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AGENDA

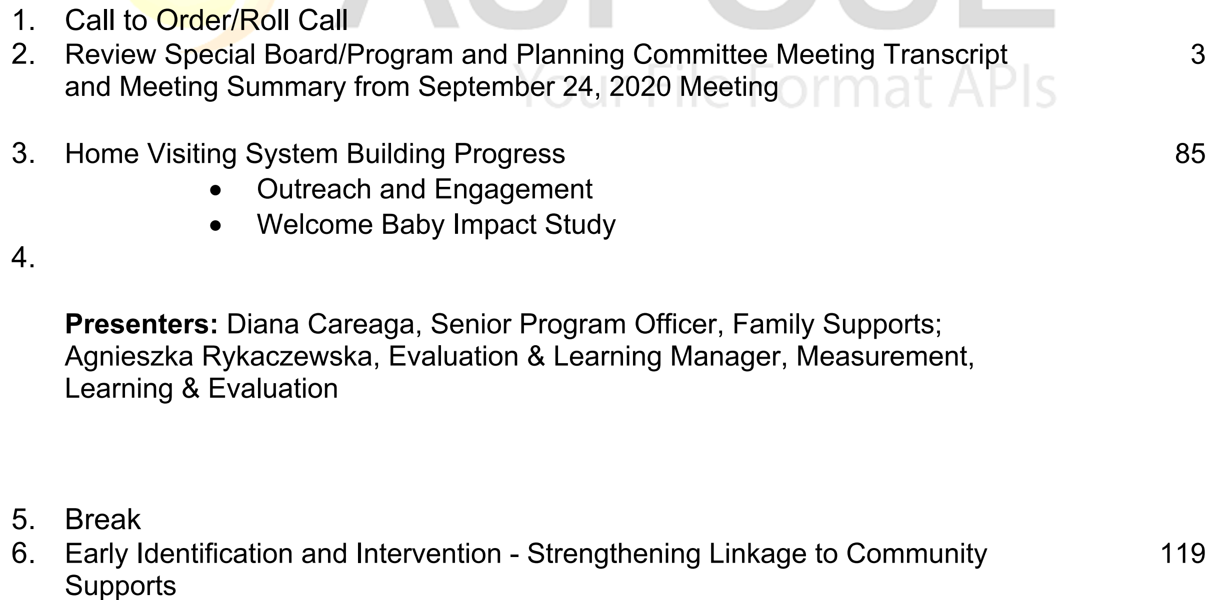
MEETING OF THE BOARD OF COMMISSIONERS

Chair: Sheila Kuehl

Thursday, October 29, 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. Call to Order/Roll Call
2. Review Special Board/Program and Planning Committee Meeting Transcript and Meeting Summary from September 24, 2020 Meeting — 3

3. Home Visiting System Building Progress — 85
   - Outreach and Engagement
   - Welcome Baby Impact Study
4.

   Presenters: Diana Careaga, Senior Program Officer, Family Supports; Agnieszka Rykaczewska, Evaluation & Learning Manager, Measurement, Learning & Evaluation

5. Break
6. Early Identification and Intervention - Strengthening Linkage to Community Supports — 119

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Bobby Cagle
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Romalis J. Taylor
Keesha Woods
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EXECUTIVE VICE PRESIDENT
John A. Wagner

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750 N. Alameda Street, Suite 300 Los Angeles, CA 90012 Phone: 213.482.5902 Fax: 213.482.5903 First5LA.org

Presenters: Tara Ficek, Director, Health Systems; Cristina Peña, Senior Program Officer, Health Systems; Steve Baldwin, Director, Children's Health Outreach Initiatives, Maternal Child Adolescent Health, LA County Department of Public Health

7. Establish Strategic Partnerships with LACOE, Child 360, and the Child Care Alliance of Los Angeles for Dual Language Learner Pilot Expansion in the Amount of $1,887,676 for a Period of 13 months **(Written Only)** 189

Presenters: Becca Patton, Director, Early Care & Education; Gina Rodriguez, Program Officer, Early Care & Education

8. Establish a Strategic Partnership with the Los Angeles County Office of Education (LACOE) in the Amount of $6,349,422 to implement QSLA's IMPACT 2020 award from First 5 CA for the period of November 1, 2020 through June 30, 2023 **(Written Only)** 192

9. Establish a Strategic Partnership with California Health Foundation and Trust, Fiscal Sponsor for the Public Health Alliance of Southern California and Communities Lifting Communities in the Amount of $250,000 for a period of 12 Months for the Cherished Futures for Black Moms and Babies Hospital Quality Improvement Project **(Written Only)** 194

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Presenters: Tara Ficek, Director, Health Systems; Brandi Sims, Program Officer, Family Supports

10. Public Comment (for items not on the agenda)
11. Adjournment

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SUMMARY MINUTES

FIRST 5 LA
September 24, 2020
Special Board/Program & Planning Committee Meeting (VIRTUAL)
1:30-3:30 pm

PROGRAM & PLANNING COMMITTEE MEMBERS PRESENT:
Astrid Heger
Romalis Taylor
Keesha Woods
Marlene Zepeda (Chair)

Ex-Officio Commissioners:
Wendy Garen
Deanne Tilton
Karla Pleitez Howell

NON-COMMITTEE MEMBERS PRESENT
Judy Abdo
Barbara Ferrer
Yvette Martinez

PROGRAM & PLANNING COMMITTEE MEMBERS ABSENT:
Bobby Cagle [Excused]

STAFF PRESENT:
Christina Altmayer, Vice President of Programs
Peter Barth, Interim Chief of Staff
Kim Belshé, Executive Director
John Wagner, Executive Vice President

1. Call to Order / Roll Call

Committee Chair Zepeda called the meeting to order at 1:30 pm. Quorum was present.

2. Review Program and Planning Committee Transcript from February 27, 2020

The transcript was received and filed with no deletions, additions or changes.

3. 2020 Indicators Report

Ms. Kimberly Hall, Ms. Neszka Rykaczewska, Mr. Bryan Fahrbach, Ms. Ofelia Medina and Mr. John Guevarra presented on First 5 LA's 2020 Indicators Report. This presentation resulted in a lot of Commissioner feedback ranging from dubbing the Report a milestone achievement for First 5 LA's deployment of data in service of children and families, to it serving as a report card for assessing how young children in our County are faring. Commissioners lifted up the importance of the report's disaggregation of data, by race, ethnicity, income and geography, to help focus the work of First LA and others.

They shared their expectation that the report will spur critical conversations regarding what's behind the data – the root causes – and what it will take – by First 5 LA, our partners, policy makers – to drive systems-level changes that meet the needs of young children and their families. Across nearly all Commissioners, they spoke of the importance of building public will to prioritize young children – a systems change strategy fundamental to our work at First 5 LA.

4. Break

5. 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

The Indicators Report discussion was a great tee up for the AAIMM presentation that was led by Ms. Tara Ficek, Dr. Debbie Allen of the L.A. County DPH, Pritzker Fellow Melissa Franklin, and Ms. Brandi Sims. The team's AAIMM presentation clearly made a connection with Commissioners.

Commissioners noted their appreciation of how the initiative is grounded in root cause analysis – namely, racism as the fundamental driver of Black infant and maternal mortality disparities. They lauded AAIMM as an exemplar for Black women shaping and leading the initiative. They lifted up how AAIMM is a powerful and concrete example of how systems can be transformed through collaboration and partnership. And, they underscored that while "systems change" can be somewhat opaque, what the team was presenting was fundamentally human-centered – the outcome of joyous and healthy births for Black children and mothers.

6. 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)

This was a written only item. There was no discussion.

7. Public Comment (for items not on the agenda)

There were no Public Comments

ADJOURNMENT:

The Commission adjourned at 3:29.

NEXT MEETING:

The next Special Board/Program & Planning Committee Meeting will take place on Thursday, October 29, 2020 at 1:30 pm.

VIRTUAL BOARD MEETING
Meeting details will be posted per Brown Act Requirements

Meeting minutes were recorded by Linda Vo, Board Relations Manager.

