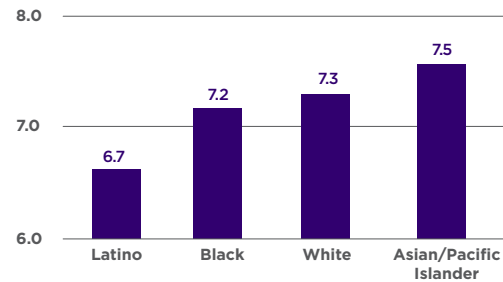


RACE/ETHNICITY DETAIL

Among the four race or ethnic groups compared, Latino students were most likely to be enrolled in special education at an earlier age. The average age of Latino students enrolled in special education for SLI was 6.7 years old in the 2018-19 school year. Black students had the next lowest average age at 7.2, yet this average age was above the countywide average of 6.8 years old. The average age of White students enrolled in special education for SLI was 7.3 years old. Asian/Pacific Islander students were least likely to be enrolled at an earlier age, with an average age of 7.5 years old. In the four years since 2015-16, the average age of Latino students declined from 6.9 to 6.7 and the average age for Asian/Pacific Islander students declined from 7.7 to 7.5. The average ages for White and Black students did not change appreciably.

LATINO STUDENTS HAVE THE LOWEST AVERAGE AGE

Average Age of Los Angeles County Students Enrolled in Special Education for Speech or Language Impairment by Race/Ethnicity, 2018-19



DATA NOTES AND LIMITATIONS

The data is a proxy for measuring earlier identification for special education. Identification for speech or language impairment (SLI) was selected as the proxy indicator because this condition can typically be identified early, prior to kindergarten entry. It is also one of the most common identifications and can be co-occurring with other developmental delays; therefore, tracking this condition reaches a large proportion of children in special education. There are limitations on what the data can say about the age of identification for special education. First, the indicator measures the age of all children identified with SLI, not age at entry. Consequently, the change in average age is affected by the age of entry to special education as well as the age of exit. Second, since the measure only tracks SLI, change in the average age for SLI may not be indicative of change in average age for special education identification overall. Further disaggregation by race/ethnicity is limited due to data suppression criteria employed by the data source.

Full Indicator Language: Decreased average age of L.A. County children entering into special education services.

Source: California Department of Education



DISPARITIES IN CPS INVOLVEMENT ARE SUBSTANTIAL AND GROWING

This indicator measures what proportion of Los Angeles County children were involved with Child Protective Services (CPS) during their first five years of life, including what proportion were referred to the Department of Children and Family Services (DCFS) with allegations of abuse or neglect (maltreatment), had allegations that were substantiated, and were placed in out-of-home care.

Why is it Important?

Strong families and strong communities are critical for preventing abuse, neglect and other trauma. According to research by the Children's Data Network at the University of Southern California, a report of maltreatment, regardless of whether or not an allegation is substantiated, is an important signal of a child's risk of death, developmental difficulties, and other adversities.¹ Monitoring CPS involvement rates can inform our understanding of risks to children's well-being, efforts to prevent maltreatment, and structural factors that contribute to CPS involvement.

¹ Putnam-Hornstein, E. (2011). Report of maltreatment as a risk factor for injury death: A prospective birth cohort study. *Child maltreatment*, 16(3), 163-174.

Current Context

The disparities evident in the data — along race/ethnic lines as well as by socioeconomic status — warrant a deep and intentional look at the effect systemic racism and poverty have on rates of CPS involvement. Understanding these impacts can inform our work to change systems that perpetuate bias and to prevent conditions that contribute to higher rates of CPS involvement. Services that connect families to resources and supports, such as the Prevention and Aftercare Networks, are critical components of prevention efforts that proactively support child and family well-being.

School staff and health care providers are significant sources of child welfare reports because they interact with children frequently and they are legally obligated to report suspected maltreatment. With the closure of schools and the decrease in medical visits as a result of the COVID-19 pandemic, officials report a dramatic reduction in maltreatment calls to law enforcement and child abuse hotlines. While most allegations do not result in a substantiated case of maltreatment, the decline is still a concern for child well-being.

MOST RECENT YEAR

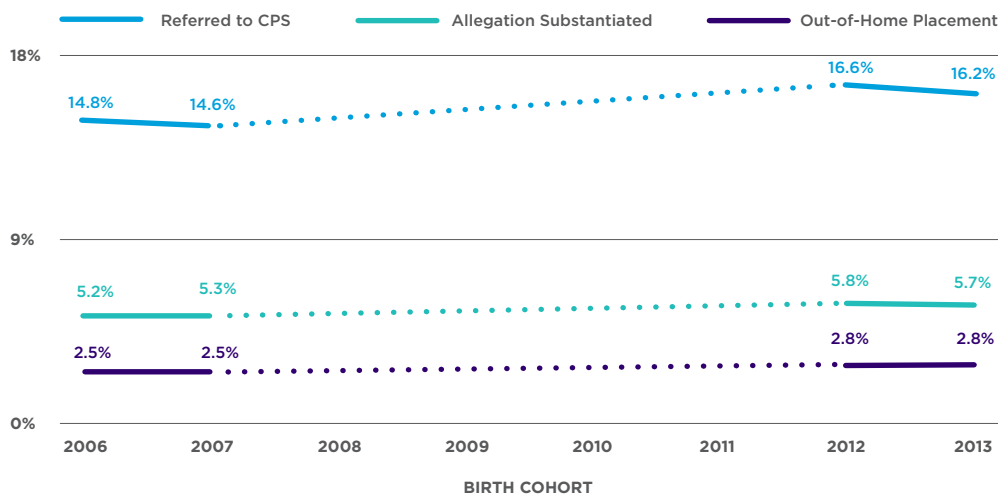
Of Los Angeles County children born in 2013, 16.2 percent were referred to CPS with allegations of maltreatment by the time they turned five in 2018. Within this 2013 birth cohort, 5.7 percent had allegations that were substantiated, and 2.8 percent were placed in out-of-home care at least once during their first five years of life.

TREND

Slightly more children in the 2013 birth cohort were referred with allegations at least once during their first five years of life compared to the 2006 birth cohort (children born in 2006) — 16.2 percent and 14.8 percent, respectively. Similarly, there were slightly higher rates of children with substantiated cases or out-of-home placements among the 2013 birth cohort compared to the 2006 birth cohort.

SLIGHT INCREASE IN OVERALL RATE OF CPS INVOLVEMENT

Percentage of Los Angeles County Children Involved With Child Protective Services in Their First Five Years of Life, Birth Cohorts 2006, 2007, 2012 and 2013



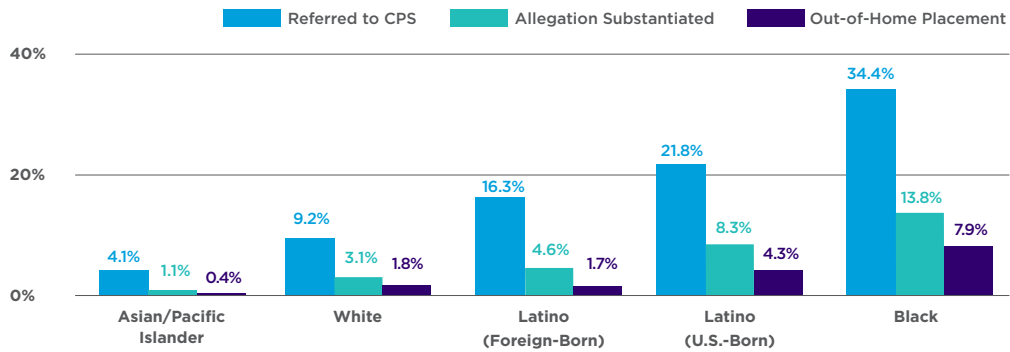
Data has been analyzed for birth cohort years 2006, 2007, 2012 and 2013 only. Intervening years without data are represented by a dotted line in the chart.

RACE/ETHNICITY DETAIL

Analyzing what proportion of children within each race and ethnic group experience CPS involvement reveals vast disparities, with children born to Black and Latina mothers having significantly higher rates of allegations, substantiations and out-of-home placements compared to other racial/ethnic groups. For example, of all children born to Black mothers in 2013, 34.4 percent were referred to CPS by age five, compared to 4.1 percent of children of Asian/Pacific Islander mothers. Since the 2006 birth cohort, rates of Black and Latino children involved in CPS have steadily increased.

SUBSTANTIAL RACIAL AND ETHNIC DISPARITIES IN CPS INVOLVEMENT

Percentage of Los Angeles County Children Born in 2013 Involved With Child Protective Services in Their First Five Years of Life by Race or Ethnicity



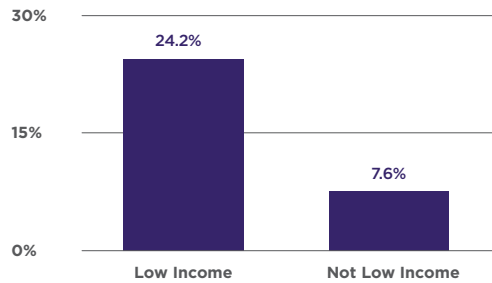
Data can be interpreted according to the following example: 34.4 percent of children born in Los Angeles County in 2013 to Black mothers were referred to CPS for maltreatment by age five. Trend data by race/ethnicity is provided in the Supplemental Tables.

SOCIOECONOMIC STATUS DETAIL

Children born in 2013 to families with low income were referred to CPS at four times the rate as the children who were born into families that were not low income. The children in low-income families had allegations that were substantiated and were placed in out-of-home care at almost five times the rate of children who were not from low-income families.

1 IN 4 LOW-INCOME CHILDREN HAVE CPS INVOLVEMENT BY AGE FIVE

Percentage of Los Angeles County Children Born in 2013 Involved With Child Protective Services in Their First Five Years of Life by Socioeconomic Status



Trend data and data for substantiated allegations and out-of-home care placement by socioeconomic status are provided in the Supplemental Tables.

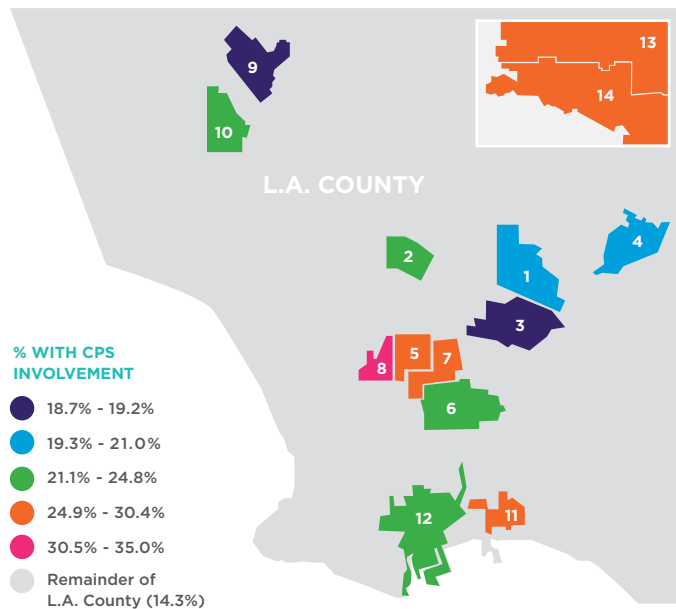
GEOGRAPHIC DETAIL

All *Best Start* geographies have CPS involvement rates that are higher than the county average of 16.2 percent and higher than the 14.3 percent average for the remainder of L.A. County (areas outside of *Best Start* geographies). West Athens, Broadway-Manchester, Watts-Willowbrook, Central Long Beach, Palmdale and Lancaster all had rates of CPS involvement that were more than 10 percentage points above the county average of 16.2 percent.

CPS INVOLVEMENT IN *BEST START* GEOGRAPHIES HIGHER THAN COUNTY AVERAGE

Percentage of Los Angeles County Children Born in 2013 Involved With Child Protective Services in Their First Five Years of Life by *Best Start* Geography

REGION 1	
1 East LA	20.9%
2 Metro LA	24.8%
3 Southeast LA	18.7%
4 South El Monte/El Monte	21.0%
REGION 2	
5 Broadway-Manchester	30.4%
6 Compton	24.7%
7 Watts-Willowbrook	29.0%
8 West Athens	35.0%
REGION 3	
9 Northeast Valley Communities	19.2%
10 Panorama City & Neighbors	23.5%
REGION 4	
11 Central Long Beach	26.8%
12 Wilmington	23.6%
REGION 5	
13 Lancaster	26.5%
14 Palmdale	26.6%



DATA NOTES AND LIMITATIONS

A birth cohort refers to all Los Angeles County children born in a given calendar year. Out-of-home care, or foster care, refers to the variety of placements a child might encounter when removed from their home for their protection, including relative care, non-relative care, and group home care. The data is sourced from birth records which record the race and ethnicity of the mother; the race and ethnicity of the child is not recorded. Consequently, the race and ethnic data is based on the race and ethnicity of the mother. Data for Latina mothers is disaggregated by foreign-born and U.S.-born due to the notable variation in CPS involvement rates. Socioeconomic status is estimated by the method of payment for the birth, where publicly funded is considered low income and privately funded is considered not low income. Since the measure of socioeconomic status is based on payment at the time of birth, a child’s socioeconomic status could change during the first five years of life. The estimates presented in this indicator should not be considered official county or state birth statistics.

Full Indicator Language: Decreased rate of L.A. County children with Child Protective Services involvement at any point during the first 5 years of life.

Source: Children’s Data Network at the University of Southern California (analyses of CPS involvement, based on linked administrative records); Los Angeles Times, “Coronavirus Leads to Alarming Drop in Child Abuse Reports,” April 21, 2020 (cited in Current Context)



Family Engagement With Child

RESULT INDICATOR 6

MORE FAMILIES SUPPORT EARLY LITERACY THROUGH MUSIC THAN READING

This indicator measures the percentage of parents participating in WIC (the federal food assistance program for low-income pregnant women, breast-feeding women and children under the age of five) who report that someone in the household plays music, sings, reads, tells stories, or teaches letters, words or numbers to their young child on a daily basis.

Why is it Important?

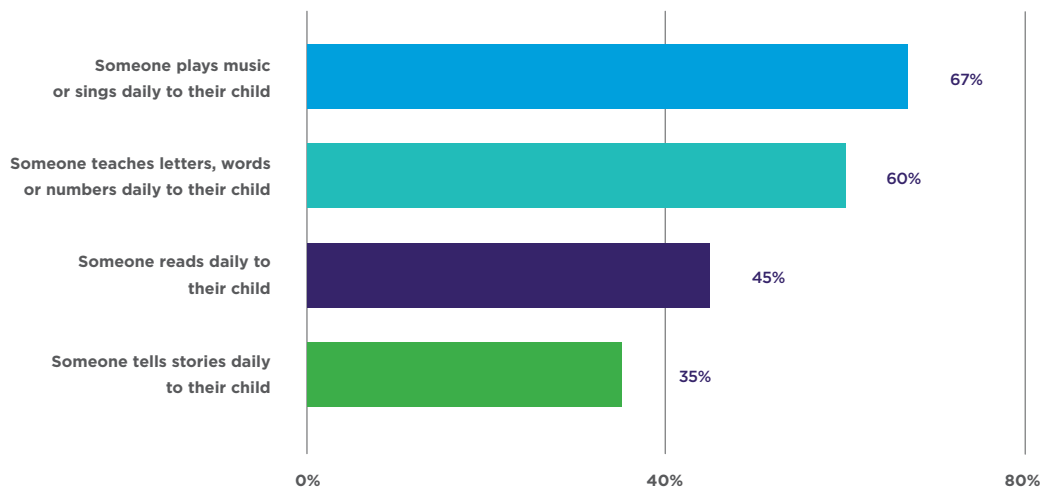
Families play a significant role in supporting a child's early development. Early literacy activities, whether in English or another language, provide cognitive benefits and strengthen children's social, emotional and character development. This indicator captures the various ways that families can support their child's language development and can inform strategies to reduce barriers to active family engagement.

MOST RECENT YEAR

In 2017, roughly two-thirds of surveyed parents participating in WIC reported that someone in the household plays music, sings, or teaches letters, words, or numbers to their child on a daily basis. Less than half reported that someone reads or tells stories to their child daily.

MOST PLAYED MUSIC TO, SANG WITH, OR TAUGHT THEIR CHILD ABOUT LETTERS AND NUMBERS EVERY DAY

Percentage of L.A. County WIC Survey Respondents Reporting Family Early Literacy Engagement With Child by Activity, 2017

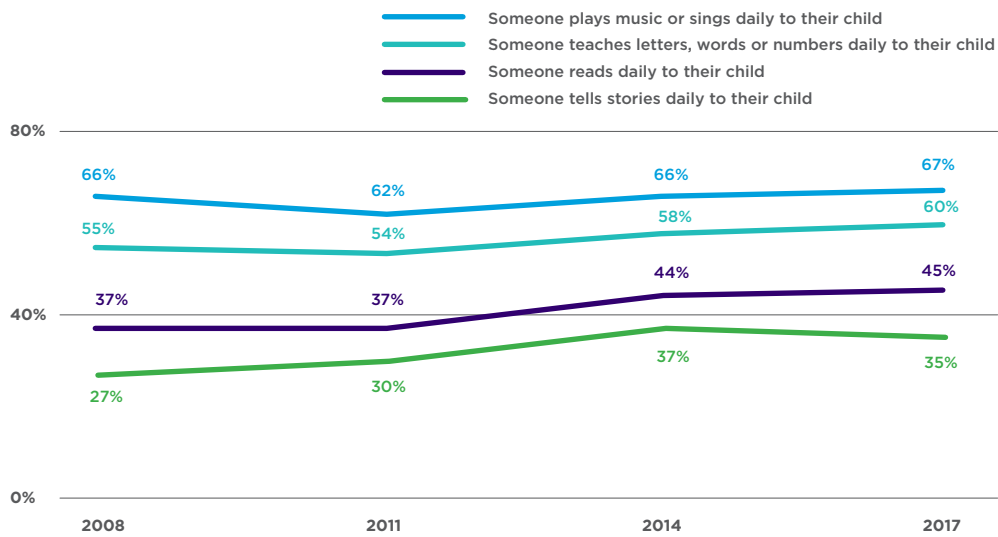


TREND

Since 2008, there have been modest increases across all early literacy measures, including the percentage of parents participating in WIC reporting that someone reads to their child everyday (from 37 percent to 45 percent) and the percentage of parents reporting that someone tells stories to their child every day (from 27 percent to 35 percent).

EARLY LITERACY ENGAGEMENT INCREASING SLIGHTLY OVER TIME

Percent of L.A. County WIC Survey Respondents Reporting Family Early Literacy Engagement by Activity, 2008, 2011, 2014 and 2017

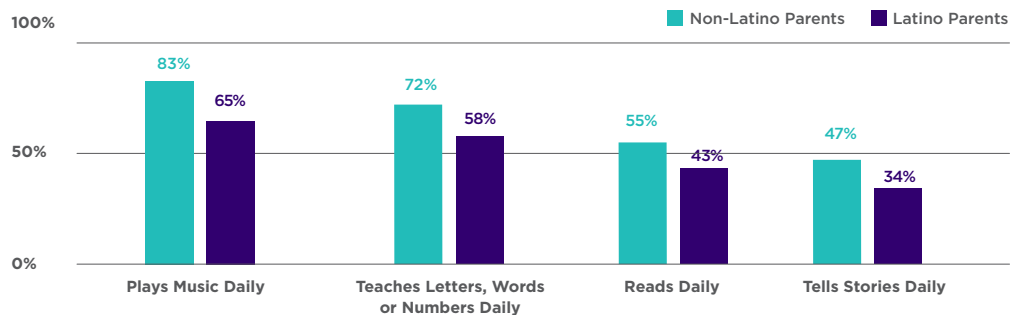


RACE/ETHNICITY DETAIL

Latino parents participating in WIC reported lower rates of engaging in activities that support their child's language development compared to non-Latino parents participating in WIC.

LATINO PARENTS REPORT LOWER RATES OF EARLY LITERACY ENGAGEMENT

Percentage of L.A. County WIC Survey Respondents Reporting Family Early Literacy Engagement by Activity and Ethnicity, 2017

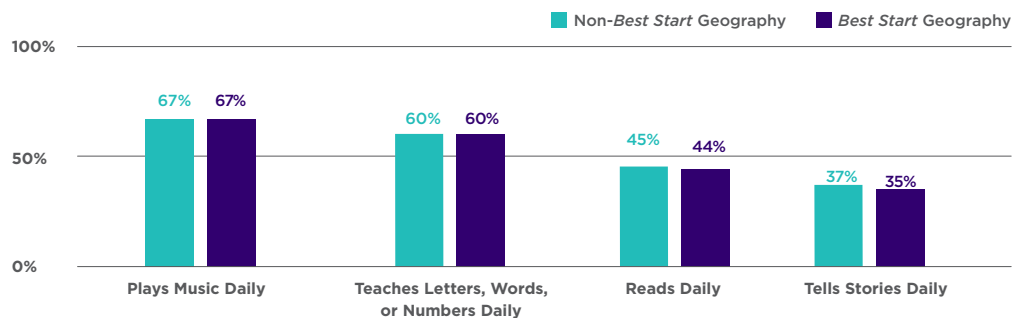


GEOGRAPHIC DETAIL

Parents participating in WIC who reside within a *Best Start* geography reported similar rates of early literacy engagement as parents participating in WIC who reside outside a *Best Start* geography.

SIMILAR LEVELS OF ENGAGEMENT IN *BEST START* AND *NON-BEST START* GEOGRAPHIES

Percentage of L.A. County WIC Survey Respondents Reporting Family Early Literacy Engagement by Activity and Geography, 2017



DATA NOTES AND LIMITATIONS

In 2017, 48 percent of L.A. County families with children under the age of 5 participated in WIC. While the L.A. County WIC Survey is representative of the population of low-income WIC participants, it is not a population-wide measure for L.A. County broadly. Further, it is possible that because of the services and supports that participants received through WIC, mothers participating in WIC may have responded differently to survey questions than mothers that were not WIC participants, if they were surveyed. Due to small sample sizes, race/ethnicity disaggregation is limited to Latino/non-Latino in order to protect respondents' confidentiality.

Full Indicator Language: Increased rate of L.A. County families with children birth through age 5 who read, tell stories, sing, play music or teach letters, words or numbers to their child daily.

Source: Los Angeles County WIC Survey administered by Public Health Foundation Enterprises Special Supplemental Nutrition Program for Women, Infants, and Children (PHFE WIC) Research and Evaluation Department

Home Visiting Participation

RESULT INDICATOR 7

FAMILY RESOURCES



CHILD SAFETY



HOME VISITING ENROLLMENT INCREASES

This indicator estimates percentage of Los Angeles County families with an infant that are participating in a First 5 LA-funded home visiting program. The numerator is the number of families enrolled and the denominator is the number of children in L.A. County under age 1. Home visiting is a prevention strategy that supports pregnant women and new parents to promote infant and child health, development and safety.

Why is it Important?

Evidence has shown that home visiting is an effective service for connecting families with necessary supports and family-strengthening resources. This indicator captures L.A. County's progress towards the vision of a universal, voluntary system of home visiting within a larger system of family supports. This indicator is also a measure of early childhood system performance, serving as a proxy for how well families can access the services and supports that they need to help optimize their child's development.

Current Context

In late 2016, the L.A. County Board of Supervisors passed a motion directing the Department of Public Health as the lead, along with First 5 LA, the Children’s Data Network, LA County Perinatal and Early Childhood Home Visitation Consortium, and every child and family serving county agency, to develop a plan to build a universal home visiting system in the county. This work culminated in a report, *Strengthening Home Visiting in Los Angeles: A Plan to Improve Child, Family, and Community Well-Being*. A key goal of the plan is “to identify a framework to maximize resources by leveraging available funding, and where possible, identify new and existing, but not maximized, revenue streams to support home visiting expansion.” The increases in home visiting enrollment shown in this indicator document First 5 LA’s investments in service to the countywide goal of universal home visiting.

MOST RECENT YEAR

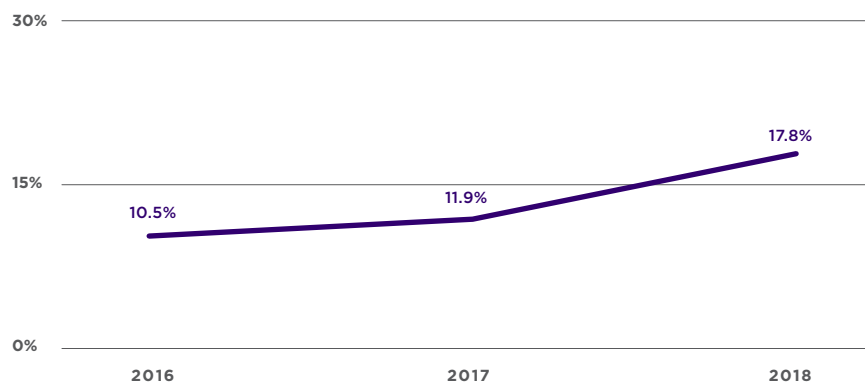
In 2018, 17.8 percent of families with an infant enrolled in a First 5 LA-funded home visiting program.

TREND

Enrollment in home visiting grew more than seven percentage points between 2016 and 2018, from 10.5 percent of L.A. County families with an infant in 2016 to 17.8 percent in 2018.

HOME VISITING RATE INCREASES SUBSTANTIALLY IN THREE YEARS

Percentage of L.A. County Families With an Infant Enrolled in a First 5 LA-Funded Home Visiting Program, 2016-2018

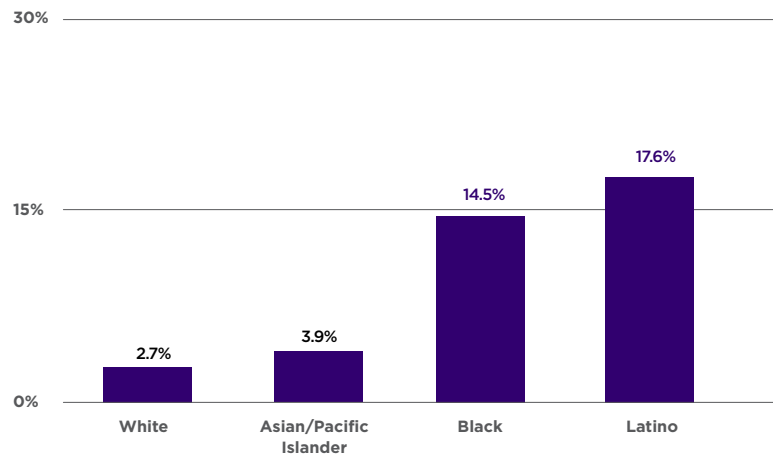


RACE/ETHNICITY DETAIL

Among Latino families with an infant, approximately 17.6 percent were enrolled in 2018 in a First 5 LA-funded home visiting program — the highest rate across the different race/ethnic groups. Black families had the next highest rate, with 14.5 percent of Black families with an infant enrolled. Of all Asian/Pacific Islander families with an infant, only 3.9 percent were enrolled in a First 5 LA home visiting program in 2018. White families had a similarly low rate, with only 2.7 percent enrolled. All race/ethnic groups saw increased rates of home visiting participation between 2016 and 2018.

MORE LATINO AND BLACK FAMILIES WITH AN INFANT PARTICIPATE IN HOME VISITING

Percentage of L.A. County Families With an Infant Enrolled in a First 5 LA-Funded Home Visiting Program by Race/Ethnicity, 2018



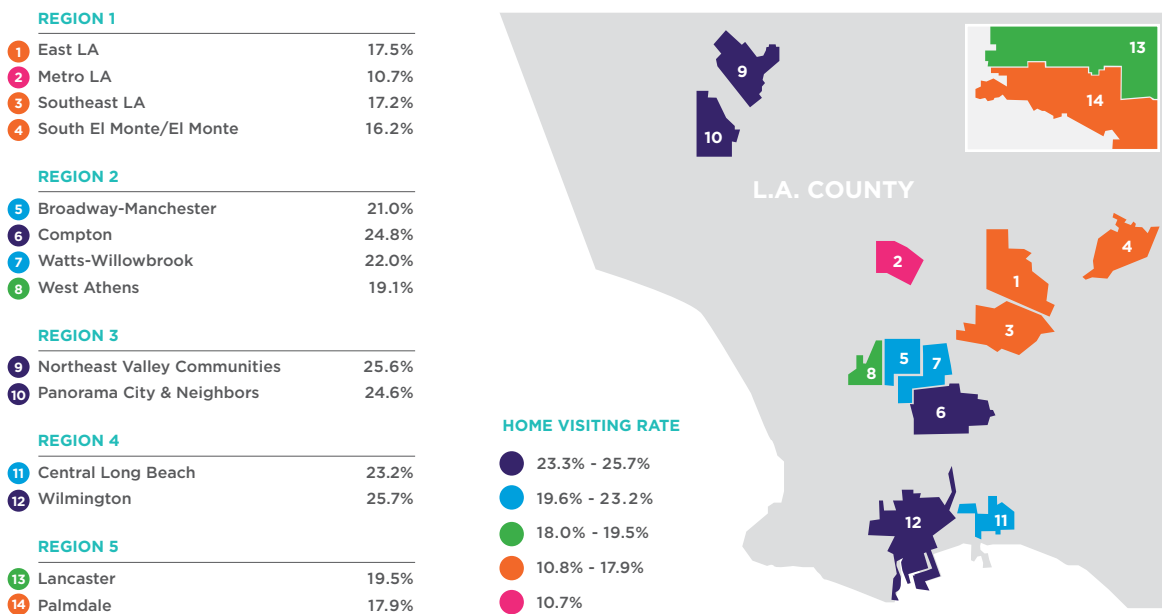
Data by race/ethnicity for 2016 and 2017 is provided in the Supplemental Tables. Race/ethnicity data can be interpreted according to the following example: Among all Latino families with an infant under age one, 17.6 percent participate in a First 5 LA-funded home visiting program.

GEOGRAPHIC DETAIL

Among *Best Start* geographies, families in Regions 2, 3 and 4 were generally more likely to be enrolled in home visiting. Region 1 had the lowest rates of home visiting participation. While the *Best Start* data is not directly comparable to the countywide average due to the need to use a different denominator, *Best Start* geographies tend to have higher rates of home visiting due to First 5 LA investments in *Best Start* geographies.

CONSISTENT WITH FIRST 5 LA INVESTMENTS, HOME VISITING PARTICIPATION IS HIGH IN MANY *BEST START* GEOGRAPHIES

Percentage of L.A. County Families With an Infant Enrolled in a First 5 LA-Funded Home Visiting Program by *Best Start* Geography, 2018



Enrollment data by geography for 2016 and 2017 is provided in the Supplemental Tables.

DATA NOTES AND LIMITATIONS

The data included in this report represents First 5 LA-funded home visiting programs only. First 5 LA is working with its partners to gather a broader countywide perspective of home visiting participation to include in future iterations of this report. The count of home visiting enrollments includes participation in the following First 5 LA-funded programs: Welcome Baby, Healthy Families America and Parents As Teachers. Families are eligible for a First 5 LA home visiting program regardless of risk factors, income or need, but must give birth at a participating Welcome Baby hospital. The home visiting program model and program dosage is based on family risk factors identified at birth through the Bridges for Newborns Screening Tool and whether a family lives in a *Best Start* geography. Enrollment is voluntary. Families can enroll prenatally (through Welcome Baby) as well as postpartum at the hospital. The enrollment counts are based on fiscal years (July-June) and include both prenatally and postnatally enrolled families. Counts of enrolled families by race/ethnicity do not tally to the total count of families enrolled since race/ethnicity data was not available for all participants. This contributes to the lower rates for all race/ethnic groups than the countywide average.

Full Indicator Language: Increased rate of L.A. County families who participated in home visiting programs at any point prenatally through age 5.

Source: LA Best Babies Network (count of families participating); California Department of Finance population projections (denominator for countywide and race/ethnicity calculations); Esri (denominator for geographic calculations)

Participation in Safety Net Programs

RESULT INDICATOR 8

FAMILY RESOURCES



CHILD SAFETY



PRIOR TO COVID-19, PARTICIPATION IN CERTAIN SAFETY NET PROGRAMS WAS ON THE DECLINE

This indicator measures the number of young children enrolled in four public health and social service programs: CalFresh, which provides food assistance for individuals and families; California Work Opportunity and Responsibility for Kids (CalWORKs), which provides cash assistance, early care and education subsidies, and other supports for families; Special Supplemental Nutrition Program for

Women, Infants, and Children (WIC), which provides food assistance for pregnant women, breastfeeding women, and children under the age of five; and California Medical Assistance Program (Medi-Cal), which provides health insurance coverage for individuals and families.

Why is it Important?

Public health and social service benefit programs like CalFresh, CalWORKs, WIC, and Medi-Cal make available critical resources for children and families. In the face of Los Angeles County's high cost of living and wages that may not keep up with the rising cost of food, housing, childcare and health care, these programs can help fill the gap. Participation in these programs can change a family's trajectory, supporting their path to financial stability, which can in turn positively impact young children's development and readiness for school. Eligible families may face barriers to participation, and some families in need of support may not be eligible. Tracking these data can inform discussions of service demand and barriers families may experience accessing these supports.

Current Context

Various factors can impact participation in safety net programs. Efforts to remove barriers to enrollment and increase outreach to enroll more eligible families can increase participation. Conversely, it is not uncommon to see participation in safety net programs decline in a strong economy, as families earn more and may no longer need or qualify for the supports. The COVID-19 pandemic and the stay-at-home orders that it prompted have had an enormous impact on family economic stability, which has in turn increased demand for some safety net programs. For example, as of publication, the Los Angeles County Department of Public Social Services reports that CalFresh enrollment has more than doubled since the first stay-at-home order was issued in the spring of 2020. The higher public benefit program participation figures anticipated for 2020 may partly reflect increased outreach efforts, but financial stress from job losses associated with COVID-19 is likely to be the most significant driver of the increases.

MOST RECENT YEAR

In 2019, there were 406,854 children from birth through age 5 participating in Medi-Cal. For context, there were an estimated 715,000 children from birth through age 5 in L.A. County. While not all children from birth through age 5 are eligible for Medi-Cal, the Medi-Cal participation count of 406,854 reveals that over half of young children in L.A. County were enrolled in Medi-Cal.

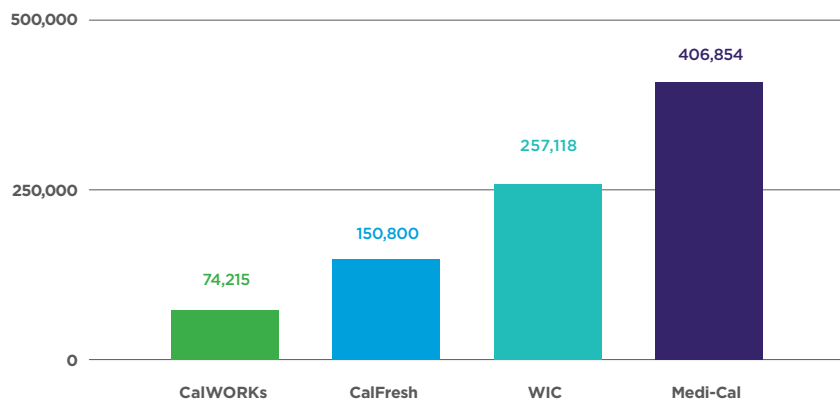
WIC was the next most highly enrolled public service program, with 257,118 L.A. County children from birth through age 4 participating in 2019. Of this number, 194,865 were ages 1 through 4 and 62,253 were under 1 year of age.

CalFresh had 150,800 participants from birth through age 5 as of 2019.

CalWORKs serves the fewest young children of the programs shown in this indicator. In 2019, 74,215 children from birth through age 5 were enrolled in CalWORKs.

HIGH NUMBERS OF YOUNG CHILDREN ARE COVERED BY MEDI-CAL

Number of Young Children Participating in CalWORKs (Ages 0-5), CalFresh (Ages 0-5), WIC (Ages 0-4), and Medi-Cal (Ages 0-5), 2019



TREND

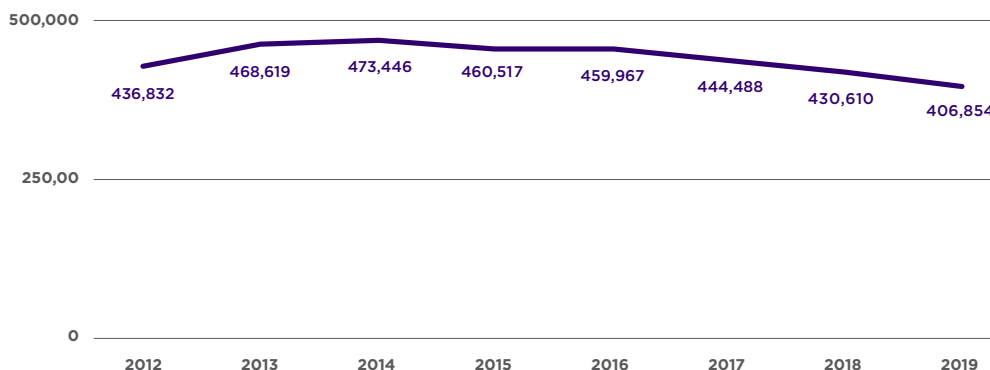
Between 2012 and 2019, Medi-Cal enrollment among children birth through age 5 declined 7 percent, which aligns with the estimated population decline of 8 percent among young children over this same time period. However, from the 8-year high in enrollment in 2014, enrollment has declined 14 percent, outpacing population declines of 7 percent over this period.

Participation in WIC among young children from birth through age 4 has declined substantially, falling 36 percent between 2010 and 2019, from 399,408 children to 257,118. The pace of declining enrollment was roughly the same for infants (under 1) and young children (1-4) at 33 and 36 percent, respectively.

Trend data for CalFresh and CalWORKs are not available at this time.

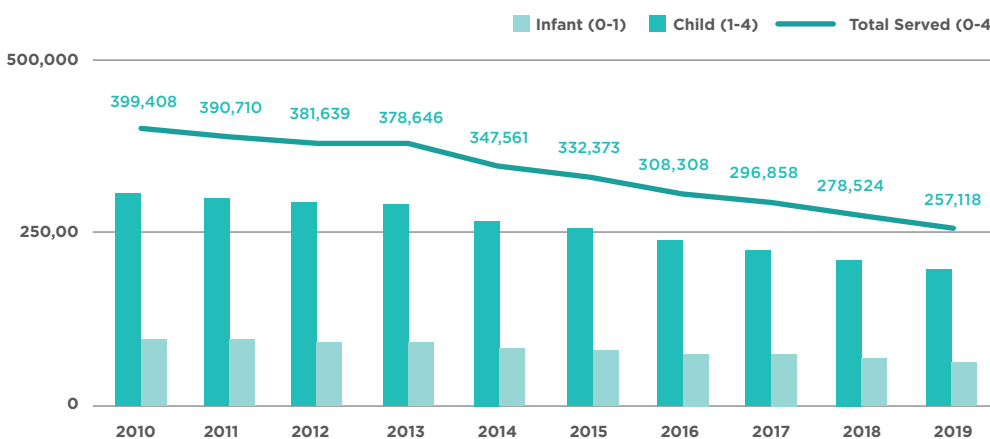
NUMBER OF YOUNG CHILDREN PARTICIPATING IN MEDI-CAL DECLINING

Number of Young Children Participating in Medi-Cal (Birth Through Age 5), 2012-2019



NUMBER OF YOUNG CHILDREN PARTICIPATING IN WIC FALLING SHARPLY

Number of Children Participating in WIC (Under Age 1 and Ages 1 Through 4), 2010-2019

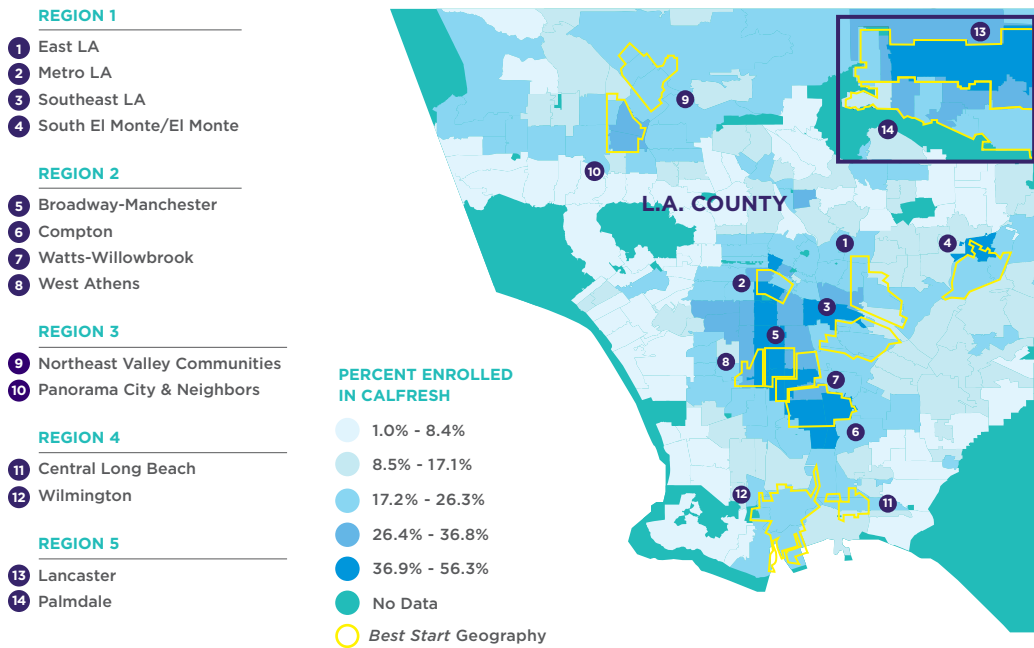


GEOGRAPHIC DETAIL

The following maps show where there are greater concentrations of CalFresh and CalWORKs participation among children from birth through age 5 in L.A. County. These percentages are based on of the total number of children from birth through age 5 residing in each zip code and do not take eligibility for these safety net programs into account. Overlays of *Best Start* geographies show that the highest rates of participation in CalFresh and/or CalWORKs include parts of Lancaster, Compton, Watts-Willowbrook, Broadway-Manchester and Metro LA. Geographic data for Medi-Cal and WIC are not available at this time.