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8 MEETING OF FIRST 5 LOS ANGELES PROGRAM AND PLANNING
9 Thursday, September 24, 2020
10 750 North Alameda Street, First Floor
11 Los Angeles, California 90012
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24 STENOGRAPHICALLY REPORTED BY:
HEATHERLYNN GONZALEZ
25 CSR #13646

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1 Thursday, September 24, 2020; Los Angeles, California
2 1:31 p.m.
3 -oOo-
4 COMMISSIONER ZEPEDA: Let's call the first virtual
5 meeting for P and P meeting together. So I'm happy to see
6 everybody, whether or not it's being recorded. So let's go
7 ahead and do a roll call. So I'll hand it over it Jamie.
8 THE SECRETARY: Thank you so much, Commissioner.
9 So I'll go ahead and -- actually, I'll set the ground rules
10 first, if that's okay, and then follow with the roll call.
11 Is that right?
12 COMMISSIONER ZEPEDA: Sure.
13 THE SECRETARY: Thank you so much and good
14 afternoon, Commissioners, staff, and public members. My
15 name is Jamie Knolls with First 5 LA, and I'll be the
16 acting board secretary for today's meeting. Before I
17 begin, I just wanted to set -- cover some guidelines for
18 today. Pursuant to Governor Newsom's Executive Order
19 N-25-20, members of the First 5 LA board of commissioners
20 or staff my participate in this meeting via teleconference.
21 In an interest in maintaining appropriate social
22 distancing, members of the public may observe this meeting
23 telephonically or otherwise electronically as posted on our
24 website and this agenda. To provide a public comment, you
25 can e-mail me at JknollsFirst5LA.Org or you can call me at

1 213-482-6010, and please indicate your item number that
2 you're comment corresponds with if providing public
3 comment. I should receive those public comments before
4 1:30 p.m. today, and those will be read aloud. And if they
5 are received after 1:30 p.m. today, they'll become a part
6 of public record.
7 Before we begin, I just want to note the
8 following: We will conduct today's meeting with video and
9 audio. That will allow all meeting participants and public
10 members to view presentations via shared screen. To
11 minimize background disruptions, all committee members and
12 staff should place their lines on mute until called upon to
13 speak. Very important to minimize multiple people speaking
14 at the same time and ensure for a coherent dialogue. If
15 you wish to speak or have a question, please text our
16 committee chair, Marlene Zepeda, at 310-902-0967, and she
17 will call on you to speak or you may text -- sorry. Chat
18 me on the Zoom chat box and I'll let her know that you are
19 interested in speaking via text, and then she'll call on
20 you to speak in the order she receives those requests.
21 If you need any technical assistance, please give
22 me a call at 213-482-6010, and will connect with you IT.
23 So with that, I'll hand it back over to you,
24 Chair, or can I just go ahead and start the roll call.
25 COMMISSIONER ZEPEDA: Thanks, Jamie, for reminding

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1 everybody of the protocol. Let's go ahead and, Jamie,
2 maybe you can start with the roll call and then we can move
3 on to the next item.
4 THE SECRETARY: Thank you so much. Everyone, go
5 head and take yourself off mute of you're a commissioner so
6 you can be ready for the roll call.
7 I will start with Judy Abdo.
8 COMMISSIONER ABDO: Here.
9 THE SECRETARY: Barbara Ferrer.
10 Astrid Heger.
11 COMMISSIONER HEGER: Here.
12 THE SECRETARY: Yvette Martinez.
13 COMMISSIONER MARTINEZ: Here.
14 THE SECRETARY: Jonathan Sherin.
15 Romalis Taylor.
16 COMMISSIONER TAYLOR: Here.
17 THE SECRETARY: Keesha Woods.
18 COMMISSIONER WOODS: Here.
19 THE SECRETARY: Marlene Zepeda?
20 COMMISSIONER ZEPEDA: Here.
21 THE SECRETARY: Bobby Cagle.
22 Wendy Garen.
23 Deanne Tilton.
24 COMMISSIONER TILTON: Here.
25 THE SECRETARY: Carla Pleitez Howell.

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1 COMMISSIONER HOWELL: Here.
2 THE SECRETARY: Sheila Kuehl.
3 And that completes the roll call. Thank you so
4 much.
5 COMMISSIONER ZEPEDA: Typically, we -- in our in
6 vivo committee meetings, we allow people to introduce
7 themselves, including the members of the audience, but I
8 think we're skipping that this time. Correct, Jamie?
9 THE SECRETARY: I just wasn't aware if we were
10 doing that. I'm happy -- I mean we can do that if you'd
11 like.
12 COMMISSIONER ZEPEDA: I think for time sake and
13 everybody's Zoom knowledge.
14 THE SECRETARY: I think that was the goal from
15 Linda, was just go to the roll call.
16 COMMISSIONER ZEPEDA: Let's move on to the
17 transcript. If you had an opportunity -- it was a very
18 lengthy transcript. I don't know if you had a chance to
19 even peruse it. But are there any questions about the
20 transcript? Any comments, any calls for modification of
21 the transcripts from our last meeting?
22 Okay. All right. Hearing none, we'll accept the
23 transcripts.
24 I do have a question and maybe about the
25 transcripts, and that is that in our regular meetings, we

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1 had moved to kind of a summary transcript. Isn't that
2 correct, Kim? And this was not a summary transcript. This
3 was the quote/unquote the original type of transcript.
4 MS. BELSHE: Yeah, this is a work in progress in
5 terms of extending it to all of our board committees as
6 well as our regular board meeting.
7 COMMISSIONER ZEPEDA: All right. I just wanted to
8 -- because what I was looking at was quite long.
9 Okay. So hearing none, we'll accept the
10 transcripts.
11 And we're going to go into our first big
12 presentation, which is the 2020 indicators report. And our
13 presenters are Kimberly Hall and I -- I apologize -- you've
14 got to pronounce it for me.
15 MS. RYKACZEWSKA: Agnieszka.
16 COMMISSIONER ZEPEDA: Roll that R. Thank you.
17 And we have Bryan Fahrbach, Ofelia Medina, and
18 John Guevarra who will be presenting on this indicators
19 report that we've all been working on for quite a while
20 now. So I'll hand it over to you.
21 MS. HALL: Good afternoon, Commissioners. I'm
22 really excited to join you this afternoon to discus the
23 inaugural impact framework indicator report. This report
24 is a first of its kind for First 5 LA. The development of
25 this report was a significant undertaking with many

1 contributors, including my co-presenters. I want to give a
2 special thanks and congratulate the staff of the
3 measurement learning and evaluation department and, in
4 deed, the entire integration and learning divisions for
5 their efforts in every stage of the process and for leading
6 the effort to achieve this significant milestone.
7 In our presentation today, we will acknowledge and
8 offer thanks to all of the many other hands who helped
9 shaped the clay and will no doubt joining with us into the
10 next phase, which is using the data from the report to
11 guide and measure our progress. With that introduction,
12 I'd like to walk you through the outline for today's
13 presentation.
14 To ground our discussion today's presentation with
15 Agnieszka, the impact framework measurement lead, talking
16 about where we've been. She'll do that by providing a
17 reorientation to the impact framework and a reminder of
18 previous board engagements focused on the impact framework.
19 Next, Bryan, the organizational development
20 specialist who managed the report development process, will
21 begin the discussion of where we are now by providing an
22 orientation to the report and sharing key findings.
23 We will then move into some specific examples to
24 illustrate how we're connecting the findings illuminated by
25 the report, the implementation planning, and ultimately to

1 achieving the results for children and families outlined in
2 the strategic plan.
3 Ofelia, our senor policy strategist, will share an
4 example related to our policy work in early care and
5 education. And John Guevarra, a program officer
6 representing the communities department, will share an
7 example related to our built environment work in the Best
8 Start geographies. I'll round out the discussion on where
9 we are now by offering some reflections on challenges that
10 we experienced in developing the report and how we face
11 those challenges head on by leaning into our organizational
12 values.
13 I do want to note that we will pause after each
14 example connecting our work to the report findings, to hear
15 questions and reactions, and have some discussions with
16 commissioners.
17 Before we close out the presentation, I'll provide
18 some insights on where we're going, including our efforts
19 related to dissemination that's making a difference.
20 So with that overview of our conversation, I'd
21 like to hand it off to Agnieszka.
22 MS. RYKACZEWSKA: Thank you, Kim. And good
23 afternoon, commissioners.
24 My role today will be to briefly recap our journey
25 to date with the impact framework. We're going to be begin

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1 by going to slide four. Our journey, as all First 5 LA
2 journeys, start with our 2020-2028 strategic plan which is
3 summarized by this visual as the pathway we're taking to
4 reach our north star. I'll cover this more visual more in
5 depth later in the presentation, but for now I'd like to
6 highlight that the impact framework was born from a need to
7 understand how we are progressing along with pathway.
8 Slide, please. Through the impact framework, we
9 will be monitoring four different types of data indicators
10 which are summarized in this visual. I'll review each of
11 them briefly. First, we have our results for children and
12 families indicators, or result indicators for short. These
13 are the population level indicators which capture child and
14 family conditions that reflect progress towards the north
15 star. And we'll be using these indicators to gauge how
16 well are systems working for children and families.
17 Next, are our long-term system outcome indicators.
18 These indicators are about whether family-serving systems
19 are improving and better supporting children and families.
20 And these indicators will help us understand progress on
21 our systems change strategies.
22 Third, we have our short-term markers of progress,
23 which are the early changes of systems we expect to see
24 from our strategies, and these will be used to guide course
25 correction.

1 And then finally, in the circle in the background,
2 we have our contextual indicators which capture the
3 conditions in LA County that affect our work. And they'll
4 be helping us understand our context so that we can really
5 tailor our strategies to be LA County specific.
6 So you may ask, how do these different types of
7 indicators connect to the strategic plan. In the next
8 slides, we'll be highlighting these connections. And so
9 we're going to start at the top with the results for
10 children and families, which are the four conditions for
11 children and families that are necessary to reach our north
12 star.
13 Our result indicators will be the ones that help
14 us understand the progress that we're making on children
15 and families having these conditions met.
16 Next slide. We recognize that, in order for
17 children and families to have these conditions met, systems
18 have to have certain characteristics. They need to be
19 accessible, quality, aligned, and sustainable. And so our
20 long-term system outcome indicators will help us monitor
21 progress towards systems having these characteristics.
22 And then, finally -- slide -- our strategic
23 priorities articulate how we will focus our efforts and
24 contributions to change systems. And our short-term
25 markers of progress will give us the early indicators that

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1 we're making progress on this component of the strategic
2 plan.
3 Slide. So our impact framework indicators give us
4 insights into the progress that we're making at each stop
5 along our pathway to our north star.
6 One more slide. Now, if all this information
7 sounds a little familiar, that's because we have presented
8 on key pieces of the impact framework before. Exactly a
9 year ago we presented our ten result indicators and
10 followed up on October 2019 with our 20 contextual
11 indicators. This past February, we spoke to our
12 implementation and learning approach, which brings us to
13 today.
14 So I'm going to hand it off to my integration and
15 learning colleague, Bryan Fahrbach, to introduce our
16 inaugural impact framework report.
17 MR. FAHRBACH: Thank you, Agnieszka. Good
18 afternoon, everyone.
19 So where are we now? Well, we have a report and
20 it's called The Pathway to Progress - Indicators of Young
21 Child Well-being in Los Angeles county. And I'm going to
22 talk a bit about how we got here and what you can find in
23 the report. And I'd also like to note that this is the
24 first time, as Kim mentioned this earlier, that First 5 LA
25 has prepared this type of indicator report, covering

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1 conditions of young children and families in Los Angeles
2 county.
3 So first up, the report has several purposes; one
4 is to share the impact framework and how we will measure
5 the progress of our strategic plan. We also want to
6 document the conditions of LA county children and families
7 prior to the launch of the 2020-2028 strategic plan. We
8 want to encourage use of indicator data internally at First
9 5 LA and externally and we want to provide a resource with
10 population and subgroup data.
11 And here you see the different audiences for the
12 report. In the top row, we have First 5 LA staff,
13 commissioners, and our grantees and contractors. And these
14 are our primary audiences. And then in the next slide, the
15 ones that are in color are actually people and audiences
16 that were engaged during development of the report and
17 specific indicators. In addition to our top row of primary
18 audiences, we also engaged our data partners, partners at
19 the county -- different county departments and agencies,
20 advocacy partners, and also partners in higher education.
21 And then what information is provided for each
22 indicator? In the report, each of the result and
23 contextual indicators has a spread of about two to six
24 pages. And in each of these you'll find these elements:
25 You'll find a description of the indicator, you'll find a

1 description of the importance of the indicator, you'll find
2 some current context, and then we have findings. And I
3 should note that not all of these findings are available
4 for all of the indicators. It sort of depends on which --
5 what data is available. But, in general, we have things
6 such as the most recent years of data and findings, trends,
7 race/ethnicity detail, socioeconomic status detail,
8 geographic detail. And then we have lots of charts and
9 maps to illustrate these things in a colorful and
10 easy-to-read way. And, finally, each indicator also has
11 some notes on the data and limitations of the data.
12 I also wanted to point out another of the
13 executive summary in the reports. And in that section, we
14 have some findings at a glance for the result indicators,
15 which you see here. For each indicator, we attempted to
16 rank them on a scale of mostly positive, which is the light
17 blue if you look at the key on the right; mostly positive
18 to a mixed or modestly good, which is, like, a purple; to
19 mostly negative, yellow. And the gray means unknown when
20 we didn't have enough data to make a determination.
21 And also you'll see that there are four columns,
22 not just one with circles in them. And I'll now go ahead
23 and explain what each of those mean. So the first measure
24 we looked at was trend, historical trend of the data. Are
25 systems or conditions improving, worsening, or unchanged

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1 for all children in LA county.
2 Next up we have equity. Do children or families
3 of color have equitable conditions or are they at a modest
4 or substantial disadvantage? What does data tell us about
5 equity for children from low income families or from
6 different communities in Los Angeles?
7 The third column was access. Are many children
8 connected to a positive intervention or being protected
9 from a harmful or negative circumstance or is it a modest
10 proportion or only a small proportion.
11 So then the final column overall, that considers
12 the three measures, trend, equity and access altogether.
13 And once shows us how children are fairing or systems are
14 perform overall.
15 And a few notes about what we're seeing in these
16 findings is, there are some places where we see mostly
17 positive trends in that first column, but when we dig
18 deeper, we can see that there are still issues in access or
19 equity. In these instances, we can build on the positives
20 while addressing these issues, such as Number 6, which is
21 family engagement with child where we see that transaction
22 is actually trending more positively but there's still work
23 to be done in equity and in access.
24 Another thing that we're finding is that there are
25 some areas where things aren't going so well. You can see

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1 in the overall column, which is number 2 indicator,
2 publicly funded ECE; indicator 3, early identification and
3 intervention; or number 5, CFS involvement where we'll have
4 to improve or reverse one or more of these aspects to see
5 the overall improvement that we want to see.
6 And as mentioned before, you'll notice that there
7 are several gray circles throughout the visual, which means
8 unknown. And in some instances, we can't determine what is
9 happening due to lack of data and/or disaggregation in the
10 data. An example of this could be number 1 where you see a
11 lot of gray. And that's where we only have limited data
12 that represents about ten percent of the population of LA
13 county. So we can't make broader conclusions about
14 high-quality ECE for the larger population.
15 Altogether these findings help us better
16 understand the condition for children and families in LA
17 county and can support additional conversations on how
18 systems are contributing to these conditions. And they
19 also provide a baseline for tracking our progress to
20 improve these conditions by improving systems.
21 So now let's take a quick pause to see if there
22 are any questions about any of the information I've just
23 presented.
24 COMMISSIONER ZEPEDA: Okay. Does anybody have any
25 questions about the overview we just received? Looking to

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1 see if I have any texts.
2 Jamie, did you see anybody on chat? No. I'm not
3 seeing any questions.
4 Bryan, I did -- how did you decide -- I do have a
5 question if nobody else has one.
6 How did you decide on the rating? Maybe this is
7 getting too much in the weeds, but in terms of -- did you
8 have, like, a numerical scoring system of some sort that
9 you decided was going to be low, medium, and high? I mean,
10 you must have operationalized that in some form or fashion.
11 MR. FAHRBACH: I'd like to invite either Agnieszka
12 into our party -- Kari Parsons is here and she's consultant
13 that worked on the report with us to address that question.
14 MS. PARSONS: Sure. Pleased to jump in. That's
15 an excellent question.
16 So a couple of considerations with regard to the
17 criteria development. First, important to keep in mind the
18 purpose of that visual and of the -- the assessment that we
19 did. And then the other to -- some of the limitations
20 around that. So first of all, the key purpose of that
21 visual is communication. It's trying to distill a lot of
22 information into an easy-to-access, easy-to-digest piece of
23 information. With that understanding, it's the high level.
24 And then the -- as you go deeper, as you review this, you
25 can go a little bit deeper and find more context in the

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1 indicator itself.
2 So that's one thing to keep in mind, is the intent
3 is communication and summary not necessarily policy
4 setting. However, we did keep in mind some of the goals
5 related to First 5 LA. So, for example, home visiting,
6 that there's a goal to have that be universally accessible.
7 So that comes into play when we're assessing how we're
8 doing on that particular measure, for example.
9 The challenge of trying to assess and rate
10 disparity measures, we can't fairly add a numeric value,
11 say, you're okay if it's ten percent, that's good, bad or
12 not, since we have data that's all over. Some are ten
13 percent may be fantastic for one indicator or abysmal for
14 another. So that's a challenge that we struggled with. So
15 necessarily that requires some flexibility and a more
16 descriptive approach to the assessment. So that's the
17 approach we took.
18 And with any kind of assessment, there is an
19 inherent subjectivity involved. That's not necessarily a
20 bad thing. I actually think there can be challenges when
21 you just apply things by specific numeric metric. You're
22 losing some of the context and nuance when that happens.
23 So there's definitely subjectivity involved in that. And
24 one of the ways we approached that and tried to make sure
25 that wasn't a disadvantage was to get a lot of input on the

1 assessment.

2 So I developed a criteria. If you go to Page 11,

3 can you see the -- the overarching levels of assessment.

4 And so, again, really broad, not very specific, not point

5 related. And then we took those basic criteria and then

6 did a first cut by going through the indicators and seeing

7 how that -- how that appears to have -- you know, what the

8 results appear as.