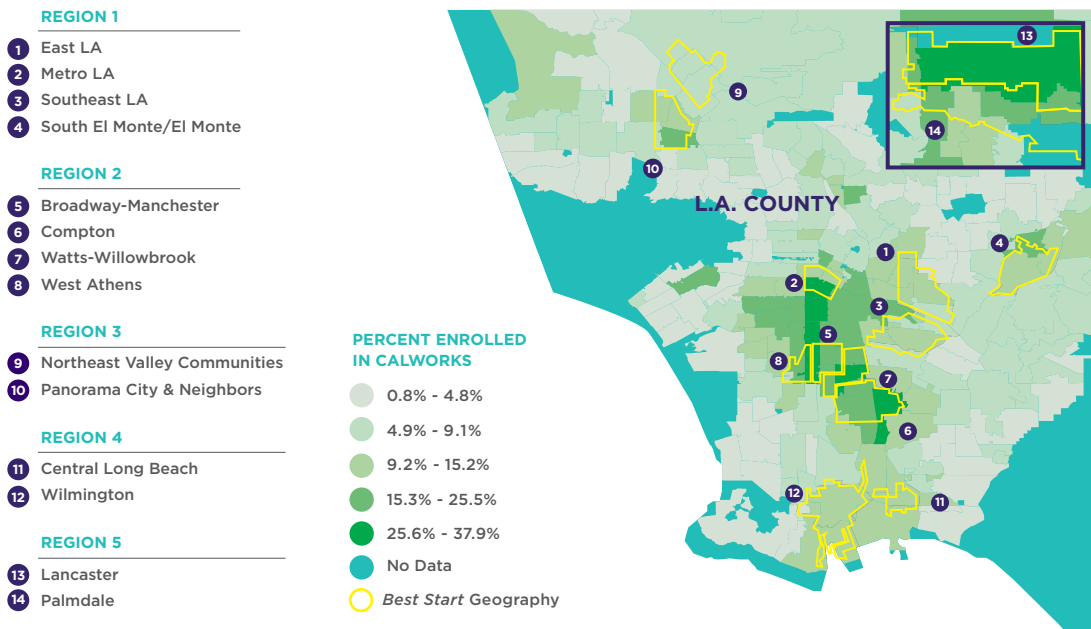
FROM ONE-THIRD TO ONE-HALF OF YOUNG CHILDREN PARTICIPATE IN CALFRESH IN PARTS OF REGION 2

Percentage of Young Child Population Participating in CalFresh (Birth Through Age 5) by Zip Code With *Best Start* Geography Overlay, 2019



CALWORKS PARTICIPATION LOWEST IN NORTHEAST VALLEY COMMUNITIES AND PARTS OF EAST LA, SOUTHEAST LA AND PALMDALE

Percentage of Young Child Population Participating in CalWORKs (Birth Through Age 5) by Zip Code With *Best Start* Geography Overlay, 2019



DATA NOTES AND LIMITATIONS

The counts of participants in this indicator reflect enrollment in the four programs, but they do not necessarily reflect whether participants are able to easily access and use the services and supports. At time of publication, counts of eligible children for the four programs presented were not available; therefore, rates of participation among eligible children were not possible to calculate. Detail by race/ethnicity was not available for the four programs presented and geography data was not available for WIC and Medi-Cal. The participation rate maps for CalFresh and CalWORKs differ from the preceding analysis; rather than counts, they represent the percentage of all L.A. County children from birth through age 5 who participate in these programs, regardless of eligibility. The population data for the denominator are 2020 estimates.

Full Indicator Language: Increased rate of eligible L.A. County families with children prenatal through age 5 participating in safety net programs.

Source: California Department of Social Services (CalFresh and CalWORKs), California Department of Health and Human Services (Medi-Cal), Public Health Foundation Enterprises (WIC), California Department of Finance Projections (population cited in Findings section), Esri (population for maps)

Social Support

RESULT INDICATOR 9

FAMILY RESOURCES



CHILD SAFETY



MOST PARENTS REPORT HAVING SOMEONE THEY CAN TURN TO IN TIMES OF NEED

This indicator measures the percentage of low-income parents of young children that report they had someone to talk to for comfort in times of need. The data is from a survey of parents participating in Los Angeles County Women, Infants and Children program (WIC) — a federal food assistance program for low-income pregnant women, breastfeeding women and children under the age of five.

Why is it Important?

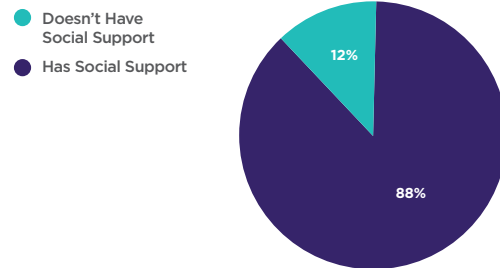
Research suggests that having stable social connections provide critical support for families that helps them to manage economic, social and parental stress. These connections for parents can, in turn, help them support their child's optimal development.

MOST RECENT YEAR

In 2017, 88 percent of surveyed parents participating in WIC reported having someone they could turn to if they needed someone to comfort or listen to them.

MOST PARENTS REPORT HAVING INFORMAL SOCIAL SUPPORT

Percentage of Parents That Have Someone They Can Turn to in Times of Need, 2017

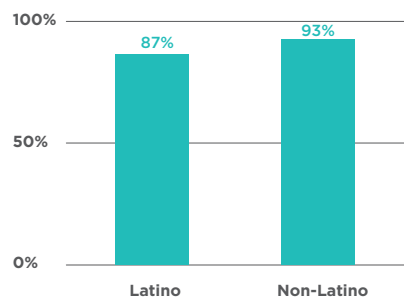


RACE/ETHNICITY DETAIL

A large majority of both Latino and non-Latino parents reported having someone to turn to if they needed support, though the percentage of Latino parents reporting this access was slightly smaller than the percentage of non-Latino parents reporting this support.

SLIGHTLY SMALLER SHARE OF LATINO PARENTS REPORT HAVING SOCIAL SUPPORT

Percentage of Parents That Have Someone They Can Turn to in Times of Need, 2017

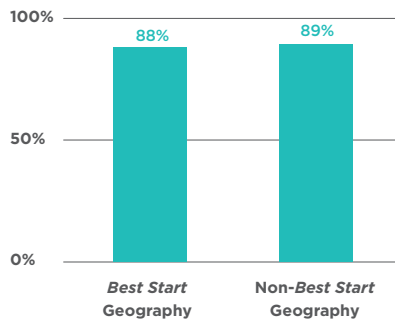


GEOGRAPHIC DETAIL

Parents who reside in *Best Start* geographies reported similar rates of social support compared to those parents who reside outside of *Best Start* geographies.

PARENTS IN BEST START AND NON-BEST START GEOGRAPHIES REPORT INFORMAL SUPPORT

Percentage of Parents That Have Someone They Can Turn to in Times of Need, 2017



DATA NOTES AND LIMITATIONS

In 2017, 48 percent of L.A. County families with children under the age of 5 participated in WIC. While the L.A. County WIC Survey is representative of the population of low-income WIC participants, it is not a population-wide measure for L.A. County broadly. Further, it is possible that because of the services and supports that participants received through WIC, mothers participating in WIC may have responded differently to survey questions than mothers that were not WIC participants, if they were surveyed. Due to small sample sizes, race and ethnic disaggregation is limited to Latino/non-Latino to protect respondents' confidentiality. Similarly, geographic disaggregation is limited to *Best Start*/*non-Best Start* to protect respondents' confidentiality.

Full Indicator Language: Increased rate of L.A. County families with children birth through age 5 who report having one or more people to talk to in times of need.

Source: Source: Los Angeles County WIC Survey administered by Public Health Foundation Enterprises Special Supplemental Nutrition Program for Women, Infants, and Children (PHFE WIC) Research and Evaluation Department



Access to Parks

RESULT INDICATOR 10

HALF OF YOUNG CHILDREN IN L.A. COUNTY LIVE WITHIN WALKING DISTANCE OF A PARK

This indicator measures the percentage of Los Angeles County children from birth through age 5 who reside within walking distance (one half-mile) of a park or other open space. Beaches are not included in the analysis.

Why is it Important?

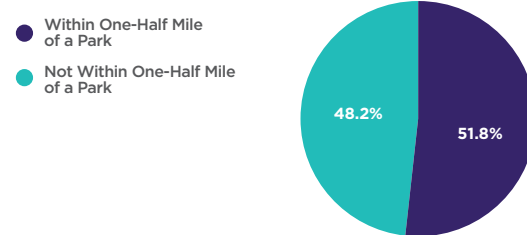
The relationship between park availability and physical activity in children is well documented. Research is also finding that access to green space may support increased prosocial behavior among children. By increasing access to parks and open spaces, particularly in neighborhoods with low access, families may have more opportunities to be active and connect with others.

MOST RECENT YEAR

Among L.A. County children from birth through age five, 51.8 percent live within walking distance of a park or open space.

MORE THAN HALF OF YOUNG CHILDREN LIVE CLOSE TO A PARK

Percentage of Los Angeles County Children from Birth Through Age 5 Who Live Within One-Half Mile of a Park or Open Space by *Best Start* Geography, 2016



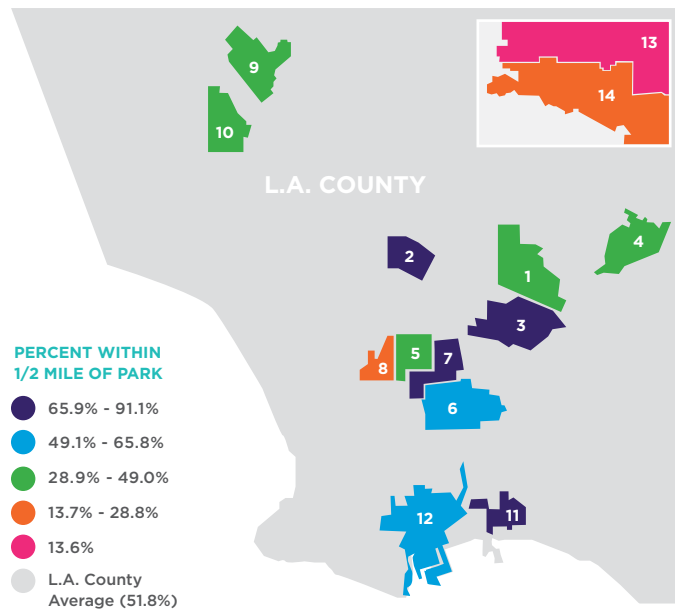
GEOGRAPHIC DETAIL

Among First 5 LA's *Best Start* geographies, there is wide variation in access to parks. In Lancaster, only 13.6 percent of young children live within walking distance of a park, whereas in Central Long Beach, 91.1 percent of children do.

SUBSTANTIAL VARIATION IN PARK ACCESS DEPENDING ON COMMUNITY

Percentage of Los Angeles County Children From Birth Through Age 5 Who Live Within One-Half Mile of a Park or Open Space by *Best Start* Geography, 2016

REGION 1	
1 East LA	43.5%
2 Metro LA	77.4%
3 Southeast LA	76.8%
4 South El Monte/El Monte	42.9%
REGION 2	
5 Broadway-Manchester	46.5%
6 Compton	59.0%
7 Watts-Willowbrook	83.8%
8 West Athens	28.8%
REGION 3	
9 Northeast Valley Communities	49.0%
10 Panorama City & Neighbors	48.4%
REGION 4	
11 Central Long Beach	91.1%
12 Wilmington	65.8%
REGION 5	
13 Lancaster	13.6%
14 Palmdale	23.7%



DATA NOTES AND LIMITATIONS

The geographic data numerator is from 2016; the population data for children from birth through age 5 is from 2020. The distance from each household to the access points of all adjacent parks was calculated along the walkable road/pedestrian network rather than “as the crow flies.” Since pedestrians cannot safely or legally walk on highways or freeways, this method takes these barriers into account. The result is a more accurate assessment of the distance a pedestrian would need to travel to reach a park. The analysis does not take into account perceived safety, criminal activity or other factors that impact access, such as lighting and the quality and age-appropriateness of the play equipment.

Full Indicator Language: Increased rate of L.A. County families with children birth through age 5 that have access to parks and open spaces.

Source: Los Angeles County Department of Parks and Recreation (park data); Esri (population data)



CONTEXTUAL INDICATORS

CHILD CHARACTERISTICS

- 1. Birth Rate
 - 2. Infant Mortality Rate
 - 3. Low Birth Weight
 - 4. Well-Child Visits
 - 5. Preventable Injuries
 - 6. Healthy Weight
 - 7. Dual Language Learners
 - 8. Special Education Enrollment
 - 9. Third Grade Literacy
-

MATERNAL CHARACTERISTICS

- 10. Prenatal Care
 - 11. Postpartum Care
 - 12. Maternal Depression
 - 13. Breastfeeding
 - 14. Educational Attainment
-

FAMILY RESOURCES

- 15. Assets at Birth
 - 16. Children Living in Poverty
 - 17. Food Insecurity
 - 18. Children Experiencing Homelessness
-

COMMUNITY CHARACTERISTICS

- 19. California Healthy Places Index
 - 20. Access to Transit
-

Birth Rate

CONTEXTUAL INDICATOR 1

BIRTH RATE DECLINING FOR ALL RACE AND ETHNIC GROUPS

This indicator measures the birth rate, which is the annual number of births per 1,000 population of Los Angeles County overall or by subgroup.

Why is it important?

Birth rates can help inform our understanding of trends within our target population — children prenatal through age 5. Rising or falling birth rates may impact the demand for services.

MOST RECENT YEAR

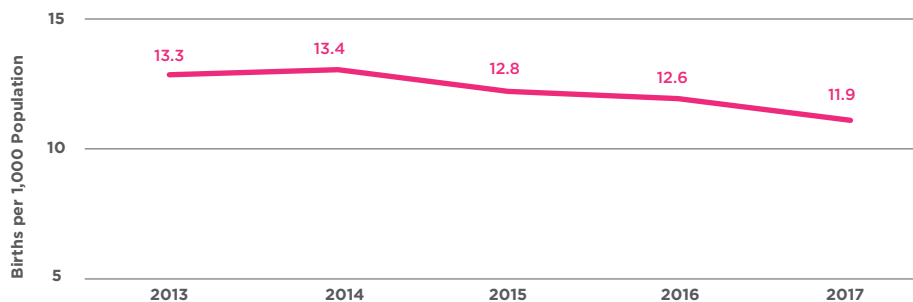
In 2017, the birth rate in Los Angeles County was 11.9 per 1,000 population.

TREND

Between 2013 and 2017, the L.A. County birth rate fell from 13.3 per 1,000 to 11.9 per 1,000. In terms of the number of births, there was a 9 percent decline over this period.

COUNTYWIDE BIRTH RATE STEADILY DECLINING

Birth Rate in Los Angeles County, 2013-2017

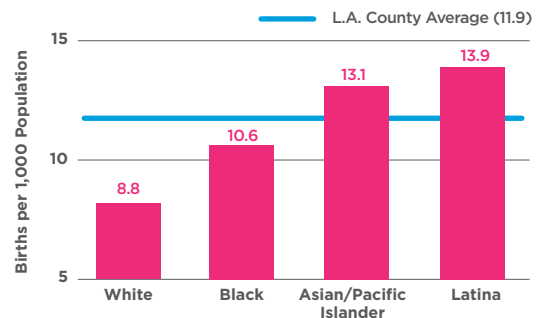


RACE/ETHNICITY DETAIL

In 2017, the birth rate was highest among Latina mothers, followed by Asian/Pacific Islander mothers (13.9 per 1,000 and 13.1 per 1,000, respectively). Birth rates for both Black and White mothers were less than the countywide average of 11.9 per 1,000. Between 2013 and 2017, the birth rate declined for all race and ethnic groups, falling most rapidly among Latina mothers.

BIRTH RATE HIGHEST AMONG LATINA AND ASIAN/PACIFIC ISLANDER MOTHERS

Birth Rate in Los Angeles County by Race or Ethnicity of the Mother, 2017



Trend data by race/ethnicity is available in the Supplemental Tables.

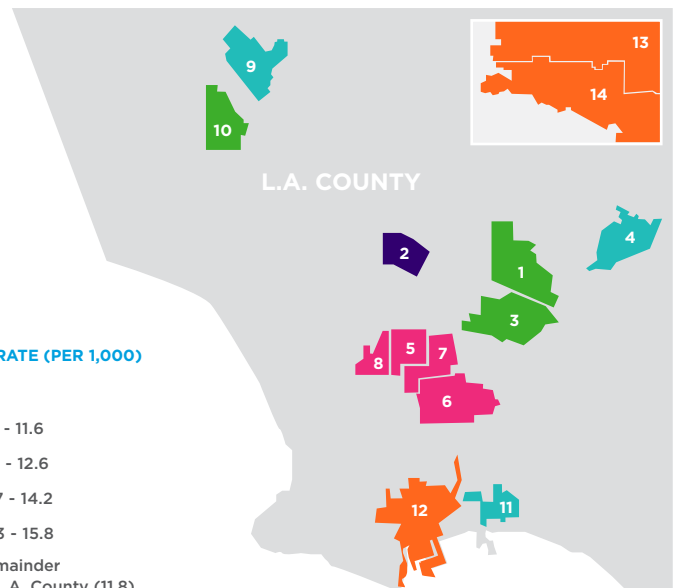
GEOGRAPHIC DETAIL

In 2017, among First 5 LA's *Best Start* geographies, Watts-Willowbrook and Broadway-Manchester in Region 2 had the highest birth rates, both with a rate of 15.8 per 1,000 population. Most *Best Start* geographies had birth rates above the countywide average of 11.9 per 1,000 population, but Metro LA was notably below at 8.5 per 1,000 population.

METRO LA HAS SUBSTANTIALLY LOWER BIRTH RATE COMPARED TO THE COUNTYWIDE AVERAGE

Birth Rate by *Best Start* Geography, 2017

REGION 1	
1 East LA	12.5
2 Metro LA	8.5
3 Southeast LA	12.6
4 South El Monte/El Monte	11.6
REGION 2	
5 Broadway-Manchester	15.8
6 Compton	14.6
7 Watts-Willowbrook	15.8
8 West Athens	14.6
REGION 3	
9 Northeast Valley Communities	11.4
10 Panorama City & Neighbors	12.4
REGION 4	
11 Central Long Beach	11.2
12 Wilmington	13.2
REGION 5	
13 Lancaster	14.2
14 Palmdale	13.1



Trend data by *Best Start* geography are available in the Supplemental Tables.

DATA NOTES AND LIMITATIONS

Birth rates by socioeconomic status were not calculated due to the lack of an appropriate denominator. Birth rates by age were not calculated due to variable methods for age-based birth rate calculations (please see the Methods section for more detail). The totals produced for this local analysis may differ from other published sources; these should not be considered official county or state birth statistics.

Full Indicator Language: Annual number of live births per 1,000 total population in L.A. County.

Source: Children's Data Network at the University of Southern California (births); Advancement Project analysis of 2017 U.S. Census Bureau American Community Survey, 5-Year Estimates, Table S0101 (population by geography); California Department of Finance, Demographic Research Unit, Population Projections, Table P-3 (all other populations groups)

Infant Mortality

CONTEXTUAL INDICATOR 2

INFANT MORTALITY RATE RISING; BLACK RESIDENTS DISPROPORTIONATELY AFFECTED

This indicator measures the infant mortality rate, which is the annual number of deaths of children under one year of age per 1,000 live births in Los Angeles County. Data for Los Angeles County overall is single-year data; data by subgroup is six-year averages (2011-2016).

Why is it Important?

Infant mortality is a widely-used indicator of the health of a population because it is associated with maternal health, access to quality and timely health care, implicit bias in the health care system, systemic racism and socioeconomic conditions. High rates of infant mortality can emphasize the need for services that address structural bias, such as economic supports, routine health care, prenatal care, postpartum care and home visiting.

Current Context

Black infants are more likely to die in their first year than any other race and their mothers are more likely to die during childbirth and the first postpartum year than their counterparts of any other race. While infant and maternal mortality varies among women within each race/ethnicity group based on income and education, the gaps between Black women and infants and other groups persist despite socioeconomic status, education level and other risk factors, such as smoking. An emerging body of research suggests that racism (not race) drives these inequalities, beginning with adverse social experiences, which lead to psychological stress, which in turn leads to physiological stress that accumulates over time to wear down organ systems in the body. This cumulative health burden, termed “allostatic load,” has been associated with a range of adverse health outcomes including infant and maternal mortality.

MOST RECENT YEAR

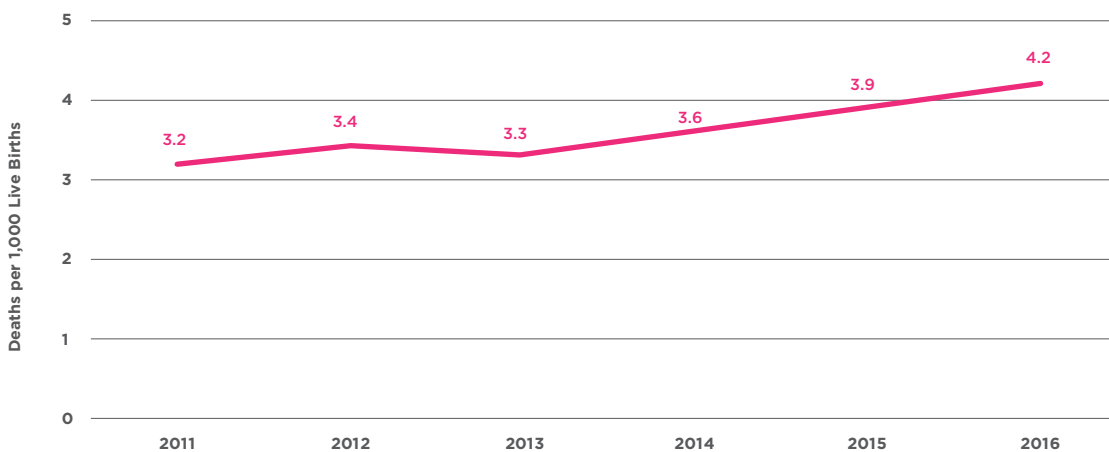
In 2016, the rate of infant mortality in Los Angeles County was 4.2 out of 1,000 live births.

TREND

Since 2011, the infant mortality rate has increased from 3.2 per 1,000 live births to 4.2 per 1,000 live births in 2016.

INFANT MORTALITY RATE IS RISING

Infant Mortality Rate in Los Angeles County, 2011-2016

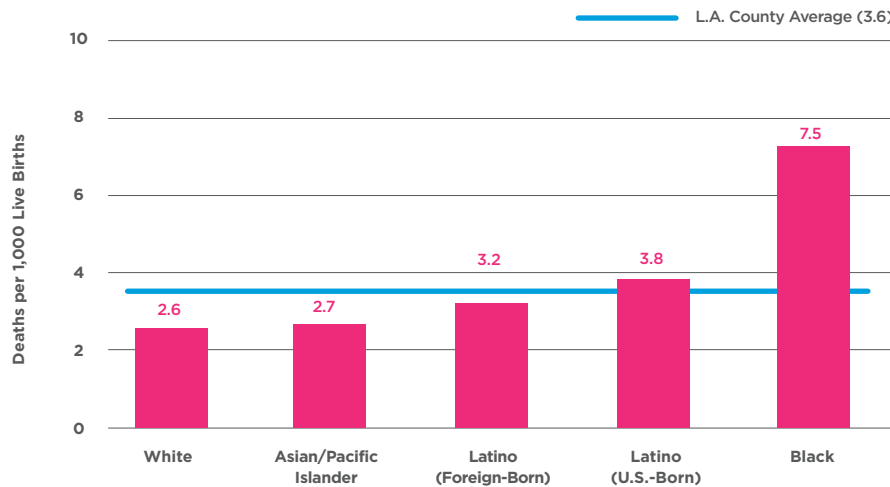


RACE/ETHNICITY DETAIL

The mortality rate of infants born to Black mothers in Los Angeles County is nearly three times the mortality rate of infants born to White mothers — 7.5 per 1,000 compared to 2.6 per 1,000. Mortality rates for infants born to Asian/Pacific Islander mothers and Latina mothers are also low compared to Black mothers and the countywide average of 3.6 per 1,000 (2011-2016 average).

BLACK INFANT MORTALITY RATE SUBSTANTIALLY HIGHER THAN OTHER RACE/ETHNIC GROUPS

Infant Mortality Rate in Los Angeles County by Race or Ethnicity of the Mother, 2011-2016 Results Averaged



SOCIOECONOMIC STATUS DETAIL

The mortality rate is higher among infants born to mothers whose birth was covered by public health insurance than among infants born to mothers with private health insurance coverage — 4.2 per 1,000 compared to 3.0 per 1,000. The birth payment method, whether public (i.e., Medi-Cal or other public insurance) or private (i.e., private insurance, employer-provided, or self-pay) is used as a proxy for income status.

MORTALITY RATE HIGHER AMONG INFANTS BORN TO LOW-INCOME MOTHERS

Infant Mortality Rate in Los Angeles County by Socioeconomic Status, 2011-2016 Results Averaged



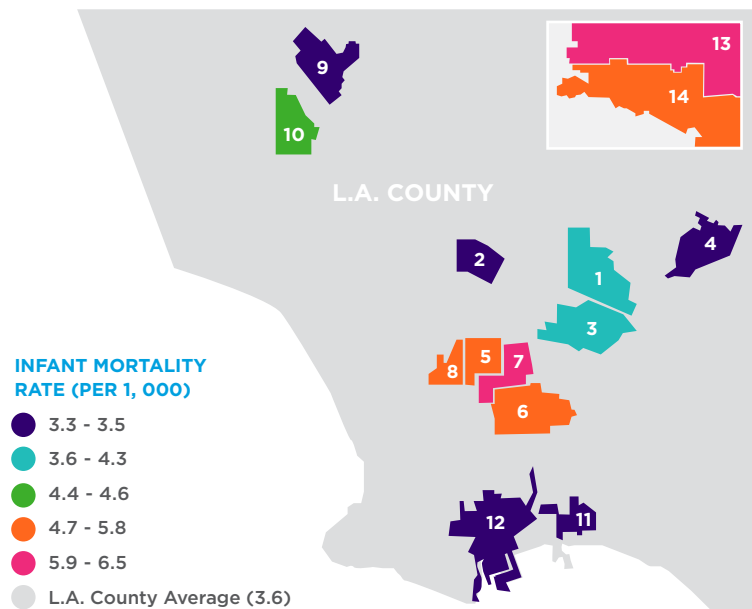
GEOGRAPHIC DETAIL

Among First 5 LA's *Best Start* geographies, Watts-Willowbrook and Lancaster had the highest rates of infant mortality at 6.5 per 1,000 and 6.0 per 1,000, respectively. Several *Best Start* geographies had infant mortality rates lower than the countywide average of 3.6 per 1,000 (2011-2016 average), including South El Monte/El Monte, Metro LA, Central Long Beach, Northeast Valley and Wilmington.

REGIONS 2 AND 5 EXPERIENCE HIGHEST RATES OF INFANT MORTALITY

Infant Mortality Rate (per 1,000 Live Births) by *Best Start* Geography, 2011-2016 Results Averaged

REGION 1		
1	East LA	4.3
2	Metro LA	3.4
3	Southeast LA	4.2
4	South El Monte/El Monte	3.5
REGION 2		
5	Broadway-Manchester	5.8
6	Compton	5.4
7	Watts-Willowbrook	6.5
8	West Athens	5.5
REGION 3		
9	Northeast Valley Communities	3.3
10	Panorama City & Neighbors	4.6
REGION 4		
11	Central Long Beach	3.3
12	Wilmington	3.3
REGION 5		
13	Lancaster	6.0
14	Palmdale	5.7



DATA NOTES AND LIMITATIONS

The infant mortality rates presented in this indicator may differ from other published sources and should not be considered official county or state birth statistics.

Full Indicator Language: Annual number of deaths of children under one year old per 1,000 live births in L.A. County.

Source: Children's Data Network at the University of Southern California

Low Birth Weight

CONTEXTUAL INDICATOR 3

BLACK MOTHERS HAVE COMPARATIVELY HIGH RATE OF LOW BIRTH WEIGHT BABIES

This indicator measures the annual percentage of Los Angeles County infants born at low birth weight (less than 2,500 grams) overall and by subgroups.

Why is it Important?

Low birth weight is one of the leading causes of infant death and a risk factor for lifelong disability. While all instances of low birth weight are not preventable, tracking low birth weight can improve our understanding of the issue and inform systems change strategies to reduce risk of low birth weight.

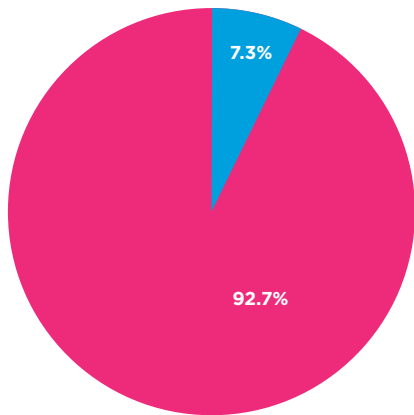
MOST RECENT YEAR

Approximately one in 14 infants born in Los Angeles County in 2017 had a low birth weight (7.3 percent).

1 IN 14 INFANTS HAVE LOW BIRTH WEIGHT

Percentage of Infants Born at Low Birth Weight in Los Angeles County, 2017

- Not Low Birth Weight
- Low Birth Weight

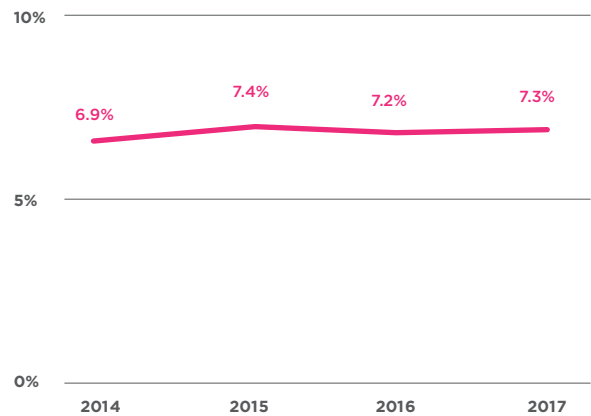


TREND

The percentage of infants born at low birth rate has remained relatively unchanged in the four-year period between 2014 and 2017, ranging from a low of 6.9 percent of births in 2014 to a high of 7.4 percent in 2015.

LITTLE CHANGE IN LOW BIRTH WEIGHT OVER FOUR-YEAR PERIOD

Percentage of Infants Born at Low Birth Weight in Los Angeles County, 2014-2017

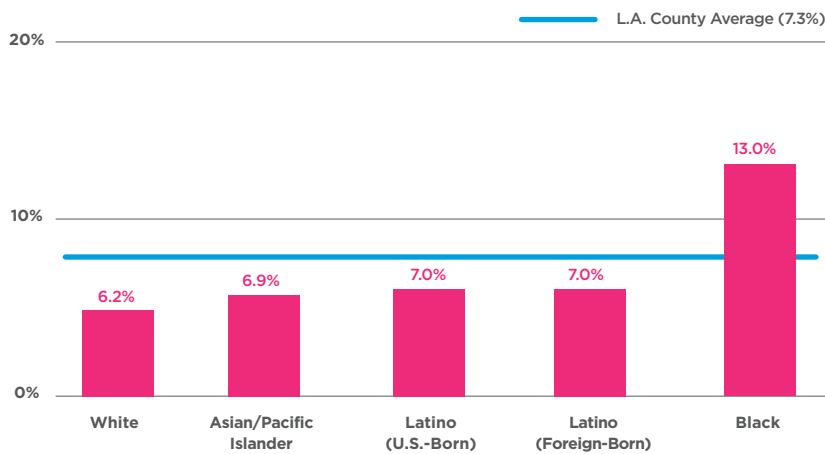


RACE/ETHNICITY DETAIL

In 2017, infants born to Black mothers had nearly twice the rate of low birth weight as infants born to mothers from all other race or ethnic groups. While low birth weight rates fluctuate from year to year, in the four-year period between 2014 and 2017, the trends were generally toward slightly increasing rates of low birth weight for all race and ethnic groups except White mothers.

INFANTS BORN TO BLACK MOTHERS MORE LIKELY TO BE LOW BIRTH WEIGHT THAN OTHER RACE/ETHNIC GROUPS

Percentage of Infants Born at Low Birth Weight in Los Angeles County by Race/Ethnicity, 2017



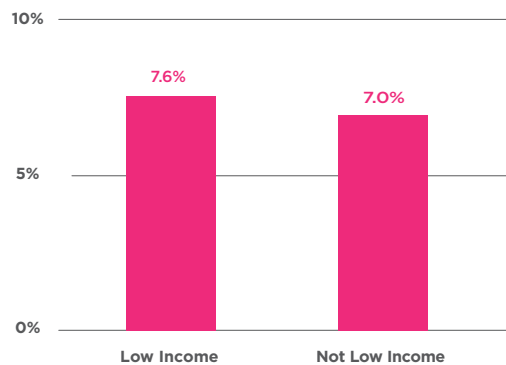
Trend data by race and ethnicity are provided in the Supplemental Tables.

SOCIOECONOMIC STATUS DETAIL

In 2017, slightly more infants born to mothers with low income were low birth weight than infants born to mothers who were not low-income — 7.6 percent compared to 7.0 percent, respectively.

INCOME STATUS NOT A SIGNIFICANT VARIABLE FOR LOW BIRTH WEIGHT

Percentage of Infants Born at Low Birth Weight in Los Angeles County by Socioeconomic Status, 2017



Trend data by income status are provided in the Supplemental Tables.

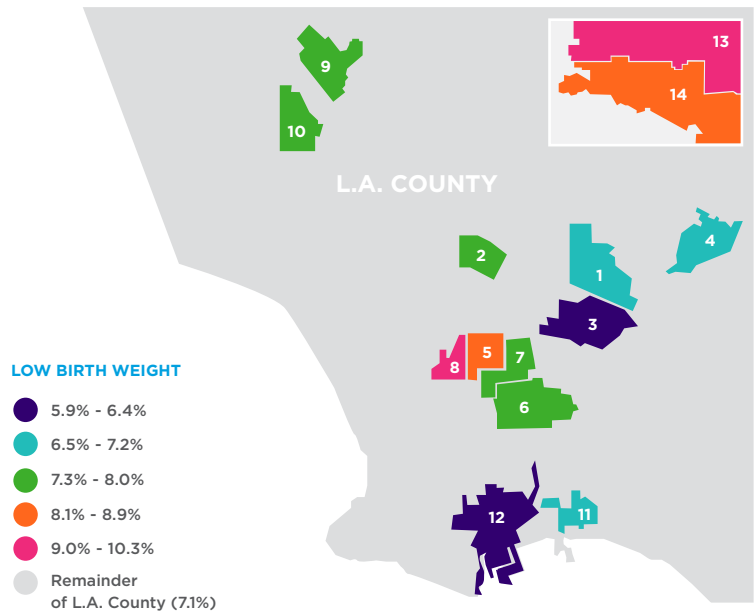
GEOGRAPHIC DETAIL

Among First 5 LA’s *Best Start* geographies, the communities of West Athens and Lancaster had the highest rates of low birth weight infants, at 10.3 percent and 10.2 percent, respectively. Wilmington and Southeast LA had the lowest rates, at 5.9 percent and 6.4 percent, respectively.

MOST BEST START GEOGRAPHIES HAVE HIGHER THAN AVERAGE RATES OF LOW BIRTH WEIGHT

Percentage of Infants Born at Low Birth Weight in Los Angeles County by *Best Start* Geography, 2017

REGION 1		
1	East LA	7.2%
2	Metro LA	8.0%
3	Southeast LA	6.4%
4	South El Monte/El Monte	7.0%
REGION 2		
5	Broadway-Manchester	8.8%
6	Compton	7.9%
7	Watts-Willowbrook	8.0%
8	West Athens	10.3%
REGION 3		
9	Northeast Valley Communities	8.0%
10	Panorama City & Neighbors	7.6%
REGION 4		
11	Central Long Beach	6.9%
12	Wilmington	5.9%
REGION 5		
13	Lancaster	10.2%
14	Palmdale	8.9%



Trend data by geography are provided in the Supplemental Tables.

DATA NOTES AND LIMITATIONS

The birth payment method, whether public (i.e., Medi-Cal or other public insurance) or private (i.e., private insurance, employer-provided, or self-pay), is used as a proxy for income status. The totals produced for this local analysis may differ from other published sources; they should not be considered official county or state birth statistics.

Full Indicator Language: Annual percentage of infants born at low birth weight (less than 2,500 grams).

Source: Children’s Data Network at the University of Southern California

Well-Child Visits

CONTEXTUAL INDICATOR 4

MOST CHILDREN RECEIVE RECOMMENDED WELL-CHILD VISITS

This indicator presents the percentage of children ages 2 through 5 in Los Angeles County who have received the recommended well-child visit for their current age. According to the American Academy of Pediatrics periodicity schedule, children between the ages of 2 and 6 should have a well-child visit at age 2, 2.5, 3, 4 and 5.

Why is it Important?

Well-child visits track the growth and development of children at various age time-points. These visits are opportunities for physicians to discuss with parents the child's physical development, immunizations, cognitive development and social/emotional development. Well-child visits provide important treatment and preventive services, such as appropriate developmental screenings, that support overall health and development.

Current Context

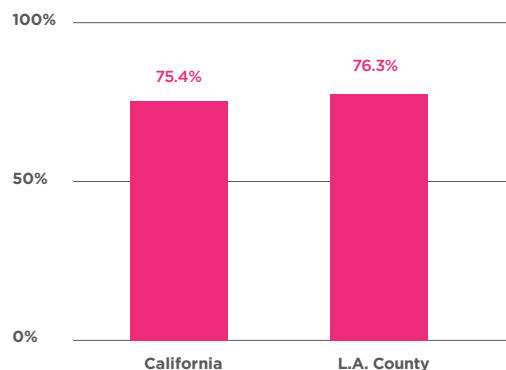
Due to the COVID-19 pandemic, medical experts report a reduction in well-child visits and estimate that statewide vaccination rates as of May 2020 were 40 percent lower than the previous year. Missed well-child visits also impact the rate that children are screened for developmental delays. Fortunately, AB 1004 will increase oversight and improve data collection around developmental screening practices in the state. This will help ensure that, during a well-child visit, a full and complete developmental screen using a validated tool occurs. Prior to this legislation, California did not adequately track whether developmental screens were being completed during well-child visits, and if they were, whether the provider was using a validated tool to conduct the screen versus just their observation alone. AB 1004 was the first piece of legislation sponsored by First 5 LA to become law.

MOST RECENT YEAR

In 2018, 76 percent of children ages 2 through 5 years in L.A. County received the recommended well-child visit. This rate is similar to the rate of 75 percent of children in the state of California.

COUNTY AND STATEWIDE WELL-CHILD VISIT RATES ARE SIMILAR

Well-Child Visit Rates Among Children Ages 2 Through 5 in California and Los Angeles County, 2018

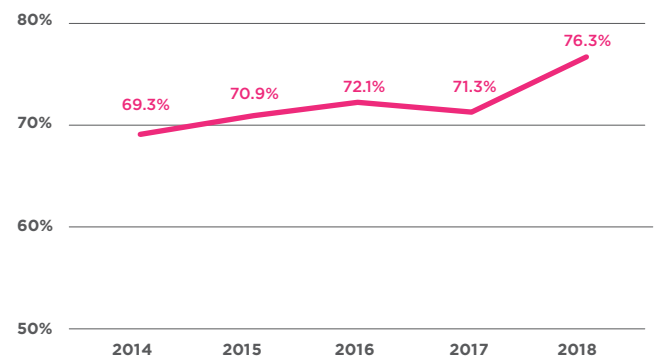


TREND

The rate of children receiving the recommended number of well-child visits in L.A. County has increased over time. The largest increase occurred between 2017 and 2018, when the rate rose from 71 percent to 76 percent.

WELL-CHILD VISIT RATES HAVE INCREASED OVER TIME

Well-Child Visit Rates Among Children Ages 2 Through 5 in Los Angeles County, 2014-2018



DATA NOTES AND LIMITATIONS

The well-child visit rates provided are the number of completed well-child visits out of the total recommended number of visits. The data does not measure whether children are receiving all components of a well-child visit during their visit, including appropriate developmental screening with a validated tool. The data source presents the data as well-child visits in the “third, fourth, fifth, and sixth years of life” which translates to ages 2 through 5. Data disaggregated by race/ethnicity, income status, age or geography is not provided by the data source, nor is the well-child visit rate of children under age 2.

Full Indicator Language: Annual percentage of children birth through age 5 in L.A. County who have received the recommended well-child visits for their current age.

Source: California Department of Health Care Services: Medi-Cal Pediatric Health Dashboard

Preventable Injuries

CONTEXTUAL INDICATOR 5

NO LASTING DECREASE IN PREVENTABLE DEATHS OVER TIME; BLACK CHILDREN DISPROPORTIONATELY AFFECTED

This indicator presents the rate of preventable (unintentional or accidental) injury and death of children from birth through age 5 in Los Angeles County. The data presented reflects the number of deaths per 100,000 children from birth through age 5. Injuries or deaths due to intentional causes, such as assault or homicide, are not tracked in this indicator.

Why is it Important?

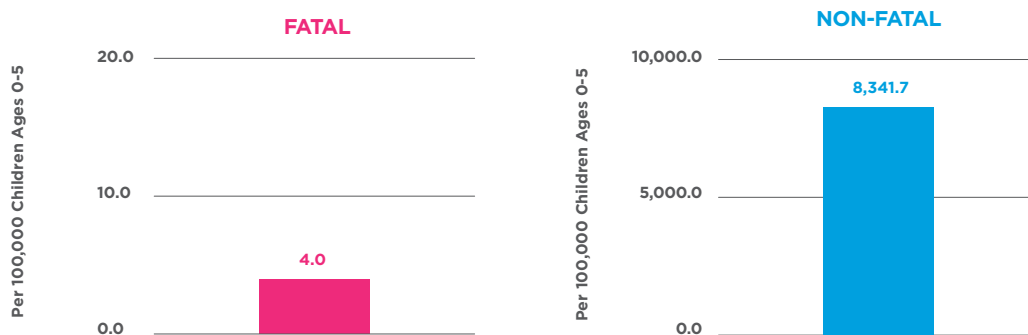
Preventable injuries, particularly those that result in a child's death, are a tragedy for family, friends and the community. Non-fatal preventable injuries that require an emergency department visit or hospitalization also take their toll, contributing to potential long-term disability for the child, health care expenses and lost work time for parents, and increased demand on health systems.

MOST RECENT YEAR

Fatal and Non-Fatal Injuries: In 2017, there were 30 preventable deaths of young children from birth through age 5 in L.A. County. This is equivalent to a rate of 4.0 preventable deaths per 100,000 young children from birth through age 5. In 2015, which is the latest year of data available for preventable non-fatal injuries, there were 1,833 hospitalizations of young children for non-fatal preventable injuries and 62,570 emergency department visits for a total of 64,453 non-fatal preventable injuries. This is equivalent to a rate of 8,341.7 non-fatal hospitalizations or emergency room visits per 100,000 young children in L.A. County.