9 And then that went through -- the evaluation

10 learning team reviewed. They got input from other staff

11 members. So there were many people looking at this,

12 looking at the data deeply, and assessing what they felt

13 was progress or not.

14 So that's kind of in a nutshell how the assessment

15 process went. And, again, at the end of the day, it's

16 important to understand those limitations and the

17 challenges we had with that, and understand that it's

18 primarily a communication tool.

19 COMMISSIONER ZEPEDA: Kari, thank you for that.

20 Do any of the other commissioners have questions?

21 I'm not getting any questions from anyone.

22 COMMISSIONER TILTON: I do, but I don't know how

23 to get through to you.

24 COMMISSIONER ZEPEDA: Is that Deanne?

25 COMMISSIONER TILTON: I do have a question. Can

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1 you hear me?
2 COMMISSIONER ZEPEDA: Yes.
3 COMMISSIONER TILTON: Okay. Here's my question.
4 I have a question, for example, on the CPS involvement. Is
5 the mostly negative indicating that being involved with CPS
6 is mostly negative or that the results of the involvement
7 was mostly negative?
8 MR. FAHRBACH: Agnieszka, do you want to weigh in
9 on this one?
10 MS. RYKACZEWSKA: Sure. So this is -- I'll
11 address the two yellow circles within that one in
12 particular. So when it comes to the first yellow circle
13 under trend, what we are expressing there is that the trend
14 is mostly negative, which mean that over time, we have seen
15 that more and more children are becoming involved in CPS.
16 So it is really just looking at the historical trend. It's
17 not looking at the outcomes of this. It's just looking at
18 any level of involvement.
19 In terms of equity, what we're looking at there is
20 whether there are -- the data reveals any disparities in
21 terms of who is getting involved and who is not. And we
22 were seeing certainly when we disaggregated the data that
23 over the first five years of life, there was significantly
24 more black children -- or children of black mothers that
25 were involved in CPS than compared to other races. And so

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1 we were seeing far more involvement and disparities there.
2 And so that's what this is referring to. It's not
3 necessarily looking at the outcomes.
4 And so to Kari's point about limitations, every
5 data indicators, every high level observation will have
6 limitations. And this is one where there certainly are
7 limitations because we recognize that sometimes CPS
8 involvement is a very good thing. It allows for addressing
9 underlying issues that need support. So the fact that we
10 are seeing an increase is concerning in the sense of there
11 clearly are many issues that we're trying to address, but
12 we -- we are recognizing that there are limitations to our
13 understanding of the trend at this time.
14 COMMISSIONER TILTON: Thank you. I just want to
15 clarify, make sure that we're very clear that having a
16 contact or report or involvement of CPS should not be
17 considered negative because we're discouraging reports and
18 we're discouraging positive interventions and lifesaving
19 efforts.
20 So I know that the -- I realize the
21 disproportionality. We see it across the board. But we do
22 want to make sure that there's an understanding that there
23 are significant interventions that are important and life
24 saving for children. So I don't want -- I don't want the
25 fact that there's a CPS involvement to be seen as negative.

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1 I think that, if you look at CPS involvement as indicating
2 there's a negative situation, that's something else.
3 Do you understand what I'm saying?
4 MS. RYKACZEWSKA: Absolutely. Absolutely. And I
5 think in -- within the effort of capturing the conditions
6 for children and families, what you're speaking to of CPS
7 involvement being a recognition that there is, you know, an
8 issue or something to be addressed is speaking to that
9 condition, not necessarily the fact that CPS involvement is
10 a negative.
11 COMMISSIONER TILTON: Okay.
12 COMMISSIONER ZEPEDA: Thank you. Commissioner
13 Taylor that's has a question. I just got a text from him.
14 COMMISSIONER TAYLOR: Yeah. I'm up now. Okay.
15 COMMISSIONER ZEPEDA: You're up.
16 COMMISSIONER TAYLOR: My thing is that -- the
17 access issue. The understanding where CPS was and in 2007,
18 2008 where they are now and the actions that the department
19 took to reduce access to support services to these
20 communities and these people of need is a big issue. And
21 they haven't remedied that that I could tell. So the end
22 result is that, even though you're entering to try to help
23 them, if they can't get the resources in the community and
24 it's not made accessible to them by getting on somebody's
25 priority list, then you're not going to effect the change

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1 you wanted to do in trying to help them. Some of these
2 people are abandoned to try and come up with their own way
3 of getting services. And that's what family preservation
4 was about, family support was about. And then the
5 department for some reason in the following years cut that.
6 And then they eliminated how we engage families without
7 team decision making and things of that nature, which
8 seemed to have been working in reducing the number of
9 children going into child welfare. That's where it can be
10 perceived by the families in the community that they can
11 mistakenly think that the department is targeting them,
12 because they don't see the other side of that and help.
13 And that's what family preservation was and why we cut it
14 and why we didn't keep doing that or why we eliminated the
15 kinds of impact we have with that is beyond me. But maybe
16 the new director can answer that question.
17 But the bottom line is that we need to dig deeper
18 into why it is an increased impact because what happens is,
19 you're getting more referrals and you're getting more
20 engagement with less resources to effect the change.
21 So I'm just wondering, are we digging that deep
22 into these -- this information or not.
23 MR. FAHRBACH: Would I say, as I said before, this
24 report, commissioner, is the data that was available and
25 this is a starting point for the conversations that we will

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1 be having and Kim will be speaking about a little later to
2 dig in. We're going to start digging into it using this as
3 a starting point.
4 COMMISSIONER TAYLOR: All right. Well, the other
5 question I have about this chart is, how can you assume
6 things are well and fine when most of the indicators before
7 are showing mostly negative impacts? So I'm just trying to
8 get to, how do we make the overall conclusion based on most
9 of the other indicators showing some level of problem and
10 dynamics in the overall indicators.
11 MR. FAHRBACH: Kim Hall, would you like to speak
12 to that?
13 MS. HALL: Sure. So I'm looking at the chart and
14 I'm wondering if you're referring to maybe indicator 6.
15 Because in many cases, if there's any yellow indicating
16 that we're not doing good in an area, the trend -- also
17 home visiting is another one -- would be mostly negative.
18 But when we are seeing a change -- a positive change that's
19 consistent with efforts we're implementing. So in the case
20 of home visiting where we've been really trying to increase
21 the amount of access, increase the number of families that
22 are enrolled, serve families in high-need communities like
23 our Best Start geographies where there are families of
24 color where we're seeing that positivity, even though we
25 haven't hit the milestone of making in universal. We

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1 wanted to acknowledge that we are seeing a positive trend
2 in two of those areas. And that's reflected by the mixed
3 or modestly good rating there, as an example.
4 I think that is a part of what Kari was sharing;
5 that we wanted to take into context some of what we're
6 seeing, some of the nuances and positive improvements that
7 we're seeing that related to our efforts.
8 COMMISSIONER ZEPEDA: Thank you, Kim.
9 I think what -- we need to move on. Maybe we'll
10 get back to some of these questions as we move through the
11 presentation because we only have so much time. I'm
12 concerned about our time. So let's go onto the next part.
13 MS. MEDINA: Good afternoon, commissioners. My
14 name is Ofelia Medina, and I'm a senior policy strategist
15 with the policy and government affairs team. Disclosure.
16 You will hear my baby in the background. So I do apologize
17 for that.
18 We're going to dive into today's discussion first
19 by highlighting two report findings: The first one related
20 to publicly-funded ECE and the second one related to access
21 to (audio distortion). We are then using each example and
22 sharing how they're connected to both our implementation
23 plan, but also to our work.
24 Finally we'll spend some time again reflecting and
25 discussing any reactions, observations, or questions you

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1 might have from each of the accounts.
2 Slide please and then one more slide. So our
3 first finding from the report we want to highlight centers
4 around the second results indicator, publicly-funded ECE.
5 What we found is that only about one quarter of eligibility
6 children under the age of five are enrolled. Of these
7 children, roughly around 15 percent are enrolled in
8 subsidized slot in state contracted centers, while seven
9 percent are enrolled through the voucher system. This
10 graphic, however, is children birth to five. So when we
11 think about our infants and toddlers, that number looks
12 even smaller with five percent of eligible infants and
13 toddlers enrolled in contracted sites and five percent in
14 the voucher system.
15 This is why you see mostly negative at the measure
16 in the key findings slide that we just discussed right now.
17 So one of the ways to address this indicator is through our
18 work to strengthen public and community systems,
19 specifically with our objective 1.4 in our implementation
20 plan. So as you know, California has a hodgepodge of
21 programs because they're financed by federal, state, and
22 local funding streams. Each program might have different
23 program and eligibility requirements ranging from family
24 income, teacher education preparation, reimbursement
25 mechanisms, and general oversight. Through our policy

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1 efforts and definitely in coordination and partnership with
2 out ECE colleagues, we are seeking to better align
3 requirements so that more families and children are served,
4 while at the same time streaming the ECE system.
5 Objective 1.4, we're also looking at ways to
6 increase the availability and access to full-day, full-year
7 preschool programs and also increasing the percentage of
8 eligible families participating in Head Start both
9 strategies within our Best Start geography when using them
10 as short markers for progress for our work.
11 Slide please. So sharing that, we want to hear
12 from you again. Do you have any reactions to this finding
13 about publicly-funded ECE? Do you have any observations or
14 questions about the connection between this finding and our
15 work.
16 And I'll turn it over to Commissioner Zepeda.
17 COMMISSIONER ZEPEDA: Okay. Thank you. Any
18 questions from the commissioners? I do have a number, but
19 any questions from commissioners in this area?
20 Commissioner Woods, do you have any questions?
21 Okay. Keesha, do you have any reactions to this?
22 COMMISSIONER WOODS: I do have reactions in my
23 thinking but none that I want to share at the moment. It's
24 coming up and processing that this is so low.
25 COMMISSIONER ZEPEDA: Okay. All right.

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1 Ofelia, I do have a reaction. And maybe, Keesha,
2 could -- will resonate with you. When I was looking at
3 data because I've been looking at a lot of data from the
4 master plan, that it's almost like apples and oranges when
5 we -- when we're looking at the number -- the high number
6 of children that we have in LA county. We have -- I don't
7 know if we have the largest in the nation, but we have a
8 high number of children in the county. And when we look at
9 that as a denominator to compare the children who are, say,
10 in high-quality care and all that, it's going to look
11 negative, just of the sheer number of the children that we
12 need to address. And so that kind of threw me when I
13 looked at that. Because, knowing what we know about trying
14 to improve quality, it's been a really tough slog to move
15 in that direction and to get people on board for all kinds
16 of reasons that we don't need to go into depth here.
17 So I just thought it was -- it -- what I'm seeing
18 is, is it's like just a growth indicator. It's not -- it's
19 -- it doesn't provide the more nuanced story other than the
20 fact that we have less infants and toddlers being serviced
21 or -- than preschoolers, but that's -- that's a reaction I
22 have when I was reading the report this morning.
23 So I don't know if that's something that the ECE
24 people when you were working on this were thinking about,
25 because it does give the impression that we're not doing

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1 very well, frankly and -- the impression that we need to
2 give. I'm not sure.
3 MS. HALL: I wanted to just offer a quick
4 clarification because there is a difference in the
5 denominator that was used for indicators 1 and 2. So
6 indicator 1, which is looking at enrollment in high-quality
7 ECE does consider all the children in LA county from zero
8 to five; whereas, indicator number 2 is looking
9 specifically at income-eligible children. And so there is
10 a smaller denominator, although I will acknowledge there is
11 a limitation because different public funding programs have
12 different income eligibility thresholds. But we did take
13 into account income when determining the percentage
14 enrolled.
15 COMMISSIONER ZEPEDA: Okay. I just wanted to make
16 that comment because I think that may come up as you're --
17 we disseminate this going forward.
18 Commissioners have any other questions?
19 COMMISSIONER WOODS: I would like to, madam chair,
20 and -- I agree with you. The numbers are -- they're
21 concerning for me because my data shows me -- that I use
22 with my program shows that we're serving a much larger
23 number of children and in subsidized or contracts programs,
24 if you would.
25 I do think that there is some difference between

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1 eligibility for State programs versus federal programs. I
2 am interested in knowing how we actually came to the 15
3 percent and what is the baseline data we're using. For
4 example, are we using the same baseline data that the
5 Office of the Advancement of Childcare does for the
6 eligible population that we have to submit to CDE? So just
7 looking at what those baseline data sources are so that I
8 can get a better understanding of how we got to 15 percent
9 because, again, I'm just in the process of doing community
10 assessment and our numbers are looking a lot different than
11 this.
12 MS. HALL: Keesha, thank you for those questions.
13 I do want to share that we worked with both your office as
14 well as the Office for Advancement of Early Care and
15 Education to use the data that is collected on both Head
16 Start programs and State-contracted programs. We also work
17 with the Childcare Alliance of Los Angeles and the resource
18 and referral agencies, as well as the alternative voucher
19 program agencies to get data that -- the data is reported
20 here.
21 And in terms of the denominator, so how do we
22 determine that the number of kids who are income eligible,
23 we also used the data that the Office for the Advancement
24 and Early Care and Education uses, which is published by
25 the American Institutes for Research on behalf of CDE.

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1 COMMISSIONER WOODS: Okay. Thank you, Kim. I
2 appreciate that.
3 COMMISSIONER ZEPEDA: Thanks, Keesha, for that.
4 I know both you and I are very involved with this.
5 So I think -- Kim, this is going to be a concern as we
6 disseminate this because I think we can -- everybody can
7 look at this through their own particular lens and see
8 different methodological challenges. And I think this kind
9 of question is going to come up repeatedly as we go through
10 the report so -- but that's the nature of what it is that
11 we're doing, and I think we need to recognize that and be
12 prepared for that.
13 MS. HALL: Absolutely.
14 COMMISSIONER ZEPEDA: Okay. Let's see.
15 Commissioner Garen, would like to -- has a question.
16 COMMISSIONER GAREN: Yeah, I actually have more of
17 a comment than a question. We've known, you know, since I
18 finished graduate school in the '70s and we started really
19 talking about childcare when Richard Nixon vetoed national
20 childcare saying it would Soviet-ize American youth. This
21 has been a big public policy question and it remains one
22 the biggest public policy questions in front of us.
23 So I believe the stat is wholly accurate. We
24 hardly reach any of the poor people who really need the
25 help. It's tragic. And, ultimately, it's about public

1 will. And what do we do to change the public will to
2 create more money to support families and to invest now?
3 It's the pay now or pay later. And we have not yet won not
4 this argument.
5 California actually stands out as one of the
6 states that has led in providing some public funds. So I
7 don't think it's anything to be -- that reflects badly on
8 our organization. This reflects on all of us as a society
9 that puts, you know -- what are our real values? It's
10 where we really put the money.
11 So it's better than it used to be. But we've got
12 this enormous way to go. And I was just very heartened
13 that in the political campaign that the issue of childcare
14 actually came up on the national stage this last year. And
15 that's the first time in a long time that I feel like we've
16 had much traction.
17 COMMISSIONER ZEPEDA: Thank you, Commissioner
18 Garen, for that. That reality check for us. Thank you.
19 You Commissioner Pleitez has a comment.
20 COMMISSIONER HOWELL: Thank you, Dr. Zepeda.
21 Completely echo what Wendy is sharing, and wanted
22 to offer up that the Alliance For Early Success, many of
23 you probably know, released a report that talks about
24 childcare as a public good. So this data is true across
25 the nation and really changing the narrative and a policy

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1 shift for public good. So really aligning this data to a
2 larger ask would be useful, and there is a healthy movement
3 in the ECE national world to do that.
4 Secondly, this data makes me think about the
5 pandemic and the Covid-19 impacts on all of these. So I
6 know that the numbers keep on changing and it's a moving
7 target, but it's really a different story than the data we
8 had two or three years ago. So in putting this out, being
9 able to really articulate that our system has been
10 devastated during these times. And I -- I personally
11 believe that less than a quarter are receiving these
12 services at this time. So I think we could have a more
13 sticky message on this particular indicator.
14 COMMISSIONER ZEPEDA: Thank you, Commissioner
15 Plietez Howell.
16 Okay. I don't see any more questions so we can go
17 ahead and move on to the next part of the presentation.
18 MR. GUEVARRA: Good afternoon, commissioners. My
19 name is John Guevarra, and I help support the communities
20 department as a program officer.
21 So in this slide, you'll see a map of LA county
22 displaying data from result indicator number 10, which
23 focuses on access to parks and open space, specifically
24 children through age five living within a half mile of a
25 park or open space in the Best Start geographic areas. So

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1 you can see a substantial variation in park access,
2 depending on which community you live in. The dark blue
3 indicates the higher access while the magenta and orange
4 indicate lower access to parks and open space.
5 Animation, please. We're going to address this
6 indicator primarily objective 2.4, which is an opportunity
7 for us to really optimize policy, partnership, and advocacy
8 efforts in transportation, food and open space, as well as
9 elevate these early childhood considerations in
10 environmental health and other community priorities.
11 So in this example to really think about the
12 equity of public resources, we set a short-term marker of
13 progress to increase the amount of parks and open space
14 funding within the Best Start geographies. We want all the
15 Best Start communities to have the highest access to parks
16 and open spaces possible. And it starts with that having
17 that available funding in the communities that need it the
18 most.
19 So I know there's a lot of data. You might be
20 thinking, okay, access to parks and open space is one side
21 of the story. And it is. You know, parents, children, and
22 families and the Best Start communities might tell a
23 different story, right, about the quality, the maintenance,
24 and the feelings of safety of their local park. But this
25 type of disaggregated data, meaning data that's focused on