APPROXIMATELY 1 IN 12 YOUNG CHILDREN VISITED THE EMERGENCY DEPARTMENT OR WERE HOSPITALIZED DUE TO UNINTENTIONAL INJURY

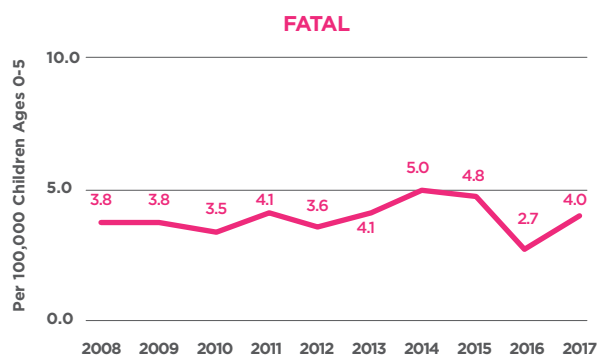
Rate of Preventable Fatal and Non-Fatal Injuries Among Children Birth Through Age 5 in Los Angeles County, 2015 (Non-Fatal Injuries) and 2017 (Fatal Injuries)

**TREND**

Fatal Injuries: In the 10-year period between 2008 and 2017, the preventable death rate for young children in L.A. County fluctuated between a low of 2.7 per 100,000 children from birth through age 5 to a high of 5.0 per 100,000 children from birth through age 5. No discernable positive or negative trend has emerged over this period.

YOUNG CHILD PREVENTABLE DEATH RATE SHOWS NO LASTING IMPROVEMENT OVER 10 YEARS

Rate of Preventable Fatal Injuries Among Children Birth Through Age 5 in Los Angeles County, 2008-2017



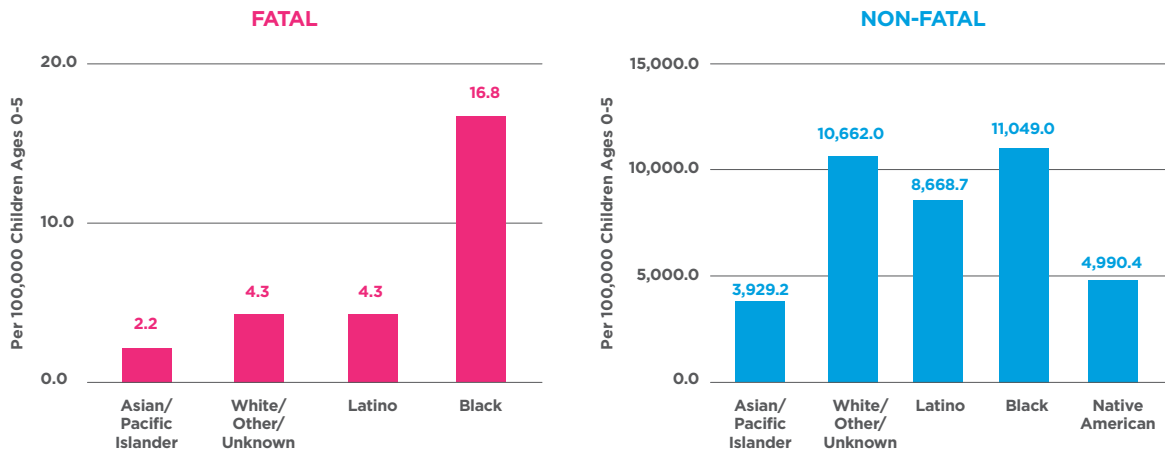
RACE/ETHNICITY DETAIL

Fatal Injuries: In 2015, 16.8 out of 100,000 young Black children from birth through age 5 died of a preventable injury. This rate of preventable death was four times higher than the rate of preventable death for Latino children and children in the White/Other/Unknown category. Asian/Pacific Islander children had the lowest rate of preventable death in L.A. County at 2.2 per 100,000 Asian/Pacific Islander children from birth through age 5. Rates of death fluctuate from year to year; however, between 2010 and 2017, a marked upward trend was emerging in deaths among Black children, with a more modest upward trend among the White/Other/Unknown group. The trend for Latino and Asian/Pacific Islander young children was relatively flat over this period.

Non-Fatal Injuries: Non-fatal injury rates among young children were highest among Black young children at 11,049.0 per 100,000 Black young children, followed by the White/Other/Unknown group at 10,662.0 per 100,000 young children in the White/Other/Unknown group. Injury rates for Latino young children were also high compared to their Native American and Asian/Pacific Islander counterparts.

BLACK YOUNG CHILDREN HAVE FOUR TIMES THE RATE OF PREVENTABLE DEATH AS THEIR WHITE AND LATINO PEERS

Rate of Preventable Fatal and Non-Fatal Injuries Among Children Birth Through Age 5 in Los Angeles County by Race/Ethnicity, 2015



Preventable death trend data by race/ethnicity is available in the Supplemental Tables. Mortality data for Native American children is not available.

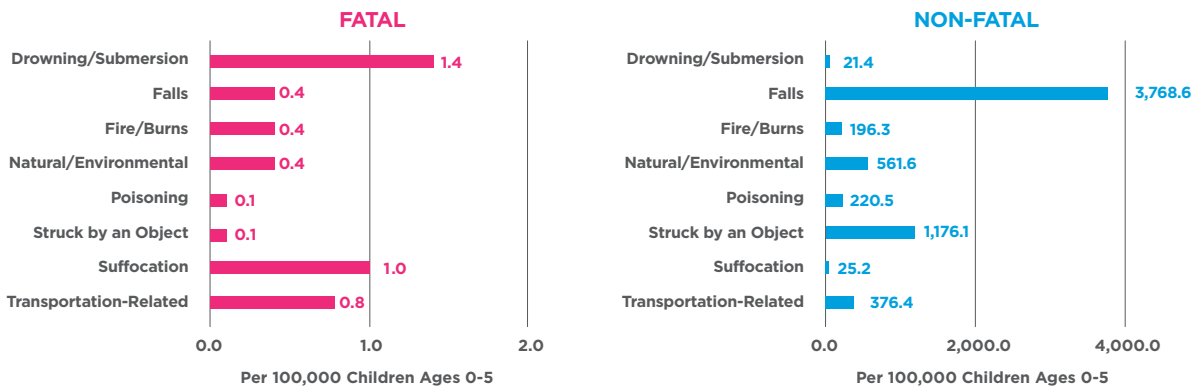
CAUSE OF INJURY DETAIL

Fatal Injuries: In 2015, most preventable deaths of young children in L.A. County were due to drowning or submersion. Non-fatal injuries due to submersion were among the less common causes of non-fatal hospitalizations or emergency department visits, pointing to the deadly nature of water accidents. Suffocation and transportation-related accidents (including motor vehicle, bicycle, pedestrian or other transport) were, respectively, the second and third most common causes of death in 2015. Rates of unintentional death fluctuate from year to year; however, between 2010 and 2017, there was a slight downward trend in transportation-related deaths and deaths due to falls. Suffocation deaths increased in this 10-year period. Other causes of death did not show discernable trends.

Non-Fatal Injuries: In 2015, among the causes of injury shown, falls accounted for the most frequent cause of non-fatal hospitalizations or emergency department use. This was followed by unintentional non-fatal injuries due to being struck by an object and natural or environmental causes, which includes exposure to severe heat, severe cold, lightning, sunstroke, large storms and natural disasters, as well as lack of food or water.

**DROWNINGS ARE LEADING CAUSE OF PREVENTABLE DEATH;
FALLS ARE LEADING CAUSE OF NON-FATAL INJURIES**

Rate of Preventable Fatal and Non-Fatal Injuries Among Children Birth Through Age 5 in Los Angeles County by Cause, 2015



Leading causes of preventable death or injury for young children are shown in the charts. Some cause groups have been pooled or are not shown in the charts. Additional detail is provided in the Supplemental Tables.

DATA NOTES AND LIMITATIONS

The latest data available for non-fatal injuries is 2015 and this data is not comparable to prior years. The latest data available for deaths is 2017 and trend data is available. Race/ethnicity groups are determined by the data source and cannot be further disaggregated, including the grouping of White/Other/Unknown. Non-fatal injury data is comprised of the combination of unintentional injury non-fatal hospitalizations and non-fatal emergency department visits (treat and release, or transfer to another facility). While the coding used in the medical profession to identify causes of injury or death are detailed, they may not be sufficiently detailed to enable researchers to know the precise circumstances contributing to the injury or death. Further, the data may include cases of intentional harm that were not detected by the health care professional diagnosing and coding the injury or death. The estimate that 1 in 12 children experience non-fatal injuries that result in an emergency department visit or hospitalization is an illustration that does not take into account possible duplication (e.g., when a child has more than one non-fatal emergency department visit or hospitalization in a given year.)

Full Indicator Language: Annual rate of preventable injuries among children birth through age 5 in L.A. County.

Source: California Department of Public Health (CDPH) EpiCenter, based on CDPH Vital Statistics Death Master File and California Office of Statewide Health Planning and Development, Inpatient Discharge Data

Healthy Weight

CONTEXTUAL INDICATOR 6

OVER HALF OF YOUNG CHILDREN HAVE A HEALTHY WEIGHT; SLIGHT TREND TOWARD INCREASING WEIGHT

This indicator measures the percentage of Los Angeles County children ages 3 and 4 from families with low income that have a healthy weight. A healthy weight is defined as not being underweight, overweight or obese according to an assessment of Body Mass Index.

Why is it important?

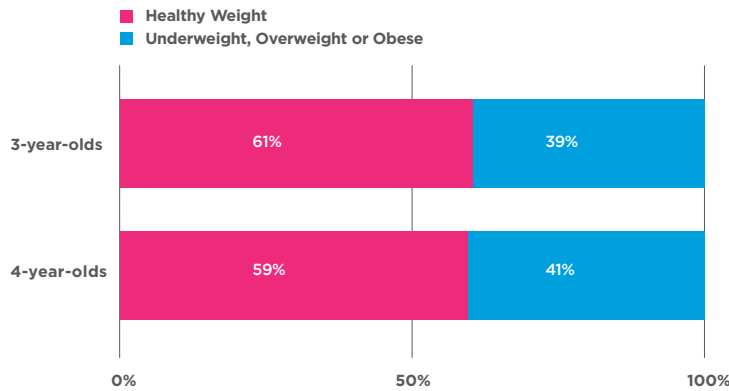
Research points to a combination of genetic, environmental and behavioral factors that contribute to developing obesity. Since childhood obesity puts children at risk for poor health outcomes later in life, tracking healthy weight aligns with a prevention model for long-term health.

MOST RECENT YEAR

More than half of L.A. County young children from low-income families had a healthy weight. In 2018, 61 percent of 3-year-old children had a healthy weight and 59 percent of 4-year old children had a healthy weight.

6 IN 10 YOUNG CHILDREN HAVE A HEALTHY WEIGHT

Percentage of Los Angeles County Young Children From Low-Income Families Who Have a Healthy Weight by Age, 2018

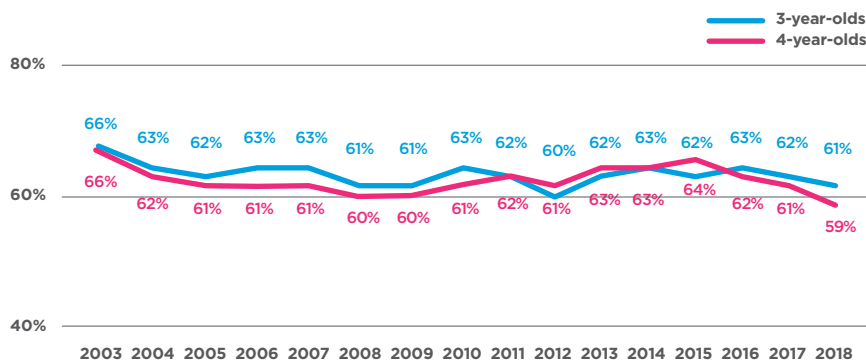


TREND

Between 2003 and 2018, the percentage of young children ages 3 and 4 with a healthy weight fluctuated, but a slight trend toward increasing weight was emerging. Most notably, there was a five-percentage point decline in healthy weight among 4-year-old children since 2015.

TREND EMERGING OVER 16 YEARS: SLIGHTLY FEWER CHILDREN WITH HEALTHY WEIGHT

Percentage of Los Angeles County Young Children From Low-Income Families Who Have a Healthy Weight, 2003-2018

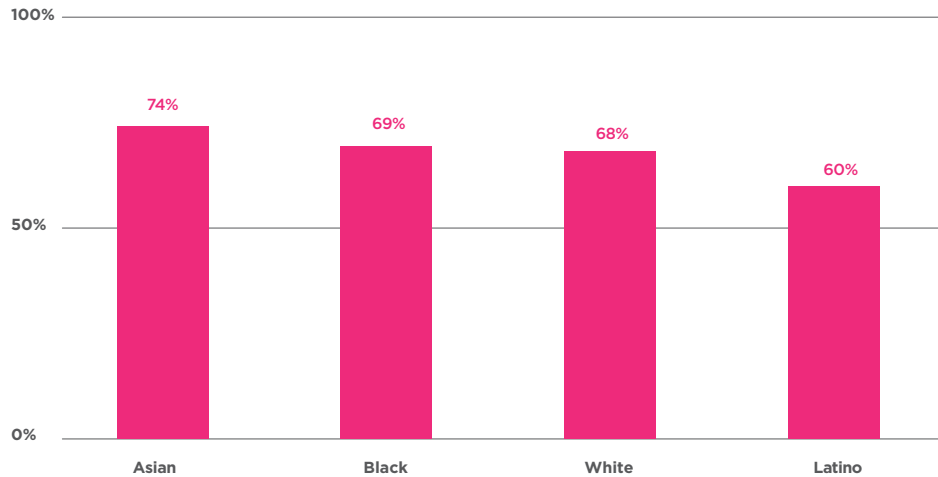


RACE/ETHNICITY DETAIL

Almost three-quarters of 4-year-olds with Asian mothers have a healthy weight (74 percent), compared to 69 percent of 4-year-olds with Black mothers and 68 percent of 4-year-olds with White mothers. Four-year-old children with Latina mothers had the lowest rate of healthy weight at 60 percent. Over the past 16 years, 4-year-old children with Latina mothers consistently had the lowest rate of healthy weight and, while rates fluctuate from year to year, there was a gradual trend toward increasing weight. No discernable trend was evident among children of White and Black mothers, while children of Asian mothers have seen an increasing rate of healthy weight over the past 16 years.

THREE-QUARTERS OF ASIAN 4-YEAR-OLDS HAVE A HEALTHY WEIGHT

Percentage of Los Angeles County 4-Year-Old Children From Low-Income Families Who Have a Healthy Weight by the Race/Ethnicity of the Mother, 2018



Data by race/ethnicity for 3-year-old children and for years 2003-2018 is available in the Supplemental Tables.

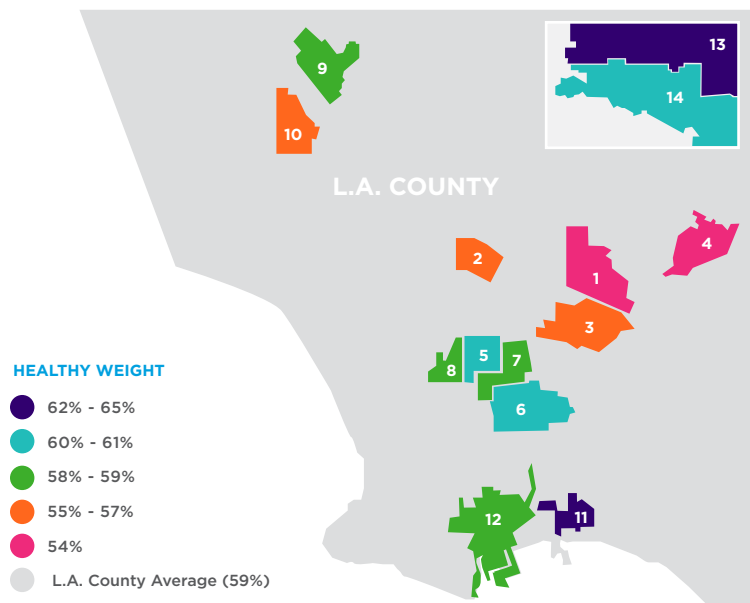
GEOGRAPHIC DETAIL

Of the 14 *Best Start* geographies in L.A. County, most have a somewhat lower proportion of 4-year-olds with a healthy weight than the countywide average of 59 percent. The *Best Start* geographies with the lowest proportion are South El Monte/El Monte and East LA, both at 54 percent. The *Best Start* geographies with the highest proportion of children with healthy weight include Lancaster and Central Long Beach, at 64 percent and 65 percent, respectively. Over the past 16 years, the proportion of 4-year-olds with a healthy weight has declined in all 14 *Best Start* geographies.

MODEST VARIATION ACROSS *BEST START* GEOGRAPHIES IN WEIGHT STATUS AMONG 4-YEAR-OLDS

Percentage of Los Angeles County 4-Year-Old Children From Low-Income Families Who Have a Healthy Weight by *Best Start* Geography, 2018

REGION 1	
1 East LA	54%
2 Metro LA	56%
3 Southeast LA	57%
4 South El Monte/El Monte	54%
REGION 2	
5 Broadway-Manchester	61%
6 Compton	61%
7 Watts-Willowbrook	58%
8 West Athens	58%
REGION 3	
9 Northeast Valley Communities	59%
10 Panorama City & Neighbors	57%
REGION 4	
11 Central Long Beach	65%
12 Wilmington	58%
REGION 5	
13 Lancaster	64%
14 Palmdale	61%



Data by geography for 3-year-old children and for years 2003-2018 is available in the Supplemental Tables.

DATA NOTES AND LIMITATIONS

Data is based on children participating in WIC, the federal food assistance program for low-income pregnant women, breastfeeding women, and children under the age of five. As such, the results are a proxy for weight status among low-income children. Race/ethnic detail is based on the race/ethnic identity of the mother.

Full Indicator Language: Annual percentage of children ages 2 through 5 in L.A. County with a Body Mass Index (BMI) that falls within a healthy weight range.

Source: Public Health Foundation Enterprises WIC (Special Supplemental Nutrition Program for Women Infants and Children)

Dual Language Learners

CONTEXTUAL INDICATOR 7

FEWER DUAL LANGUAGE LEARNERS COMPARED TO SIX YEARS AGO

This indicator measures the annual percentage of Los Angeles County public school kindergarten students who are Dual Language Learners. Young children exposed to two or more languages simultaneously, or young children who learn a second language while continuing to develop their first, are known as Dual Language Learners (DLLs). For this indicator, kindergarten students designated English Learners or Fluent English Proficient (bilingual) are used as a proxy for estimating the proportion of young children that are Dual Language Learners.

Why is it Important?

DLLs possess the natural advantage of being able to acquire native-level fluency in both English and another language if they are provided with the right support at home and systems are designed to meet their needs, such as an early learning workforce that is trained to support DLLs. Tracking English Learner and Fluent English Proficient designations informs our understanding of our target population and speaks to the need for strategies to support families raising children in bilingual environments and for professional development among the early childhood workforce on skills that effectively support DLLs in early learning settings.

Current Context

According to 2017 research by the UCLA Center for Health Policy Research, approximately 60 percent of households in California with children from birth through age five were Dual Language Learner families, meaning that the household members spoke a language other than, or in addition to, English. This research, when viewed next to the estimates provided in this indicator of 29.3 percent English Learners plus 6.6 percent bilingual students, suggests a possible undercount of Dual Language Learners in the schools. For example, some practitioners in the field reported anecdotally that immigrant families may avoid completing the Home Language Survey for fear of immigration enforcement action or stigma around being designated an English Learner. The decline observed in the proportion of kindergarteners that were English Learners is likely attributable to the perceived stigma, as well as declines in immigration and the birth rate.

MOST RECENT YEAR

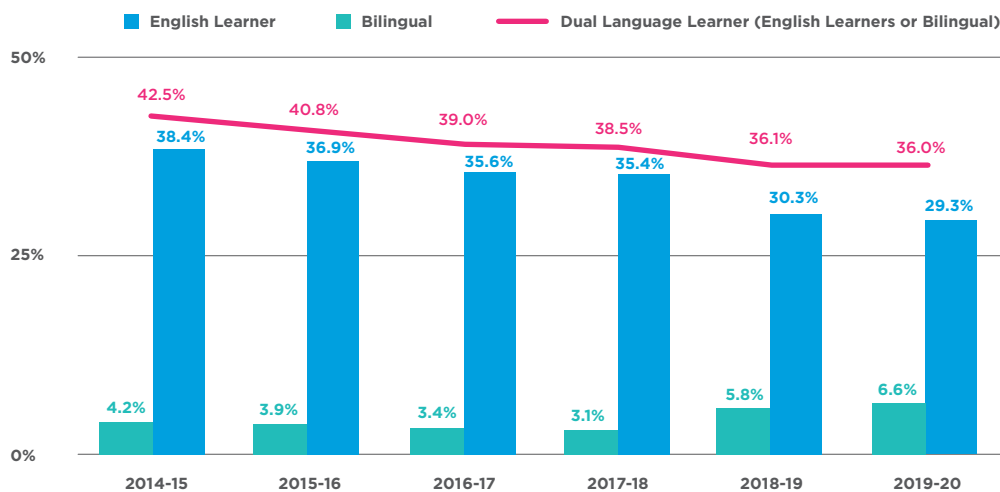
In the 2019-20 school year, 36.0 percent of Los Angeles County public school kindergarten students were Dual Language Learners, where 29.3 percent were designated English Learners and another 6.6 percent were designated bilingual.

TREND

Between 2014-15 and 2019-20, the proportion of the kindergarten cohort comprised of Dual Language Learners fell by approximately seven percentage points, from 42.5 percent to 36.0 percent. The drop was driven by a nine-percentage point decline in the proportion of kindergarteners who were designated English Learners, from 38.4 percent to 29.3 percent. Over the same period, the proportion of kindergarten students that were designated bilingual increased from 4.2 percent to 6.6 percent.

PROPORTION OF KINDERGARTENERS THAT ARE DUAL LANGUAGE LEARNERS IS FALLING

Percentage of Los Angeles County Kindergarteners Who Are Designated English Learners or Bilingual, 2014-15 to 2019-20



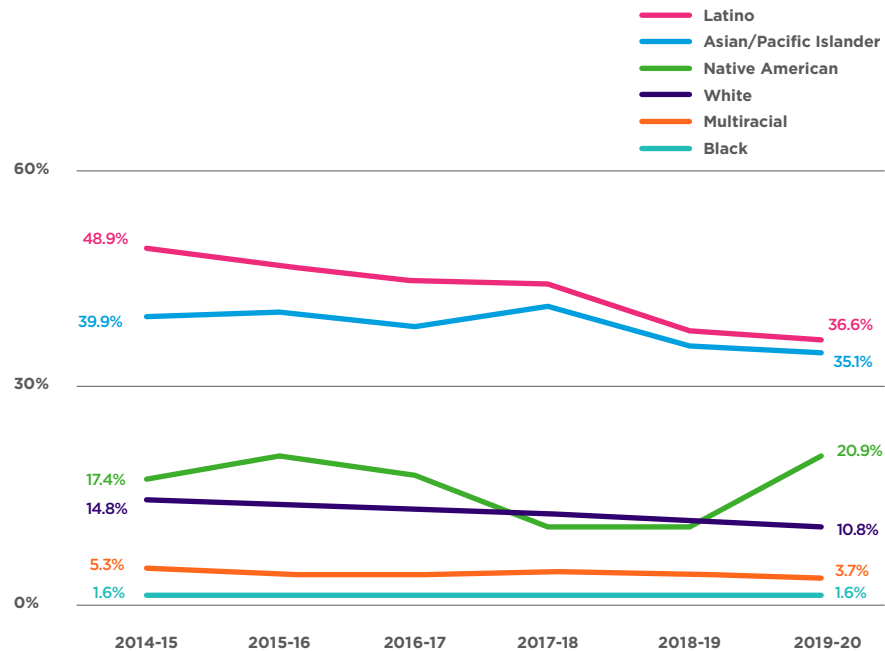
RACE/ETHNICITY DETAIL

Only English Learner data is available by race/ethnicity. Among the most recent cohort of kindergarteners, 36.6 percent of Latino students were designated English Learners in 2019-20. This rate is similar to the proportion of Asian/Pacific Islander kindergarteners who were designated English Learners (35.1 percent). One in five Native American kindergarteners (20.9 percent) were designated English Learners in 2019-20, followed by 10.8 percent of White kindergarten students, 3.7 percent of multiracial students, and 1.6 percent of Black students.

The decline in the countywide percentage of English Learners is driven primarily by substantial declines in the percentage of Latino and Asian/Pacific Islander English Learners. In 2014-15, nearly half (48.9 percent) of Latino kindergarteners were designated English Learners; six years later, just 36.6 percent were. The percentage of Asian/Pacific Islander kindergarteners who were English Learners fell from 39.9 percent to 35.1 percent over the same period. White and multiracial kindergarteners also witnessed a decline in the percentage that were designated English Learners. Rates of Native American English Learners fluctuated over the six years shown, while rates among Black kindergarteners were steady at 1.6 percent.

SUBSTANTIAL DECLINE IN PERCENTAGE OF LATINO KINDERGARTENERS THAT ARE ENGLISH LEARNERS

Percentage of Los Angeles County Kindergarteners Who Are Designated English Learners by Race/Ethnicity, 2014-15 to 2019-20



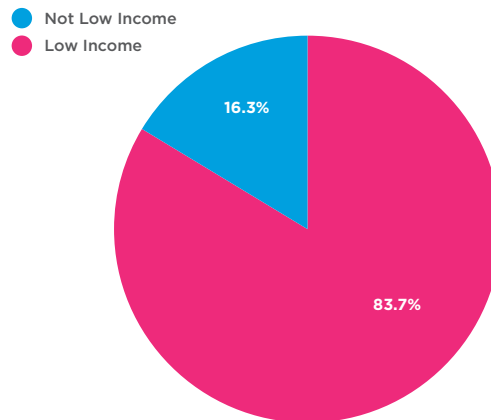
Trend data by race and ethnicity is provided in the Supplemental Tables.

SOCIOECONOMIC STATUS DETAIL

Dual Language Learner kindergarten students are predominantly from families with low income. In 2019-20, fully 83.7 percent were from families with low income and 16.3 percent were from families that were not low-income.

MOST DUAL LANGUAGE LEARNER KINDERGARTENERS ARE FROM FAMILIES WITH LOW INCOME

Percentage of Los Angeles County Kindergarteners Who Are Dual Language Learners by Socioeconomic Status, 2019-20



Trend data by income status is provided in the Supplemental Tables.

DATA NOTES AND LIMITATIONS

According to the California Department of Education, a child is designated an English Learner if their parent or guardian reports on the Home Language Survey that a language other than English is spoken at home and, upon follow-up assessment, the child is determined to lack defined English language skills of listening, speaking, reading and/or writing considered necessary to succeed in the school's regular instructional programs. Students are designated Initial Fluent English Proficient (or bilingual) if a language other than English is spoken at home and, upon initial assessment, the student is determined to be proficient in English. Students may also be designated as Reclassified Fluent English Proficient; the counts of these students are included in the bilingual/Fluent English Proficient counts. The term Dual Language Learner (DLL) encompasses young children who are exposed to two or more languages simultaneously or who are learning a second language while continuing to develop their first. The term English Learner or English Language Learner is generally applied to older, non-native English speakers who have gained proficiency in their native language and are now learning English in addition to mastering academic content. The English Learner and Fluent English Proficient data presented in this indicator is used as a proxy for understanding the DLL population. Data is available from the data source beginning in the 2014-15 academic year. Income status data is based on California Department of Education's determination of Socioeconomically Disadvantaged (SED) status. SED students have one or more of the following: both parents have not received a high school diploma; students are eligible for Free or Reduced-Price Meals; or students are migrant, homeless or foster youth.

Full Indicator Language: Annual percentage of kindergarteners in L.A. County who are Dual Language Learners.

Source: California Department of Education; Early Edge, "Improving Teacher Preparation to Support California's Dual Language Learners," May 2020 (Why Important section); UCLA Center for Health Policy Research, "Families with Young Children in California: Findings from the California Health Interview Survey, 2011-2014," May 2017 (Current Context inset); California Department of Education, Glossary of Terms for English Learner Reports (Data Notes and Limitations); National Conference of State Legislatures (Data Notes and Limitations)

Special Education Enrollment

CONTEXTUAL INDICATOR 8

SPECIAL EDUCATION ENROLLMENT INCREASING

This indicator measures the percentage of Los Angeles County children from birth through age 5 who are enrolled in special education services through their local school district.

Why is it Important?

This indicator helps inform our understanding of the demand for services that will promote learning and developmental growth for children with special needs.

MOST RECENT YEAR

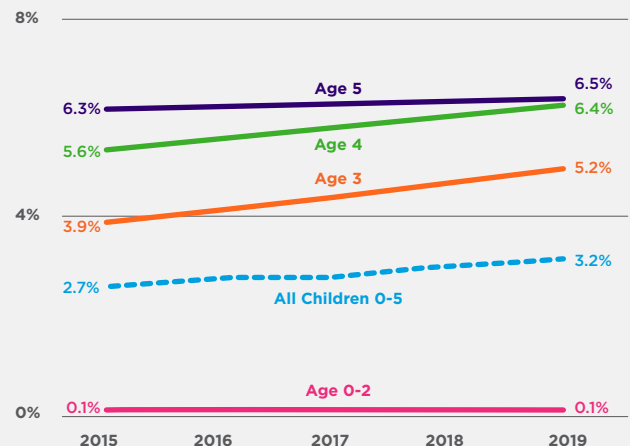
In 2019, 3.2 percent of children from birth through age 5 in L.A. County were enrolled in special education services. The rate was highest among 5-year-old children, with 6.5 percent of 5-year-old children enrolled in special education services, compared to 6.4 percent of 4-year-old children and 5.2 percent of 3-year-old children.

TREND

The proportion of L.A. County children from birth through age 5 enrolled in special education services through their local school district has grown from 2.7 percent to 3.2 percent of the population between 2015 and 2019. The growth over this period was driven primarily by increases among 3-year-old children (rising from 3.9 percent to 5.2 percent of all 3-year-olds) and 4-year-old children (rising from 5.6 percent to 6.4 percent of all 4-year-olds).

PROPORTION OF 3- AND 4-YEAR-OLDS ENROLLED IN SPECIAL EDUCATION IS GROWING

Percentage of Los Angeles County Children Enrolled in School District Special Education Services by Age, 2015-2019



Trend data by age is available in the Supplemental Tables.

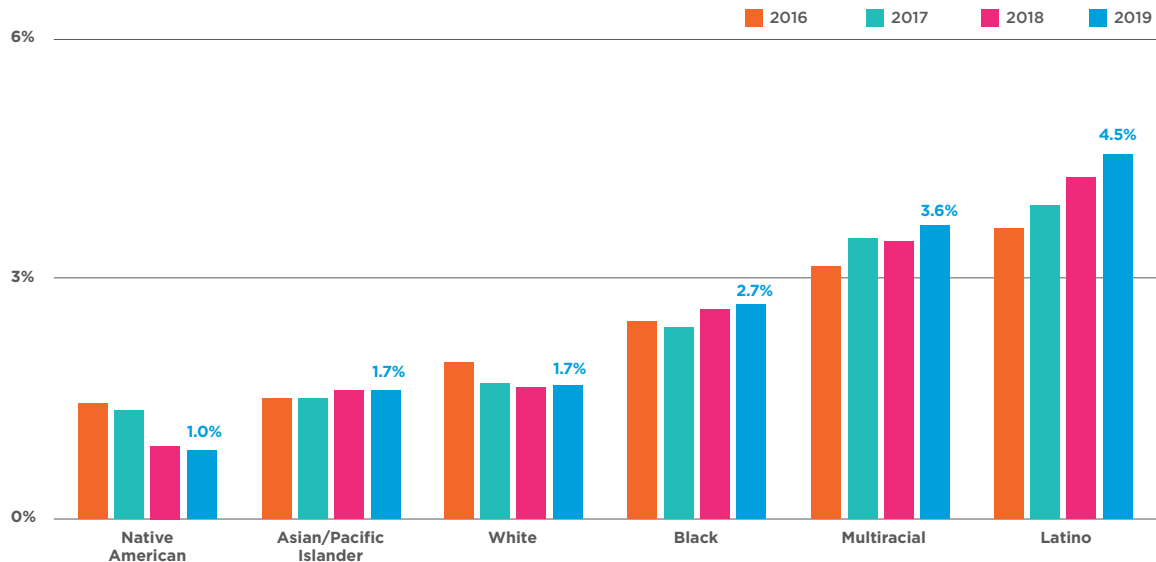
RACE/ETHNICITY DETAIL

Latino young children had the highest rate of enrollment in special education at 4.5 percent of all Latino children from birth through age 5 in 2019. This is followed by 3.6 percent of multiracial young children and 2.7 percent of Black young children. Native American, Asian/Pacific Islander and White young children had the lowest rates of enrollment in special education services.

Since 2016, the proportion of young children receiving special education services through their local school district grew the most among Latino young children (from 3.6 percent in 2016 to 4.5 percent in 2019). Rates of special education enrollment among multiracial and Black students also increased over this period, but less significantly. Asian/Pacific Islander rates of special education enrollment remained flat, while Native American and White rates declined somewhat.

LATINO YOUNG CHILDREN ARE SOMEWHAT MORE LIKELY TO BE IN SPECIAL EDUCATION THAN THEIR PEERS OF OTHER RACES/ETHNICITIES

Percentage of Los Angeles County Children Enrolled in School District Special Education Services by Race/Ethnicity, 2016-2019



Trend data by race and ethnicity is provided in the Supplemental Tables.

DATA NOTES AND LIMITATIONS

This count of special education enrollment for pre-kindergarten-age students is not inclusive of all young children receiving early intervention services or special education services. Please see the Methods section for additional detail on source data.

Full Indicator Language: Annual percentage of children from birth through age 5 in L.A. County who are enrolled in special education.

Source: California Department of Education (number of children in special education); California Department of Finance, Demographic Research Unit, Population Projections, Table P-3 (child population)

Third Grade Literacy

CONTEXTUAL INDICATOR 9

PERCENTAGE OF THIRD GRADERS MEETING LITERACY STANDARDS IS INCREASING

This indicator provides the annual percentage of third grade students in Los Angeles County who meet or exceed the grade-level standard in English Language Arts (ELA). The English Language Arts assessment measures proficiency in reading comprehension, writing, and speaking and listening.

Why is it Important?

Third grade marks the transition in elementary education from “learning to read” to “reading to learn.” A delay in reading proficiency can persist and grow over a child’s education and impact their long-term outcomes. Given the association between kindergarten readiness and later reading proficiency, understanding third grade ELA proficiency can inform early care and education programming, including access and quality, and other practices that promote school readiness.

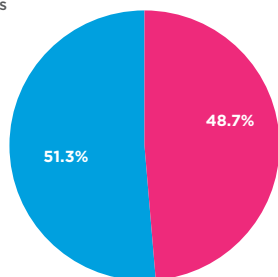
MOST RECENT YEAR

In school year 2018-19, 48.7 percent of third graders in Los Angeles County met or exceeded grade-level standards in English Language Arts.

ALMOST HALF OF L.A. COUNTY THIRD GRADERS MEET LITERACY STANDARDS

Percentage of Third Graders That Met or Exceeded English Language Arts Standards, 2018-19

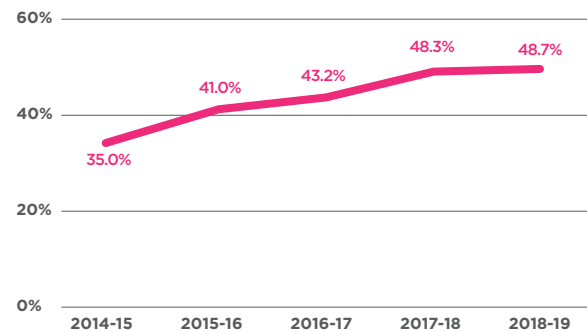
- Met ELA Standards
- Did Not Meet ELA Standards

**TREND**

The percentage of third graders in Los Angeles County that met or exceeded grade-level standards in ELA has increased steadily over time, from 35.0 percent in 2014-15 to 48.7 percent in 2018-19.

PERCENTAGE OF STUDENTS MEETING ELA STANDARDS HAS INCREASED STEADILY OVER TIME

Percentage of Third Graders That Met or Exceeded English Language Arts Standards, 2014-15 to 2018-19

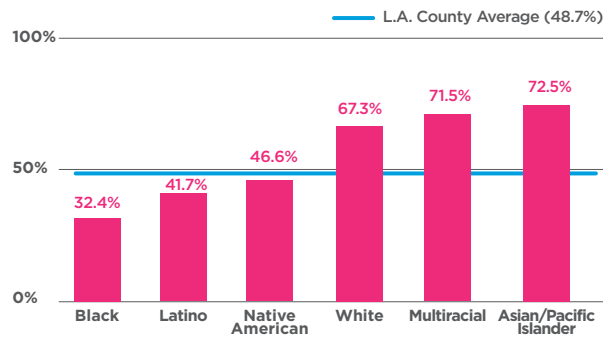


RACE/ETHNICITY DETAIL

In the 2018-19 school year, three-quarters of Asian/Pacific Islander students met or exceeded the ELA standards, while one-third of Black students met or exceeded these benchmarks. Although the percentage of third graders in L.A. County that met or exceeded grade-level standards in English Language Arts has increased across race and ethnic groups from 2014-15 to 2018-19, Black, Latino and Native American students continue to lag behind their Asian/Pacific Islander, White and multiracial peers.

SUBSTANTIAL RACIAL AND ETHNIC DISPARITIES IN LITERACY PROFICIENCY

Percentage of Third Graders That Met or Exceeded English Language Arts Standards by Race/Ethnicity, 2018-2019



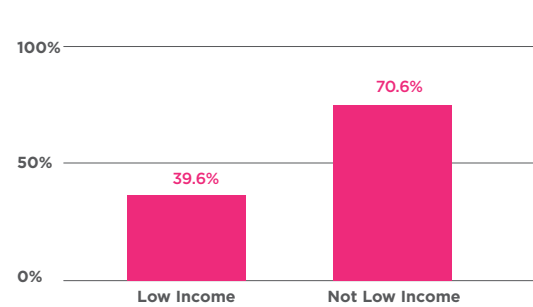
Trend data by race/ethnicity is provided in the Supplemental Tables.

SOCIOECONOMIC STATUS DETAIL

Students from families with low income are less likely to meet ELA standards than their peers who are not from families with low income. In the 2018-19 school year, just over one-third of low-income students met or exceeded ELA standards, compared to almost three-quarters of students who are not low income. This pattern was consistent over time, with higher proportions of students who are not low income meeting or exceeding ELA standards compared to their low-income peers over the past five school years.

LOW-INCOME STUDENTS ARE LESS LIKELY TO MEET LITERACY STANDARDS

Percentage of Third Graders That Met or Exceeded English Language Arts Standards by Socioeconomic Status, 2018-19



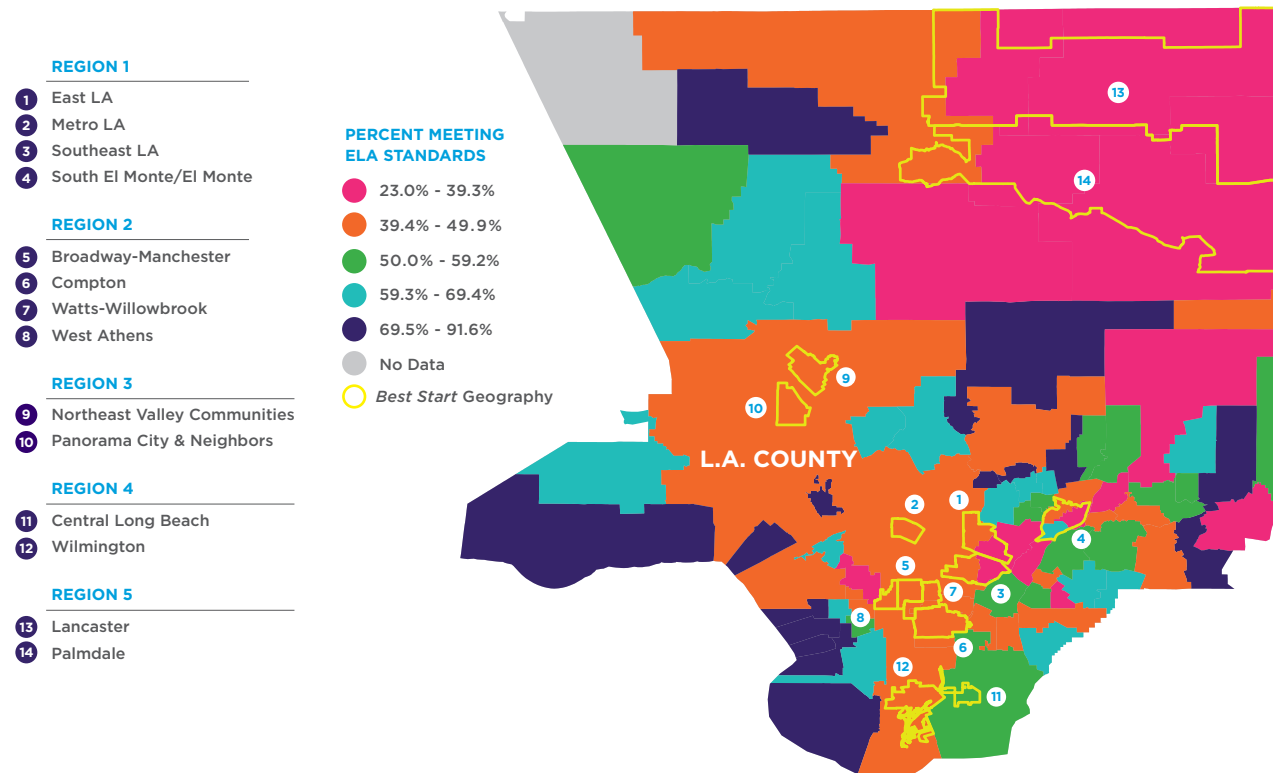
Trend data by socioeconomic status is provided in the Supplemental Tables.

GEOGRAPHIC DETAIL

Geographic data is provided by school district with the boundaries of *Best Start* geographies overlaid. A visual assessment shows that the *Best Start* geographies of Central Long Beach and South El Monte/El Monte are partly served by school districts that had higher than average rates of students who met or exceeded literacy standards. The remaining *Best Start* geographies are served by school districts that were at or below the countywide average. A determination of the percentage meeting or exceeding literacy standards for each *Best Start* geography is not possible with the data available.

CENTRAL LONG BEACH AND PART OF SOUTH EL MONTE/EL MONTE ARE SERVED BY SCHOOL DISTRICTS THAT OUTPERFORM THE L.A. COUNTY AVERAGE

Percentage of Third Graders That Met or Exceeded English Language Arts Standards by *Best Start* Geography, 2018-19



DATA NOTES AND LIMITATIONS

Income status data is based on California Department of Education's determination of Socioeconomically Disadvantaged (SED) status. SED students have one or more of the following: both parents have not received a high school diploma; students are eligible for Free or Reduced-Price Meals; or students are migrant, homeless or foster youth.

Full Indicator Language: Annual percentage of third grade students in L.A. County who meet or exceed the grade-level standard in English Language Arts.

Source: California Assessment of Student Performance and Progress (CASPP) English Language Arts Standards from California Department of Education

Prenatal Care

CONTEXTUAL INDICATOR 10

COUNTYWIDE PRENATAL CARE TREND IS FLAT, BUT SEVERAL *BEST START* GEOGRAPHIES SEE IMPROVEMENT

This indicator measures the annual percentage of mothers in Los Angeles County who gave birth in the last year and received early prenatal care (in the first trimester of their pregnancy).

Why is it Important?

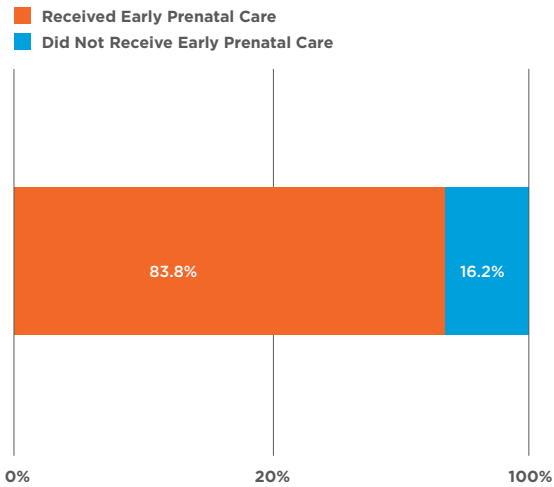
Prenatal care in the first trimester offers an opportunity for providers to diagnose and treat maternal or fetal medical conditions early. It also provides expecting parents with counseling on healthy behaviors that increase the chances of having a healthy pregnancy and baby. Tracking prenatal care rates provides important information on trends and disparities in access to needed services.

MOST RECENT YEAR

In 2017, 83.8 percent of mothers who gave birth received early prenatal care.

8 IN 10 L.A. COUNTY MOTHERS RECEIVE EARLY PRENATAL CARE

Early Prenatal Care Rate in Los Angeles County, 2017

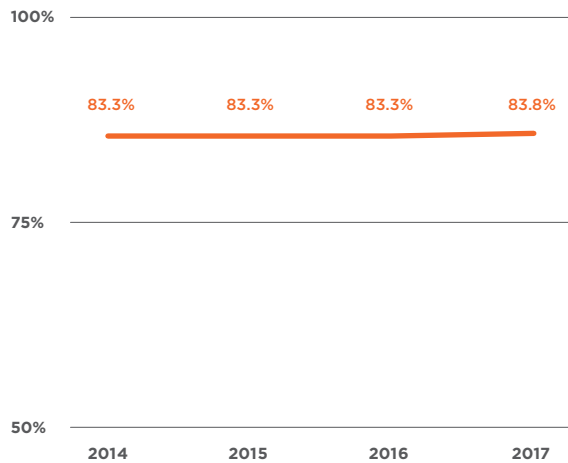


TREND

The percentage of pregnant mothers getting early prenatal care has remained largely unchanged in the four-year period between 2014 and 2017, from a low of 83.3 percent in 2014, 2015 and 2016 to 83.8 percent in 2017.

LITTLE CHANGE IN PRENATAL CARE RATE OVER FOUR YEARS

Early Prenatal Care Rate in Los Angeles County, 2014-2017

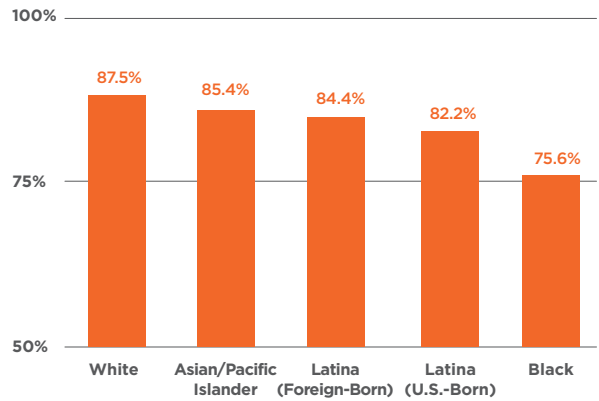


RACE/ETHNICITY DETAIL

In 2017, prenatal care rates among mothers of color — Asian/Pacific Islander, Latina and Black — were somewhat or substantially lower than prenatal care rates of White mothers. Changes in prenatal care rates between 2014 and 2017 were mixed for the race and ethnic groups. Prenatal care rates for Asian/Pacific Islander mothers and White mothers increased slightly, while rates for foreign-born Latina mothers declined slightly. No discernable trends emerged for Black mothers or U.S.-born Latina mothers.

MOTHERS OF COLOR HAVE LOWER PRENATAL CARE RATES THAN WHITE MOTHERS

Early Prenatal Care Rate in Los Angeles County by Race/Ethnicity, 2017



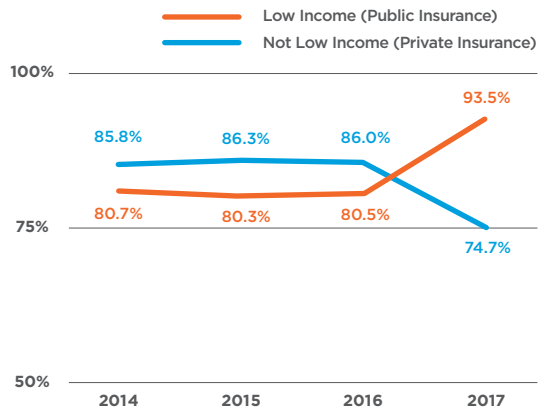
Trend data by race and ethnicity are provided in the Supplemental Tables.

SOCIOECONOMIC STATUS DETAIL

The birth payment method— whether public or private — is used as a proxy for the income status of the mother. Lower-income mothers who used public insurance to pay for the birth had higher prenatal care rates in 2017 than mothers who used private insurance — 93.5 percent and 74.7 percent, respectively. This marked a rather substantial change from previous years. Prenatal care rates among mothers with public insurance rose 16 percent between 2014 and 2017, while prenatal care rates fell 13 percent among mothers with private insurance over the same period.

LOW-INCOME MOTHERS HAVE HIGH RATES OF PRENATAL CARE

Early Prenatal Care Rate in Los Angeles County by Socioeconomic Status, 2014-2017



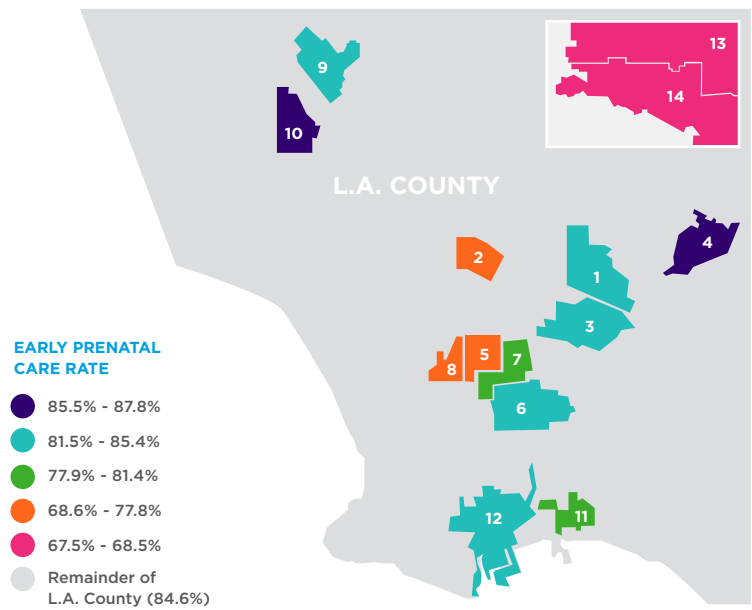
GEOGRAPHIC DETAIL

Prenatal care rates varied by more than 20 percentage points among First 5 LA's *Best Start* geographies, with Lancaster and Palmdale at the low end (67.5 and 68.5 percent, respectively) and South El Monte/El Monte and Panorama City & Neighbors at the high end (87.8 percent and 86.7 percent, respectively). Despite the lower rate in Palmdale, the 2017 rate marked a 6-percentage point increase since 2014. Wilmington and Central Long Beach also saw notable improvement over this period, rising 9 and 6 percentage points, respectively.

LOW EARLY PRENATAL CARE RATES IN BEST START REGION 5

Early Prenatal Care Rate by *Best Start* Geography, 2017

REGION 1	
1 East LA	85.4%
2 Metro LA	76.1%
3 Southeast LA	85.2%
4 South El Monte/El Monte	87.8%
REGION 2	
5 Broadway-Manchester	76.8%
6 Compton	83.4%
7 Watts-Willowbrook	79.3%
8 West Athens	77.8%
REGION 3	
9 Northeast Valley Communities	83.8%
10 Panorama City & Neighbors	86.7%
REGION 4	
11 Central Long Beach	81.4%
12 Wilmington	85.1%
REGION 5	
13 Lancaster	67.5%
14 Palmdale	68.5%



Trend data by geography is provided in the Supplemental Tables.

DATA NOTES AND LIMITATIONS

The totals produced for this local analysis may differ from other published sources; they should not be considered official county or state birth statistics.

Full Indicator Language: Annual percentage of mothers in L.A. County who gave birth in the last year that received prenatal care in the first trimester of their pregnancy.

Source: Children's Data Network at the University of Southern California

Postpartum Care

CONTEXTUAL INDICATOR 11

MOST NEW MOTHERS HAVE A POSTPARTUM CHECKUP

This indicator provides the annual percentage of mothers in Los Angeles County who gave birth in a given year and had at least one postpartum checkup.

Why is it Important?

Postpartum care visits provide important physical and behavioral health care to new mothers. New mothers may be at risk of serious health complications in the days and weeks after giving birth. Additionally, some new mothers experience changes in their mental health status that may require medical attention. Postpartum checkup rates inform our understanding of whether mothers are receiving support to treat immediate health issues and to prevent further health complications.

Current Context

As of publication, the worldwide COVID-19 pandemic is continuing to unfold. Widespread stay-at-home orders, reduced medical capacity to handle non-COVID-19 issues, and fear of visiting medical offices amidst the pandemic have contributed to reduced well-being visits. This may impact postpartum checkup rates.

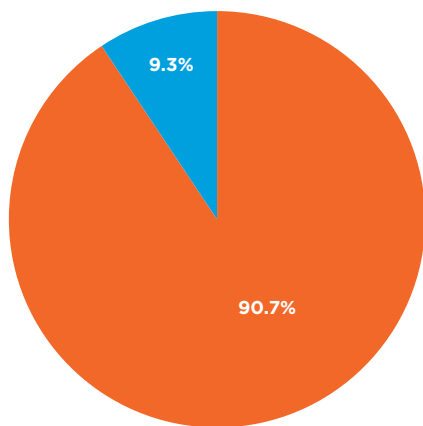
MOST RECENT YEAR

In 2016, an estimated 90.7 percent of mothers in L.A. County who gave birth in the last year had at least one postpartum checkup.

9 OUT OF 10 MOTHERS HAVE AT LEAST ONE POSTPARTUM CHECKUP

Percentage of New Mothers in Los Angeles County Who Had At Least One Postpartum Checkup, 2016

- Had a Postpartum Checkup
- Did Not Have a Postpartum Checkup

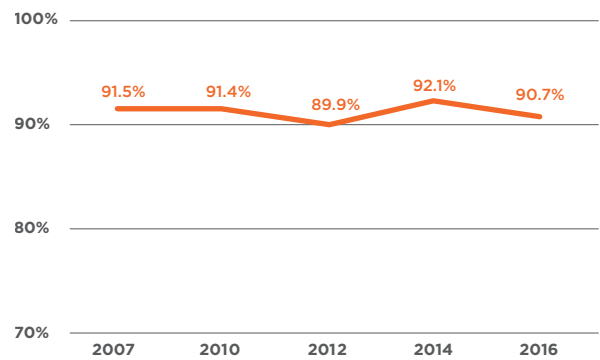


TREND

The annual percentage of mothers in L.A. County who gave birth and had a postpartum checkup has remained relatively stable from 2007 to 2016, with slight fluctuation over time.

POSTPARTUM CHECKUP RATES HAVE REMAINED RELATIVELY STABLE OVER TIME

Percentage of New Mothers in Los Angeles County Who Had At Least One Postpartum Checkup, 2007-2016

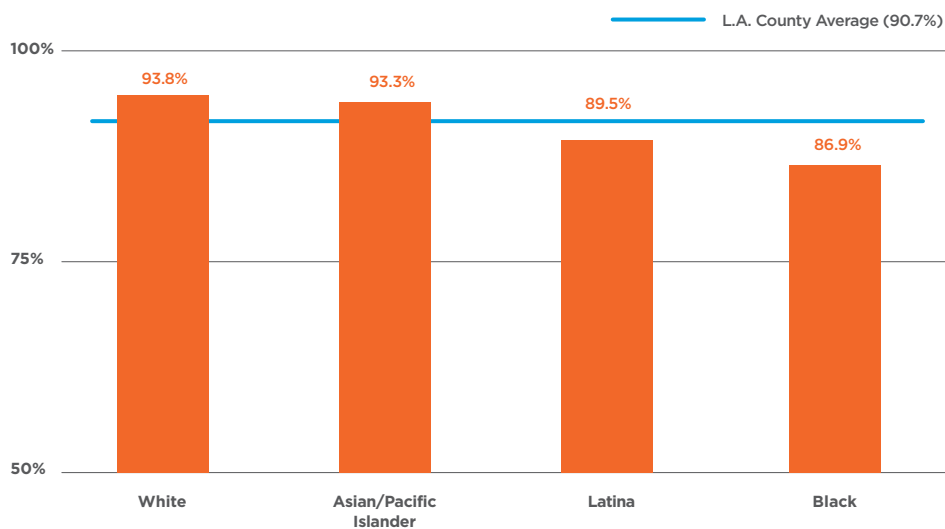


RACE/ETHNICITY DETAIL

Black mothers in L.A. County had lower rates of postpartum visits than mothers in other racial and ethnic groups. In 2016, 86.9 percent of Black new mothers had received a postpartum checkup, compared to 93.8 percent of White mothers, 93.3 percent of Asian/Pacific Islander mothers, and 89.5 percent of Latina mothers. The rate of new mothers receiving postpartum visits has remained relatively stable over time within each race/ethnic group.

BLACK MOTHERS HAVE POSTPARTUM CHECKUPS AT LOWER RATES

Percentage of New Mothers in Los Angeles County That Had At Least One Postpartum Checkup by Race/Ethnicity, 2016



Trend data by race and ethnicity is provided in the Supplemental Tables.

GEOGRAPHIC DETAIL

Rates of mothers in L.A. County that had a postpartum checkup in 2016 ranged from 84.2 percent in SPA 1 (Antelope Valley) to 96.2 percent in SPA 5 (West). Over time, mothers in SPA 1 and SPA 6 (South) have consistently had postpartum checkups at lower rates compared to other SPAs, while mothers in SPA 5 and SPA 2 (San Fernando Valley) have had higher rates of postpartum checkups.

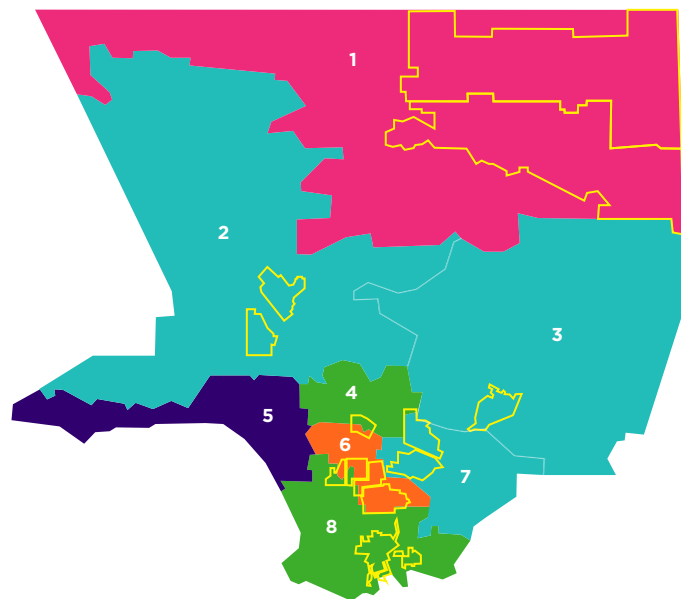
MOTHERS IN ANTELOPE VALLEY HAVE THE LOWEST POSTPARTUM CHECKUP RATES

Percentage of New Mothers in Los Angeles County That Had At Least One Postpartum Checkup by SPA, 2016

SPA 1 Antelope Valley	84.2%
SPA 2 San Fernando Valley	93.2%
SPA 3 San Gabriel Valley	91.1%
SPA 4 Metro	89.1%
SPA 5 West	96.2%
SPA 6 South	87.0%
SPA 7 East	91.4%
SPA 8 South Bay	90.6%

POSTPARTUM CHECKUP RATE

- 93.3% - 96.2%
- 90.7% - 93.2%
- 87.1% - 90.6%
- 84.3% - 87.0%
- 84.2%
- Best Start Geography
- L.A. County Average (90.7%)



Trend data by geography is provided in the Supplemental Tables.

DATA NOTES AND LIMITATIONS

Results from the Los Angeles Mommy and Baby (LAMB) survey are presented in set race/ethnic categories; further disaggregation of additional race/ethnic categories is not possible. Service Planning Areas, or SPAs, are determined by the Los Angeles Department of Public Health.

Full Indicator Language: Annual percentage of mothers in L.A. County who gave birth in the last year that had a postpartum checkup.

Source: Los Angeles Mommy and Baby (LAMB) Survey administered by L.A. County Department of Public Health, Maternal, Child & Adolescent Health Division

Maternal Depression

CONTEXTUAL INDICATOR 12

ONE-QUARTER OF NEW MOTHERS EXPERIENCE POSTPARTUM DEPRESSION

This indicator measures the annual percentage of mothers in Los Angeles County who gave birth in the last year and displayed signs of prenatal (during pregnancy) or postpartum (after birth) depression. Data on prenatal depression is available over time, while data on postpartum depression is available only for 2016.

Why is it important?

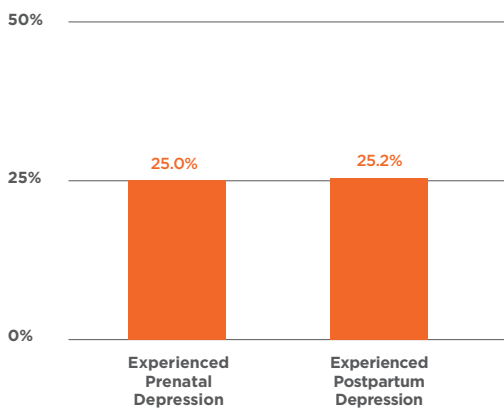
Maternal depression negatively impacts a mother's health and well-being and has further consequences on her child's development. Prenatal depression can lead to inadequate prenatal care, poor nutrition, higher pre-term birth, low birth weight and other negative impacts. Tracking maternal depression can inform our understanding of the demand for interventions including social support, home visiting, family therapy, psychotherapy or medication.

MOST RECENT YEAR

In 2016, one-quarter (25.0 percent) of L.A. County mothers reported prenatal depression and one-quarter (25.2 percent) reported postpartum depression since the birth of their child.

1 IN 4 MOTHERS EXPERIENCE PRENATAL OR POSTPARTUM DEPRESSION

Percentage of Mothers in Los Angeles County Experiencing Prenatal and/or Postpartum Depression, 2016



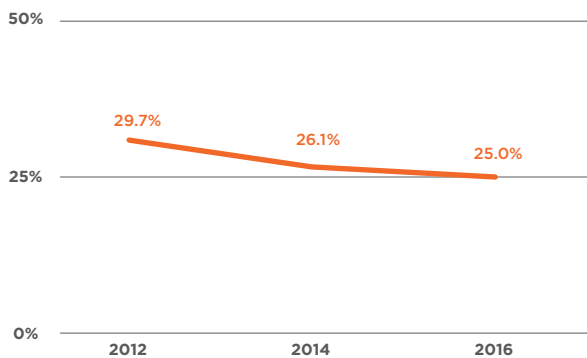
The percentage of mothers experiencing prenatal and postpartum depression are separate questions in the LAMB survey, and therefore, while some overlap may exist, the data does not necessarily reflect the same group of mothers.

TREND

The percentage of mothers experiencing depression during pregnancy has decreased from 29.7 percent in 2012 to 25.0 percent in 2016. The percentage of mothers experiencing depression before pregnancy remained relatively stable over that time, as illustrated in the Supplemental Tables.

PRENATAL DEPRESSION RATE IS DECREASING OVER TIME

Percentage of Mothers in Los Angeles County Experiencing Prenatal Depression, 2012-2016

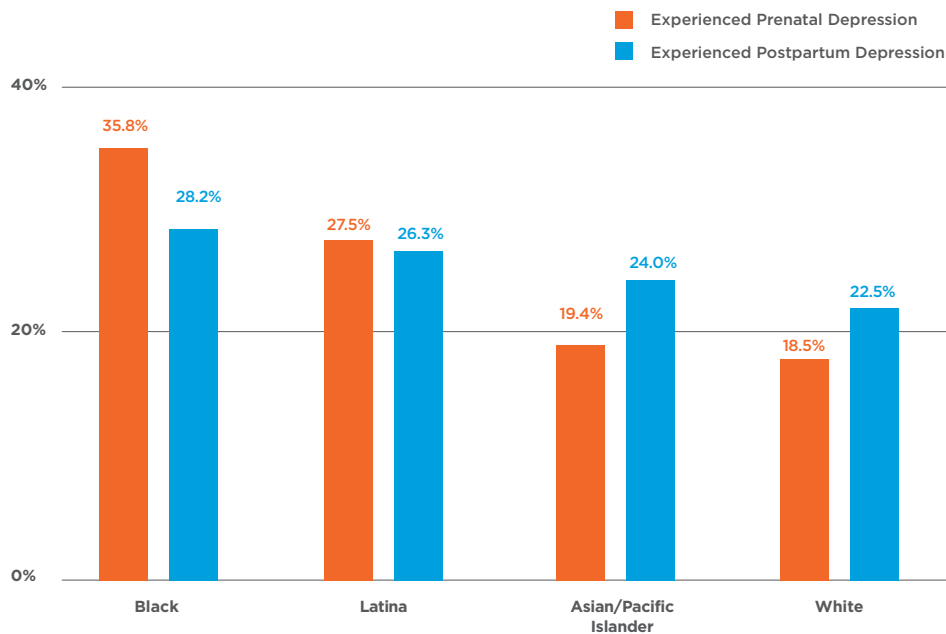


RACE/ETHNICITY DETAIL

In 2016, Black and Latina mothers in L.A. County experienced prenatal and postpartum depression at higher rates compared to Asian/Pacific Islander or White mothers. Rates of prenatal depression among White or Asian/Pacific Islander mothers have remained relatively stable over time and rates have decreased among Latina mothers. The prenatal depression rate among Black mothers decreased from 39.5 percent to 32.5 percent between 2012 and 2014, and increased to 35.8 percent in 2016.

BLACK AND LATINA MOTHERS EXPERIENCE HIGHER RATES OF PRENATAL AND POSTPARTUM DEPRESSION

Percentage of Mothers in Los Angeles County Experiencing Prenatal and/or Postpartum Depression by Race/Ethnicity, 2016



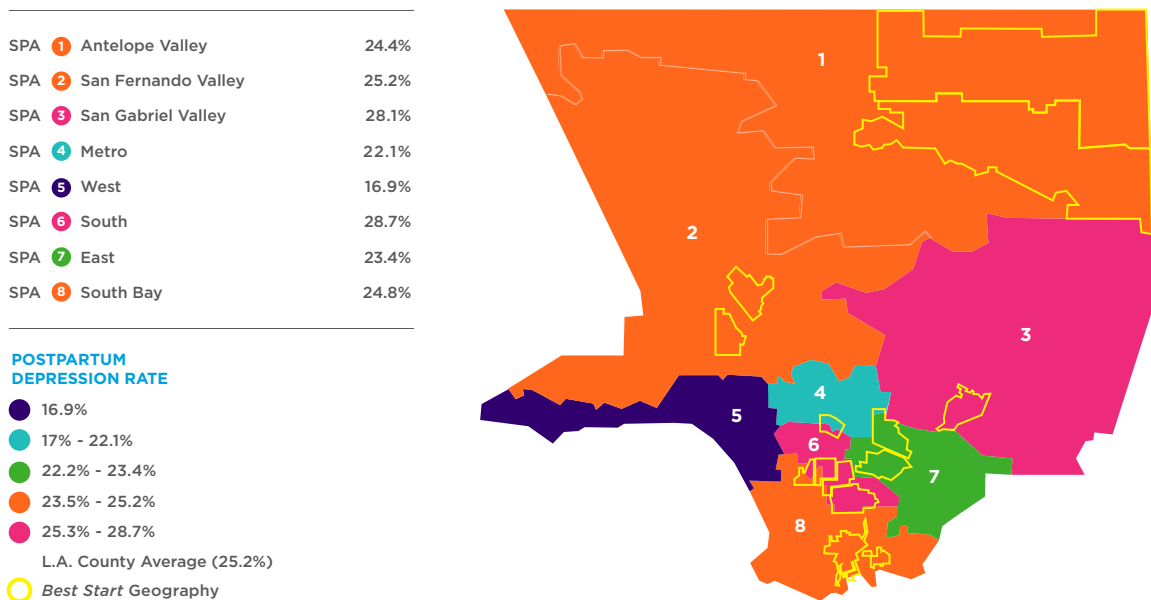
Trend data by race and ethnicity is provided in the Supplemental Tables.

GEOGRAPHIC DETAIL

Among L.A. County SPAs in 2016, mothers in SPA 5 experienced the lowest rates of postpartum depression, at 16.9 percent. Mothers in SPA 6 experienced the highest rates of postpartum depression, at 28.7 percent. The map shows the *Best Start* geography boundaries overlaid onto the SPA regions, allowing for a rough visual assessment of postpartum depression rates in these communities.

POSTPARTUM DEPRESSION RATES WERE HIGHER IN SPA 3 AND SPA 6

Percentage of Mothers in Los Angeles County Experiencing Postpartum Depression by SPA, 2016



Additional data is available in the Supplemental Tables.

DATA NOTES AND LIMITATIONS

The percentage of mothers experiencing prenatal and postpartum depression are separate questions in the LAMB survey, and therefore, while some overlap may exist, the data does not necessarily reflect the same group of mothers. The LAMB survey asked a two-part question to assess prenatal (or postpartum) depression: “For 2 weeks or longer during (or since) your most recent pregnancy did you feel sad, empty or depressed for most of the day?” and “For 2 weeks or longer during (or since) your most recent pregnancy did you lose interest in most things like work, hobbies, and other things you usually enjoyed?” Respondents who answered “Yes” to either response were coded as having “depressed mood.” Data on depressed mood after birth is not available for 2012 or 2014 because the survey question to capture this data changed in 2016 and does not align with postpartum data collected in 2012 and 2014. Data collected on depression before pregnancy is available over time and provided in the Supplemental Tables.

Full Indicator Language: Annual percentages of mothers in L.A. County who gave birth in the last year that displayed signs or symptoms of prenatal or postpartum depression.

Source: Los Angeles Mommy and Baby (LAMB) Survey administered by the L.A. Department of Public Health

Breastfeeding

CONTEXTUAL INDICATOR 13

BREASTFEEDING RATES DECLINE CONSIDERABLY BY THREE MONTHS AFTER BIRTH

This indicator measures the annual percentage of mothers in Los Angeles County who gave birth in the last year and were providing any breastfeeding at one week, one month and three months after childbirth.

Why is it Important?

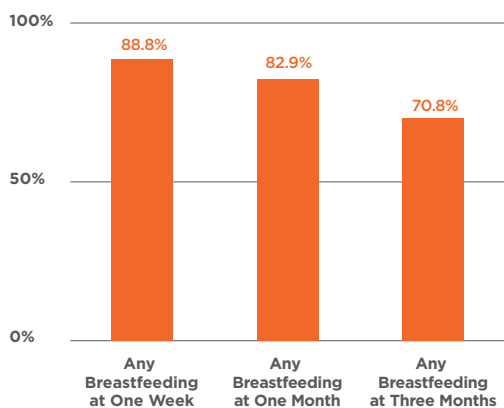
Breastfeeding provides many health benefits for both infants and mothers. It is also less expensive than formula feeding, freeing up household resources for other needs. Tracking breastfeeding can inform our understanding of variation in breastfeeding rates among different groups and the need to reduce barriers to breastfeeding.

MOST RECENT YEAR

Most new mothers in L.A. County reported at least some breastfeeding through three months after birth. In 2016, 88.8 percent of mothers reported any breastfeeding at one week, 82.9 percent reported any breastfeeding at one month, and 70.8 percent reported any breastfeeding at three months after birth.

MOST MOTHERS STILL BREASTFEED AT THREE MONTHS AFTER BIRTH

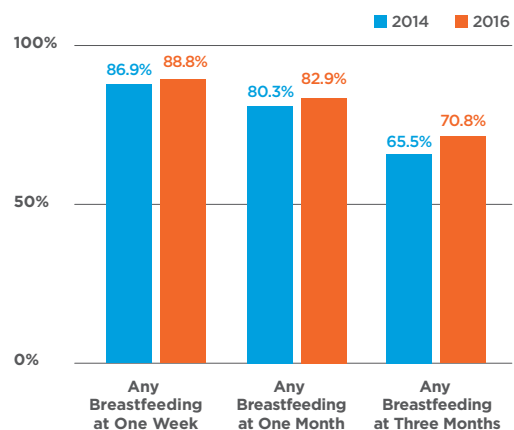
Percentage of Mothers in Los Angeles County Reporting Any Breastfeeding at One Week, One Month and Three Months After Birth, 2016

**TREND**

Between 2014 and 2016 the percentage of mothers breastfeeding at each time interval increased. The percentage of mothers breastfeeding at three months increased the greatest in this time, from 65.5 percent in 2014 to 70.8 percent in 2016. The percentages of mothers breastfeeding at one week and one month have also increased during this time, though these increases were slightly smaller.

BREASTFEEDING RATES HAVE INCREASED

Percentage of Mothers in Los Angeles County Reporting Any Breastfeeding at One Week, One Month and Three Months After Birth, 2014 and 2016

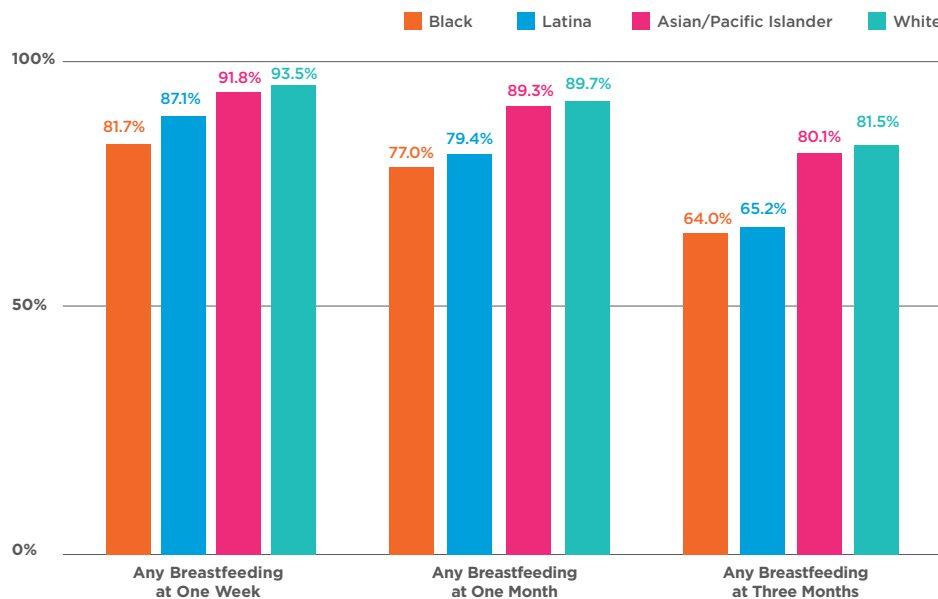


RACE/ETHNICITY DETAIL

In 2016, Black and Latina mothers in L.A. County were less likely to breastfeed at each time interval, with increasing disparity between their White and Asian/Pacific Islander peers over time. At one week after birth, 81.7 percent of Black mothers and 87.1 percent of Latina mothers reported any breastfeeding, compared to 91.8 percent of Asian/Pacific Islander mothers and 93.5 percent of White mothers. By three months after birth, 64 percent of Black mothers and 65.2 percent of Latina mothers reported breastfeeding compared to 80.1 percent of Asian/Pacific Islander mothers and 81.5 percent of White mothers. Despite increases in the percentage of mothers breastfeeding across all race/ethnic groups, this trend is persistent over time, with similar patterns of disparity in breastfeeding rates by race/ethnicity in 2014 and 2016.

BLACK AND LATINA MOTHERS REPORT LESS BREASTFEEDING

Percentage of Mothers in Los Angeles County Reporting Any Breastfeeding at One Week, One Month and Three Months After Birth by Race/Ethnicity, 2016



Trend data by race/ethnicity is available in the Supplemental Tables.

GEOGRAPHIC DETAIL

The percentage of mothers who reported any breastfeeding at three months after the birth of their child varied somewhat by geography. Mothers in SPA 6 (South) reported the lowest rates of any breastfeeding at three months (58.9 percent). SPA 5 (West) had the largest share of mothers reporting any breastfeeding at three months (90.1 percent). The boundaries of *Best Start* geographies overlaid on the map enable a visual approximation of breastfeeding rates in *Best Start* geographies.

SOUTH SPA AND ANTELOPE VALLEY SPA HAVE LOWEST BREASTFEEDING RATES AT THREE MONTHS

Percentage of Mothers in Los Angeles County Reporting Any Breastfeeding at Three Months After Birth, 2016

SPA 1	Antelope Valley	59.9%
SPA 2	San Fernando Valley	71.4%
SPA 3	San Gabriel Valley	71.9%
SPA 4	Metro	77.4%
SPA 5	West	90.1%
SPA 6	South	58.9%
SPA 7	East	67.9%
SPA 8	South Bay	74.2%

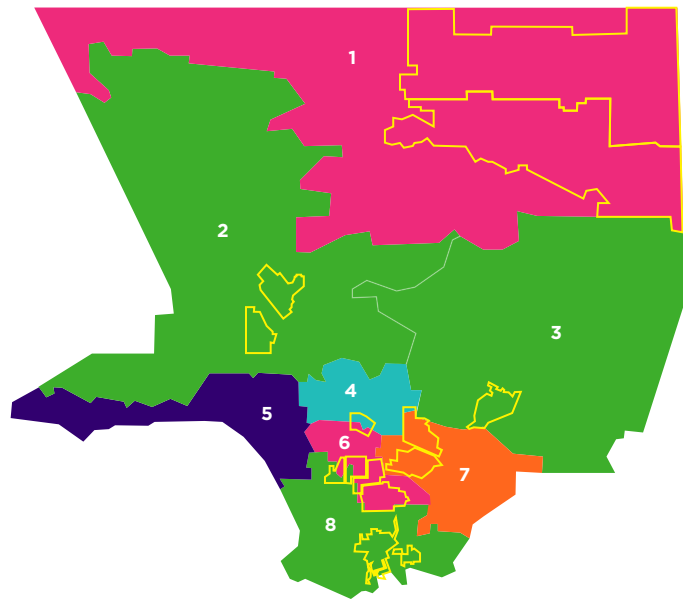
PERCENT BREASTFEEDING AT THREE MONTHS

- 77.5% - 90.1%
- 74.3% - 77.4%
- 68.0% - 74.2%
- 60.0% - 67.9%
- 58.9% - 59.9%

L.A. County Average (70.8%)

 Best Start Geography

Data on breastfeeding at one week and one month by geography is available in the Supplemental Tables.



DATA NOTES AND LIMITATIONS

The breastfeeding data provided illustrates whether mothers reported any breastfeeding at each interval, not whether they were exclusively breastfeeding at each point in time.

Full Indicator Language: Annual percentages of mothers in L.A. County who gave birth in the last year that were breastfeeding at one week, one month, and three months after childbirth.

Source: Los Angeles Mommy and Baby (LAMB) Survey administered by the L.A. Department of Public Health

Educational Attainment

CONTEXTUAL INDICATOR 14

ALMOST 85 PERCENT OF MOTHERS IN L.A. COUNTY HAVE A HIGH SCHOOL DIPLOMA OR HIGHER

This indicator measures the annual percentage of mothers of newborns (women who gave birth to an infant in a given year) in Los Angeles County by their highest level of education completed.

Why is it important?

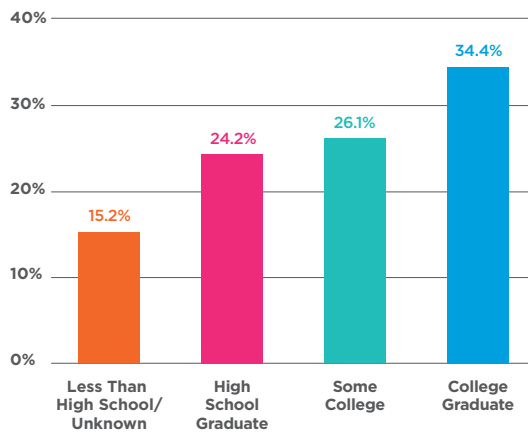
Parental education levels are associated with child outcomes such as birth weight, educational attainment, academic achievement and health. Additionally, parent education levels are linked to family income stability, which supports child development and opportunity.

MOST RECENT YEAR

In 2017, one-third (34.4 percent) of mothers in L.A. County were college graduates and nearly one-quarter (24.2 percent) were high school graduates. One-quarter (26.1 percent) had some college. Taken together, fully 84.7 percent of mothers had a high school degree or higher. Nearly 1 in 7 mothers (15.2 percent) had less than a high school degree or their educational attainment level was unknown.

6 IN 10 MOTHERS IN L.A. COUNTY HAVE SOME COLLEGE OR A COLLEGE DEGREE

Percentage of Mothers of Newborns in Los Angeles County by Highest Level of Education Completed, 2017

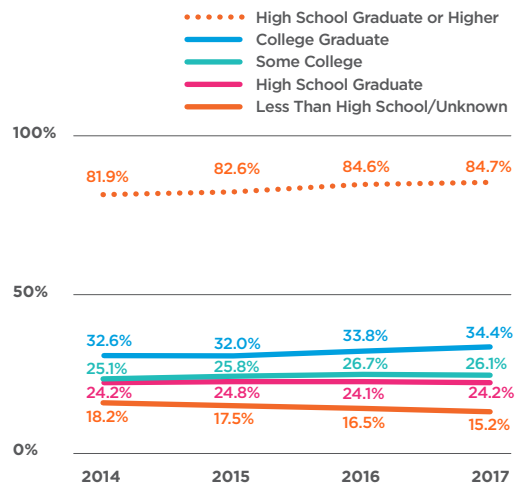


TREND

Between 2014 and 2017, the educational attainment of mothers with children birth through age 5 in L.A. County increased slightly. In 2014, 81.9 percent of mothers had a high school diploma or higher, compared to 84.7 percent in 2017. There was a slight decrease over this time in the percentage of mothers with less than a high school degree or with unknown educational attainment status. The percentage of mothers who graduated from college has increased slightly, from 32.6 percent in 2014 to 34.4 percent in 2017.

EDUCATIONAL ATTAINMENT OF MOTHERS INCREASED SLIGHTLY

Percentage of Mothers of Newborns in Los Angeles County by Highest Level of Education Completed, 2014-2017

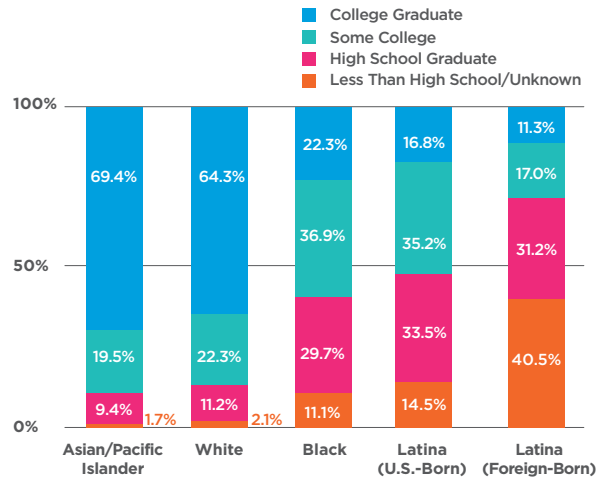


RACE/ETHNICITY DETAIL

In 2017, among Asian/Pacific Islander mothers, nearly all had a high school degree or higher and fully 69.4 percent had a college degree. Similarly, nearly all White mothers had a high school degree or higher and 64.3 percent had a college degree. While most Black and Latina mothers had high school degree or higher (88.9 percent and 85.5 percent, respectively) the proportion with a college degree (22.3 percent and 16.8 percent, respectively) was substantially less than Asian/Pacific Islander and White mothers. Foreign-born Latina mothers had the lowest level of educational attainment, with only 59.5 percent having a high school diploma or higher and 11.3 percent with a college degree. Educational attainment levels have increased over the past four years for all race/ethnic groups except Asian/Pacific Islanders.

SUBSTANTIAL RACE/ETHNIC DISPARITIES IN EDUCATIONAL ATTAINMENT

Percentage of Mothers of Newborns in Los Angeles County by Highest Level of Education Completed and Race/Ethnicity, 2017



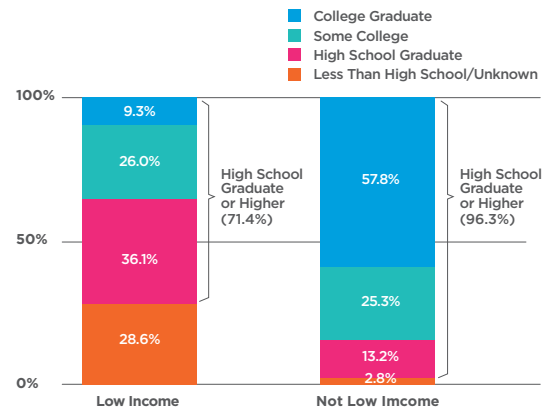
Race/ethnicity trend data is available in the Supplemental Tables.

SOCIOECONOMIC STATUS DETAIL

Among mothers with low income, 71.4 percent had a high school degree or higher, while for mothers without low income, the percentage with a high school degree or higher was 96.3 percent.

EDUCATIONAL ATTAINMENT STRONGLY CORRELATES WITH INCOME STATUS

Percentage of Mothers of Newborns in Los Angeles County by Highest Level of Education Completed and Socioeconomic Status, 2017



Income trend data is available in the Supplemental Tables.