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1 zero to five, is a unique to our field. It's a starting
2 point and it's complementary to the work we're doing to
3 catalyze these opportunities for equitable parks funding.
4 So just as an example of the work we're doing
5 around parks and open space, there's a program that First 5
6 LA helped to launch called Link. And it's a program that
7 is addressing policy and practice change opportunities for
8 parks and open space. And just really quickly, in this
9 program, we've partnered with other funders to bring
10 together teams of a community-based organization, a park
11 expert organization and the willing city partner to support
12 the creation of a park mission document. We know that many
13 cities lack the staff capacity and resources to create this
14 kind of a document, which really is an essential resource
15 to go after funding like Measure A, Prop 68, and Measure W.
16 And the locations we're working in right now are in the
17 areas of El Monte and southeast LA, specifically the cities
18 of Cudahy and Maywood, with the goal of expanding the
19 program to all 14 Best Start communities.
20 So similar to the previous section, we wanted to
21 hear from you. Commissioners, what are your reactions and
22 do you have any observations or questions about the
23 connections between this finding and our work?
24 COMMISSIONER ZEPEDA: Okay, commissioners.
25 Commissioner Abdo, did I miss your comment on the

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1 early childhood or do you want to make a comment on the
2 parks?
3 COMMISSIONER ABDO: I'll talk about both of them.
4 COMMISSIONER ZEPEDA: Okay.
5 COMMISSIONER ABDO: One of the sort of overarching
6 comments that I have to make is that we're not looking at
7 the whole county, at least in some of these indicators.
8 And so that -- that makes it more difficult for anyone to
9 look at the data and then have a -- you know, a specific
10 reaction to how it -- or understanding of how it works for
11 the whole county. That's one thing.
12 But another thing I wanted to say is that, anyone
13 who looks at -- at the funding situation for early
14 childhood in California is going to find that it's a mess,
15 that there's no way to understand it, if you are a family
16 coming in with a young child and you want to access early
17 childhood. There is no easy way to understand what the
18 access points are or to understand what eligibility means
19 to that particular family. And I hope that somehow in all
20 of this we can at least share that message with people who
21 are going to be looking at this report and wonder, why are
22 some of these numbers one way and why are others another
23 way. We're not comparing, as somebody said already, apples
24 to apple here. We're talking about a lot of different
25 issues and comparing things -- or people will compare

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1 things in different ways and will use this information in
2 ways that are not necessarily going to be accurate.
3 So I don't know how to handle all of that, but I
4 just wanted to put it out there and also to say that I
5 agree with everything that Wendy Garen was saying about the
6 overall understanding of how our society treats young
7 children and families with young children.
8 That's it.
9 COMMISSIONER ZEPEDA: Thank you, Commissioner
10 Abdo.
11 I believe Commissioner Martinez has a question.
12 COMMISSIONER MARTINEZ: Yes. This is really
13 helpful. And I do agree we're only looking at the Best
14 Start regions, so it is hard to -- when you look at entire
15 county, we know where the huge pockets of disparities are.
16 And I'm thinking, you know, the point of the Best Start
17 regions is to improve the situation and that -- and invest
18 heavily in that region. So it would be good to overlay our
19 Best Start regions with the rest of the park poor,
20 deficient agencies to sort of see, are we making any
21 headway in these regions compared to the rest of the park
22 deficient, park poor regions.
23 I mean, I'm pretty sure we all know where they
24 are, but -- you know, I mean, I'm looking at region 1, East
25 LA and that whole -- I know there's been concerted effort

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1 around the river, you know, and some of those registrations
2 to do better. And then I'm looking at Lancaster Palmdale
3 and wondering, are we doing so poorly there just because of
4 the -- you know, the nature of that region geographically,
5 physically. I don't know.
6 MS. HALL: Marlene, I'd like to offer a couple of
7 responses. I think one thing I wanted to do was just
8 highlight that, if you look at the gray circle at the
9 bottom of the legend, the gray represents the overall
10 average for LA county. So while this table does highlight
11 the Best Start geographies in particular, we did also look
12 at the average access rate to parks. What I'm hearing from
13 Commissioner Martinez is that we might want to even go a
14 step further and look at other communities. And that's a
15 really great idea. And I think that we will have an
16 opportunity to do that as we move into the next phase of
17 this work, which is having conversations to really unpack
18 what the data means, similar to what Commissioner Abdo was
19 sharing. She was offering a lot of insights that might
20 help us, and other commissioners as well to understand
21 what's behind these numbers, what do they really mean and
22 what are some of the underlying issues. And that's exactly
23 where we want to go next. Because just looking at the data
24 doesn't tell us what do we need to do, how do we start to
25 address them. And so that is exactly the next phase of the

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1 work. The purpose of the report is to say, where are we
2 right now and then to figure out where do we go. And we
3 know we can't determine that alone. So we engage with
4 commissioners and others as we --
5 COMMISSIONER MARTINEZ: I get it. Maybe we need
6 to find stronger park champions in these regions and
7 identify people who be willing to do that and prop them and
8 train them and have them be stronger ambassadors for that
9 in these regions. And I think that was the whole point
10 with the Best Start communities.
11 So I get it. Thank you.
12 COMMISSIONER ZEPEDA: Thank you, Commissioner
13 Martinez and Kim.
14 I think this -- I think you're right, Kim, this is
15 going to be -- this is the start of the conversation.
16 Right? And it's going to help people in different arenas
17 and different domains to start to look at it more closely.
18 And we have to -- I think one of the things I'm thinking
19 about is how we're going to present this to the greater
20 public and to the different stakeholder groups as we move
21 forward and how we're going to engage them. So I'm looking
22 at this like a report card. It's almost like a kind of
23 general report card of where we are.
24 I know there's a number of other commissioners
25 that have some questions. I'm a bit concerned about time.

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1 But let's move on. Commissioner Garen had a question and I
2 think Commissioner Taylor had a question on early
3 childhood. So let's finish this up and we'll go to
4 Commissioner Taylor.
5 Commissioner Garen.
6 COMMISSIONER GAREN: I don't think I've ever seen
7 park data presented through the zero-to-five lens in this
8 way. I think it's important powerful because it speaks to
9 the parks that we need to be building now would be there
10 for these kids when they're eight, nine, and ten. It's
11 really useful. And what I'm thinking is about how are we
12 going to very deliberately share this information with the
13 cities that create parks, with metro who is spending money
14 on park aligned projects, with figuring out who our civic
15 partners are to join with, which includes River LA and
16 their very bold reenvisioning of the southeast region for a
17 Gehry-designed project above the river, which is going to
18 be important and I think is going to happen.
19 So I'd like to just think of this as a way that we
20 sort of get out of our silo and connect to the broader
21 world that's working to create parks.
22 COMMISSIONER ZEPEDA: Thank you, Commissioner
23 Garen.
24 Commissioner Taylor, did you want to ask a
25 question?

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1 COMMISSIONER TAYLOR: Mine goes back to -- I think
2 Commissioner Garen's point is well taken. In that in order
3 for these communities of great need, access to
4 transportation to get there is important and the alignment
5 is important. So I think that broader thinking needs to be
6 there as well.
7 But my question was going back to the earlier
8 numbers that show a smaller population is because I thought
9 -- and then you can clarify this for me, Kim -- is that
10 your focus for that number was based on the QRLA concept of
11 quality educational programs and only those agencies that
12 are doing it within LA county as being reason why the
13 numbers is small.
14 Am I wrong or is there something else that I'm
15 missing?
16 MS. HALL: I think what you're talking about kind
17 of relates to indicator 1, which is enrollment in
18 high-quality ECE.
19 COMMISSIONER TAYLOR: Yes.
20 MS. HALL: The limitation with that data that we
21 have is that we only know if children are in a high-quality
22 program, if they've gone through the rating process as part
23 of participation in Quality Start LA.
24 So as Bryan noted, we only know for ten percent of
25 the children in the county. For the other children, we

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1 don't know what level of quality it is that they're
2 experiencing. The indicator that we presented on here with
3 the low number was about the income eligible children who
4 are enrolled in publicly-funded ECE. Both ECE-related
5 indicators but looking at two different issues: One around
6 public access -- I'm sorry. Publicly funded -- access
7 through public funds and the other looking at high-quality
8 ECE participation.
9 COMMISSIONER TAYLOR: Okay. Because I know that
10 the access to publicly-funded things, the State and the
11 feds govern how -- who can qualify and they use income to
12 do it. And we just had a big election push about that --
13 or push with the State saying, you need to add just that so
14 more people can access the -- the resources. And it's
15 self-limiting. And so the idea is maybe that's part of
16 saying, okay, we need to change our strategy to allow more
17 access to these services because that is self-limiting if
18 you have to have a lower salary in order to access
19 something. So it's a part of you developing strategies
20 around how we broaden that -- that scope. Right?
21 MS. HALL: That's exactly right, Commissioner
22 Taylor. And that's a really significant issue with Head
23 Start, which is federally funded because they use a federal
24 poverty level, which doesn't account for the cost of living
25 in LA. So it's even more challenging for families to