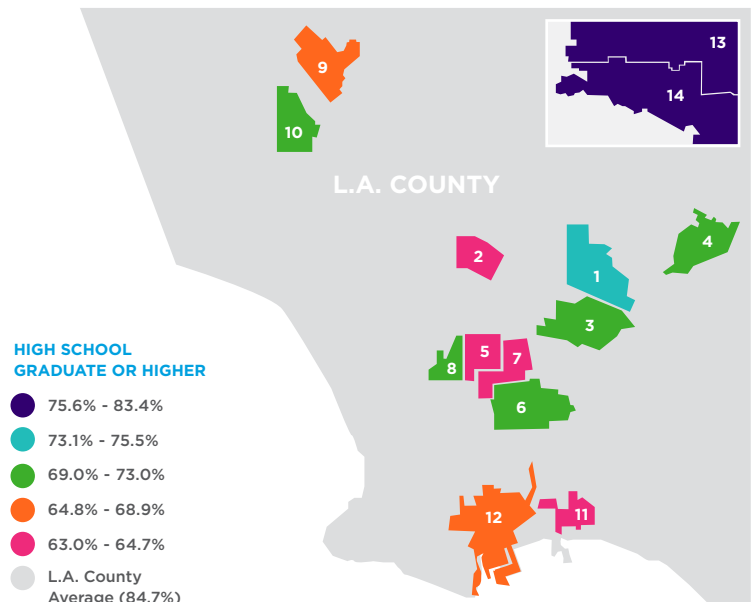
GEOGRAPHIC DETAIL

Mothers in all *Best Start* geographies had lower levels of educational attainment than the county average. In 2017, 84.7 percent of all mothers in L.A. County with children birth through five had attained a high school degree or higher. Mothers in Lancaster and Palmdale had the highest educational attainment within the *Best Start* geographies, with 83.5 percent and 80.0 percent, respectively, having a high school degree or higher. Mothers in Watts-Willowbrook had the lowest percentage of mothers with a high school degree or higher, at 62.9 percent.

ALL BEST START GEOGRAPHIES HAVE LOWER THAN AVERAGE MATERNAL EDUCATIONAL ATTAINMENT

Percentage of Mothers of Newborns in Los Angeles County Who Have a High School Degree or Higher by *Best Start* Geography, 2017

REGION 1		
1	East LA	75.6%
2	Metro LA	64.3%
3	Southeast LA	72.9%
4	South El Monte/El Monte	71.4%
REGION 2		
5	Broadway-Manchester	64.6%
6	Compton	71.9%
7	Watts-Willowbrook	62.9%
8	West Athens	70.4%
REGION 3		
9	Northeast Valley Communities	68.9%
10	Panorama City & Neighbors	71.7%
REGION 4		
11	Central Long Beach	64.1%
12	Wilmington	65.9%
REGION 5		
13	Lancaster	83.5%
14	Palmdale	80.0%



Geographic trend data is available in the Supplemental Tables.

DATA NOTES AND LIMITATIONS

These estimates were developed by the Children’s Data Network using vital birth records maintained by the California Department of Public Health. Each year presented equates to the educational attainment level of women who gave birth to an infant that year. Estimates by socioeconomic status are a proxy based on the birth payment method, where births paid for by public health insurance were considered low income and births paid for by private insurance or self-pay were considered not low income. Totals produced for this local analysis may differ from other published sources; these should not be considered official county or state birth statistics.

Full Indicator Language: Annual percentages of mothers with children birth through age 5 in L.A. County by their highest level of education completed.

Source: Children’s Data Network at the University of Southern California

Assets at Birth

CONTEXTUAL INDICATOR 15

GEOGRAPHIC AND RACE/ETHNIC DISPARITIES IN ACCESS TO ASSETS AT BIRTH

This indicator measures the annual average number of assets a child has at birth in Los Angeles County according to the California Strong Start Index (CASSI). The CASSI measures 12 assets across family, health, service and financial domains.

Why is it Important?

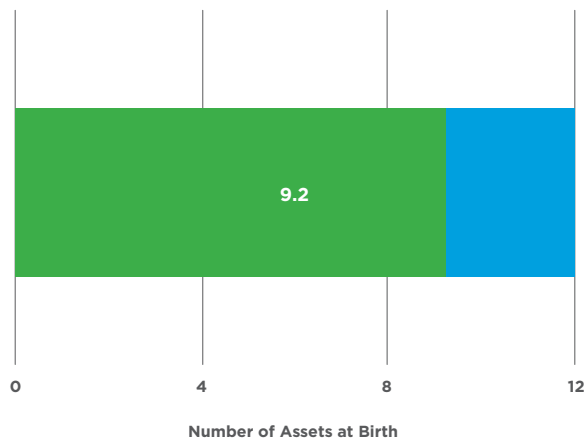
Birth asset scores, which summarize the conditions in which children are born, reveal variation in access to resources by identifying communities in which children have fewer assets at birth. Understanding these variations can inform the allocation of services and supports to address historic underinvestment and promote greater equity. Making these investments early in a child's life can have the greatest impact.

MOST RECENT YEAR

In 2017, Los Angeles County children had an average of 9.2 assets out of 12 at birth.

ON AVERAGE, L.A. COUNTY CHILDREN ARE BORN WITH 9.2 OUT OF 12 POSSIBLE ASSETS

Average Number of Assets of Children at Birth in Los Angeles County, 2017

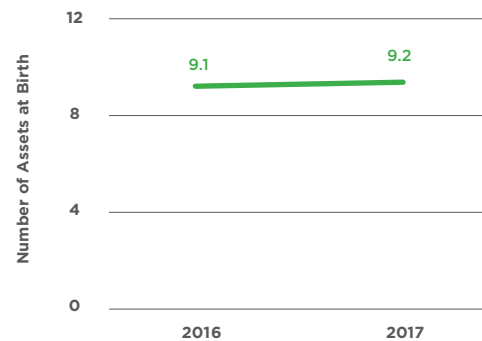


TREND

The CASSI is a new tool that, as of report publication, has only two years of results available: 2016 and 2017. There was little variation in average access to assets between these two vintages of data — 9.1 and 9.2, respectively.

NUMBER OF ASSETS AT BIRTH REMAINS STEADY

Average Number of Assets of Children at Birth in Los Angeles County, 2016 and 2017

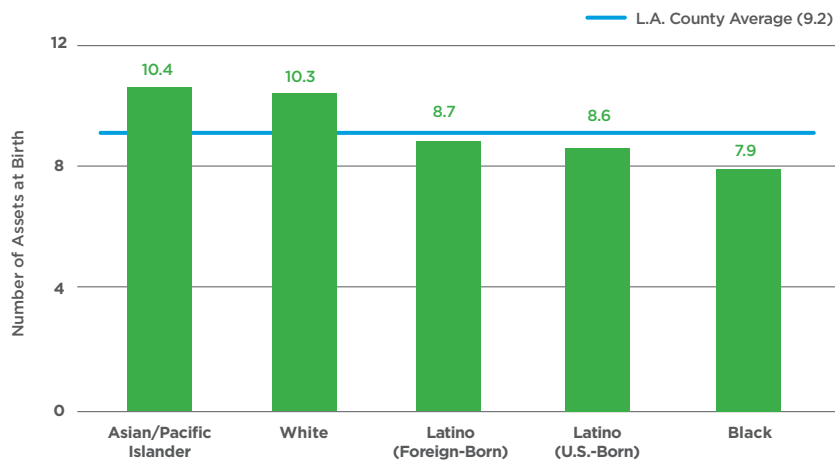


RACE/ETHNICITY DETAIL

Calculations of assets at birth for different racial and ethnic groups reveal inequities in access to resources. Children born to Black mothers had an average of 7.9 assets at birth compared to 8.6 assets for children born to U.S.-born Latina mothers and 8.7 assets for children born to foreign-born Latina mothers. The children of both White and Asian/Pacific Islander mothers had the greatest access to assets — 10.3 and 10.4 assets, respectively.

ASSETS AT BIRTH BY RACE/ETHNICITY REVEAL INEQUITIES IN RESOURCE ACCESS

Average Number of Assets of Children at Birth in Los Angeles County by Race/Ethnicity of the Mother, 2017



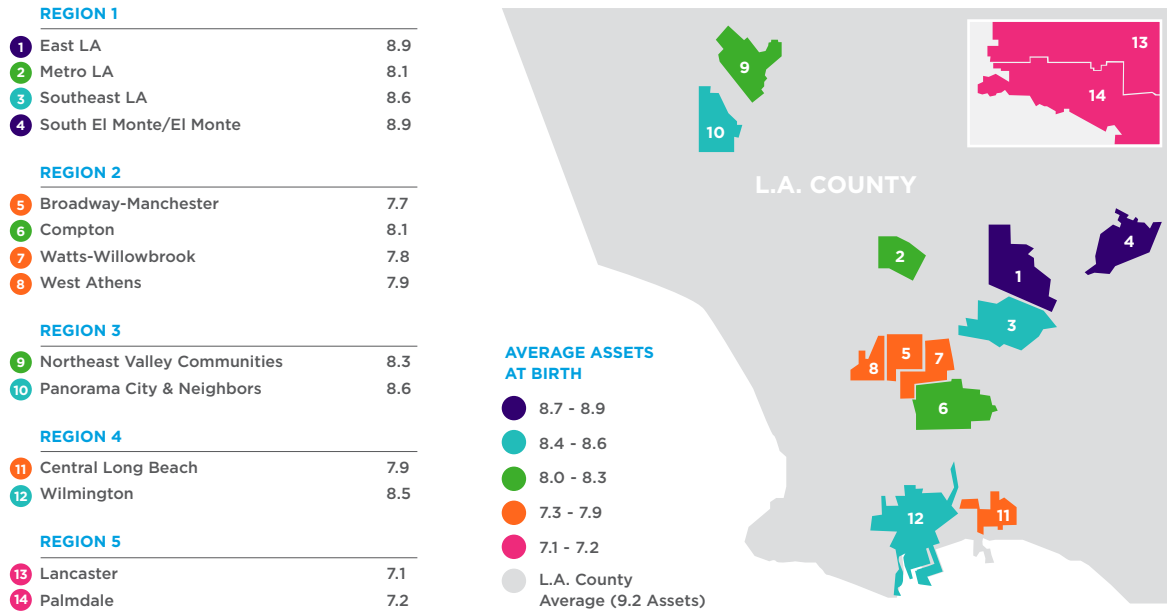
Data for 2016 by race/ethnicity is available in the Supplemental Tables.

GEOGRAPHIC DETAIL

On average, children born in all of First 5 LA's *Best Start* geographies had fewer assets at birth than the countywide average.

ALL BEST START GEOGRAPHIES HAVE LOWER THAN AVERAGE ASSET SCORES

Average Number of Assets of Children at Birth in Los Angeles County by *Best Start* Geography, 2017



California Strong Start Indicators

FAMILY

- Legal parentage established at birth
- Born to non-teen parents
- Born to parents with at least a high school diploma

HEALTH

- Healthy birth weight
- Absence of congenital anomalies, abnormalities or complications at birth
- Absence of transmissible (mother-to-child) infections

SERVICE

- Access to and receipt of timely prenatal care
- Receipt of nutritional services (WIC) if eligible
- Hospital with high percentage of births with timely prenatal care

FINANCIAL

- Ability to afford and access health care
- Born to a parent with a college degree
- Born to parents with employment history

Full indicator language: Annual average number of assets at birth in L.A. county

Source: California Strong Start Index

Children Living in Poverty

CONTEXTUAL INDICATOR 16

NEARLY A QUARTER OF L.A. COUNTY YOUNG CHILDREN LIVE IN POVERTY

This indicator measures the percentage of Los Angeles County children birth through age 5 who live in poverty based on the federal poverty thresholds. The poverty threshold varies depending on the size of the household. For example, the poverty threshold for a 4-person household with two children was \$25,465 in 2018.

Why is it Important?

Living in poverty is associated with an array of risk factors, yet research indicates that even modest increases in earnings for low-income families with young children can have lasting positive outcomes for the children. Tracking poverty is also important for understanding demand for public or subsidized services.

Current Context

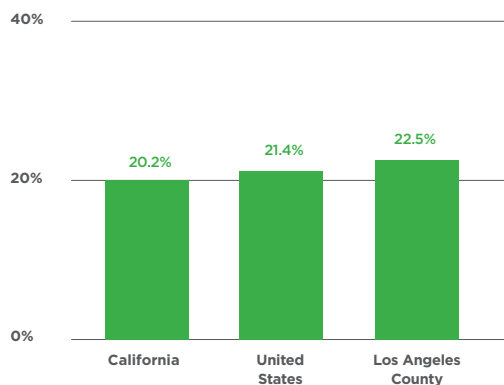
The worldwide COVID-19 pandemic is having massive, and likely long-lasting, economic impacts on family financial stability. Federal aid and the expansion of unemployment benefits kept many legal residents from slipping into poverty, but as of publication, it remains to be seen if these supports will be continued as long as they are needed. If not, young families, who may be near the start of their working lives and earning less, are among the populations particularly vulnerable to the economic stresses wrought by the pandemic. Other vulnerable populations include undocumented workers who did not receive relief, even if they have children that are U.S. citizens.

MOST RECENT YEAR

In 2018, 22.5 percent of L.A. County children from birth through age 5 lived in poverty. This rate was slightly higher than the state (20.2 percent) and nation (21.4 percent).

YOUNG CHILD POVERTY IS SLIGHTLY HIGHER IN L.A. COUNTY THAN THE STATE AND NATION

Percentage of Los Angeles County Children Birth Through Age 5 Living in Poverty Compared to California and the United States, 2018

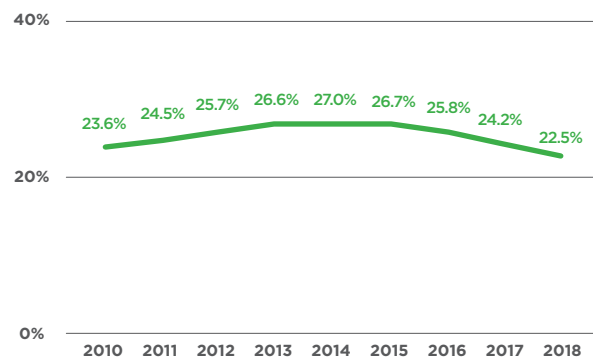


TREND

Since 2010, the poverty rate for L.A. County's young children reached a high of 27.0 percent in 2014, but has been declining ever since, falling to 22.5 percent in 2018. The U.S. and California poverty rates for young children follow similar trends as L.A. County.

POVERTY RATE DECLINED OVER FOUR CONSECUTIVE YEARS

Percentage of Los Angeles County Children Birth Through Age 5 Living in Poverty, 2010-2018

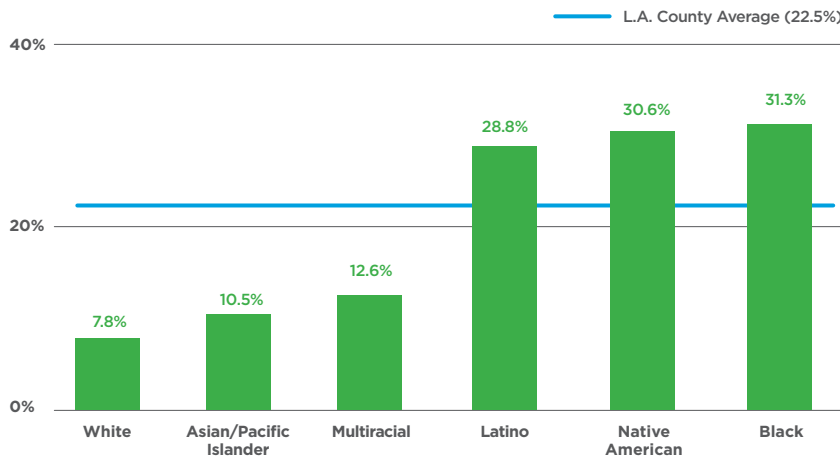


RACE/ETHNICITY DETAIL

Black, Native American and Latino young children were substantially more affected by poverty than their White, Asian/Pacific Islander and multiracial peers. The poverty rate was four times higher among Black young children than White young children.

SUBSTANTIAL RACIAL AND ETHNIC DISPARITIES IN POVERTY RATES

Percentage of Los Angeles County Children Birth Through Age 5 Living in Poverty by Race or Ethnicity, 2018



California Poverty Measure

The California Poverty Measure (CPM) estimates the proportion of Los Angeles County children from birth through age 5 living in poverty. Unlike the official Federal Poverty Rate, which is displayed in this indicator, the CPM accounts for California’s high cost of living and a range of family needs and resources, including social safety net benefits. It is considered a more accurate estimate of poverty, but the ability to disaggregate data by subgroup is limited due to the smaller sample size.

POVERTY AMONG LOS ANGELES COUNTY CHILDREN FROM BIRTH THROUGH AGE 5 ACCORDING TO THE CALIFORNIA POVERTY MEASURE:

- 23.2% of all Los Angeles County children (2017)
- 32.8% of Latino children (2015-17)
- 12.3% of White children (2015-17)
- 18.1% of children from all other backgrounds (2015-17)

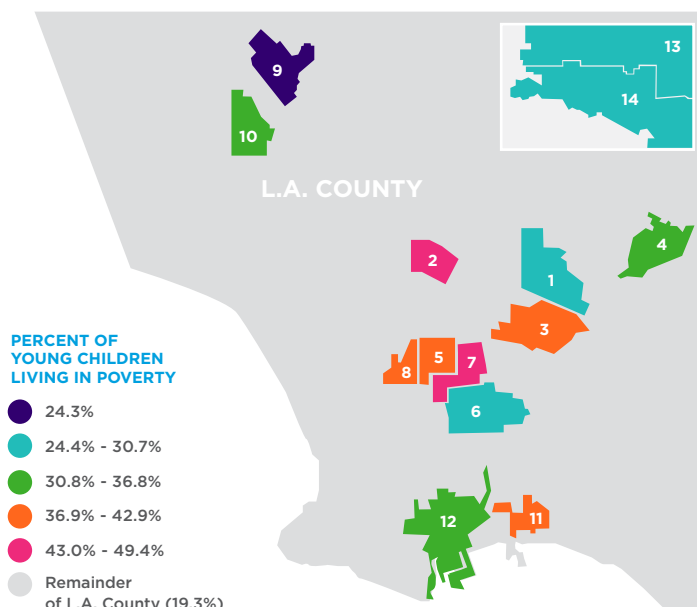
GEOGRAPHIC DETAIL

Nearly half (49.4 percent) of young children living in the Metro LA *Best Start* geography in 2018 were living in poverty, followed by 44.8 percent of young children in Watts-Willowbrook. All *Best Start* geographies have higher rates of young child poverty than the countywide average (22.5 percent) and the average of the remainder of L.A. County (19.3 percent in the area outside of the *Best Start* geographies).

ONE-QUARTER TO ONE-HALF OF YOUNG CHILDREN IN BEST START GEOGRAPHIES ARE LIVING IN POVERTY

Percentage of Los Angeles County Children Birth Through Age 5 Living in Poverty by *Best Start* Geography, 2018

REGION 1		
1	East LA	28.1%
2	Metro LA	49.4%
3	Southeast LA	39.6%
4	South El Monte/El Monte	32.8%
REGION 2		
5	Broadway-Manchester	40.1%
6	Compton	29.2%
7	Watts-Willowbrook	44.8%
8	West Athens	42.9%
REGION 3		
9	Northeast Valley Communities	24.3%
10	Panorama City & Neighbors	36.8%
REGION 4		
11	Central Long Beach	41.1%
12	Wilmington	33.0%
REGION 5		
13	Lancaster	30.7%
14	Palmdale	29.4%



DATA NOTES AND LIMITATIONS

The data is sourced to the American Community Survey and represents 5-year estimates, where 2018, for example, is the combination of data from 2014, 2015, 2016, 2017 and 2018 survey years. Survey respondents are asked to identify their race (White, Black, Native American, Asian, Pacific Islander, two or more races, or some other race) and their ethnicity (Latino or non-Latino). For the data displayed, the racial category White is non-Latino; all other racial categories may include Latino or non-Latino. Latino may include any race.

Full Indicator Language: Annual percentage of children birth through age 5 in L.A. County living in poverty.

Source: U.S. Census Bureau, American Community Survey, 2010-2018, 5-Year Estimates, Tables B17001 and B17001A-I

Food Insecurity

CONTEXTUAL INDICATOR 17

1 IN 4 FAMILIES WITH LOWER INCOME EXPERIENCE FOOD INSECURITY

This indicator measures food insecurity among low-to-moderate income families with young children. It is calculated as the annual percentage of Los Angeles County households with children birth through age 5 with incomes less than 300 percent of the federal poverty level (FPL) that experience food insecurity. A household is considered food insecure if it faces barriers at some time during the year to purchasing healthy foods like fruits, vegetables, lean meats and foods high in fiber.

Why is it Important?

Food insecurity is associated with many poor health outcomes, and children in food-insecure households may experience delayed development, diminished academic performance, impaired social skills and early onset of obesity. Tracking food insecurity builds awareness of how many families are struggling to afford food on top of child care, housing and other basic needs. It can also lead to interventions that address historic underinvestment and improve access to fresh, affordable foods in neighborhoods where access is limited.

MOST RECENT YEAR

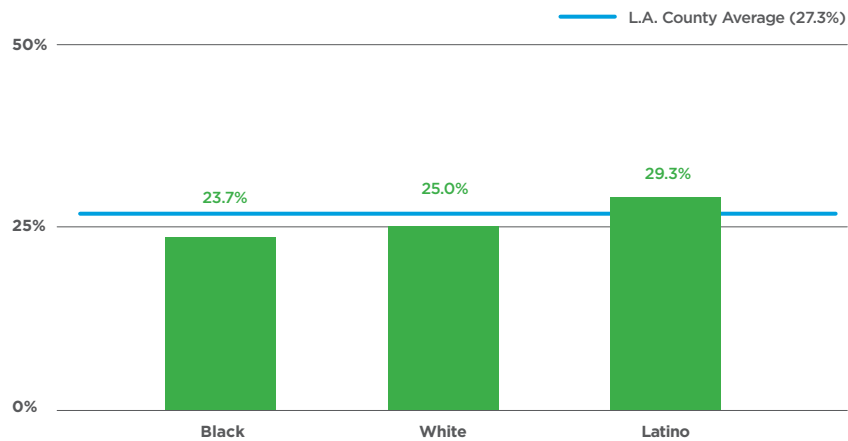
In 2018, just over one-quarter of families (27.3 percent) with low-to-moderate income who had children birth through age 5 experienced food insecurity.

RACE/ETHNICITY DETAIL

In 2018, 29.3 percent of Latino families with low-to-moderate income with young children experienced food insecurity, compared to one-quarter (25.0 percent) of peer White families and 23.7 percent of peer Black families.

LATINO FAMILIES EXPERIENCE HIGHER RATES OF FOOD INSECURITY

Percentage of L.A. County Families With Incomes Less than 300 Percent Federal Poverty Level That Have Children Birth Through Age 5 That Experience Food Insecurity by Race/Ethnicity, 2018



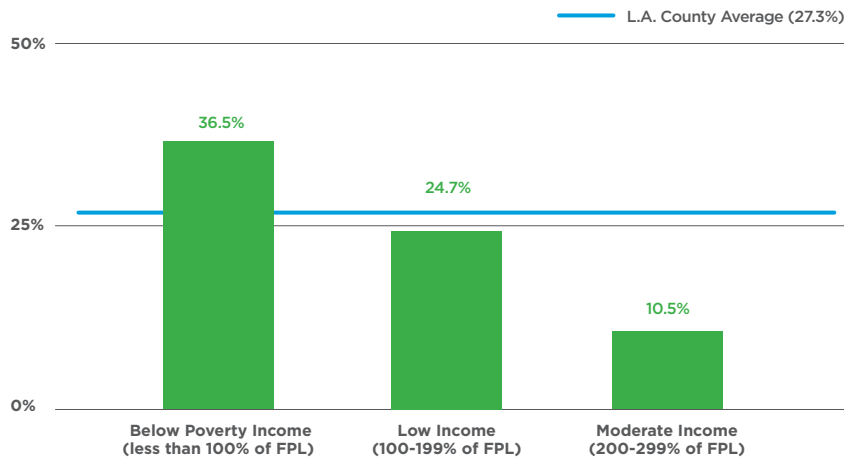
Results for White families are considered unstable.

SOCIOECONOMIC STATUS DETAIL

Families with less income experienced greater food insecurity. More than a third (36.5 percent) of families with incomes below the poverty level experienced food insecurity, compared to one-quarter (24.7 percent) of families with low income and one-tenth (10.5 percent) of families with moderate income.

FAMILIES WITH LESS INCOME EXPERIENCE GREATER FOOD INSECURITY

Percentage of L.A. County Families with Children Birth Through Age 5 That Experience Food Insecurity by Income Level, 2018



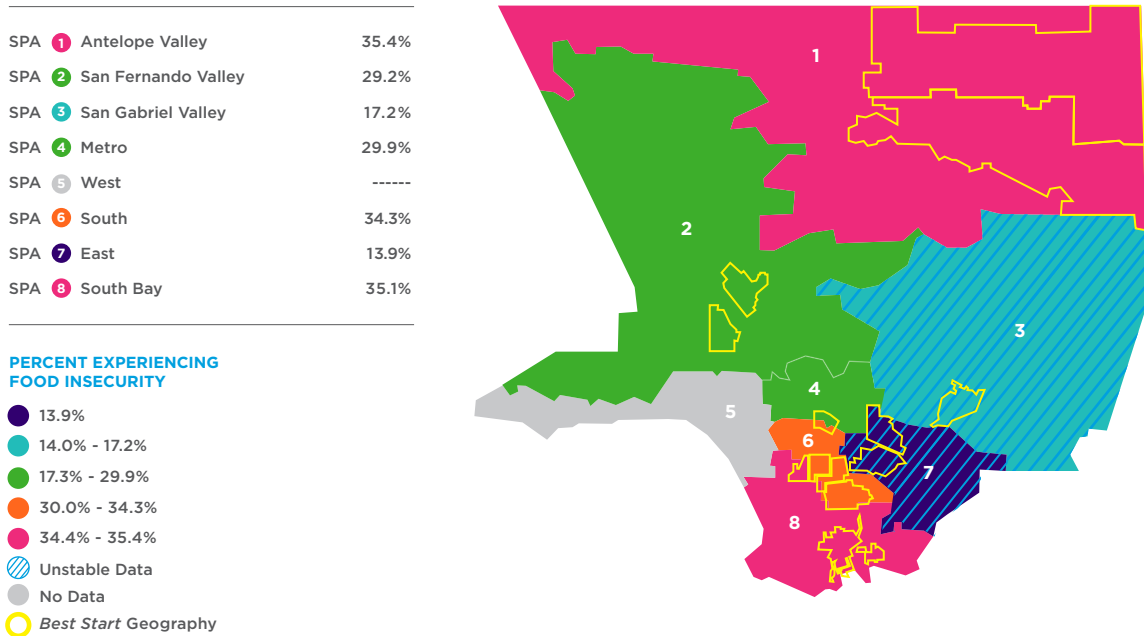
Results for families with incomes between 200 and 299 percent of the federal poverty level (FPL) are considered unstable.

GEOGRAPHIC DETAIL

Countywide, 27.3 percent of families with young children were food insecure and most *Best Start* geographies were in SPAs that had higher than average food insecurity rates. The highest rates were in SPA 1, where 35.4 percent of families below 300 percent FPL with children birth to age 5 experienced food insecurity, and SPA 8, where 35.1 percent of families experienced food insecurity. SPA 3 and SPA 7 experienced the lowest rates of food insecurity, at 17.2 percent and 13.9 percent, respectively; however, the data is unstable for these two areas.

MOST SPA REGIONS HAVE HIGHER THAN AVERAGE FOOD INSECURITY RATES

Percentage of L.A. County Families with Incomes Less than 300 Percent Federal Poverty Level That Have Children Birth Through Age 5 That Experience Food Insecurity by SPA, 2018



Data for Service Planning Area 5 (West) are not available and data for SPA 3 (San Gabriel Valley) and SPA 7 (East) are considered unstable.

DATA NOTES AND LIMITATIONS

Due to changes in data analysis methodology, trend data over time is not available for this measure. The percentage of families that experience food insecurity is statistically unstable for the following data points: White families, families with incomes between 200 and 299 percent of FPL, families in San Gabriel Valley SPA, and families in East SPA; this data may not be appropriate for planning or policy purposes. For a family of four with two children in 2018, less than 300 percent FPL is equivalent to a household income under \$76,395. For the same family size and makeup, less than 200 percent FPL is equivalent to a household income of less than \$50,930, and poverty level is household income less than \$25,465. Thresholds vary depending on the size and makeup of the household.

Full Indicator Language: Annual percentage of households with children birth through age 5 in L.A. County who experience food insecurity.

Source: L.A. County Health Survey

Children Experiencing Homelessness

CONTEXTUAL INDICATOR 18

NUMBER OF YOUNG CHILDREN EXPERIENCING HOMELESSNESS GROWS

This indicator measures the number of children from birth through age 5 who experienced homelessness at least one month of a given year. The data reflects children who have been identified as homeless in records from the Homeless Management Information System, the Los Angeles County Department of Public Social Services, and the Los Angeles County Department of Children and Family Services.

Why is it Important?

Experiencing homelessness in youth is widely acknowledged as a risk factor for behavioral health challenges, inconsistent school attendance, below average academic performance and poorer health. Tracking the number of young children experiencing homelessness can inform our understanding of the magnitude of children at risk for these poor outcomes and the demand for housing and supportive services for families.

MOST RECENT YEAR

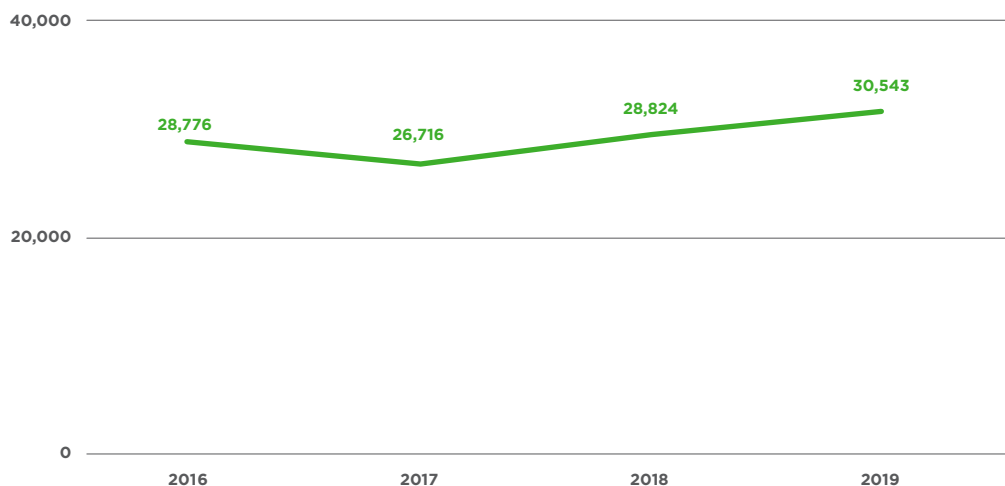
In 2019, there were an estimated 30,543 children from birth through age 5 who experienced homelessness for a least one month during the year.

TREND

Between 2016 and 2019, the number of young children experiencing homelessness grew 6 percent, from 28,776 in 2016 to 30,543 in 2019, which is the highest count in the four years of data available.

SIX PERCENT GROWTH IN YOUNG CHILD HOMELESSNESS OVER FOUR YEARS

Number of Los Angeles County Children from Birth Through Age 5 Experiencing Homelessness, 2016-2019

**DATA NOTES AND LIMITATIONS**

The three source agencies do not necessarily operate with the same definition or criteria for homelessness. As such, the de-duplicated totals are not standardized or uniform in terms of definitions. LAHSA considers homelessness as an individual or family who lacks a fixed, regular and adequate nighttime residence. DPSS, which administers CalWORKS, and DCFS have broader definitions that include children and families who do not have access to a long-term housing option.

Full Indicator Language: Annual number of children birth through age 5 in L.A. County who experience homelessness.

Source: Los Angeles County Chief Executive Office analysis of records from the Homeless Management Information System administered by the Los Angeles Homeless Services Authority (LAHSA) and the Los Angeles County Departments of Public Social Services (DPSS) and Children and Family Services (DCFS)

Healthy Places Index

CONTEXTUAL INDICATOR 19

WIDE DISPARITIES IN L.A. COUNTY NEIGHBORHOOD CONDITIONS

This indicator measures the annual percentile rank of Los Angeles County compared to other California counties on the California Healthy Places Index (HPI), which assesses community conditions that affect health outcomes. A rank closer to 100 indicates healthier community conditions and a rank closer to zero indicates less healthy community conditions. HPI is a new tool and therefore only one year of data is available to date.

Why is it Important?

Physical health and longevity are not only influenced by healthy behaviors and genetics; they are influenced by access to social and economic opportunities, such as good schools, safe neighborhoods and access to fresh foods. Collectively, these social and economic factors are referred to as the social determinants of health. The HPI provides a way to understand the social determinants of health at the neighborhood level by looking at community conditions that predict life expectancy. For example, tools like the HPI can shed light on long-standing racial and ethnic inequities that impact neighborhood conditions and children's healthy development. This type of examination can inform cross-sector policy and advocacy actions that address systemic racism and improve neighborhood conditions, public health and individual well-being.

MOST RECENT YEAR

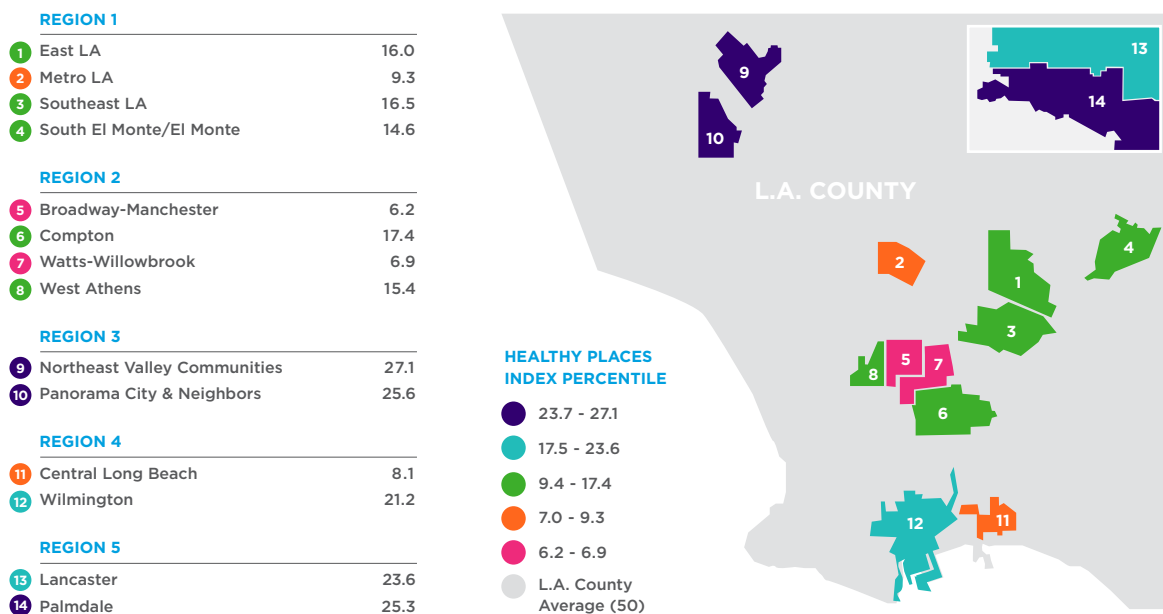
Los Angeles County has an overall HPI percentile score of 50, which indicates that L.A. County has healthier overall community conditions than 50 percent of other California counties.

GEOGRAPHIC DETAIL

Large disparities in community conditions were found across L.A. County. All *Best Start* geographies had HPI index percentiles that were lower than the county average. HPI index scores of *Best Start* geographies ranged from 6.2 in Broadway-Manchester to 27.1 in Northeast Valley Communities. A 6.2 percentile score means that 93.8 percent of other California communities have healthier conditions than Broadway-Manchester. Similarly, a score of 27.1 means that 72.9 percent of California communities have healthier conditions than Northeast Valley Communities.

ALL BEST START GEOGRAPHIES HAVE SCORES THAT ARE LOWER THAN THE COUNTY AVERAGE

Healthy Places Index Percentile Scores by *Best Start* Geography, 2018



DATA NOTES AND LIMITATIONS

The California Healthy Places Index incorporates data from multiple domains into a single community health index score. The HPI score is the sum of its eight weighted Policy Action Areas: Economic, Education, Transportation, Social, Neighborhood, Housing, Clean Environment, and Health Care Access. The final HPI scores are then assigned a percentile rank, with ranks closer to 100 indicating healthier community conditions and ranks closer to 0 indicating less healthy community conditions.

Full Indicator Language: Annual percentile rank of L.A. County compared to other California counties on community conditions which affect health outcomes.

Source: The California Healthy Places Index (HPI) from the Public Health Alliance of California

Access to Transit

CONTEXTUAL INDICATOR 20

NUMBER OF TRANSIT STOPS EVENLY MATCHED TO THE NUMBER OF FAMILIES IN MOST OF L.A. COUNTY

This indicator measures the level of access to transit services that Los Angeles County families with children from birth through age 5 have by comparing the number of transit stops (bus, rail and metro) to the number of families with young children in a given zip code. Each zip code is designated as having a high, medium or low number of stops, and having a high, medium, or low number of families with young children. A match is considered an average or expected level of access (such as, a medium

number of stops and a medium number of families). A mismatch could signal either better access (such as a high number of stops and low number of families) or poorer access (such as a low number of stops and a high number of families).

Why is it important?

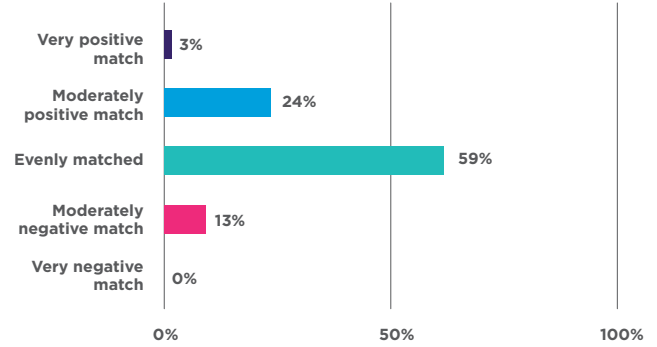
Transit access is important for families that cannot afford to, or choose not to, own a car. Lack of safe, accessible and affordable transportation to work, school, child care or errands contributes to family stress. Transportation barriers are also cited as barriers to accessing health care, including parents seeking care for themselves or well-child and sick visits for their children.

MOST RECENT YEAR

Over half (59 percent) of L.A. County zip codes had an even match between the number of stops and the number of young families. Another 24 percent had a moderately positive match and 3 percent had a very positive match, which is signified by having a high number of stops and a low number of families. Still, 13 percent of zip codes had a moderately negative match between the number of stops and families, but no zip codes had a very negative match.

TRANSIT ACCESS EVENLY MATCHED IN MOST OF COUNTY

Assessment of the Match Between the Number of Transit Stops and the Number of Families With Young Children in Los Angeles County Zip Codes, 2019



GEOGRAPHIC DETAIL

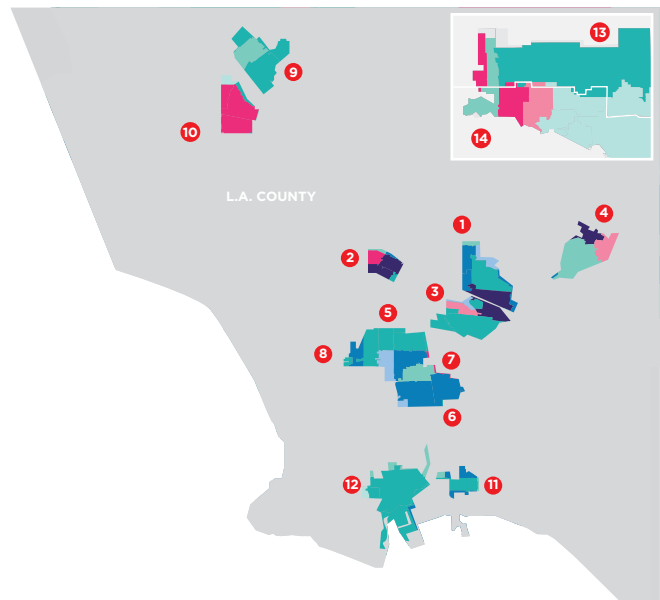
The map shows the *Best Start* geography boundaries overlaid onto the zip codes. A visual assessment reveals that most *Best Start* geographies had evenly or positively matched numbers of families and numbers of transit stops. Exceptions include parts of Palmdale, Lancaster and nearly all of Panorama City & Neighbors. Small portions of Metro LA, Southeast LA and South El Monte/El Monte also had lower than average access.

MOST BEST START GEOGRAPHIES HAVE EVENLY OR POSITIVELY MATCHED ACCESS TO TRANSIT

Assessment of the Match Between the Number of Transit Stops and the Number of Families With Young Children in Los Angeles County Zip Codes With *Best Start* Geography Overlays, 2019

- REGION 1**
 - 1 East LA
 - 2 Metro LA
 - 3 Southeast LA
 - 4 South El Monte/El Monte
- REGION 2**
 - 5 Broadway-Manchester
 - 6 Compton
 - 7 Watts-Willowbrook
 - 8 West Athens
- REGION 3**
 - 9 Northeast Valley Communities
 - 10 Panorama City & Neighbors
- REGION 4**
 - 11 Central Long Beach
 - 12 Wilmington
- REGION 5**
 - 13 Lancaster
 - 14 Palmdale

INTERPRETATION	NUMBER OF FAMILIES	NUMBER OF STOPS
Very Positively Matched	Low	High
Moderately Positively Matched	Medium	High
	Low	Medium
Evenly Matched	High	High
	Medium	Medium
	Low	Low
Moderately Negatively Matched	High	Medium
	Medium	Low



DATA NOTES AND LIMITATIONS

Transit stop data is from 2019. Counts of families with children under 6 are from 2018. Please see the Methods section for detailed information on the methodology and limitations of this analysis.

Full Indicator Language: Annual percentage of families with children birth through age 5 in L.A. County who use public transit.