1 qualify for that access. That certainly is an issue across
2 the board, and we really appreciate you highlighting that.
3 COMMISSIONER TAYLOR: Thank you.
4 COMMISSIONER ZEPEDA: Okay. Thank you,
5 Commissioner Taylor.
6 I think that -- that concludes our presentation.
7 I want to thank the presenters.
8 MS. BELSHE: Actually, Marlene, we have a quick
9 summary or final slide that Kim Hall wanted to touch on if
10 we can take two more minutes. Grateful for that. Thank
11 you. Because it touches on some of the themes that
12 commissioners have been lifting up in your comments and
13 questions.
14 COMMISSIONER ZEPEDA: Okay. Thanks for the
15 reminder.
16 Kim.
17 MS. HALL: Thank you. Previous slide, please.
18 I'm going to go through this very quickly, but on
19 this slide what we do is highlight some of the challenges
20 that we encountered in developing the report. And in
21 thinking about those challenges, also tying -- you know,
22 how we really lean into our values to overcome those
23 challenges.
24 So the first one I'll highlight is measuring
25 change in complex systems. We know that's a very difficult

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1 thing to do. But consistent with our integrity values, we
2 wanted to hold ourselves accountable to progress. And so
3 we put out, as Marlene -- Commissioner Zepeda referred to
4 it, a report card to say, we know it's hard, we know it's
5 difficult, there's a lot of factors that contribute to
6 what's going on, but we still want a way to measure our
7 progress. So that's one of the things that is represented
8 in this report now and I think will continue to be the case
9 over the life of our strategic plan.
10 We also started with less than perfect indicators,
11 but we are committed to getting started and refining over
12 time. And I do want to note that we have less than perfect
13 indicators because in some cases there wasn't data
14 available to measure exactly what we wanted to measure,
15 exactly what we think would be indicative of progress
16 toward our results. But we got started with what data was
17 available to us and we expected, as we work with our
18 partners and county agencies and elsewhere, we can get
19 better data over time.
20 Also wanted to note that we had limited access to
21 disaggregated data. Given our value and our governance
22 guidelines around equity, having access to disaggregated
23 data is of utmost importance because it allows us to
24 highlight disparities where they exist so we can develop
25 strategies and make progress towards eliminating those

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1 disparities. But given the limitations, we highlight
2 disparities where possible. It wasn't perfect, but we did
3 the best that we can with what we had available.
4 And then lastly, another challenge was really
5 right sizing the report content and the tone. So how much
6 information could we include and what was the tone that we
7 wanted to strike. And we worked with our internal and
8 external content experts to get input to think about what
9 are some of the most important areas to touch on. And
10 that's where we landed on talking about you know, current
11 data, trends, and disaggregating based on those three
12 characteristics. And we also just -- we decided that we
13 wanted to maintain a factual tone. We're putting out the
14 data. We're not interpreting it. We're not giving the
15 causes for what we're seeing. We're presenting what the
16 facts are. And we'll move into the next phase of working
17 with our partners internally and externally to understand
18 what does the data mean, why are the conditions what they
19 are, and what are ways that we can improve them to address
20 conditions for children and families.
21 Slide please. And so, lastly, I just wanted to
22 talk about where we're going. And we we've already alluded
23 to this in the conversation. You know, it all starts with
24 dissemination. Now that we have the report, we want to
25 share it and get it into the hands of other people who care

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1 about the issues we care about and those that we want to
2 invite to join us. And so dissemination efforts are
3 underway, both with our staff and our commissioners through
4 today's presentation but also to the contractors and
5 grantees that we work with as well as our partners and
6 others.
7 So following dissemination, we need to make sense
8 of the report. We've talked about. What does the data
9 means? What are the challenges and limitations of the
10 data? What are the system issues that underlie what we're
11 seeing in terms of conditions for children and families?
12 All of that will be part of a process we refer to as sense
13 making, which is, essentially, bringing people together to
14 talk about what the data means, identifying implications,
15 thinking about how we can take collective action.
16 Once we have a better understanding through sense
17 making, we really want to focus on report use. We want to
18 have concrete goals that say, how are we going to use the
19 data to align our work and to align with the broader field
20 based on the conditions that we're seeing in children and
21 families.
22 And so with that, that completes our presentation
23 and I turn it back over to the chair.
24 COMMISSIONER ZEPEDA: Thank you, Kim.
25 First, I want to congratulate you and your team,

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1 everyone that worked on this presentation. As Bryan
2 mentioned earlier, First 5 LA has never done anything like
3 this before. It goes to the collective impact idea of
4 trying to measure systems change, which is really the
5 overarching goal of much of our strategic plan going
6 forward. How do you measure that is going to be a
7 challenge. And in a lot of ways, this is very innovative.
8 Even though there's all of these weaknesses, you
9 know, as I've always said, you can always attack something
10 methodologically. You're always going to find some issues
11 with it, but I think that, as long as we're transparent and
12 we're clear and we work with our stakeholders, as you say,
13 Kim, in a very factual way, it's going to be I think very
14 helpful, even in the post-Covid because we'll know what the
15 baseline was -- or is as we move into that post Covid,
16 whenever that happens.
17 So I want to thank everybody that participated in
18 this. I think it's very, very important report as -- and
19 marks a very important, I think, milestone for the
20 organization having known the organizations since its
21 inception.
22 So thank you for that.
23 Want to know if there's any public comment.
24 Jamie.
25 THE SECRETARY: There are no public comments.

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1 COMMISSIONER ZEPEDA: Okay. If there's no public
2 comment, I think we're scheduled for a break for about ten
3 minutes, which it's now 2:37. So if we can be back around
4 2:47. Take a water break or whatever kind of break you
5 want to take and we'll see you in about ten minutes.
6 (A brief break.)
7 COMMISSIONER ZEPEDA: We're moving onto our next
8 item, which is collaborative efforts to close the infant
9 and maternal mortality gap in LA County, to establish a
10 strategic partnership with the LA County Department of
11 Public Health to support -- this is long -- the evaluation
12 of the African American infant and maternal mortality
13 initiative in the amount of $400,000.
14 So we do have presenters today. Tara is our
15 director of health systems. We're going to also have
16 Melissa Franklin who is our Pritzker fellow. Correct?
17 Melissa, you're our Pritzker fellow, right? And Brandy
18 Sims, ours program officer for family supports.
19 we welcome you and we're ready for your
20 presentation.
21 MS. FICEK: All right. Well, thank you. Good
22 afternoon, commissioners.
23 Let me start by saying, staff has been counting
24 down the days to this presentation. Once we opened PPC
25 back up, we have been eager and ready to share the latest

1 in our collaborative efforts to close the infant and
2 maternal mortality gap. All of this work, I need to start
3 by saying, wouldn't be possible without LA County
4 Department of Public Health as our leader and key partner.
5 So certainly wanted to offer an appreciation to Dr. Allen
6 for joining us today.
7 But before I hand it over to the team, I wanted to
8 emphasize the work that we are sharing closely aligns with
9 our strategic plan. As you will see, it is grounded in our
10 values of collaboration and learning as well as diversity,
11 equity, and inclusion. And there certainly will be more to
12 come in the presentation. We'll be highlighting the
13 connection to our strategic priorities.
14 So with that, and in the interest of time, I'm
15 going to pass it over to Dr. Allen to get us started.
16 DR. ALLEN: I think we are actually just starting
17 off with Melissa, although glad to dive in if I'm wrong.
18 MS. FICEK: I believe it is you, Dr. Allen.
19 DR. ALLEN: Then this slide is a graphic and
20 tragic description of why we are here, which is that, on
21 the left, the four times represents the ratio of maternal
22 mortality among Black women as compared to maternal
23 mortality among White women and other women in the county
24 because for other groups, White, Latina and Asian, the
25 rates are very close together. Minor variations, but very

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1 close. And for Black women, it's just so striking the
2 difference in California and the two to three times is --
3 that's the variation from year to year, but the general
4 pattern that we see over the last period of time of
5 Black/White difference in infant mortality. And although
6 there have been many efforts over the years to address
7 this, we have not seen that pattern change.
8 And our theory of change that -- the approach we
9 take is based on the idea that there has been -- the
10 factors involved in that fundamentally have to do with
11 racism expressed as implicit bias, as expressed as stress
12 in the everyday lies of Black women, expressed as
13 structural racism in institutions, and then finally as
14 system failure to effectively deal with those combined
15 sources of overwhelming stress in the lives of Black women.
16 And, you know, I think recent events give us some sense of
17 what that stress -- what the components of that stress are
18 in terms of day-to-day life.
19 Next slide. So the background aim is the
20 African-American Infant and Maternal Mortality Initiative.
21 So this is the background of this -- of this effort. We
22 first although the -- historically, there was always
23 attention to this issue in the County, on the part of the
24 County of First 5 LA, and of many other partners. We most
25 definitively released a five-year plan in April of 2018