Source: Metro (number of stops); U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2018 (families with children under age 6)

Acknowledgments

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Advancement Project California
California Department of Education
California Department of Health Care Services
California Department of Public Health
California Department of Social Services
Child360
Child Care Alliance of Los Angeles:
- Child Care Resource Center
- City of Norwalk
- Connections for Children
- Crystal Stairs, Inc.
- Drew Child Development Corporation
- International Institute of Los Angeles
- Mexican American Opportunity Foundation
- Options for Learning
- Pathways LA
- Pomona Unified School District – Resource & Referral
Children’s Data Network, University of Southern California
Children’s Home Society of California
Early Edge California

Family Resource Center Network of Los Angeles County:
- Carolyn Kordich Family Resource Center
- Family Focus Resource & Empowerment Center
- Family Resource Library (Eastern Los Angeles)
- Harbor Regional Center
- The Koch-Young Resource Center
- Long Beach Family Resource Center
- San Gabriel/Pomona Parents’ Place Family Resource and Empowerment Center
- South Central Los Angeles Regional Center
- Early Start Family Resource Center
- Southeast Family Resource Center
- Southwest Special Education Family Resource Center
- Westside Family Resource and Empowerment Center
Los Angeles Best Babies Network
Los Angeles County Chief Executive Office
Los Angeles County Chief Information Office
Los Angeles County Child Care Planning Committee
Los Angeles County Department of Child and Family Services
Los Angeles County Department of Parks and Recreation

Los Angeles County Department of Public Health:

- Division of Maternal, Child and Adolescent Health
- Office for the Advancement of Early Care and Education
- Office of Health Assessment and Epidemiology

Los Angeles County Department of Public Social Services

Los Angeles County Metropolitan Transportation Authority

Los Angeles County Office of Child Protection

Los Angeles County Office of Education

Los Angeles Homeless Services Authority

Los Angeles Regional Centers for the Developmentally Disabled:

- East Los Angeles Regional Center
- Frank D. Lanterman Regional Center
- Harbor Regional Center
- North Los Angeles County Regional Center
- South Central Los Angeles Regional Center
- San Gabriel/Pomona Regional Center
- Westside Regional Center

Partnerships for Education, Articulation and Coordination through Higher Education

Public Health Alliance of Southern California

Public Health Foundation Enterprises WIC Research and Evaluation Department

Public Policy Institute of California

Quality Start Los Angeles

In addition to these valued partners, First 5 LA executive leadership would like to acknowledge the guidance and expertise that the First 5 LA Board of Commissioners lent to this effort. We also would like to express our appreciation to the First 5 LA Department of Measurement, Learning and Evaluation, which managed the development of the report, and to First 5 LA staff across the agency who contributed many hours to the effort to ensure that the content of this report is meaningful, actionable and accurate. Finally, we would like to thank [Parsons Consulting](#) and [Datalink Partners](#) for their writing, data analysis and mapping development services, and [Bumpercar, Inc](#) for their graphic design services.

FULL INDICATOR LANGUAGE

The indicators presented in this report aim to measure the specific results or conditions listed below. The Results Indicators are worded in an objective format, using “increased” or “decreased” to signal the outcome First 5 LA is seeking for each indicator. The Contextual Indicators do not include objective language since they are meant to present the conditions of young children and their families and are not tied to specific desired results.

In some cases, data was not available to measure the precise result or condition specified, so alternative data was presented for the time being. Because of this, the descriptions below may not match the data presented in the associated indicator.

RESULTS INDICATORS

- RI No. 1** Increased rate of L.A. County children birth through age 5 enrolled in a high-quality early care and education program.
- RI No. 2** Increased rate of income-eligible L.A. County children birth through age 5 enrolled in publicly funded early care and education programs.
- RI No.3** Increased rate of L.A. County children birth through age 5 with a developmental delay participating in early intervention services.
- RI No. 4** Decreased average age of L.A. County children entering into special education services.
- RI No. 5** Decreased rate of L.A. County children with Child Protective Services involvement at any point during the first 5 years of life.
- RI No. 6** Increased rate of L.A. County families with children birth through age 5 who read, tell stories, sing, play music, or teach letters, words or numbers to their child daily.
- RI No. 7** Increased rate of L.A. County families who participated in home visiting programs at any point prenatally through age 5.
- RI No. 8** Increased rate of eligible L.A. County families with children prenatal through age 5 participating in safety net programs.
- RI No. 9** Increased rate of L.A. County families with children birth through age 5 who report having one or more people to talk to in times of need.
- RI No. 10** Increased rate of L.A. County families with children birth through age 5 that have access to parks and open spaces.

CONTEXTUAL INDICATORS




- CI No. 1** Birth Rate: Annual number of live births per 1,000 total population in L.A. County.
- CI No. 2** Infant Mortality Rate: Annual number of deaths of children under one year old per 1,000 live births in L.A. County.
- CI No. 3** Low Birth Weight: Annual percentage of infants born at low birth weight (less than 2,500 grams).
- CI No. 4** Well-Child Visits: Annual percentage of children birth through age 5 in L.A. County who have received the recommended well-child visits for their current age.
- CI No. 5** Preventable Injuries: Annual rate of preventable injuries among children birth through age 5 in L.A. County.
- CI No. 6** Healthy Weight: Annual percentage of children ages 2 through 5 in L.A. County with a Body Mass Index (BMI) that falls within a healthy weight range.
- CI No. 7** Dual Language Learners: Annual percentage of kindergarteners in L.A. County who are Dual Language Learners.
- CI No. 8** Special Education Enrollment: Annual percentage of children birth through age 5 in L.A. County who are enrolled in special education.
- CI No. 9** Third Grade Literacy: Annual percentage of third grade students in L.A. County who meet or exceed the grade-level standard in English Language Arts.
- CI No. 10** Prenatal Care: Annual percentage of mothers in L.A. County who gave birth in the last year that received prenatal care in the first trimester of their pregnancy.
- CI No. 11** Postpartum Care: Annual percentage of mothers in L.A. County who gave birth in the last year that had a postpartum check-up.
- CI No. 12** Maternal Depression: Annual percentage of mothers in L.A. County who gave birth in the last year that displayed signs or symptoms of prenatal or postpartum depression.
- CI No. 13** Breastfeeding: Annual percentage of mothers in L.A. County who gave birth in the last year that were breastfeeding at one week, one month and three months after childbirth.
- CI No. 14** Educational Attainment: Annual percentage of mothers with children birth through age 5 in L.A. County by their highest level of education completed.
- CI No. 15** Assets at Birth: Annual average number of assets at birth in L.A. County.
- CI No. 16** Children Living in Poverty: Annual percentage of children birth through age 5 in L.A. County living in poverty.
- CI No. 17** Food Insecurity: Annual percentage of households with children birth through age 5 in L.A. County who experience food insecurity.
- CI No. 18** Homelessness: Annual number of children birth through age 5 in L.A. County who experience homelessness.
- CI No. 19** California Healthy Places Index: Annual percentile rank of L.A. County compared to other California counties on community conditions which affect health outcomes.
- CI No. 20** Access to Transit: Annual percentage of families with children birth through age 5 in L.A. County who use public transit.

METHODS

Indicator Selection Criteria



RESULTS INDICATORS

The Results Indicators were selected according to three main criteria: that they reflect best practices in the use of indicators as measurement tools; that they align with and build on the broader context of work supporting young children and their families in the state and region; and that they achieve to the extent possible the empirical goals of validity, reliability, utility and feasibility. Within each of the three main criteria are specific attributes sought for the indicators or guidance to aid selection:

 <p>BEST PRACTICE</p>	 <p>CONTEXTUAL</p>	 <p>EMPIRICAL</p>
<p>Select a small but meaningful set of indicators.</p> <hr/> <p>Use best approximations in the absence of the perfect indicator.</p> <hr/> <p>Identify indicators that encompass the collective set of Results and avoid indicators that are only related to one Result.</p> <hr/> <p>Prioritize indicators that are connected to the systems change and policy work being implemented by First 5 LA.</p>	<p>Alignment with policy and advocacy efforts, or statewide momentum around an issue.</p> <hr/> <p>Alignment with other critical partners (e.g., work being done in L.A. County).</p> <hr/> <p>Maximizing current windows of opportunity where there is momentum among critical decisionmakers.</p>	<p>Validity Considerations:</p> <ul style="list-style-type: none"> • Relevance • Credibility <hr/> <p>Reliability Considerations:</p> <ul style="list-style-type: none"> • Sound methodology • Data quality <hr/> <p>Utility Considerations:</p> <ul style="list-style-type: none"> • Disaggregation • Communication power <hr/> <p>Feasibility Considerations:</p> <ul style="list-style-type: none"> • Accessibility

CONTEXTUAL INDICATORS

The selection process for the Contextual Indicators considered the four criteria described below. Candidate indicators had to meet the three required criteria to be selected; candidates that aligned with external measurement efforts were prioritized but this was not a required feature.

 <p>REQUIRED CRITERIA</p>	<p>Significance to First 5 LA's work: Does the proposed indicator relate to and inform First 5 LA strategies?</p>	<p>Uniqueness: Is the indicator discrete from other indicators selected, providing new information?</p>	<p>Data Availability: Is data available for the candidate indicator?</p>
 <p>PRIORITY CRITERIA</p>	<p>Alignment with External Measurement Efforts: Does the measure align with other early childhood measurement efforts by partner or leading organizations in the field, including county, state or national efforts?</p>		

Methodological Notes and Limitations for Specific Indicators

Data notes and limitations are provided for each indicator in the body of the report. The content in this section provides additional methodological information as needed. Not all indicators have additional methodological information.

HIGH-QUALITY EARLY CARE AND EDUCATION: RESULT INDICATOR 1

Values provided in the supplemental tables for race/ethnicity or age (infant/toddler or preschool) may not sum to totals since some children are served at alternative settings that do not provide age or race/ethnic breakdowns. Infants and toddlers are defined as children from birth through age 2; preschoolers are defined as children ages 3 and 4 plus one-quarter of the 5-year-old population. ECE considered high quality are programs that received a rating of Tier 3, 4 or 5; programs receiving a rating of Tier 1 or 2 are considered rising quality. Programs are evaluated for child development and school readiness practices (Core I), teachers and teaching (Core II), and program and environment, including administration and leadership (Core III). Within each core, programs are evaluated on elements. Within Core I, there are two elements; programs are evaluated based on the type and frequency of child observation tool used and how developmental and health screenings are used. Within Core II, there are two elements; programs are evaluated based on the qualifications of the teachers and performance on teacher assessments conducted. Within Core III, there are three elements; programs are evaluated for the student-teacher ratio and group size, how the program performs on an environment rating scale tool, and the qualifications of the director. Centers are evaluated by all seven elements for a total possible point value of 35 points, while Family Child Care Homes (FCCH) are evaluated by five elements for a total possible point value of 25 points. To be considered high quality (Tier 3 or above), centers must receive 20 or more points and FCCHs must receive 14 or more. Rising-quality centers (Tier 1 or 2) must receive a minimum of seven points and rising-quality FCCH homes must receive a minimum of five points. For more information, visit <https://qualitystartla.org/>

PUBLICLY FUNDED EARLY CARE AND EDUCATION: RESULT INDICATOR 2

Please see the Supplemental Tables for this indicator for detail on the programs included in the analysis.

EARLY INTERVENTION SERVICES: RESULT INDICATOR 3

Individuals with Disabilities Education Act (IDEA) data is publicly available on the U.S. Department of Education website (<https://www2.ed.gov/programs/osepidea/618-data/state-level-data-files/index.html>). The data files analyzed from this public portal to populate this indicator were Part C Child Count and Settings (birth through age 2) and Part B Child County and Educational Environments (ages 3 through 5). The counts for the two populations were summed and divided by population figures publicly available from the California Department of Finance.

AVERAGE AGE OF STUDENTS IN SPECIAL EDUCATION: RESULT INDICATOR 4

Source data is publicly available for the overall number of students enrolled in special education for speech or language impairment by age at the California Department of Education (CDE) DataQuest website. Detail by race/ethnicity for each age group was obtained by special request from CDE. The special request reduced the level of data suppression, but some data was still suppressed even after combining certain smaller race/ethnic groups. In certain years, data for students in all race/ethnic groups except Latino was suppressed at

the lower and higher ends of the age range (e.g., 2 or 18). Since there are relatively fewer numbers of students enrolled at these ages, the impact on the average age calculation is likely to be negligible. To calculate average age, an average age/grouped frequency formula was used. This can be done by multiplying the age by the frequency of people that age.

CHILD PROTECTIVE SERVICES INVOLVEMENT: RESULT INDICATOR 5

Birth records for which the address of the mother could not be determined were omitted from the analysis. Socioeconomic status is estimated by the method of payment for the birth, where publicly funded is considered low income and privately funded is considered not low income. Publicly funded refers to Medi-Cal and other forms of government-sponsored health insurance. In California, mothers who give birth without health insurance coverage are retroactively enrolled in a public program. These estimates were developed by the Children's Data Network by matching California Department of Public Health vital birth records for all children born in Los Angeles County in 2006, 2007, 2012 and 2013 to California Department of Social Services child protection records. Records were disaggregated by demographic characteristics and geography. Birth records that could not be geocoded were omitted from the analyses. Please note that these estimates were generated using coded research datasets; these should not be considered official county or state birth statistics.

HOME VISITING PARTICIPATION: RESULT INDICATOR 7

Counts of enrollment are sourced to the LA Best Babies Network (LABBN) and are not publicly available. The count of home visiting enrollments includes participation in the following First 5 LA-funded programs: Welcome Baby, Healthy Families America (HFA), and Parents As Teachers (PAT). Welcome Baby enrollment counts include HFA and PAT; therefore, Welcome Baby numbers represent all First 5 LA-funded enrollments. Some families may choose not to participate or be lost to follow-up after hospital enrollment, but many families receive services bedside in the hospital, including breastfeeding support, assistance with follow up appointments, or referrals to specific needed services. The enrollment counts are by fiscal year and include both prenatally and postnatally enrolled families. The denominators used to calculate the rates are counts of children under age 1. The family enrollment count and infant count are combined to act as a proxy for families with an infant who participate in home visiting. The denominator for the calculation of the rates for the county overall and by race/ethnicity is sourced to the Department of Finance population projections and is by calendar year; for example, 2018 data is used as the denominator for 2018/19 numerator data. The geographic calculations use the 2018/19 numerator. The denominator for the geographic calculations is sourced to Esri and is 2020 calendar-year data.

PARTICIPATION IN SAFETY NET PROGRAMS: RESULT INDICATOR 8

Data for Medi-Cal was obtained from publicly available online databases. Data for CalFresh, CalWORKs and WIC were obtained by request. The CalFresh and CalWORKs data are from the California Department of Social Services and are enrollment counts from MEDS June 2019. Medi-Cal enrollment counts were obtained from the California Department of Health and Human Services database and reflect enrollment in July of each year. Rates by zip code for the maps were calculated using 2020 population figures provided by Esri.

SOCIAL SUPPORT: RESULT INDICATOR 9

Approximately 5,600 WIC parents were surveyed through the Los Angeles County WIC Survey in 2017. Of this sample, 88 percent were Latino and 70 percent lived in a *Best Start* geography.

BIRTH RATE: CONTEXTUAL INDICATOR 1

The birth rate estimates were developed by the Children's Data Network using vital birth records maintained by the California Department of Public Health. Records were disaggregated by demographic characteristics and geography; however, a rate was not possible to calculate in all cases. Birth rate by age was not calculated for two reasons. First, birth rates by age typically focus on the rate of teen births. Since the method of calculating teen birth rates differs from the method of calculating overall birth rates, showing data using two different methodologies could cause confusion. Second, the age ranges of the numerator data (under 20 and 20 and over) differ from the age ranges used for typical teen birth calculations. Birth rates by socioeconomic status were not possible due to the lack of a suitable denominator for the supplied numerator data. Counts of births for Latina mothers are available disaggregated by U.S.-born and foreign-born; however, rates for these two populations of Latina mothers were not possible due to the lack of suitable denominator. Consequently, these counts were combined for a single rate for Latina mothers. Birth records that could not be geocoded were omitted from the analyses. Please note that these estimates were generated using coded research datasets; these should not be considered official county or state birth statistics.

INFANT MORTALITY: CONTEXTUAL INDICATOR 2

The estimates of infant mortality per 1,000 for children born between 2011 and 2016 in Los Angeles County were developed by the Children's Data Network by matching California Department of Public Health vital birth records to vital death records for all children under one year old. Infants with death records that could not be matched to birth records were omitted from the analysis. Likewise, infants with birth records that could not be geocoded were excluded. The calculation of these statistics relies on a birth cohort methodology for determining infant mortality rate. This methodology differs from the methodology used by county and state health officials. For this reason, totals produced for this local analysis may differ from other published sources. Please note that these estimates were generated using coded research datasets; these should not be considered official county or state birth statistics.

LOW BIRTH WEIGHT: CONTEXTUAL INDICATOR 3

The indicator measures the percentage of infants born weighing less than 2,500 grams. These estimates were developed by the Children's Data Network using vital birth records maintained by the California Department of Public Health. Records were disaggregated by demographic characteristics and geography. Birth records that could not be geocoded were omitted from the analyses. For this reason, totals produced for this local analysis may differ from other published sources. Please note that these estimates were generated using coded research datasets; these should not be considered official county or state birth statistics.

WELL-CHILD VISITS: CONTEXTUAL INDICATOR 4

The data used to populate this indicator are publicly available on the California Department of Health Care Services website, within Medi-Cal Managed Care Quality Improvement Reports. The well-child visit rates provided in the indicator are the number of completed well-child visits out of the total recommended number of visits. According to the American Academy of Pediatrics periodicity schedule, children between the ages of 2 and 6 should have a well-child visit at age 2, 2.5, 3, 4, and 5. Data disaggregated by race/ethnicity, income status or age is not provided by the data source, nor is the well-child visit rate of children under age 2.

PREVENTABLE INJURIES: CONTEXTUAL INDICATOR 5

This data is based on publicly available vital records from the California Department of Public Health at <http://epicenter.cdph.ca.gov/ReportMenus/CustomTables.aspx>. Search criteria were as follows: death, non-fatal hospitalization and non-fatal emergency department visit (treat and release, or transfer to another facility); raw figures and crude rates; single year (not pooled); Los Angeles County; ages 0 through 5; all races and ethnicities; “unintentional injury” cause group; and output formats of race/ethnicity or cause of injury. At time of publication, the latest data available for deaths was 2017 and this data is comparable to prior years. For non-fatal injuries, the latest data available was 2015 at time of publication and these results are not comparable to prior years. Non-fatal injury data is comprised of the combination of unintentional injury non-fatal hospitalizations and non-fatal emergency department visits (treat and release, or transfer to another facility). Race/ethnicity groups are determined by the data source and cannot be further disaggregated. The cause groups of focus in the indicator align with the cause of preventable death groupings identified by the Countywide Prevention Plan as measured by the Prevention Metrics, as well as causes that result in many non-fatal incidents. A cause needed to have both fatal and non-fatal cases to be included in the charts. More detail is provided in the Supplemental Tables. Understanding the factors that lead to unintentional death or injury are limited by the codes used in the medical profession to categorize causes of death or injury (ICD-10, or International Statistical Classification of Diseases and Related Health Problems, Tenth Revision). For example, deaths due to suffocation are sourced to codes W75 to W84, where W75 is suffocation and strangulation in bed. The data does not enable researchers to know the circumstances leading to the suffocation, such as whether the suffocation was the result of co-sleeping, inappropriate bedding or toys in the crib, or other factors.

HEALTHY WEIGHT: CONTEXTUAL INDICATOR 6

Data is pre-analyzed by the source and not publicly available. Healthy weight is defined as records that have no designation of underweight, overweight or obese risk codes in the WIC Management Information System.

DUAL LANGUAGE LEARNERS: CONTEXTUAL INDICATOR 7

Data is publicly available on the California Department of Education’s DataQuest website: <https://data1.cde.ca.gov/>. Upon enrollment, parents are asked to complete the Home Language Survey which asks which language the child learned when they first began to talk, which language the child uses most frequently at home, which language the parents use more frequently when speaking with the child, and which language is most often spoken by adults in the home. Students are identified as English Learners if there is a report of a language other than English on the Home Language Survey and if they are initially assessed on the English Language Proficiency Assessment for California as lacking the defined English language skills of listening, speaking, reading and/or writing necessary to succeed in the school’s regular instructional programs. The Home Language Survey has some limitations. First, the brevity of the language survey does not allow parents to provide a full picture of a dual language learning environment in the home. Second, families may avoid completing the survey, or not fill it out honestly, for fear of the stigma associated with the English Learner designation or fear of immigration enforcement action.

SPECIAL EDUCATION ENROLLMENT: CONTEXTUAL INDICATOR 8

The special education data is publicly available from the data source at the California Department of Education DataQuest website. The population data is publicly available from the California Department of Finance population projections series. The count of special education enrollment for pre-kindergarten age students is not inclusive of all young children receiving early intervention services or special education services. In California, the Department of Developmental Services (DDS) administers the federal Individuals with

Disabilities Education Act (IDEA), Part C for infants and toddlers from birth to 36 months if they have a developmental delay. DDS shares administrative responsibility for delivery of services with the California Department of Education (CDE), which is the lead agency for IDEA Part B that serves pre-kindergarten children through age 21. The data presented in this indicator is from CDE; local data from DDS was not available. See Result Indicator 3, Early Intervention Services, for Part C data for the state overall. School district data is based on school years and child population data is based on calendar years, where school year 2018-19 is calculated with 2019 population data, for example.

THIRD GRADE LITERACY: CONTEXTUAL INDICATOR 9

Data is pre-analyzed by the data source, California Department of Education, in all cases except for the presentation shown for the Asian/Pacific Islander (API) racial group. The data source provides the denominator (count of students with test scores) and the calculated percentage of students meeting or exceeding the standard, but they do not provide the numerator (count of students meeting or exceeding the standard). To calculate API results in order to maintain consistency with the display of racial and ethnic disaggregations for the majority of indicator, the numerators were derived from the data provided by the source. The numerators for Asian, Native Hawaiian or Pacific Islander and Filipino were summed, the denominators for the same groups were summed, and a rate was calculated. The data provided in the Supplemental Tables is the original data provided by the data source; the calculated rate for Asian/Pacific Islander is not included.

PRENATAL CARE: CONTEXTUAL INDICATOR 10

The indicator measures the annual percentage of pregnant mothers who receive prenatal care in the first trimester. These estimates were developed by the Children's Data Network using vital birth records maintained by the California Department of Public Health. Records were disaggregated by demographic characteristics and geography. Birth records that could not be geocoded were omitted from the analyses. For this reason, totals produced for this local analysis may differ from other published sources. Please note that these estimates were generated using coded research datasets; these should not be considered official county or state birth statistics.

POSTPARTUM CARE: CONTEXTUAL INDICATOR 11

The data used to populate this indicator is pre-analyzed by the data source and publicly available on the Los Angeles Department of Public Health website. Results from the Los Angeles Mommy & Baby (LAMB) survey are presented in set race/ethnic categories. Further disaggregation was not possible.

BREASTFEEDING: CONTEXTUAL INDICATOR 13

The breastfeeding data provided is publicly available by the source and illustrates whether mothers reported any breastfeeding at each interval, not whether they were exclusively breastfeeding at each point in time. Data on whether mothers were breastfeeding exclusively at each time interval is also publicly available.

EDUCATIONAL ATTAINMENT: CONTEXTUAL INDICATOR 14

These estimates were developed by the Children's Data Network using vital birth records maintained by the California Department of Public Health. Records were disaggregated by demographic characteristics and geography. Birth records that could not be geocoded were omitted from the analyses. For this reason, totals produced for this local analysis may differ from other published sources. Please note that these estimates were generated using coded research datasets; these should not be considered official county or state birth statistics.

ASSETS AT BIRTH: CONTEXTUAL INDICATOR 15

The California Strong Start Index is a publicly available data source that leverages birth records to summarize the conditions into which children are born across California communities. It comprises 12 indicators available on the birth record that are shown to be related to good outcomes for children along the life course. Data and detailed methodological information can be found at www.strongstartindex.org.

CHILDREN EXPERIENCING HOMELESSNESS: CONTEXTUAL INDICATOR 18

Data was obtained by request from the Los Angeles County Chief Executive Office based on client records from the L.A. County Departments of Public Social Services (DPSS) and Children and Family Services (DCFS), and the Homeless Management Information System (HMIS). The data have several limitations or characteristics that are important to note:

- The three agencies do not necessarily operate with the same definition or criteria for identifying a person as homeless. As such, the de-duplicated totals are not standardized or definitionally uniform.
- The DPSS counts are based on CalWORKs only. Inclusion of a comparatively small number of children associated with homeless households in receipt of CalFresh benefits but not CalWORKs (CalFresh Only households) would likely raise the bottom-line tallies to a negligible degree.
- The DPSS/CalWORKs tallies include unaided children in aided households.
- The HMIS totals are likely understated to a small but indeterminate degree due to missing elements needed to calculate age for between approximately 14 percent and 20 percent of children with records in the system in each of the four years tabulated.

ACCESS TO TRANSIT: CONTEXTUAL INDICATOR 20

The transportation stop data was supplied by Metro for each L.A. County zip code and for 66 transportation agencies with service in L.A. County, including bus, rail and metro service. Metro serves as the transportation planner and coordinator, designer, builder and operator for Los Angeles County. The stop data is from October 2019 and is not publicly available. The population data for this presentation is sourced to the U.S. Census Bureau American Community Survey (5-Year 2018) and is the number of families with children under 6 years of age. The analysis was as follows:

1. The zip codes were divided into three groups using natural breaks (or jenkins) based on the number of stops in each zip code. The third of zip codes with the highest number of stops was designated “high,” the third of zip codes with the lowest number of stops was designated “low,” and the remaining third was designated “medium.”
2. The data of families with children under age six by zip codes was similarly divided.
3. The result for each zip code was one of nine possible combinations. The table below shows how the different combinations were interpreted:

	NUMBER OF STOPS	NUMBER OF FAMILIES	INTERPRETATION
a.	High	High	Evenly matched
b.	High	Medium	Moderately positive match
c.	High	Low	Very positive match
d.	Medium	High	Moderately negative match
e.	Medium	Medium	Evenly matched
f.	Medium	Low	Moderately positive match
g.	Low	High	Very negative match
h.	Low	Medium	Moderately negative match
i.	Low	Low	Evenly matched

The zip codes that had matching levels were considered to have an appropriate or expected level of access. For example, a zip code with a medium number of stops and a medium number of families is considered the appropriate or expected level of access (e.). Whereas, a zip code where there is a high number of stops and a medium number of families would be considered moderately positively mismatched, since there are more stops than would be expected for the number of children (b.). A zip code where there was a high number of stops but a low number of families would be very positively mismatched (c.) — families would have a much higher ratio of stops to families than expected. Conversely, a zip code that has a medium number of stops and a high number of families would be considered moderately negatively mismatched (d.). A zip code with a low number of stops and a high number of families would be very negatively mismatched (g.). There were no zip codes with this combination in the current dataset. The most negative combinations were d. (medium number of stops and a high number of families) and h. (low number of stops and a medium number of families).

There are several data limitations that render the indicator a proxy for transportation access rather than a direct measure. First, this analysis only takes into account the number of stops; it does not take into account issues of access, such as perceived safety, barriers like highways, or infrastructure like crosswalks or lighting. Second, the data does not take into account quality measures, such as how frequently a bus comes to the stop or how often the stop is used. These access and quality factors may increase or decrease the utility of a given stop. Third, the data was divided into groups of high, medium or low without applying any normative determination of what is an optimal or suboptimal ratio of stops to population. For example, an evenly match area with a low number of families and low number of stops may have poor access for the small numbers of families in the area if the stop is far from their home. Finally, the data was only available by zip code. Zip codes are not an ideal geographic base for policy analysis since they were not created to be similar in size (unlike census tracts, which are split, if needed, to keep the population counts at a somewhat consistent level). Consequently, the range in family population for the zip codes in this analysis is from zero to approximately 4,500. Even with these limitations, the data provides a high-level understanding of gaps in transit access and density.

SUPPLEMENTAL TABLES

RESULT INDICATOR 1

Percentage and Count of Los Angeles County Young Children Participating in QSLA-Rated Programs and Programs Rated High Quality by Age, 2017-18 and 2018-19

	2018-19					2017-18				
	QSLA-Rated		Rated High Quality (Tier 3, 4, 5)		Count L.A. County Children	QSLA-Rated		Rated High Quality (Tier 3, 4, 5)		Count L.A. County Children
	Percent	Count	Percent	Count		Percent	Count	Percent	Count	
All (0-4 + 1/4 of 5)	7.5	47,501	6.6	42,105	636,605	7.0	45,824	5.7	37,111	652,141
Infant/Toddler (0-2)	1.8	6,269	1.3	4,759	353,436	1.9	7,088	1.0	3,820	368,771
Preschool (3-4 + 1/4 of 5)	14.6	41,232	13.2	37,346	283,169	13.7	38,736	11.7	33,291	283,370

Percentage and Count of Los Angeles County Young Children Participating in QSLA-Rated Programs and Programs Rated High Quality by Race and Ethnicity, 2017-18 and 2018-19

	2018-19					2017-18				
	QSLA-Rated		Rated High Quality (Tier 3, 4, 5)		Count L.A. County Young Children	QSLA-Rated		Rated High Quality (Tier 3, 4, 5)		Count L.A. County Young Children
	Percent	Count	Percent	Count		Percent	Count	Percent	Count	
Total		47,539		42,502	636,605		38,782		31,746	652,141
Latino	8.3	27,249	8.2	25,287	326,663	6.1	19,591	5.3	16,988	338,353
Native American	11.8	194	11.7	192	1,644	8.2	123	7.4	112	1,586
Asian	2.5	2,303	2.2	1,983	91,421	2.3	2,034	1.5	1,354	92,364
Black	8.8	4,100	7.5	3,517	46,701	7.4	3,373	5.6	2,570	48,203
Pacific Islander	17.1	206	15.3	184	1,202	10.7	127	8.8	104	1,262
White	4.2	6,072	3.5	5,065	144,798	2.0	2,838	1.4	1,902	146,332
Multiracial	6.3	1,523	5.0	1,210	24,176	4.7	1,078	3.1	706	24,041
Unknown		5,892		5,064			9,618		8,010	

RESULT INDICATOR 2

Los Angeles County Children Enrolled in Publicly Funded Early Care and Education Programs by Type and Age, 2019

	Infant/Toddler	Preschool	Total
Totals			
Contracted Sites	10,613	59,903	70,516
Vouchers	11,663	19,019	30,682
Voucher Programs			
CalWORKs Stage 1	2,420	2,424	4,844
CalWORKs Stage 2	4,812	8,081	12,893
CalWORKs Stage 3	1,993	4,784	6,777
California Alternate Payment Program	1,866	3,458	5,324
Emergency Bridges Vouchers	572	272	844
Contract Programs			
Early Head Start	1,985	0	1,985
Head Start	0	13,244	13,244
California State Preschool Program (CSPP)	0	21,622	21,622
Family Child Care Home Education Network (FCCHEN)	572	320	892
General Child Care and Development (CCTR) (0-2 only)	410	0	410
General Child Care and Development (CCTR) (3-4 only)	0	88	88
CCTR & CSPP Combo	3,598	12,793	16,391
Early Head Start and Head Start	616	1,259	1,875
Combo of any state/fed program	3,432	10,577	14,009
Denominator (estimate of eligible children)			
Estimated number of eligible children (2016)	220,273	235,308	455,581

RESULT INDICATOR 3

California Children Birth Through Age 5 Receiving Early Intervention Services (2012-13 - 2018-19) and Population 0 to 5 (2012-2018)

California First Grade Students in Special Education and Total First Grade Enrollment, 2010-11 to 2018-19

Children Birth Through Age 5			
	Rate	Count Served	Count Total
2018-19	4.7%	136,631	2,922,681
2017-18	4.4%	130,878	2,961,932
2016-17	4.2%	124,763	2,995,972
2015-16	4.0%	118,748	3,005,151
2014-15*	3.8%	113,536	3,004,582
2013-14	3.7%	111,104	3,019,672
2012-13	3.6%	109,022	3,037,801

First Grade Enrollment			
	Rate	Special Education Count	Total Count
2018-19	9.9%	44,380	448,028
2017-18	9.4%	43,010	456,175
2016-17	8.3%	37,873	456,002
2015-16	8.9%	39,691	444,573
2014-15	8.4%	39,067	464,323
2013-14	8.2%	38,458	470,812
2012-13	8.0%	39,035	489,504
2011-12	7.8%	38,247	490,042
2010-11	8.0%	38,208	477,277

California Children Birth Through Age 5 Receiving Early Intervention Services (2012-13 to 2018-19) and Population 0 to 5 (2012-2018) by Race/Ethnicity

	Latino			American Indian			Asian			Black			Pacific Islander			White			Multiracial		
	Rate	Count Served	Count Total	Rate	Count Served	Count Total	Rate	Count Served	Count Total	Rate	Count Served	Count Total	Rate	Count Served	Count Total	Rate	Count Served	Count Total	Rate	Count Served	Count Total
2018-19	5.9%	79,125	1,330,663	3.7%	464	12,390	3.3%	12,721	388,673	4.4%	6,842	157,202	3.6%	326	9,143	3.4%	30,306	901,494	5.6%	6,847	123,116
2017-18	5.5%	74,664	1,361,713	4.0%	501	12,609	3.2%	12,409	383,132	4.2%	6,790	160,316	3.4%	320	9,426	3.3%	29,811	913,924	5.3%	6,383	120,812
2016-17	5.1%	70,510	1,392,376	3.7%	467	12,777	3.1%	11,332	370,196	4.0%	6,639	164,249	2.8%	272	9,726	3.2%	29,411	927,351	5.1%	6,132	119,297
2015-16	4.7%	66,491	1,428,432	3.2%	412	12,881	2.9%	10,557	358,494	4.0%	6,575	165,088	2.8%	270	9,798	3.2%	29,071	909,654	4.4%	5,372	120,804
2014-15*	2.8%	41,533	1,465,000	3.3%	414	12,662	3.0%	10,128	343,216	4.1%	6,700	165,320	2.4%	231	9,819	2.2%	19,506	884,821	3.2%	4,001	123,744
2013-14	4.1%	61,821	1,510,182	3.2%	390	12,195	2.9%	9,716	333,365	4.0%	6,610	165,185	3.2%	320	9,969	3.2%	28,001	861,884	3.3%	4,246	126,892
2012-13	3.9%	60,141	1,556,254	3.4%	408	12,031	2.9%	9,477	323,769	3.9%	6,441	164,447	3.4%	347	10,088	3.3%	28,084	839,703	3.1%	4,124	131,509

RESULT INDICATOR 4

Average Age of Los Angeles County Students Enrolled in Special Education for Speech or Language Impairment by Race/Ethnicity, 2007-08 to 2018-19

Year	L.A. County Average	Other (Native American and Multiracial)	Latino	Black	White	Asian/Pacific Islander
2018-19	6.8	6.6	6.7	7.2	7.3	7.5
2017-18	6.8	6.3	6.7	7.1	7.3	7.6
2016-17	6.9	6.4	6.8	7.2	7.3	7.6
2015-16	7.0	6.4	6.9	7.1	7.2	7.7
2014-15	7.0					
2013-14	7.1					
2012-13	7.1					
2011-12	7.1					
2010-11	7.3					
2009-10	7.7					
2008-09	7.7					
2007-08	7.6					

Data is not available for all years.

RESULT INDICATOR 5

Los Angeles County Children Born in 2012 or 2013 Involved With Child Protective Services in Their First Five Years of Life by Race/Ethnicity, Socioeconomic Status and Best Start Geography

	2012					2013				
	Allegation		Substantiation	Placement	Number of Children in Birth Cohort (Denominator)	Allegation		Substantiation	Placement	Number of Children in Birth Cohort (Denominator)
	Percent	Count	Percent	Percent		Percent	Count	Percent	Percent	
L.A. County	16.6	22,825	5.8	2.8	137,578	16.2	21,737	5.7	2.8	134,201
Maternal Race / Ethnicity										
White	9.7	2,375	3.4	1.8	24,381	9.2	2,294	3.1	1.8	24,856
Black	35.4	3,678	9.5	7.6	10,399	34.4	3,496	13.8	7.9	10,173
Latino, U.S.-born	21	11,291	7.6	3.7	53,791	21.8	9,211	8.3	4.3	42,232
Latino, Foreign-born	15.9	4,341	4.5	1.6	27,299	16.3	5,657	4.6	1.7	34,645
Asian/Pacific Islander	4.6	958	1.2	0.5	21,006	4.1	891	1.1	0.4	21,569
Native American										
Other/Missing	25.9	182			702	25.9	188			726
Birth Payment Method										
Publicly Funded Birth	23.6	17,819	8.8	4.3	75,452	24.2	16,799	9.1	4.7	69,381
Privately Funded Birth	8.1	5,006	2.1	0.9	62,126	7.6	4,938	2	0.9	64,820
Best Start Geography										
Broadway-Manchester	30.2	428	11.8	5.4	1,418	30.4	479	12.7	6.5	1,575
Central Long Beach	27.7	429	12.5	6.5	1,550	26.8	403	10.1	5.1	1,502
Compton	24.3	577	8.7	4	2,375	24.7	573	9	4.7	2,319
East LA	22	473	8	3.7	2,154	20.9	451	8	3.5	2,154
Lancaster	28.9	737	12.1	6.1	2,547	26.5	684	12.2	7	2,586
Metro LA	23.8	240	10.5	5.2	1,008	24.8	267	10.1	4.3	1,079
Northeast Valley Communities	26.3	421	11.4	5.9	1,782	26.6	346	13.2	6.7	1,805
Palmdale	26.3	689	11.4	5.9	2,618	26.6	693	13.2	6.7	2,605
Panorama City & Neighbors	23.9	533	9.4	3.9	2,225	23.5	514	8.4	3.6	2,187
Southeast LA	18.4	442	6.9	2.8	2,407	18.7	484	7.2	3.1	2,586
South El Monte/El Monte	20.8	316	6.1	3.3	1,523	21	321	6.5	3.8	1,530
Watts-Willowbrook	28.5	429	11.2	5.5	1,506	29	443	10.5	6	1,527
West Athens	33.4	200	13	6.5	598	35	237	13.2	6.1	677
Wilmington	22.6	199	6.2	2.8	882	23.6	217	6.4	3.2	918

RESULT INDICATOR 05

Los Angeles County Children Born in 2006 or 2007 Involved With Child Protective Services in Their First Five Years of Life by Race/Ethnicity and Socioeconomic Status

	2006				2007			
	Allegation	Substantiation	Placement	Number of Children in Birth Cohort (Denominator)	Allegation	Substantiation	Placement	Number of Children in Birth Cohort (Denominator)
	Percent	Percent	Percent		Percent	Percent	Percent	
L.A. County	14.8	5.2	2.5	158,631	14.6	5.3	2.5	158,619
Maternal Race / Ethnicity								
White	10	3.9	2	27,791	10	3.7	2	26,997
Black	29.8	12.3	7.1	11,938	30	12.8	7.1	11,810
Latino, U.S.-born	19.8	7.7	4.2	38,124	19.6	7.9	4.1	39,789
Latino, Foreign-born	13.7	3.8	1.3	62,733	13.4	3.9	1.3	60,897
Asian/Pacific Islander	5.2	1.7	0.8	17,489	4.9	1.6	0.6	18,462
Native American	29.9	13.9	8.6	361	33.9	16.8	11.4	387
Other / Missing								
Birth Payment Method								
Publicly Funded Birth	19.5	7.3	3.6	92,093	19.2	7.3	3.5	93,595
Privately Funded Birth	8.4	2.4	1.1	66,538	8	2.4	1	65,024

RESULT INDICATOR 7

Count of Los Angeles County Family Enrollment in First 5 LA-Funded Home Visiting Programs, Count of Infants Under Age 1, and Home Visiting Rates for Los Angeles Overall and by Race/Ethnicity, 2016-2018

	2018			2017			2016		
	Rate	Enrollment (2018-19)	Under Age 1 (2018)	Rate	Enrollment (2017-18)	Under Age 1 (2017)	Rate	Enrollment (2016-17)	Under Age 1 (2016)
L.A. County	17.8%	20,154	113,016	11.9%	14,377	120,714	10.5%	12,777	122,018
Asian/Pacific Islander	3.9%	606	15,513	3.1%	553	17,597	3.0%	496	16,393
Black	14.5%	1,210	8,334	13.5%	1,191	8,790	12.4%	1,081	8,684
White	2.7%	722	26,489	2.5%	678	27,412	2.1%	599	28,354
Latino	17.6%	10,158	57,831	15.2%	9,391	61,911	14.3%	9,122	63,858
Multiracial	6.2%	286	4,601	7.3%	345	4,717	6.5%	291	4,455
Other/Unknown		525			545			457	
Native American			248			287			274

Count of Los Angeles County Family Enrollment in First 5 LA-Funded Home Visiting Programs, Count of Infants Under Age 1, and Home Visiting Rates by *Best Start* Geography, 2016-2018

	2018			2017	2016
	Rate	Enrollment (2018-19)	Under Age 1 (2020)	Enrollment (2017-18)	Enrollment (2016-17)
Broadway-Manchester	21.0%	337	1,603	305	303
Central Long Beach	23.2%	375	1,616	449	524
Compton	24.8%	598	2,413	539	588
East LA	17.5%	419	2,401	437	457
Lancaster	19.5%	520	2,670	773	551
Metro LA	10.7%	134	1,249	118	108
Northeast Valley Communities	25.6%	517	2,018	439	491
Palmdale	17.9%	514	2,874	698	578
Panorama City & Neighbors	24.6%	639	2,593	631	733
Southeast LA	17.2%	495	2,883	519	515
South El Monte/EI Monte	16.2%	249	1,539	262	281
Watts-Willowbrook	22.0%	365	1,657	354	336
West Athens	19.1%	125	655	113	96
Wilmington	25.7%	267	1,037	210	305
Others		-		61	-

Los Angeles County Family Enrollment in First 5 LA-Funded Home Visiting Programs by Income, 2016-2018

	Enrollment (2018-19)	Enrollment (2017-18)	Enrollment (2016-17)
Less than \$10,000	1,297	1,640	1,579
\$10,000- \$14,999	486	786	810
\$15,000- \$19,999	611	720	745
\$20,000- \$24,999	457	549	547
\$25,000- \$29,999	312	411	335
\$30,000- \$39,999	295	470	419
\$40,000- \$49,999	184	237	203
\$50,000- \$74,999	185	259	192
\$75,000- \$99,999	74	97	71
\$100,000 or more	96	130	103
Do not know	6,983	5,578	5,122
Decline to answer	2,526	1,823	1,954

RESULT INDICATOR 8

Young Child Population (Birth Through Age 5) Participating in CalWORKs, CalFresh, WIC, and/or Medi-Cal 2019 or 2010-2019

Year	CalWORKs	CalFresh	WIC			Medi-Cal
	Total (0-5)	Total (0-5)	Total (0-4)	Infant (0-1)	Child (1-4)	Total (0-5)
2019	74,215	150,800	257,118	62,253	194,865	406,854
2018			278,524	68,043	210,481	430,610
2017			296,858	72,885	223,973	444,488
2016			308,308	73,331	234,977	459,967
2015			332,373	78,490	253,883	460,517
2014			347,561	80,998	266,563	473,446
2013			378,646	89,711	288,935	468,619
2012			381,639	90,358	291,281	436,832
2011			390,710	93,689	297,021	
2010			399,408	92,824	306,584	

Data is not available for all years.

RESULT INDICATOR 10

Percentage and Count of Children From Birth Through Age 5 Who Live Within One-Half Mile of a Park or Open Space in Los Angeles County Overall and by *Best Start* Geography

	Rate	Children 0-5 within 1/2 mile (2016)	Count children 0-5 (2020)
L.A. County	51.8%	305,697	590,148
Broadway-Manchester	46.5%	4,472	9,627
Central Long Beach	91.1%	8,639	9,478
Compton	59.0%	8,620	14,604
East LA	43.5%	6,260	14,402
Lancaster	13.6%	2,189	16,046
Metro LA	77.4%	5,425	7,012
Northeast Valley Communities	49.0%	6,067	12,394
Palmdale	23.7%	4,112	17,341
Panorama City & Neighbors	48.4%	7,373	15,219
Southeast LA	76.8%	13,180	17,172
South El Monte/El Monte	42.9%	3,947	9,210
Watts-Willowbrook	83.8%	8,112	9,685
West Athens	28.8%	1,175	4,078
Wilmington	65.8%	4,031	6,130

CONTEXTUAL INDICATOR 1

Birth Rate in Los Angeles County by Race or Ethnicity of the Mother, 2013-2017

	2017			2016			2015			2014			2013		
	Rate per 1,000	Births	Population	Rate per 1,000	Births	Population	Rate per 1,000	Births	Population	Rate per 1,000	Births	Population	Rate per 1,000	Births	Population
White	8.8	23,867	2,702,321	9.1	24,643	2,714,273	9.2	25,141	2,729,005	9.2	25,139	2,737,944	9.1	24,856	2,743,302
Black	10.6	8,939	846,694	11.0	9,310	847,354	10.9	9,199	847,505	11.7	9,919	848,659	12.0	10,173	846,535
Latino, U.S.-born	13.9	41,503	4,877,169	14.9	42,689	4,859,927	15.3	42,819	4,844,124	15.6	42,578	4,821,054	16.0	42,232	4,796,131
Latino, Foreign-born		26,480			29,651			31,352			32,682			34,645	
Asian/Pacific Islander	13.1	20,950	1,601,785	13.9	21,843	1,567,580	13.6	20,976	1,537,510	16.6	24,994	1,503,541	14.7	21,569	1,470,155
Other/Missing	3.2	723	227,764	1.9	431	222,217	3.4	740	217,887	3.4	717	213,008	3.5	726	208,786

Births and Population in Los Angeles County by Age, 2013-2017

	2017		2016		2015		2014		2013	
	Births	Population	Births	Population	Births	Population	Births	Population	Births	Population
Under Age 20	4,921	2,598,017	5,613	2,615,679	6,397	2,638,897	7,373	2,655,255	8,486	2,674,027
Age 20 and Older	117,541	7,657,716	123,306	7,595,672	123,830	7,537,134	128,656	7,468,951	125,715	7,390,882

Births in Los Angeles County by Birth Payment Method (proxy for socioeconomic status), 2013-2017

	2017	2016	2015	2014	2013
Public	59,067	63,489	64,868	66,464	69,381
Private	63,395	65,430	65,359	69,565	64,820

Births in Los Angeles County by *Best Start* Geography, 2013-2017

	2017			2016	2015	2014	2013
	Rate per 1,000	Births	Population	Births	Births	Births	Births
Broadway-Manchester	15.8	1,368	86,857	1,465	1,439	1,490	1,575
Central Long Beach	11.2	1,149	102,574	1,280	1,321	1,423	1,502
Compton	14.6	2,051	140,137	2,240	2,129	2,292	2,319
East LA	12.5	1,764	140,622	1,910	1,982	2,037	2,154
Lancaster	14.2	2,384	167,877	2,576	2,543	2,496	2,586
Metro LA	8.5	974	114,639	1,004	1,020	1,076	1,079
Northeast Valley Communities	11.4	1,495	131,390	1,716	1,696	1,831	1,805
Palmdale	13.1	2,371	180,486	2,494	2,525	2,520	2,605
Panorama City & Neighbors	12.4	2,064	166,285	2,254	2,151	2,331	2,187
Southeast LA	12.6	2,186	173,859	2,228	2,341	2,329	2,586
South El Monte/El Monte	11.6	1,185	102,236	1,273	1,467	1,460	1,530
Watts-Willowbrook	15.8	1,358	85,972	1,468	1,425	1,569	1,527
West Athens	14.6	663	45,355	674	692	774	677
Wilmington	13.2	833	63,337	816	886	915	918
Remainder of L.A.	11.8	100,617	8,554,107				

CONTEXTUAL INDICATOR 3

Low Birth Weight (LBW) in Los Angeles County by Race or Ethnicity, 2014-2017

	2017			2016			2015			2014		
	Percent	Count LBW	Count Births	Percent	Count LBW	Count Births	Percent	Count LBW	Count Births	Percent	Count LBW	Count Births
White	6.2	1,482	23,867	6.5	1,597	24,643	6.8	1,708	25,141	6.4	1,619	25,139
Black	13	1,163	8,939	11.6	1,080	9,310	12.2	1,126	9,199	12.4	1,226	9,919
Latino, U.S.-born	7	2,903	41,503	6.8	2,921	42,689	7.1	3,043	42,819	6.8	2,899	42,578
Latino, Foreign-born	7	1,865	26,480	6.8	2,010	29,651	6.9	2,162	31,352	6.4	2,090	32,682
Asian/Pacific Islander	6.9	1,447	20,950	7.1	1,546	21,843	6.9	1,454	20,976	6.1	1,534	24,994
Other/Missing	7.7	56	723	16.9	73	431	10	74	740	9.1	65	717

Low Birth Weight in Los Angeles County by Socioeconomic Status, 2014-2017

	2017			2016			2015			2014		
	Percent	Count LBW	Count Births	Percent	Count LBW	Count Births	Percent	Count LBW	Count Births	Percent	Count LBW	Count Births
Public (i.e., Medi-Cal or other public insurance coverage)	7.6	4,474	59,067	7.4	4,679	63,489	7.6	4,917	64,868	7.2	4,771	66,464
Private (i.e., Private insurance or self-pay)	7	4,442	63,395	7	4,548	65,430	7.1	4,650	65,359	6.7	4,662	69,565

Low Birth Weight in Los Angeles County by Best Start Geography, 2014-2017

	2017			2016			2015			2014		
	Percent	Count LBW	Count Births	Percent	Count LBW	Count Births	Percent	Count LBW	Count Births	Percent	Count LBW	Count Births
Broadway-Manchester	8.8	120	1,368	8.9	130	1,465	8.3	119	1,439	10.3	153	1,490
Central Long Beach	6.9	79	1,149	6.8	87	1,280	8.2	108	1,321	8.1	115	1,423
Compton	7.9	162	2,051	8.2	183	2,240	8.1	173	2,129	7.5	171	2,292
East LA	7.2	127	1,764	7.5	143	1,910	7.7	153	1,982	6.6	134	2,037
Lancaster	10.2	242	2,384	8.8	227	2,576	9.4	240	2,543	8.9	223	2,496
Metro LA	8	78	974	8.2	82	1,004	7.8	80	1,020	5.9	63	1,076
Northeast Valley Communities	8	120	1,495	6.3	108	1,716	7	118	1,696	7.8	143	1,831
Palmdale	8.9	212	2,371	9.2	229	2,494	7.9	200	2,525	9.4	236	2,520
Panorama City & Neighbors	7.6	156	2,064	7.9	177	2,254	7.5	161	2,151	6.9	160	2,331
Southeast LA	6.4	139	2,186	5.6	124	2,228	6.9	162	2,341	6.7	156	2,329
South El Monte/El Monte	7	83	1,185	6.1	78	1,273	6.4	94	1,467	6.2	91	1,460
Watts-Willowbrook	8	109	1,358	7.8	115	1,468	8.5	121	1,425	8.8	138	1,569
West Athens	10.3	68	663	8.8	59	674	11.1	77	692	9.6	74	774
Wilmington	5.9	49	833	7	57	816	6.8	60	886	5.5	50	915

CONTEXTUAL INDICATOR 5

Unintentional Injury Deaths Among Children Birth Through Age 5 in Los Angeles County Overall and by Race/Ethnicity, 2008-2017

	L.A. County Overall			White/Other/Unknown			Black			Latino			Asian/Pacific Islander		
	Rate per 100,000	Numerator	Denominator	Rate per 100,000	Numerator	Denominator	Rate per 100,000	Numerator	Denominator	Rate per 100,000	Numerator	Denominator	Rate per 100,000	Numerator	Denominator
2017	4.0	30	755,880	5.4	8	147,032	11.9	6	50,515	3.2	14	437,249	2.1	2	93,982
2016	2.7	21	765,800	2.1	3	141,123	9.6	5	51,916	2.2	10	451,530	3.2	3	94,307
2015	4.8	37	772,656	4.3	6	139,571	16.8	9	53,679	4.3	20	461,728	2.2	2	90,681
2014	5.0	39	774,011	6.6	9	137,384	12.8	7	54,875	4.5	21	471,166	2.4	2	83,514
2013	4.1	32	777,060	2.2	3	135,299	7.2	4	55,769	4.4	21	480,929	5.1	4	78,056
2012	3.6	28	778,668	3.0	4	133,473	5.3	3	56,403	4.1	20	488,679	1.4	1	73,079
2011	4.1	32	777,302	3.8	5	132,128	7.1	4	56,882	4.3	21	490,988	2.8	2	70,522
2010	3.5	27	772,686	2.3	3	130,375	3.5	2	56,508	4.3	21	488,897	1.4	1	70,222
2009	3.8	30	782,721		1						25				2
2008	3.8	30	794,043		1						18				4

Data is not available for all years.

CONTEXTUAL INDICATOR 5

Unintentional Injury Non-Fatal Hospitalizations and Emergency Department Visits Among Children Birth Through Age 5 in Los Angeles County Overall and by Race/Ethnicity, 2015

		Rate per 100,000	Numerator	Denominator
L.A. County Overall	Non-Fatal Hospitalizations	243.7	1,883	755,880
	Non-Fatal Emergency Department Visits	8,098.0	62,570	
White/Other/Unknown	Non-Fatal Hospitalizations	338.2	472	147,032
	Non-Fatal Emergency Department Visits	10,323.8	14,409	
Black	Non-Fatal Hospitalizations	357.7	192	50,515
	Non-Fatal Emergency Department Visits	10,691.3	5,739	
Latino	Non-Fatal Hospitalizations	237.2	1,095	437,249
	Non-Fatal Emergency Department Visits	8,431.6	38,931	
Native American	Non-Fatal Hospitalizations	96.0	1	93,982
	Non-Fatal Emergency Department Visits	4,894.4	51	
Asian/Pacific Islander	Non-Fatal Hospitalizations	135.6	123	93,982
	Non-Fatal Emergency Department Visits	3,793.5	3,440	

Unintentional Injury Deaths Among Children Birth Through Age 5 in Los Angeles County by Cause, 2008-2017

	Burn		Cut/Pierce		Drowning		Fall		Firearm		Motor Vehicle-Involved Accident		Bicycle, Pedestrian or Other Transport		Denominator
	Rate per 100,000	Numerator	Rate per 100,000	Numerator	Rate per 100,000	Numerator	Rate per 100,000	Numerator	Rate per 100,000	Numerator	Rate per 100,000	Numerator	Rate per 100,000	Numerator	
2017	0.0	0	0.0	0	1.1	8	0.0	0	0.0	0	1.1	8	0.3	2	755,880
2016	0.1	1	0	0	0.8	6	0.1	1	0.0	0	0.9	7	0.4	3	765,800
2015	0.4	3	-	0	1.4	11	0.4	3	-	0	0.6	5	0.1	1	772,656
2014	0.0	0	0	0	1.6	12	0.1	1	0.1	1	1.0	8	0.8	6	774,011
2013	0.0	0	0	0	1.2	9	0.4	3	0.0	0	1.2	9	0.1	1	777,060
2012	0.0	0	0	0	0.9	7	0.0	0	0.0	0	1.4	11	0.4	3	778,668
2011	0.3	2	0	0	0.9	7	0.1	1	0.0	0	0.8	6	0.6	5	777,302
2010	0.0	0	0	0	1.3	10	0.8	6	0.0	0	0.1	1	0.9	7	772,686
2009	0.0	0	0	0	1.3	10	0.3	2	0.0	0	1.9	15	0.3	2	782,721
2008	0.0	0	0	0	0.6	5	0.1	1	0.0	0	1.5	12	0.8	6	794,043

	Natural/Environmental		Overexertion		Poisoning		Struck by Object		Suffocation		Other		Denominator
	Rate per 100,000	Numerator	Rate per 100,000	Numerator	Rate per 100,000	Numerator	Rate per 100,000	Numerator	Rate per 100,000	Numerator	Rate per 100,000	Numerator	
2017	0.0	0	0.0	0	0.1	1	0.0	0	1.3	10	0.1	1	755,880
2016	0.0	0	0.0	0	0.0	0	0.0	0	0.4	3	0.0	0	765,800
2015	0.4	3	0.0	0	0.1	1	0.1	1	1.0	8	0.1	1	772,656
2014	0.3	2	0.0	0	0.0	0	0.4	3	0.5	4	0.3	2	774,011
2013	0.0	0	0.0	0	0.0	0	0.1	1	1.2	9	0.0	0	777,060
2012	0.0	0	0.0	0	0.1	1	0.3	2	0.4	3	0.1	1	778,668
2011	0.0	0	0.0	0	0.3	2	0.4	3	0.5	4	0.3	2	777,302
2010	0.0	0	0.0	0	0.0	0	0.0	0	0.4	3	0.0	0	772,686
2009	0.0	0	0.0	0	0.1	1	0.0	0	0.0	0	0.0	0	782,721
2008	0.0	0	0.0	0	0.3	2	0.0	0	0.3	2	0.3	2	794,043

Unintentional Injury Non-Fatal Hospitalizations Among Children Birth Through Age 5 in Los Angeles County by Cause, 2015

	Burn/Fire		Cut/Pierce		Drowning		Fall		Firearm		Motor Vehicle-Involved Accident		Bicycle, Pedestrian or Other Transport		Denominator
	Rate per 100,000	Numerator	Rate per 100,000	Numerator	Rate per 100,000	Numerator	Rate per 100,000	Numerator	Rate per 100,000	Numerator	Rate per 100,000	Numerator	Rate per 100,000	Numerator	
2015	180.4	1394	230.5	1,781	15.5	120	3,656.6	28253	0.1	1	290.7	2246	72.9	563	772,656

	Natural/Environmental		Overexertion		Poisoning		Struck by Object		Suffocation		Other		Denominator
	Rate per 100,000	Numerator	Rate per 100,000	Numerator	Rate per 100,000	Numerator	Rate per 100,000	Numerator	Rate per 100,000	Numerator	Rate per 100,000	Numerator	
2015	549.5	4,246	173.2	1338	198.7	1535	1,168.7	9030	19.3	149	1,542.0	11914	772,656

Unintentional Injury Non-Fatal Emergency Department Visits Among Children Birth Through Age 5 in Los Angeles County by Cause, 2015

	Burn/Fire		Cut/Pierce		Drowning		Fall		Firearm		Motor Vehicle-Involved Accident		Bicycle, Pedestrian or Other Transport		Denominator
	Rate per 100,000	Numerator	Rate per 100,000	Numerator	Rate per 100,000	Numerator	Rate per 100,000	Numerator	Rate per 100,000	Numerator	Rate per 100,000	Numerator	Rate per 100,000	Numerator	
2015	180.4	123	230.5	11	15.5	45	3,656.6	865	0.1	2	290.7	77	72.9	22	772,656

	Natural/Environmental		Overexertion		Poisoning		Struck by Object		Suffocation		Other		Denominator
	Rate per 100,000	Numerator	Rate per 100,000	Numerator	Rate per 100,000	Numerator	Rate per 100,000	Numerator	Rate per 100,000	Numerator	Rate per 100,000	Numerator	
2015	549.5	93	173.2	3	198.7	169	1,168.7	57	19.3	46	1,542.0	370	772,656

CONTEXTUAL INDICATOR 6

Percentage of Los Angeles County Children Ages 3 and 4 Who Participate in WIC Who Have a Healthy Weight, 2003-2018

Age in Years	2018 (%)	2017 (%)	2016 (%)	2015 (%)	2014 (%)	2013 (%)	2012 (%)	2011 (%)	2010 (%)	2009 (%)	2008 (%)	2007 (%)	2006 (%)	2005 (%)	2004 (%)	2003 (%)
3	60.9	61.7	62.8	62.3	63.5	62.3	60.3	61.6	63.0	61.2	61.0	63.0	62.7	61.9	63.3	66.2
4	58.7	61.5	62.5	63.7	63.0	62.7	61.4	62.3	61.1	59.7	60.3	61.4	61.3	60.9	62.2	65.7

Percentage of Los Angeles County Children Ages 3 and 4 Who Participate in WIC Who Have a Healthy Weight by Race/Ethnicity, 2003-2018

	Age in Years	2018 (%)	2017 (%)	2016 (%)	2015 (%)	2014 (%)	2013 (%)	2012 (%)	2011 (%)	2010 (%)	2009 (%)	2008 (%)	2007 (%)	2006 (%)	2005 (%)	2004 (%)	2003 (%)
White	3	68.0	67.2	68.4	68.9	71.8	71.1	68.8	68.0	71.2	67.3	66.7	69.6	66.8	66.9	67.6	72.6
	4	67.8	67.5	70.9	71.3	69.8	68.0	70.0	66.4	65.9	65.7	68.7	66.5	66.5	68.2	70.6	70.5
Black	3	70.4	70.5	71.5	69.5	71.7	72.1	68.3	72.5	72.2	69.3	70.2	72.6	72.3	70.2	70.6	75.0
	4	69.4	70.4	71.3	70.0	70.8	70.4	70.9	70.0	68.0	69.3	70.0	70.5	67.6	68.7	72.2	72.2
Latino	3	59.0	59.9	61.0	60.7	61.8	60.5	58.7	59.9	61.6	59.9	59.6	61.6	61.4	60.6	62.1	64.6
	4	59.6	61.0	62.2	61.4	61.2	59.9	60.9	59.8	58.4	58.9	60.1	60.0	59.6	60.9	64.6	65.0
Asian	3	71.4	72.1	73.5	73.6	74.0	73.3	73.2	73.7	72.6	72.0	70.9	71.3	71.0	69.4	67.8	70.3
	4	74.0	72.3	74.6	75.4	73.2	73.2	74.0	71.2	71.4	71.1	71.6	69.9	69.4	68.8	70.5	70.5
Other	3	66.4	67.1	69.2	68.3	70.8	67.8	67.3	69.5	67.2	63.1	65.6	67.4	62.4	58.3	65.7	71.8
	4	67.6	68.8	69.1	69.7	69.0	65.2	68.4	65.1	61.7	64.6	62.1	64.1	66.0	62.2	66.1	66.0

Percentage of Los Angeles County Children Ages 3 and 4 Who Participate in WIC Who Have a Healthy Weight by *Best Start* Geography, 2003-2018

	Age in Years	2018 (%)	2017 (%)	2016 (%)	2015 (%)	2014 (%)	2013 (%)	2012 (%)	2011 (%)	2010 (%)	2009 (%)	2008 (%)	2007 (%)	2006 (%)	2005 (%)	2004 (%)	2003 (%)
Broadway-Manchester	3	62	63	62	58	65	62	63	63	63	60	59	60	62	60	63	69
	4	61	65	63	67	63	63	64	63	61	60	60	59	58	60	63	64
Central Long Beach	3	65	63	67	65	64	61	62	63	60	59	63	63	59	60	63	66
	4	65	67	67	64	67	65	61	63	59	61	58	61	58	60	63	68
Compton	3	61	62	65	62	62	66	62	61	64	63	60	64	65	65	68	69
	4	61	60	64	65	64	68	63	63	66	60	63	63	64	67	66	71
East LA	3	56	58	59	58	60	57	53	59	64	61	60	64	60	58	56	64
	4	54	61	59	61	62	57	59	62	59	60	62	59	59	55	60	62
Lancaster	3	67	67	64	65	65	68	62	64	66	65	66	68	67	65	69	71
	4	64	65	68	65	67	66	65	64	68	61	62	63	67	66	65	71
Metro LA	3	54	57	57	57	57	57	53	55	56	55	57	61	59	60	61	59
	4	56	54	56	59	58	57	52	56	54	56	55	59	58	60	57	62
NE Valley Communities	3	66	65	65	63	64	64	65	61	63	63	63	63	62	58	65	65
	4	59	62	63	66	64	64	60	62	59	57	60	61	59	59	61	64
Palmdale	3	65	66	65	67	65	65	62	64	66	64	64	69	66	66	69	71
	4	61	66	68	68	63	65	59	64	64	60	64	66	63	64	68	68
Panorama City	3	62	59	61	60	63	60	61	62	65	59	56	60	61	62	65	66
	4	57	61	60	59	61	60	61	61	61	56	55	56	57	59	61	65
Southeast LA	3	60	63	62	65	69	67	64	65	66	61	62	62	65	63	65	68
	4	57	62	65	66	66	68	65	68	64	61	60	64	63	62	63	68
S. El Monte/El Monte	3	53	53	57	61	60	57	58	60	61	63	62	62	60	63	66	64
	4	54	53	60	61	58	55	62	60	61	60	60	60	62	64	60	64
Watts-Willowbrook	3	59	62	63	61	65	62	64	63	62	61	60	63	62	64	62	68
	4	58	63	63	63	64	67	63	63	61	61	60	61	63	62	61	66
West Athens	3	59	63	64	61	62	61	58	65	67	62	66	69	63	61	65	68
	4	58	60	62	65	62	65	57	62	59	65	62	62	65	63	66	62
Wilmington	3	61	64	59	59	61	59	57	62	64	59	57	61	56	58	63	65
	4	58	60	60	61	62	61	58	65	62	58	55	57	56	56	59	66

CONTEXTUAL INDICATOR 7

English Learner Kindergarteners in Los Angeles County Public Schools by Race/Ethnicity and Socioeconomic Status, 2014-15 to 2019-20

	2019-2020			2018-2019			2017-2018		
	Rate	Count English Learner Kinders	Count All Kinders	Rate	Count English Learner Kinders	Count All Kinders	Rate	Count English Learner Kinders	Count All Kinders
L.A. County overall	29.3%	36,451	124,219	30.3%	38,740	127,978	35.4%	46,540	131,341
African American	1.6%	126	8,065	1.4%	123	8,935	1.6%	142	8,908
American Indian or Alaska Native	20.9%	53	253	10.7%	24	224	10.8%	23	213
Asian	42.3%	3,880	9,182	42.4%	4,243	10,002	49.2%	4,787	9,738
Filipino	10.7%	254	2,375	12.1%	306	2,523	14.6%	364	2,488
Hispanic or Latino	36.6%	29,775	81,353	37.7%	31,626	83,872	44.3%	38,377	86,718
Pacific Islander	7.7%	22	286	7.1%	23	323	10.4%	36	346
White	10.8%	1,869	17,275	11.1%	2,018	18,176	12.7%	2,287	18,049
Two or More Races	3.7%	148	3,979	4.4%	123	2,809	4.7%	172	3,668
Not Reported	22.3%	324	1,451	22.8%	254	1,114	29.0%	352	1,213
Socioeconomically Disadvantaged	87.0%	31,709	85,531	85.5%	33,104	87,365	85.2%	39,639	90,414
Not Socioeconomically Disadvantaged	13.0%	4,742	38,688	14.5%	5,636	40,613	14.8%	6,901	40,927

	2016-2017			2015-2016			2014-2015		
	Rate	Count English Learner Kinders	Count All Kinders	Rate	Count English Learner Kinders	Count All Kinders	Rate	Count English Learner Kinders	Count All Kinders
L.A. County overall	35.6%	47,603	133,902	36.9%	48,007	130,046	38.4%	47,562	123,895
African American	1.7%	156	9,378	1.5%	140	9,508	1.6%	141	9,058
American Indian or Alaska Native	17.9%	40	223	20.6%	46	223	17.4%	45	258
Asian	45.6%	4,125	9,051	48.2%	4,116	8,542	47.7%	3,891	8,151
Filipino	15.6%	378	2,421	16.5%	389	2,364	16.3%	364	2,237
Hispanic or Latino	44.7%	39,803	88,966	46.6%	40,156	86,183	48.9%	39,903	81,551
Pacific Islander	10.9%	37	340	13.7%	53	386	13.0%	51	392
White	13.7%	2,560	18,717	14.3%	2,635	18,484	14.8%	2,674	18,119
Two or More Races	4.2%	152	3,609	4.3%	147	3,436	5.3%	163	3,098
Not Reported	29.4%	352	1,197	35.3%	325	920	32.0%	330	1,031
Socioeconomically Disadvantaged	80.1%	38,140	87,015	86.7%	41,643	91,532	85.0%	40,436	84,794
Not Socioeconomically Disadvantaged	19.9%	9,463	46,887	13.3%	6,364	38,514	15.0%	7,126	39,101

English Learner (EL) and Initial or Reclassified Fluent English Proficient (IFEP/RFEP) Kindergarteners in Los Angeles County Public Schools, 2014-15 to 2019-20

	EL and IFEP/RFEP		EL		IFEP/RFEP		Total Kindergarteners
	Rate	Count	Rate	Count	Rate	Count	
2019-2020	36.0%	44,703	29.3%	36,451	6.6%	8,252	124,219
2018-2019	36.1%	46,143	30.3%	38,740	5.8%	7,403	127,978
2017-2018	38.5%	50,628	35.4%	46,540	3.1%	4,088	131,341
2016-2017	39.0%	52,161	35.6%	47,603	3.4%	4,558	133,902
2015-2016	40.8%	53,081	36.9%	48,007	3.9%	5,074	130,046
2014-2015	42.5%	52,713	38.4%	47,562	4.2%	5,151	123,895

English Learner (EL) and Initial or Reclassified Fluent English Proficient (IFEP/RFEP) Kindergarteners in Los Angeles County Public Schools by Socioeconomic Status, 2014-15 to 2019-20

	Socioeconomically Disadvantaged				Not Socioeconomically Disadvantaged				Total EL and IFEP/RFEP
	Rate EL and IFEP/RFEP	Count EL and IFEP/RFEP	Count EL	Count IFEP/RFEP	Rate EL and IFEP/RFEP	Count EL and IFEP/RFEP	Count EL	Count IFEP/RFEP	
2019-2020	83.7%	37,431	31,709	5,722	16.3%	7,272	4,742	2,530	44,703
2018-2019	82.6%	38,110	33,104	5,006	17.4%	8,033	5,636	2,397	46,143
2017-2018	83.3%	42,152	39,639	2,513	16.7%	8,476	6,901	1,575	50,628
2016-2017	78.3%	40,819	38,140	2,679	21.7%	11,342	9,463	1,879	52,161
2015-2016	84.7%	44,981	41,643	3,338	15.3%	8,100	6,364	1,736	53,081
2014-2015	82.9%	43,691	40,436	3,255	17.1%	9,022	7,126	1,896	52,713

CONTEXTUAL INDICATOR 8

Percentage of Los Angeles County Young Children Enrolled in School District Special Education Services (according to DataQuest) and Population (according to Department of Finance) by Age, 2015-2019

	2019	2018-2019	2019	2018	2017-2018	2018	2017	2016-2017	2017
	Rate	Count in Special Education	Population	Rate	Count in Special Education	Population	Rate	Count in Special Education	Population
Total Children Age 0-5	3.2%	23,134	714,304	3.1%	22,811	731,064	2.9%	21,928	745,774
Age 0	0.1%	128	112,364	0.1%	124	113,016	0.1%	128	120,714
Age 1	0.2%	248	112,774	0.2%	264	120,438	0.2%	264	121,694
Age 2	0.3%	298	118,388	0.3%	309	119,982	0.2%	297	126,363
Age 3	5.2%	6,225	118,831	4.8%	6,040	125,375	4.4%	5,608	126,125
Age 4	6.4%	8,022	125,655	6.2%	7,865	126,307	6.0%	7,558	126,034
Age 5	6.5%	8,213	126,292	6.5%	8,209	125,946	6.5%	8,073	124,844

	2016	2015-2016	2016	2015	2014-2015	2015
	Rate	Count in Special Education	Population	Rate	Count in Special Education	Population
Total Children Age 0-5	2.9%	21,625	757,778	2.7%	20,858	765,423
Age 0	0.1%	136	122,018	0.1%	147	128,194
Age 1	0.2%	236	127,910	0.2%	250	128,609
Age 2	0.2%	294	126,667	0.2%	293	127,207
Age 3	4.3%	5,351	125,853	3.9%	4,867	124,409
Age 4	5.8%	7,258	124,890	5.6%	7,270	130,383
Age 5	6.4%	8,350	130,440	6.3%	8,031	126,621

Percentage of Los Angeles County Young Children Enrolled in School District Special Education Services (according to special request data from CDE) and Population (according to Department of Finance) by Race/Ethnicity, 2016-2019

	2019	2018-2019	2019	2018	2017-2018	2018
	Rate	Count in Special Education	Population	Rate	Count in Special Education	Population
Native American	1.0%	19	1,980	1.0%	19	1,882
Asian	1.7%	1,720	102,589	1.7%	1,756	104,859
Pacific Islander	2.7%	37	1,362	2.9%	40	1,398
Multiracial	3.6%	992	27,429	3.4%	940	27,482
Latino	4.5%	16,238	363,656	4.2%	15,831	375,902
Black	2.7%	1,437	52,473	2.7%	1,435	53,914
White	1.7%	2,832	162,950	1.7%	2,871	167,694

	2017	2016-2017	2017	2016	2015-2016	2016
	Rate	Count in Special Education	Population	Rate	Count in Special Education	Population
Native American	1.4%	26	1,819	1.5%	27	1,781
Asian	1.6%	1,634	103,765	1.6%	1,560	99,260
Pacific Islander	2.0%	30	1,493	2.6%	41	1,581
Multiracial	3.5%	940	27,030	3.1%	829	26,464
Latino	3.9%	15,057	389,809	3.6%	14,445	404,077
Black	2.5%	1,363	55,350	2.5%	1,437	56,921
White	1.8%	2,931	166,508	2.0%	3,338	165,627

CONTEXTUAL INDICATOR 9

Percentage of Third Graders That Met or Exceeded English Language Arts Standards and Count With Test Scores by Race/Ethnicity, 2014-15 to 2018-19

	2018-19		2017-18		2016-17		2015-16		2014-15	
	Percent Met or Exceeded	Count with Test Scores	Percent Met or Exceeded	Count with Test Scores	Percent Met or Exceeded	Count with Test Scores	Percent Met or Exceeded	Count with Test Scores	Percent Met or Exceeded	Count with Test Scores
L.A. County	48.7%	103,633	48.3%	102,999	43.2%	109,282	41.0%	110,966	35.0%	114,606
White	67.3%	14,717	67.1%	14,896	65.3%	15,148	66.0%	15,569	61.0%	15,963
Latino	41.7%	67,556	40.7%	67,145	35.1%	71,848	33.0%	73,315	27.0%	75,828
Black	32.4%	7,721	34.7%	7,643	29.0%	8,350	29.0%	8,418	24.0%	8,787
Asian	76.9%	7,643	77.2%	7,528	74.1%	8,404	73.0%	8,155	67.0%	8,220
American Indian or Alaska Native	46.6%	163	47.4%	175	44.7%	197	40.0%	249	36.0%	283
Native Hawaiian or Pacific Islander	42.7%	295	51.0%	312	46.4%	373	44.0%	428	32.0%	417
Filipino	73.5%	1,840	73.1%	1,838	68.0%	1,748	69.0%	1,882	62.0%	2,129
2 or more races	71.5%	3,168	71.0%	3,106	66.5%	2,788	65.0%	2,369	61.0%	2,238

Percentage of Third Graders That Met or Exceeded English Language Arts Standards and Count With Test Scores by Socioeconomic Status, 2014-15 to 2018-19

	2018-19		2017-18		2016-17		2015-16		2014-15	
	Percent Met or Exceeded	Count with Test Scores	Percent Met or Exceeded	Count with Test Scores	Percent Met or Exceeded	Count with Test Scores	Percent Met or Exceeded	Count with Test Scores	Percent Met or Exceeded	Count with Test Scores
Economically Disadvantaged	39.6%	73,108	39.2%	73,565	33.4%	76,646	31.0%	78,942	26.0%	79,155
Not Economically Disadvantaged	70.6%	30,525	71.2%	29,434	66.3%	32,636	67.0%	32,024	58.0%	35,451

Percentage of Third Graders That Met or Exceeded English Language Arts Standards and Count With Test Scores by School District, 2018-19

District Name	Total Tested with Scores	Students Tested	Percentage Standard Met and Above
ABC Unified	10,781	1,471	62.3%
Arcadia Unified	4,761	574	75.4%
Azusa Unified	4,209	604	38.7%
Baldwin Park Unified	6,572	842	37.4%
Bassett Unified	1,855	269	45.0%
Bellflower Unified	6,118	838	49.9%
Beverly Hills Unified	1,993	233	71.7%
Bonita Unified	5,202	698	73.6%
Burbank Unified	7,597	939	65.2%
Castaic Union	1,341	182	53.3%
Charter Oak Unified	2,389	324	51.8%
Ciaramonte Unified	3,560	445	58.6%
Covina-Valley Unified	5,764	736	59.1%
Culver City Unified	3,624	491	67.8%
Downey Unified	11,223	1,434	54.3%
Duarte Unified	1,949	253	52.2%
Eastside Union Elementary	2,141	361	23.0%
East Whittier City Elementary	5,740	925	61.0%
El Monte City	5,214	808	47.8%
El Rancho Unified	4,368	560	38.9%
El Segundo Unified	1,740	210	73.3%
Garvey Elementary	2,920	474	57.6%
Glendale Unified	13,210	1,935	65.2%
Glendora Unified	3,744	463	61.6%
Gorman Joint	51	7	-
Hawthorne	4,893	838	46.7%
Hermosa Beach City Elementary	912	144	76.4%
Hughes-Elizabeth Lakes Union Elementary	102	26	73.1%
Inglewood Unified	4,722	745	25.0%
Keppel Union Elementary	1,741	252	30.6%
La Cañada Unified	2,241	297	86.5%
Lancaster Elementary	9,078	1,588	30.9%
Las Virgenes Unified	5,653	699	69.4%
Lawndale Elementary	3,433	540	51.2%
Lennox	3,119	558	42.8%
Little Lake City Elementary	2,788	466	55.4%
Long Beach Unified	36,864	5,334	55.6%

District Name	Total Tested with Scores	Students Tested	Percentage Standard Met and Above
Los Angeles Unified	248,161	38,771	42.9%
Los Nietos	1,025	152	46.1%
Lowell Joint	2,117	344	61.1%
Lynwood Unified	7,097	1,045	41.5%
Monrovia Unified	2,723	358	59.2%
Montebello Unified	12,735	1,751	36.0%
Mountain View Elementary	4,031	715	37.9%
Newhall	3,783	897	65.6%
Norwalk-La Mirada Unified	9,173	1,323	48.8%
Palmdale Elementary	12,276	2,089	30.8%
Palos Verdes Peninsula Unified	5,663	740	81.9%
Paramount Unified	7,854	1,016	41.1%
Pasadena Unified	8,294	1,294	48.4%
Pomona Unified	11,945	1,783	39.3%
Rosemead Elementary	1,616	248	56.5%
San Marino Unified	1,523	203	91.6%
Santa Monica-Malibu Unified	5,290	705	72.7%
Saugus Union	5,472	1,408	65.2%
South Pasadena Unified	2,556	353	85.0%
South Whittier Elementary	1,807	254	36.2%
Sulphur Springs Union	2,981	712	60.5%
Temple City Unified	3,019	385	69.4%
Torrance Unified	11,823	1,576	66.7%
Valle Lindo Elementary	748	99	60.6%
West Covina Unified	4,381	560	49.6%
Westside Union Elementary	6,400	1,046	46.9%
Whittier City Elementary	3,880	644	50.9%
Wilsona Elementary	801	140	31.4%
Compton Unified	11,334	1,724	41.4%
Hacienda La Puente Unified	9,419	1,370	54.0%
Rowland Unified	6,870	905	46.7%
Walnut Valley Unified	7,333	851	75.9%
San Gabriel Unified	2,512	324	59.9%
Acton-Agua Dulce Unified	581	73	37.0%
Manhattan Beach Unified	3,258	408	82.4%
Redondo Beach Unified	5,230	743	77.0%
Alhambra Unified	7,836	944	61.3%
Wiseburn Unified	1,754	236	68.6%

CONTEXTUAL INDICATOR 10

Mothers in Los Angeles County Who Gave Birth in the Last Year That Received Prenatal Care in the First Trimester of Pregnancy by Race or Ethnicity, 2014-2017

	2017			2016			2015			2014		
	Rate	Count First Trimester Care	Count Total L.A. County	Rate	Count First Trimester Care	Count Total L.A. County	Rate	Count First Trimester Care	Count Total L.A. County	Rate	Count First Trimester Care	Count Total L.A. County
White	87.5	102,562	122,462	85.3	107,365	128,919	86.4	108,465	130,227	86.5	113,269	136,029
Black	75.6	20,883	23,867	74.6	21,009	24,643	74.2	21,720	25,141	75.4	21,749	25,139
Latina, U.S.-born	82.2	6,761	8,939	82.1	6,941	9,310	81.9	6,825	9,199	82.0	7,476	9,919
Latina, Foreign-born	84.4	34,107	41,503	84.6	35,032	42,689	84.9	35,071	42,819	85.5	34,926	42,578
Asian/Pacific Islander	85.4	22,346	26,480	85.5	25,088	29,651	84.3	26,620	31,352	82.5	27,941	32,682
Other/Missing	78.1	17,900	20,950	70.5	18,684	21,843	73.6	17,684	20,976	77.4	20,622	24,994

Mothers in Los Angeles County Who Gave Birth in the Last Year That Received Prenatal Care in the First Trimester of Pregnancy by Socioeconomic Status, 2014-2017

	2017			2016			2015			2014		
	Rate	Count First Trimester Care	Count Total L.A. County	Rate	Count First Trimester Care	Count Total L.A. County	Rate	Count First Trimester Care	Count Total L.A. County	Rate	Count First Trimester Care	Count Total L.A. County
Public (i.e., Medi-Cal or other public insurance coverage)	93.5	565	723	80.5	431	611	80.3	545	740	80.7	555	717
Private (i.e., Private insurance or self-pay)	74.7	55,205	59,067	86.0	51,103	63,489	86.3	52,083	64,868	85.8	53,610	66,464

Mothers in Los Angeles County Who Gave Birth in the Last Year That Received Prenatal Care in the First Trimester of Pregnancy by *Best Start* Geography, 2014-2017

	2017			2016			2015			2014		
	Rate	Count First Trimester Care	Count Total L.A. County	Rate	Count First Trimester Care	Count Total L.A. County	Rate	Count First Trimester Care	Count Total L.A. County	Rate	Count First Trimester Care	Count Total L.A. County
Broadway-Manchester	76.8	47,357	63,395	77.1	56,262	65,430	78.0	56,382	65,359	77.7	59,659	69,565
Central Long Beach	81.4	1,051	1,368	80.4	1,130	1,465	72.8	1,122	1,439	75.3	1,157	1,490
Compton	83.4	935	1,149	82.8	1,029	1,280	81.7	962	1,321	83.1	1,071	1,423
East LA	85.4	1,711	2,051	84.7	1,855	2,240	85.3	1,739	2,129	84.7	1,905	2,292
Lancaster	67.5	1,507	1,764	68.7	1,617	1,910	65.4	1,691	1,982	65.8	1,725	2,037
Metro LA	76.1	1,609	2,384	75.0	1,769	2,576	76.6	1,663	2,543	77.5	1,642	2,496
Northeast Valley	83.8	741	974	82.4	753	1,004	84.7	781	1,020	85.0	834	1,076
Palmdale	68.5	1,253	1,495	67.4	1,414	1,716	64.7	1,437	1,696	62.7	1,557	1,831
Panorama City & Neighbors	86.7	1,625	2,371	86.5	1,681	2,494	86.9	1,633	2,525	87.4	1,580	2,520
Southeast LA	85.2	1,789	2,064	85.1	1,949	2,254	86.6	1,870	2,151	86.4	2,038	2,331
South El Monte/EI Monte	87.8	1,862	2,186	88.7	1,897	2,228	86.4	2,027	2,341	86.7	2,013	2,329
Watts/Willowbrook	79.3	1,041	1,185	81.1	1,129	1,273	82.0	1,268	1,467	83.9	1,266	1,460
West Athens	77.8	1,077	1,358	77.0	1,191	1,468	78.0	1,169	1,425	76.7	1,316	1,569
Wilmington	85.1	516	663	78.1	519	674	75.4	540	692	75.8	594	774
L.A. County (without BSG)	84.6	709	833		637	816		668	886	0.0	694	915

CONTEXTUAL INDICATOR 11

Percentage of New Mothers That Had at Least One Postpartum Checkup by Race/Ethnicity, 2010, 2012, 2014 and 2016

	2016	2014	2012	2010
White	93.8	94.8	92.7	94.0
Asian/Pacific Islander	93.3	94.0	88.4	93.5
Latina	89.5	91.1	90.0	91.0
Black	86.9	88.1	84.6	85.5

Percentage of New Mothers That Had at Least One Postpartum Checkup by Service Planning Area, 2010, 2012, 2014 and 2016

	2016	2014	2012	2010
SPA 1	84.2	84.8	80.3	85.2
SPA 2	93.2	93.9	92.4	93.8
SPA 3	91.1	92.3	87.9	92.9
SPA 4	89.1	93.5	91.8	90.8
SPA 5	96.2	96.2	95.3	95.7
SPA 6	87.0	88.7	88.5	88.1
SPA 7	91.4	93.9	91.2	88.7
SPA 8	90.6	90.5	88.7	92.7

CONTEXTUAL INDICATOR 12

Percentage of New Mothers Experiencing Before Pregnancy Depression by Race/Ethnicity and Service Planning Area, 2012, 2014 and 2016

	2016 (%)	2014 (%)	2012 (%)
L.A. County	9.6	10.0	11.0
White	9.5	9.0	8.1
Latina	8.8	9.6	11.5
Black	14.7	13.4	14.8
Asian/Pacific Islander	10.0	11.1	10.9
SPA 1: Antelope Valley	15.5	11.0	9.6
SPA 2: San Fernando	6.1	7.8	9.0
SPA 3: San Gabriel	9.0	13.6	12.3
SPA 4: Metro	9.7	8.9	10.0
SPA 5: West	11.3	6.8	7.7
SPA 6: South	11.6	9.6	13.5
SPA 7: East	9.3	10.6	13.3
SPA 8: South Bay	10.9	9.5	9.9

Percentage of New Mothers Experiencing Prenatal Depression by Race/Ethnicity and Service Planning Area, 2012, 2014 and 2016

	2016 (%)	2014 (%)	2012 (%)
L.A. County	25.0	26.1	29.7
White	18.5	18.6	16.7
Latina	27.5	30.3	34.8
Black	35.8	32.5	39.5
Asian/Pacific Islander	19.4	18.7	21.3
SPA 1: Antelope Valley	25.3	30.7	35.6
SPA 2: San Fernando	24.4	26.0	28.4
SPA 3: San Gabriel	24.9	25.1	25.0
SPA 4: Metro	25.6	25.5	27.5
SPA 5: West	18.1	14.4	16.8
SPA 6: South	29.6	32.5	42.0
SPA 7: East	25.6	28.2	34.1
SPA 8: South Bay	23.3	23.4	26.5

Percentage of New Mothers Experiencing Postpartum Depression by Race/Ethnicity and Service Planning Area, 2012, 2014 and 2016

	2016 (%)	2014 (%)	2012 (%)
L.A. County	25.2%	--	--
White	22.5%	44.9%	47.6%
Latina	26.3%	46.5%	49.4%
African American	28.2%	46.6%	46.2%
Asian/Pacific Islander	24.0%	51.4%	40.0%
SPA 1: Antelope Valley	24.4%	45.5%	52.2%
SPA 2: San Fernando	25.2%	49.6%	49.5%
SPA 3: San Gabriel	28.1%	51.5%	38.9%
SPA 4: Metro	22.1%	43.0%	48.7%
SPA 5: West	16.9%	44.2%	52.7%
SPA 6: South	28.7%	42.9%	48.3%
SPA 7: East	23.4%	45.3%	50.7%
SPA 8: South Bay	24.8%	46.9%	46.8%

CONTEXTUAL INDICATOR 13

Percent of Mothers Reporting any Breastfeeding at One Week, One Month and Three Months, 2014 and 2016

	2016 (%)	2014 (%)
One Week	88.8	86.9
One Month	82.9	80.3
Three Months	70.8	65.5

Percent of Mothers Reporting any Breastfeeding at One Week, One Month and Three Months by Race/Ethnicity, 2014 and 2016

		2016 (%)	2014 (%)
White	One Week	93.5	92.2
	One Month	89.7	87.5
	Three Months	81.5	76.7
Latina	One Week	87.1	85.8
	One Month	79.4	77.3
	Three Months	65.2	60.1
Black	One Week	81.7	78.5
	One Month	77	69.4
	Three Months	64	52.8
Asian/Pacific Islander	One Week	91.8	88
	One Month	89.3	86.1
	Three Months	80.1	75.4

CONTEXTUAL INDICATOR 14

Percentage of Mothers in Los Angeles County With Children Birth Through Age 5 by Highest Level of Education Completed, 2014-2017

	2017 (%)	2016 (%)	2015 (%)	2014 (%)
Less than High School/ Unknown	15.2	16.5	17.5	18.2
High School Graduate	24.2	24.1	24.8	24.2
Some College	26.1	26.7	25.8	25.1
College Graduate	34.4	33.8	32	32.6

Percent of Mothers Reporting Any Breastfeeding at One Week, One Month and Three Months by Service Planning Area, 2014-2016

		2016 (%)	2014 (%)
SPA 1: Antelope Valley	One Week	83.9	84.8
	One Month	77.1	72.1
	Three Months	59.9	56.9
SPA 2: San Fernando	One Week	89.3	89.7
	One Month	83.5	85.3
	Three Months	71.4	68.3
SPA 3: San Gabriel	One Week	88.2	85.5
	One Month	83.6	79.2
	Three Months	71.9	67.9
SPA 4: Metro	One Week	93.5	89.9
	One Month	86.7	85.3
	Three Months	77.4	70.8
SPA 5: West	One Week	96.7	95
	One Month	94.5	93.2
	Three Months	90.1	85.3
SPA 6: South	One Week	83.5	82.4
	One Month	74.8	72.2
	Three Months	58.9	56.4
SPA 7: East	One Week	87.5	85.8
	One Month	79.7	78.2
	Three Months	67.9	61.2
SPA 8: South Bay	One Week	90.6	86
	One Month	86.5	78.8
	Three Months	74.2	62.4

Percentage of Mothers in Los Angeles County With Children Birth Through Age 5 by Highest Level of Education Completed by Race/Ethnicity, 2014-2017

		2017 (%)	2016 (%)	2015 (%)	2014 (%)
White	Less than High School/ Unknown	2.1	2.4	2.3	2.5
	High School Graduate	11.2	11.5	12.2	12
	Some College	22.3	23.1	23.6	24.1
	College Graduate	64.3	63	61.9	61.3
Black	Less than High School/ Unknown	11.1	11.8	12.2	13
	High School Graduate	29.7	29.7	30.2	30.7
	Some College	36.9	36.1	36.2	36.2
	College Graduate	22.3	22.4	21.4	20.1
Latinx, US Born	Less than High School/ Unknown	14.5	15.7	16.2	17.5
	High School Graduate	33.5	33.4	33.8	33.9
	Some College	35.2	34	34.3	33.2
	College Graduate	16.8	17	15.7	15.4
Latinx, Foreign-born	Less than High School/ Unknown	40.5	41.5	43.4	45.6
	High School Graduate	31.2	30.4	30.8	30.3
	Some College	17	16.7	15.8	15
	College Graduate	11.3	11.5	10	9.2
Asian/Pacific Islander	Less than High School/ Unknown	1.7	1.9	1.9	1.6
	High School Graduate	9.4	9.5	10.2	9.3
	Some College	19.5	20	21	20.9
	College Graduate	69.4	68.6	67	68.3
Other / Missing	Less than High School/ Unknown	11.8	12.4	12.7	12.6
	High School Graduate	23.2	18.3	20.1	21.8
	Some College	30.2	31.8	31.4	33.2
	College Graduate	34.9	37.6	35.8	32.5

CONTEXTUAL INDICATOR 14

Percentage of Mothers in Los Angeles County With Children Birth Through Age 5 by Highest Level of Education Completed and by Socioeconomic Status, 2014-2017

		2017 (%)	2016 (%)	2015 (%)	2014 (%)
Public (i.e., Medi-Cal or other public insurance coverage)	Less than High School/ Unknown	28.6	30.1	31.7	33.3
	High School Graduate	36.1	35.7	35.8	35.3
	Some College	26	24.6	24.1	23.1
	College Graduate	9.3	9.6	8.4	8.2
Private (i.e., Private insurance or self-pay)	Less than High School/ Unknown	2.8	3.2	3.3	3.6
	High School Graduate	13.2	12.8	13.8	13.5
	Some College	25.3	26.8	27.4	27
	College Graduate	57.8	57.2	55.5	55.8

Percentage of Mothers in Los Angeles County With Children Birth Through Age 5 by Highest Level of Education Completed and by *Best Start* Geography, 2014-2017

		2017 (%)	2016 (%)	2015 (%)	2014 (%)
Broadway-Manchester	Less than High School/ Unknown	35.4	36.5	38.3	39.5
	High School Graduate	35.5	36	36.3	36.6
	Some College	22.9	22.5	20.5	19
	College Graduate	6.3	5.1	4.9	5
Central Long Beach	Less than High School/ Unknown	35.9	33.1	36.5	34.8
	High School Graduate	25.3	29.5	30.3	30.8
	Some College	27.8	27.8	24.2	26.4
	College Graduate	11	9.7	9.1	8.1
Compton	Less than High School/ Unknown	28.1	28.8	32.2	31.3
	High School Graduate	37.9	38.9	37.4	39.7
	Some College	26.1	24.6	23.6	21.9
	College Graduate	7.9	7.7	6.9	7.2
East LA	Less than High School/ Unknown	24.4	28.2	28.6	31.2
	High School Graduate	38.9	37.2	39.5	38.9
	Some College	25.3	25.6	23.4	21.3
	College Graduate	11.3	9	8.6	8.6
Lancaster	Less than High School/ Unknown	16.5	18.8	19.1	20.9
	High School Graduate	28.3	25.9	26.5	25.3
	Some College	41.8	42.2	41.9	41.1
	College Graduate	13.3	13.1	12.5	12.8
Metro LA	Less than High School/ Unknown	35.7	41.1	45.2	49.3
	High School Graduate	27.3	25.6	26.6	22.2
	Some College	22.7	19.1	17.8	18.9
	College Graduate	14.3	14.1	10.4	9.7
Northeast Valley Communities	Less than High School/ Unknown	31.1	26	27.6	23.7
	High School Graduate	32.3	34.1	30.8	35.9
	Some College	24.6	26.8	27.1	29.7
	College Graduate	12	13.1	14.5	10.7
Palmdale	Less than High School/ Unknown	20	21.7	24.8	25.6
	High School Graduate	30.5	31	28.6	27
	Some College	38.3	37	36.1	37.9
	College Graduate	11.2	10.3	10.5	9.5
Panorama City & Neighbors	Less than High School/ Unknown	28.3	31.6	34	37.8
	High School Graduate	31.3	28.3	29.4	26.9
	Some College	24.1	23.1	21.9	21.8
	College Graduate	16.3	17	14.7	13.5
Southeast LA	Less than High School/ Unknown	27.1	28.8	31.5	34
	High School Graduate	38.7	41.4	38.8	39.9
	Some College	25.3	23.6	23.2	19.6
	College Graduate	9	6.2	6.5	6.5
South El Monte/El Monte	Less than High School/ Unknown	28.6	28	24.9	22.5
	High School Graduate	35.1	34.7	32.1	36
	Some College	22	25	27.5	28.2
	College Graduate	14.3	12.4	15.5	13.3
Watts-Willowbrook	Less than High School/ Unknown	37.1	35.7	34	35.2
	High School Graduate	41	39.7	37.8	38.2
	Some College	17.3	20	21.9	20.8
	College Graduate	4.7	4.6	6.3	5.8
West Athens	Less than High School/ Unknown	29.6	30.4	29.1	25.8
	High School Graduate	37	33.8	34.1	35.4
	Some College	26.1	24.9	25.2	28.5
	College Graduate	7.4	11	11.6	10.3
Wilmington	Less than High School/ Unknown	34.1	31.6	33.3	34
	High School Graduate	28.8	29.3	32.4	32.2
	Some College	27.3	26.1	22.4	23.7
	College Graduate	9.8	13	12	10.1

CONTEXTUAL INDICATOR 15

Average Number of Assets of Children at Birth in Los Angeles County by Race/Ethnicity of the Mother, 2016 and 2017

	2017 (%)	2016 (%)
White	10.3	10.1
Black	7.9	7.9
Latino, U.S.-born	8.6	8.5
Latino, Foreign-born	8.7	8.7
Asian/Pacific Islander	10.4	10.4
Other/Missing	8.8	8.6

Average Number of Assets of Children at Birth in Los Angeles County by *Best Start* Geography, 2016 and 2017

	2017 (%)	2016 (%)
Broadway-Manchester	7.7	7.7
Central Long Beach	7.9	8.0
Compton	8.1	8.2
East LA	8.9	8.8
Lancaster	7.1	7.0
Metro LA	8.1	7.9
Northeast Valley Communities	8.3	8.2
Palmdale	7.2	7.1
Panorama City & Neighbors	8.6	8.6
Southeast LA	8.6	8.6
South El Monte/El Monte	8.9	9.0
Watts-Willowbrook	7.8	7.9
West Athens	7.9	7.7
Wilmington	8.5	8.1

CONTEXTUAL INDICATOR 16

Percentage of Children Birth Through Age 5 Living in Poverty in Los Angeles County, California and the United States, 2010-2018

	2018			2017			2016		
	%	Numerator	Denominator	%	Numerator	Denominator	%	Numerator	Denominator
United States	21.4	4,996,033	23,367,117	22.4	5,250,922	23,444,808	23.5	5,535,200	23,532,756
California	20.2	589,506	2,917,731	21.6	634,326	2,940,017	22.9	677,883	2,953,752
L.A. County	22.5	164,843	731,547	24.2	179,496	742,837	25.8	192,865	747,067

	2015			2014			2013		
	%	Numerator	Denominator	%	Numerator	Denominator	%	Numerator	Denominator
United States	24.3	5,748,795	23,620,492	24.7	5,859,390	23,709,036	24.5	5,831,985	23,785,039
California	23.7	704,354	2,969,136	24.0	716,492	2,982,417	23.7	708,349	2,989,382
L.A. County	26.7	201,599	753,904	27.0	204,971	757,782	26.6	202,606	761,050

	2012			2011			2010		
	%	Numerator	Denominator	%	Numerator	Denominator	%	Numerator	Denominator
United States	23.8	5,677,509	23,846,195	22.9	5,445,386	23,821,023	22.0	5,223,584	23,755,763
California	22.8	685,358	3,001,963	21.5	644,967	2,995,678	20.5	612,940	2,990,290
L.A. County	25.7	196,831	765,539	24.5	189,044	770,289	23.6	183,625	776,667

CONTEXTUAL INDICATOR 16

Percentage of Los Angeles County Children Birth Through Age 5 Living in Poverty by Race/Ethnicity, 2018

	%	Numerator	Denominator
White, Non-Latino	7.8	9,783	124,740
Pacific Islander alone	9.5	246	2,581
Asian alone	10.6	8,425	79,730
Multiracial	12.6	7,765	61,459
Latino	28.8	127,354	442,265
Native American	30.6	1,600	5,227
Black	31.3	16,150	51,630
Other race alone	31.3	58,607	187,206

Percentage of Los Angeles County Children Birth Through Age 5 Living in Poverty by *Best Start* Geography, 2018

	%	Numerator	Denominator
Broadway-Manchester	40.1	3,687	9,190
Central Long Beach	41.1	4,193	10,196
Compton	29.2	3,704	12,679
East LA	28.1	3,174	11,311
Lancaster	30.7	4,796	15,627
Metro LA	49.4	3,884	7,869
Northeast Valley Communities	24.3	2,583	10,633
Palmdale	29.4	5,034	17,139
Panorama City & Neighbors	36.8	5,411	14,693
Southeast LA	39.6	6,231	15,731
South El Monte/EI Monte	32.8	2,573	7,848
Watts-Willowbrook	44.8	4,048	9,026
West Athens	42.9	1,771	4,126
Wilmington	33.0	2,211	6,707
Remainder of L.A. County	19.3	111,543	578,772



750 North Alameda Street | Los Angeles, CA 90012

First5LA.org

First 5 LA

SUBJECT:

Establish a Strategic Partnership with Los Angeles County Department of Public Health (LACDPH), in the Amount of \$400,000 to evaluate efforts to reduce the gap in infant mortality rates between white and black/African American babies in LA County and advance the county-wide African American Infant and Maternal Mortality Initiative (AAIMM) for the period of 12 months.

RECOMMENDATION (PROVIDED AS INFORMATION):

This memo is provided as information for the Board's consideration at the September 24, 2020 Special Meeting of the Board of Commissioners & Program and Planning Committee. First 5 LA staff recommends that at the October 8, 2020 Commission meeting, the Board approve the establishment of a Strategic Partnership with the Los Angeles Department of Public Health (LACDPH) for an amount not to exceed \$400,000 for a period of 12 months. Funds for FY 2020-21 are included within the current First 5 LA Programmatic Budget under AAIMM Birth Outcomes & Disparities- Policy and Systems Change, which was approved by the Board of Commissioners on July 9, 2020. Funds for FY 2021-22 will be included in the FY 2021-22 First 5 LA Programmatic Budget which will be presented to the Board for approval in June 2021.

BACKGROUND:

Los Angeles County's African American Infant and Maternal Mortality Initiative and the California Perinatal Equity Initiative.

The Center for Health Equity, a Los Angeles County Health Agency Initiative led by LACDPH, has a focus on eliminating the African-American infant mortality disparity. Black/African American babies are two to three times more likely to die before their first birthday than babies of other races and Black/African American women are four times more likely to die as a result of pregnancy complications than women of other races in LA County.

First 5 LA joined efforts with county health agencies to reduce infant mortality disparities and improve perinatal outcomes. First 5 LA supports several countywide strategies to reduce African-American infant and maternal mortality ("AAIMM") rates in collaboration with LACDPH and the AAIMM County-wide Steering Committee, consisting of related experts and community leaders:

1. First 5 LA staff serve on the AAIMM management team alongside LACDPH leadership to guide the implementation of the Center for Health Equity's 5-year action plan to reduce disparities by 30% and inform the activities to be funded by the State of California Perinatal Equity Initiative ("PEI") - State PEI funding expands and complements the scope of interventions provided under the Black Infant Health ("BIH") program to mitigate disparities in African American perinatal outcomes. Funding projections estimate the total funding available to LA County will be \$1.4 million annually from FY 19-20 until FY 21-22. Through a community needs, preferences and feasibility assessment, three interventions were included in the Los Angeles County PEI application: (1) group prenatal care; (2) pregnancy intentionality; and (3) fatherhood engagement. An additional \$2.2 million from FY 19-20 until FY 21-22 has been contributed by the California Department of Health Care Services (DHCS) Whole Person Care Program to expand doula support access for African American families. Launched in November 2019, the Doula Project aims to improve birth outcomes for African American women and infants and will include free doula services for eligible families, public awareness and doula trainings.
2. First 5 LA leads the AAIMM Strategic Communications Initiative - In partnership with LACDPH and with \$350,000 in funding support from PEI and DHCS' Whole Person Care, this initiative has the goal of increasing public awareness among community members, medical providers and other stakeholders about the disparity and various interventions being created, expanded or improved to address it.

3. First 5 LA is a leading funder of the AAIMM Village Fund, alongside other public and private funders including LACDPH. The AAIMM Village Fund is a pooled fund managed by the LA Partnership for Early Childhood Investment that supports community-led efforts that reinforce the broad goals of the AAIMM Initiative that are not funded through the State Perinatal Equity Initiative. The First 5 LA Board previously approved an investment in the amount of \$300,000 to the fund over three years.

First 5 LA will continually review and align our policy and systems change contributions to improve practice and service delivery to meet the needs of Los Angeles County's African American families and reduce disparities in birth outcomes. Opportunities to improve services include: (1) connections to maternal early identification and intervention and home visiting efforts; (2) supporting AAIMM efforts to engage hospitals in upstream, systems level interventions to improve African American birth outcomes and experiences; and (3) collaborating with Best Start to increase African American parent leader engagement in AAIMM and across F5LA investments. All aligned AAIMM efforts are being reviewed to determine necessary adjustments to better support the target population and reduce disparate impacts in light of COVID-19.

African American Infant and Maternal Mortality Initiative Evaluation

The AAIMM Initiative designs, supports and implements novel strategies and activities to improve pregnancy, birth and infant outcomes, improve family wellbeing, and decrease health disparities among Black women of reproductive age countywide. A robust evaluation of these initiatives is needed to demonstrate their effectiveness. First 5 LA seeks to partner with LACDPH to leverage private and public funding to support the evaluation of the AAIMM Initiative. LACDPH will contract evaluation services to evaluate the AAIMM Initiative, which includes the Perinatal Equity Initiative, the Whole Person Care Doula Project, and various countywide and regional community engagement, professional development and provider training, a public awareness campaign, and multiple clinical and community interventions.

The procured evaluator will provide the following services:

- In close collaboration with LACDPH, develop and refine an analysis and evaluation plan that evaluates the efficacy of the AAIMM processes, interventions, and activities and their impact on Black families, including data sources, statistical methods to be used, outcomes to be studied, and timelines. Portions of the plan that are continually underway will use the Results-Based Accountability (RBA) framework for performance improvement,
- Preparation for and implement the evaluation plan in collaboration with LACDPH.
- Write final report of synthesis results of LACDPH approved multi-level/multi-sector project analysis of the County of Los Angeles African American Infant and Maternal Mortality (AAIMM) Initiative.

The total budget for the 3-year AAIMM Evaluation is \$900,000. LACDPH is providing funds in the amount of \$500,000 over the course of the 3-year evaluation. First 5 LA's total contribution is \$400,000 to be disbursed in the amount of \$400,000 for a contract length of 12 months. If approved by the Board, First 5 LA would contribute \$400,000 from the FY 2020-21 budget. LACDPH's deliverables under this one year contract will include procuring an evaluator, overseeing the development of an evaluation plan and preparing for implementation.

Pursuant to the Procurement Policy, Strategic Partners of \$75,000 or more in a fiscal year must be presented to the Board for approval. Staff is requesting an establishment of a Strategic Partnership for an amount not to exceed \$400,000 to comply with this policy.

GOVERNANCE GUIDELINES #5 AND #6 (SUSTAINABILITY AND LEVERAGING):

Sustainability: First 5 LA's support to AAIMM Evaluation will build evidence for the interventions and strategies of the AAIMM Initiative, serving as a catalyst for additional adoption, scale and sustainability of interventions and strategies, fund development, and public-private partnership through the life of the AAIMM initiative.

Leveraging: The effort leverages other First 5 LA funds in support of AAIMM, including \$350,000 received from the LACDPH for the AAIMM Strategic Communications Initiative, which promotes increased utilization of AAIMM interventions, and \$300,000 of First 5 LA funds contributed to the AAIMM Village Fund, a pooled fund that supports community-driven interventions in support of AAIMM goals.

JUSTIFICATION:

This Strategic Partnership meets the criteria below:

- The Strategic Partnership can provide specific resources needed by First 5 LA to implement an approved program or initiative in a manner or on a scale that makes the Strategic Partnership more cost effective than resources provided through a competitive solicitation; or
- The Strategic Partnership can implement an approved program or initiative more expeditiously than resources provided through a competitive solicitation; or
- The Strategic Partnership can provide a demonstrated level of ability or expertise that is only available in the community through the proposed Strategic Partnership; or
- The Strategic Partnership provides an opportunity to leverage First 5 LA funds to produce additional funding for the program or initiative or service.

AND

- The proposed Strategic Partnership is aligned with the adopted Strategic Plan.

The Strategic Partnership provides an opportunity to leverage First 5 LA funds to produce additional funding for the program or initiative or service:

The Strategic Partnership provides an opportunity to leverage LACDPH, DHCS and CDPH funds to support the AAIMM Evaluation. LACDPH's contribution is projected to total approximately \$500,000 over three years and currently includes \$250,000 in CDPH awarded PEI and \$50,000 in DHCS awarded Whole Person Care funds. In addition to the \$300,000 currently committed, LACDPH also anticipates receiving an additional \$200,000 in grant funding that will be applied to the evaluation. These funds will contribute to multi-year evaluation efforts (2020-2023) beyond First 5 LA's investment time frame.

The proposed Strategic Partnership is aligned with the adopted Strategic Plan:

The proposed funding is aligned with Strategic Priority 1.2 *Advocate for policies and transformative practices to ensure that public systems provide maternal health services as well as child early identification and intervention services.* This proposed Strategic Partnership aligns with First 5 LA's policy and systems change strategy by supporting efforts to bolster African-American families' utilization of and experience with primary, prenatal and postnatal services.

To improve practice and service delivery that meet the needs of LA County's African American families and reduce disparities in birth outcomes, First 5 LA, alongside LACDPH will seek to evaluate and demonstrate the effectiveness of the AAIMM Initiative's strategies and interventions to improve support, utilization, experience and outcomes for the target population using these proposed funds.

First 5 LA's 2020-2028 Strategic Plan exemplifies our intentional efforts to strategically partner with public and private funders to maximize our impact on young children across Los Angeles County aligns with our investment guidelines as follows:

1. **Partnership:** Together with LACDPH, First 5 LA has engaged community, public, and private sector partners throughout planning, development, and execution of the AAIMM initiative. First 5 LA's contribution to the AAIMM Evaluation is a co-investment with public funders who we have

been engaging on how to reduce disparities in infant mortality rates between white and Black/African American babies in LA County.

Through this Strategic Partnership First 5 LA and LACDPH will continue to identify opportunities to leverage funding.

2. **Equity:** Black/African American babies in LA County are two to three times more likely to die before their first birthday than babies of other races. AAIMM is prioritizing Black/African American babies and mothers to intervene early and effectively when chronic stress caused by racism has placed a woman at risk. LA County's AAIMM framework is designed to maximize the opportunities for community prevention resulting in positive outcomes for kids 0-5.

NEXT STEPS:

Staff anticipates returning to the Board for action on this Strategic Partnership and approval of the contract at the October 8, 2020 Board Meeting.

Collaborative Efforts to Close the Infant and Maternal Mortality Gap in LA County

Deborah Allen, ScD
Deputy Director, LADPH

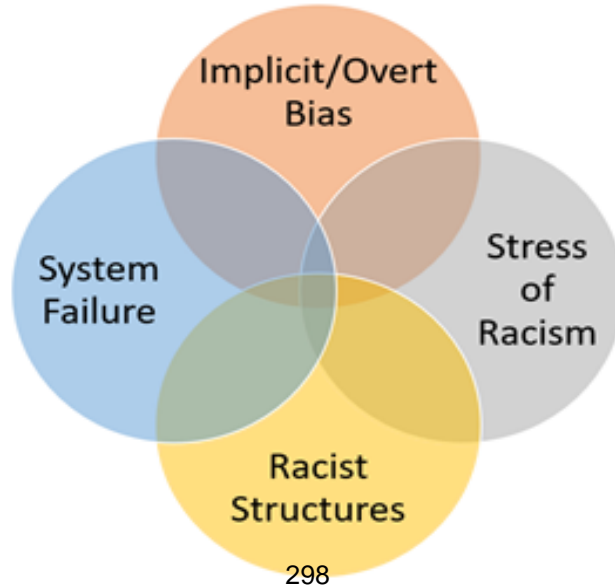
Melissa Franklin, Ed.D.
Pritzker Fellow

Brandi Sims
Program Officer, Family Supports



September 24, 2020

Why We Are Here



AAIMM Background

- Los Angeles County Department of Public Health (LACDPH) released Pathway to Equity, a 5-year plan to address birth outcome inequalities in April 2018.
- Plan challenged prevailing explanations highlighting instead a cascade of events as explanation for birth outcome inequality
 1. Black women's exposure to racism and associated social stressors
 2. Racially mediated stress results in physiological stress: fight or flight
 3. Excessive stress results in adverse health outcomes
- Plan was incorporated into Center for Health Equity Action plan, targeting a 30% reduction in infant mortality rates between white and Black/African American babies in LA County over 5 years.

Framework to Close the Infant Mortality Gap

Strategy 1: Reduce women's exposure to stressors in the social environment.

- Public awareness campaign
- Implicit bias and other health care provider training
- SDOH: Earned Income Tax Credit, paid family leave, housing

Strategy 2: Block the pathway from social stress to physiological stress.

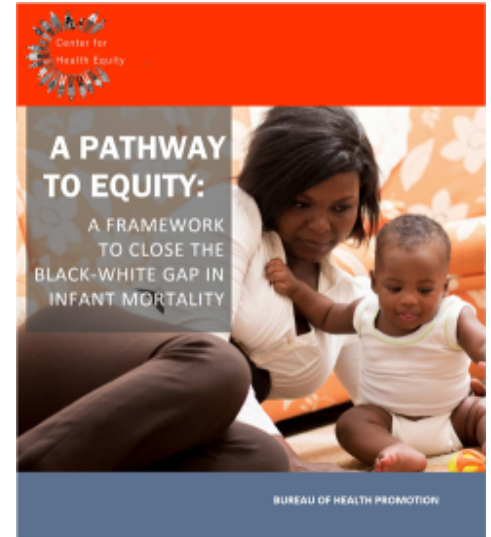
- Doula support
- Group prenatal care

Strategy 3: Intervene as early as possible if and when stress has taken a toll on health.

- Preconception and post partum care
- Clinical prevention of preterm birth: 17p, low-dose aspirin

Strategy 4: Create infrastructure required to achieve 1-3

- Establish countywide Steering Committee and Community Action Teams to guide implementation
- Build data capacity, plans for evaluation of each project
- Build constituency, including the public, policymakers, funders, media



Source:

<http://publichealth.lacounty.gov/centerfortheequity/PDF/AAIM-ActionPlan.pdf>

Pritzker NCIT Initiative – P-3 Outcomes Framework



Los Angeles County African American Infant and Maternal Mortality Initiative



We are a coalition of the LA County Health Agency (Department of Mental Health, Department of Public Health, and Department of Health Services), First 5 LA, community organizations, mental and health care providers, funders, and community members. We are united in one purpose: to address the unacceptably high rates of Black infant and maternal deaths in Los Angeles County.

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AAIMM: A Movement Built on Core Values



Racism is the root cause



Black women up front and leading



Fostering equity while fighting inequity

Black women of all socio-econ
Reproductive justice
Anti-racism, anti-implicit bias

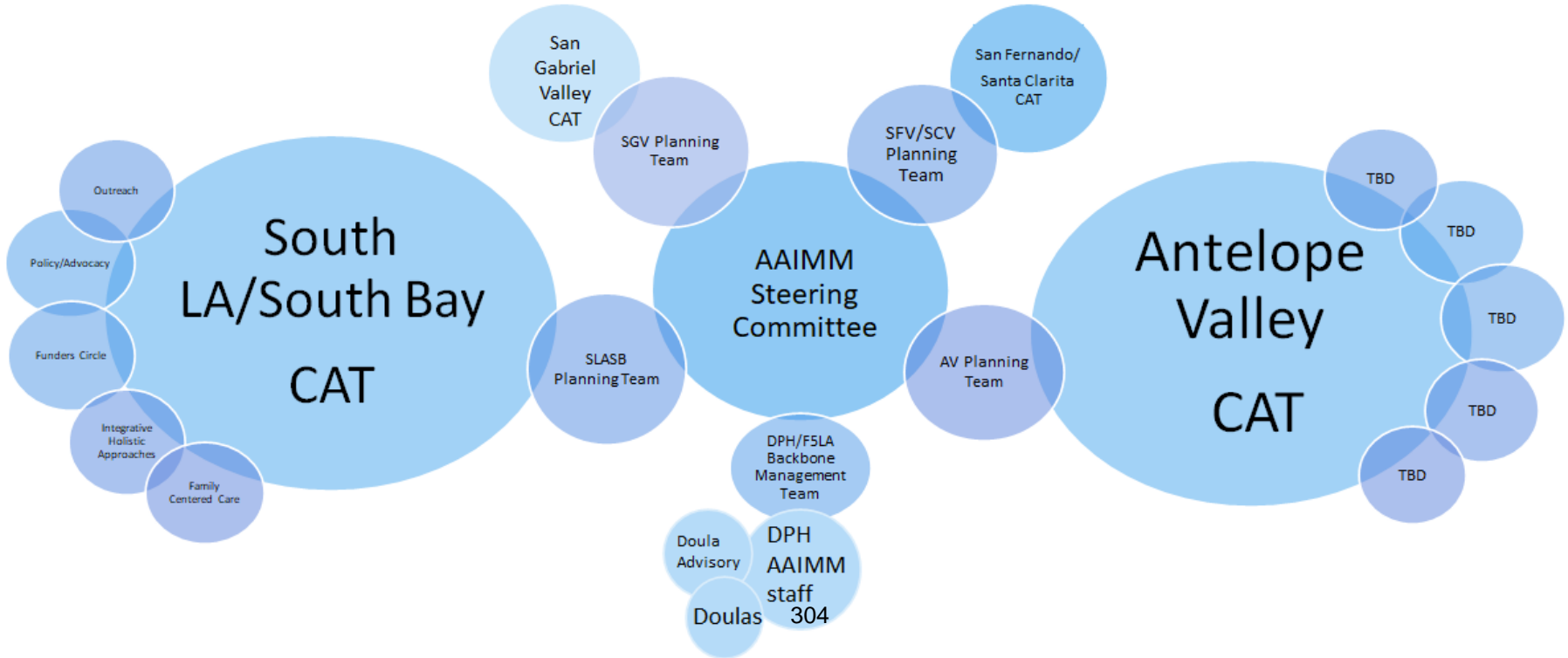


Pieces of the puzzle
Everyone has a role



No blame game

AAIMM Network Structure



AAIMM Outreach & Media Campaigns

Yr 1: 400 Years is enough

- Establish core messages and message vehicles (web, social media, newsletter)

Yr 2: It takes a Village

- CAT Team Support
- Expanded comms activities

Impact: 10M+ reach and sector awareness

Every mother and every child deserve a safe and joyous birth... let's work together to end the injustice of Black infant and maternal deaths in L.A. County.

Black babies in L.A. County are two to three times more likely to die before their first birthday than babies of other races, and Black women in L.A. County are four times more likely to die as a result of pregnancy complications than women of other races, and this, not for the reasons you think!

The stress of racism in our society and across generations is at the heart of the problem. First D LA and the L.A. County Department of Public Health, Mental Health, and Health Services are working alongside community organizations, mental and health care providers, funders, and community members to stop this injustice.



this injustice.

Join the movement to end African American maternal death.

Attend our panel discussion on Women's Health Week 2020: It Takes a Village to End Black Infant and Maternal Deaths in L.A.

Visit our Expo Booth at www.blackinfantsandfamilies.org to find out more about our location teams.

A message from

Meet the

Los Angeles County has launched a Doula pilot project to support Black/African American families in having access to a health and joyous birth. We'd like you to meet them...



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Doulas are professional childbirth companions who provide emotional support, physical comfort, education and advocacy to women and persons during pregnancy, childbirth and the newborn period. Doula support can reduce medical interventions, including c-sections, improve your mood and satisfaction with your birth experience, and increase your breastfeeding success! Doula support can be provided while maintaining social distancing guidance.

For more information on the doula pilot, contact Nakisha Robinson at NPerkins-Robinson@ph.lacounty.gov or (213) 637-8466.

JOIN US FOR BLACK MATERNAL HEALTH WEEK 2020

#WeAreTheVillage | #BFHW2020



Black Infants & Families
www.blackinfantsandfamilies.org



blackinfantsandfamilies.org



@bif_LA



@blackinfantsandfamiliesla



@blackinfantsandfamilies

What we created together: Forward Momentum

- Launch of countywide Steering Committee
- In partnership with LACDPH, secured 4 years of state Perinatal Equity Initiative funds for group prenatal, fatherhood, and preconception health
- Senate Bill 464, Dignity in Childbirth Act
- Doula program launched; ~200 families
- Tax prep events for Earned Income Tax Credit
- Groundswell of Activity – Sector Awareness with collaborations with ABWP, insurers, others
- 2 Community Action Teams covering 3 geographic areas with 2 more forming
- Robust, culturally appropriate communications platforms and messaging co-designed with community
- Implicit bias and anti-racism trainings of all county staff
- Launch of Village Fund
- Cherished Future Partnership

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A photograph of a woman with a black and orange patterned top holding a baby in a pink shirt. The baby is looking towards the camera. In the background, there are blue folders and a blue railing.

Changing Systems: Maximizing Partnerships



AAIMM Alignment to our Strategic Plan

- **Strategic Priority 1: Strengthen Public and Community Systems**
 - **Objective 1.2** Advocate for policies and transformative practices to ensure that public systems provide maternal health services as well as child early identification and intervention services.
 - **Objective 1.6a** Lead program and policy expansion of family-centered practices in systems serving children and families
- **Overarching Tactics:**
 - ✓ Relationship and Partnership Building
 - ✓ Advocacy
 - ✓ Internal Capacity Building
 - ✓ External Capacity Building
 - ✓ Communication and Dissemination
 - ✓ Data Development, Integration, Collection and Sharing
 - ✓ Community Based Participatory Research & Evaluation



AAIMM Investments FY 20-21 and Beyond

FY 20-21 F5LA Investment: \$1.4M



Strategic Priority 1: Strengthen Public and Community Systems

Stakeholder Engagement

- Public Awareness Campaign (DPH Funded)
- Backbone Support
- Consulting + Technical Assistance
- Best Start for Black Babies
- Policy & Advocacy

Research & Data

- **AAIMM Evaluation**

Innovation

- AAIMM Village Fund

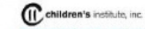
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Integration & Emerging Opportunities

Multiple Partners Contributing to AAIMM

Leveraged Supports:

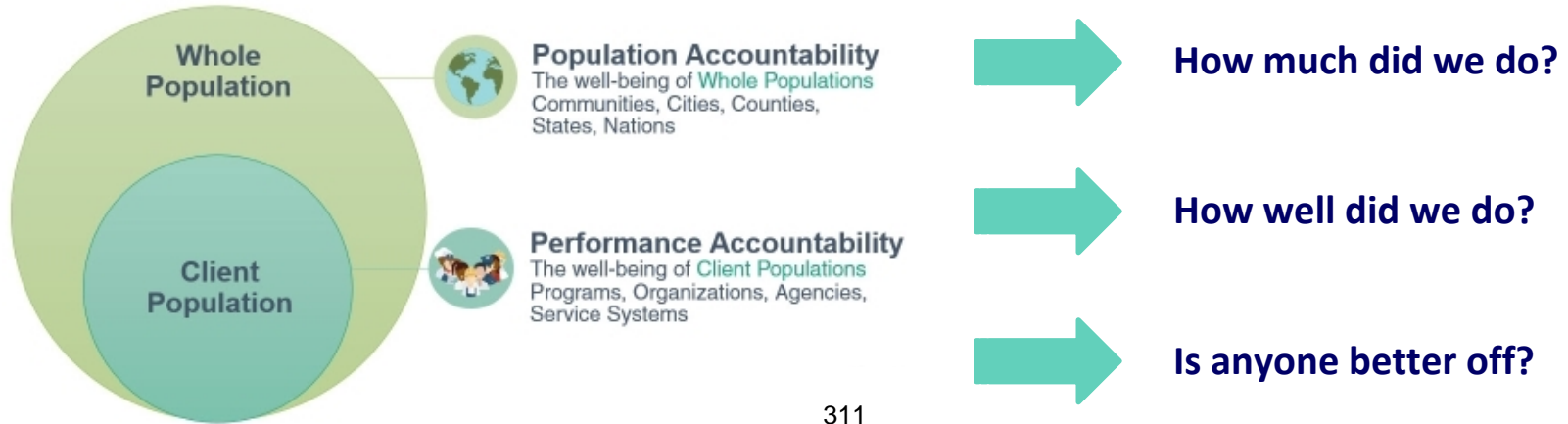
- \$3M+ in local and state public funding
- \$400K+ investments in backbone and programmatic support from private foundations
- \$1M through pooled AAIMM Village Fund
- In-kind supports from AAIMM partners



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The Need for AAIMM Evaluation

- AAIMM uses novel interventions and strategies to improve birth outcomes for Black moms and babies. Evidence is needed to demonstrate effectiveness and support optimization, scale and sustainability.
- In alignment with the CA Perinatal Equity Initiative, AAIMM will use the Results Based Accountability Framework.



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Request to Enter Strategic Partnership with DPH for AAIMM Evaluation

- **\$400,000 in matching funds to County Department of Public Health to support comprehensive evaluation**
- Goal is to evaluate AAIMM strategies and interventions including PEI interventions, AAIMM Doula program, Public Awareness Campaign and others
- DPH will procure evaluator and manage multi-year evaluation
- Next step: Oct. 2020 Board consideration via contracts consent



Let's work together to stop the injustice of black infant and maternal deaths in LA County

Join us as we advocate for...



www.blackinfantsandfamilies.org



Questions?

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FIRST 5 LA

SUBJECT:

Authorize First 5 LA to Receive Funds from First 5 California Commission for the Home Visiting Coordination Funding Project.

RECOMMENDATION:

The following recommendations are being presented as written information for the Board's consideration at the September 24, 2020 Program and Planning Committee meeting. First 5 LA staff recommends that at the October 8, 2020 Commission meeting, the Board approve the following action related to the First 5 California Home Visiting Coordination (HVC) Funding Project:

1. Approve a Budget Resolution # 2020-09 to approve receipt of funds in the amount of \$199,560 from FY 20-21 to FY 21-22 from First 5 California Commission to implement the Home Visiting Coordination (HVC) Funding Project.
2. Authorize the Executive Director to complete execution of agreement with First 5 California Commission upon approval from the Board at the October 8, 2020 Commission Meeting to receive funds over a period of two fiscal years.

BACKGROUND:

In October 2019, the First 5 California (F5CA) State Commission approved funding for Fiscal Years 2019 - 20 through 2024 - 2025 to help counties create a sustainable, unified home visiting system that supports families with the services they need and maximize available funding to serve more families. Since the F5CA Commission authorized this funding, the landscape in California has shifted, making home visiting coordination critical. During the COVID-19 public health emergency, home visiting plays a vital role in addressing the needs of pregnant women, young children, and families, whether in-person or virtually. Funding authorized by the F5CA Commission will be dedicated to helping counties focus on family recovery from the COVID-19 crisis by rebuilding and strengthening their home visiting programs and embedding home visiting into other systems of child and family support that are critical to recovery.

Funding from F5 Home Visiting Coordination project will help advance the First 5 LA Strategic Plan system building goals to support the development and expansion of a universal system of voluntary home visiting and strengthen the existing infrastructure. As the fiscal lead for this grant award for Los Angeles County, F5LA will facilitate activities that improve cross-program service coordination and integration into a system of supports that enables families to be served during their greatest need, with the most appropriate program and services to recover from the effects of the COVID-19 pandemic. Funds will be utilized to support consultants to facilitate convenings and meetings to provide integration guidance for key stakeholders and to assist in development of a Master Consent Form to facilitate sharing of data across multiple funding streams (F5LA, DPH, DPSS, and DMH). Additionally, funding will support efforts for Los Angeles County's Best Babies Network (LABBN) to achieve designation as a site administrator and trainer for Healthy Families America, a national evidenced-based program. LABBN currently coordinates cohort trainings of 150 hours required by local funders as well as national program trainings; provides programmatic technical assistance; database oversight; and coordination of regional peer networks. LABBN already conducts a significant portion of responsibilities required of an HFA Multi-Site Administrator role. Acquiring this official role would allow for stronger local oversight, increased efficiency, evaluation efforts at a network level, and standardization of model implementation across diverse funding sources.

NEXT STEPS:

Staff anticipates returning to the Board for action at the October 8, 2020 Board Meeting.

RESOLUTION NO. 2020-09

**A RESOLUTION OF THE LOS ANGELES COUNTY CHILDREN
AND FAMILIES FIRST PROPOSITION 10 COMMISSION:
APPROVAL OF RECEIPT OF HOME VISITING COORDINATION (HVC) FUNDING PROJECT FUNDS**

The Board of Commissioners of Los Angeles County Children and Families First Proposition 10 Commission (“the Commission”) hereby finds and resolves as follows:

Whereas, pursuant to the Fund Balance Policy approved on October 13, 2016, the Commission is required to approve via Resolution the receipt of restricted funds, thus formally acknowledging and reflecting externally imposed constraints placed on the use of these resources; and

Whereas, First 5 CA awarded First 5 LA a grant to be used to implement the Home Visiting Coordination (HVC) Funding project to helping counties focus on family recovery from the COVID-19 crisis by rebuilding and strengthening their home visiting programs and embedding home visiting into other systems of child and family support that are critical to recovery. Activities under HVC will include: securing consultant support to facilitate convenings and meetings to provide integration guidance for key stakeholders, assistance in development of a Master Consent Form to facilitate sharing of data across multiple funding streams (F5LA, DPH, DPSS, and DMH), and support efforts for F5LA’s Oversight Entity (FSOE) to achieve HFA Multi-Site Administrator Role.

NOW, THEREFORE, BE IT RESOLVED THAT:

1. Funding received from First 5 CA in the amount of \$199,560, invoiced semi-annually over a period of two fiscal years, will be considered restricted for fund balance purposes; and
2. The Executive Director, on behalf of First 5 LA, is authorized to accept additional funding from First 5 CA if funding for the same purpose continues, and
3. The executed copy of this Resolution shall be retained on file as evidence of the Commission’s actions herein.

PASSED, APPROVED AND ADOPTED THIS 8TH DAY OF OCTOBER 2020, BY THE FOLLOWING VOTE:

AYES: Commissioners _____

NOES: Commissioners _____

ABSTAIN: Commissioners _____

Sheila Kuehl
Chair, First 5 LA

Kim Belshé
Executive Director