1 during public health week, really attempting to set a
2 marker in the ground saying, the change starts now.
3 And the plan most fundamentally challenged prevailing
4 explanations for Black/White differences, acknowledging
5 that some of them, for example, maternal smoking, is
6 obviously a detriment to birth outcomes, but noting that
7 Black women who do not smoke have worse birth outcomes than
8 White women who do. In other words, with any racial group,
9 smoking was a terrible disadvantage in terms of birth
10 outcomes. Race actually overweighed smoking as a source of
11 adversity, which I think is just an overwhelming indicator
12 of how profound the effect is.
13 So the pathway that we highlighted in this plan
14 was that there are multiple sources of social stress to
15 which Black women are exposed, that social experience of
16 stress turns into physiological stress, the fight or flight
17 syndrome, and that experience of fight or flight repeated,
18 you know, starting in the morning when a woman may get a
19 call from the bill collector to the time she goes out to
20 her car and it's broken down and she can't get to work
21 because she can't afford repairs. That multitude of
22 different stresses that may occur over the course of a day,
23 a week, a month adds up to adverse health outcomes and is
24 expressed as it is in most health outcomes in birth
25 outcomes, including maternal mortality.

1 The plan that we released in April of 2018 was
2 then incorporated into the core action plan of our then new
3 Center for Health Equity at the Department with a very
4 specific target of a 30 percent reduction in infant
5 mortality rates -- in the difference in infant mortality
6 rates -- this says it slightly incorrectly -- between Black
7 and White women and infants in the county over five years.
8 And that's the goal of the AAIMM effort. That's what we're
9 working towards.
10 Next slide. The framework we developed to address
11 infant mortality really derives from that cascade of events
12 from social experience to biological outcome. So the first
13 thing you'd obviously want to do if we're saying women are
14 exposed to lots of stress is to say, how do we get rid of
15 the stress, what can we do to reduce the stressors in Black
16 women's lives. And this is the public awareness campaign
17 taking on racism has really been a key -- a cornerstone
18 part of the project and really where we've looked to First
19 5 LA and Melissa for leadership, really trying to both
20 communicate to the public that their notions of what the
21 causes of the differences are may be incorrect, but also
22 very importantly to communicate to Black women that they
23 are not to blame, that they are part of a national
24 statistical trend that reflects social experience and not
25 something they've done wrong, which is a really critical

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1 part of this, to make this a social issue rather than a
2 report card on the behavior of Black women during
3 pregnancy.
4 So dealing with racism, dealing with implicit bias
5 in terms of training in various institutions, and then
6 figuring out what are our opportunities to effect social
7 inequality. So one example that's here and there are
8 others is, we're working with the Department of Consumer
9 and Business Affairs to focus an earned income tax credit
10 outreach project to places where Black women work so that
11 we assure active participation of Black women in that
12 benefit program. So that's strategy number 1, what can we
13 do to reduce exposure to stressors.
14 Second -- strategy number 2, what can we do to
15 reduce the likelihood that that social experience is going
16 to turn into physiological insult. And the strategies in
17 this area are really focused on addressing the
18 psychological experience of stress among Black women by
19 offering support, for example, in the form of doula care.
20 That's an important project that you'll hear a bit more
21 about.
22 Third strategy is assuming that we will not get
23 rid of all of the sources of stress in women's lives or be
24 able to fully ameliorate the experience of physiological
25 stress is what can we do to assure that health care is --

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1 it's optimally focused on assuring that Black women get the
2 care they need to reduce the risk that that physiological
3 stress is going to turn into adverse outcomes. And one
4 example here, is that we work very closely with the March
5 of Dimes on this is their campaign to assure appropriate
6 use of progesterone, which has the effect -- can be
7 administered in a way that reduces the likelihood of
8 preterm birth in a woman at risk, similarly low dose
9 aspirin.
10 So we've -- we've tried to sort of focus in all of
11 these three areas. And then there's really a fourth
12 strategy that isn't part of that original, plan but we've
13 realized is absolutely key, and that's to create the
14 infrastructure, the governance and the funding and
15 partnerships that are required to do this work. One
16 consequence of this very expansive plan is that -- and a
17 reason for having a plan that has this kind of theoretical
18 underpinning rather than simply a list of strategies we
19 want to use, is that it creates a lot of room for other
20 people to work with us and to fit what they are doing into
21 this overall strategy.
22 So we have a countywide steering committee that
23 includes both County staff, First 5 staff, and partner
24 agency staff, including a number of organizations that are
25 Black-led community groups. And we have a steering

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1 committee rule which is that the steering committee must be
2 more than 50 percent Black women at any time really to
3 ensure that the voices of experience predominate.
4 We have two very well-established and two more
5 fledgling community action teams in parts of the county
6 where there are high levels of Black-White difference in
7 infant mortality. So those are sorts of the key parts of
8 our governance.
9 And then we're also focusing on how to build our
10 data capacity, which is part of the ask today. And then
11 really building a constituency among community leaders like
12 yourselves, public funders, media.
13 And I just want to say one very personal editorial
14 thing about the governance questions, is that it has been
15 absolutely key that -- sort of at a more concentrated level
16 above the steering committee. I don't mean to take it
17 sound hierarchal, but we have a management team that
18 consists of DPH and First 5. And we've really been joined
19 at the hip. I mean, I appreciate that we were called the
20 leaders and the buck does stop with us because we're the
21 Department of Health. But it has really been an incredibly
22 collaborative process. And I think, you know, it's been
23 like the benefits of sexual reproduction over cloning, that
24 you get the benefits of a really different way of looking
25 at things. It has been extraordinarily enriching to have

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1 that partnership. And I can't thank First 5 enough.
2 And I will stop there.
3 COMMISSIONER ZEPEDA: Thank you, Dr. Allen. I
4 overlooked you when I was noting the presenters, so I
5 apologize for that. But you are on the list. So -- and
6 thank you for those comments. Very welcome.
7 Tara, do I send it to you or who --
8 MS. FICEK: Now, going to go to Melissa.
9 Dr. Franklin, please to you.
10 You're muted.
11 MS. FRANKLIN: Thank you. I do that every time.
12 Thank you, Dr. Allen. I concur about the
13 partnership. It really has been really essential and core,
14 and just a great benefit in this work.
15 My name is Melissa Franklin. I am consulting with
16 and a Pritzker Fellow for First 5 LA. And I just want to
17 thank the commission for the opportunity to share with you
18 today as well as your support in this really important
19 work.
20 Personally, I come before you today with -- just
21 brokenhearted over the recent events surrounding the unjust
22 killing of Black individuals. And despite that common
23 anguish of these and other recent events directly impacting
24 the Black community, I remain in hope in this work under
25 the leadership of First 5 LA and DPH and some truly amazing

1 individuals are a source of that hope.
2 I'll be providing an overview of the fellowship,
3 the initiative collaborative structure, work in progress.
4 The Pritzker Fellowship was established by the National
5 Collaborative for Infants and Toddlers with the goal of
6 embedding a leader in one of 12 communities nationwide to
7 provide community capacity and to shepherd systems change.
8 First 5 LA applied for Pritzker Fellowship in partnership
9 with DPH and was awarded it in late 2018. As a result, I
10 had the pleasure and honor of being named a fellow to, one,
11 advance the implementation of the objectives and DPH's
12 center for health equity action plan, which Dr. Allen just
13 reviewed in partnership with DPH leadership; and, two, to
14 co-lead the countywide stakeholder engagement process and
15 communication plan strategy to support the goal of
16 addressing the Black/White infant and maternal mortality
17 gap in LA County.
18 The initiative for the Pritzker insight initiative
19 is grounded in prenatal to three outcomes framework. So
20 that's what's showing on the screen. The framework is
21 designed as a roadmap to support progress and assessment of
22 progress and is grounded in three areas that we know from
23 research are factors for kindergarten readiness, developing
24 a prenatal-to-three system with a focus on equity,
25 supporting families' access to high-quality services, and

1 promoting outcomes for infants, toddlers, and their
2 families. We call them our baby bosses, the fellows.
3 The areas that are circled in the graphic are
4 actually the specific focus areas for First 5 LA and LA
5 County that are along the framework: Prenatal care,
6 universal family connection and referral, and a systems
7 team specifically funding will building and community
8 engagement.
9 Next slide, pretty please. And so it is from --
10 you know, the intersection of this fellowship, County
11 Center for Health Equity Action Plan and the launch of a
12 community action team in South LA South Bay that is
13 happening around the same time, and decades of work by
14 community organizations and programs like Black Infant
15 Health, that intersection all focused on addressing
16 African-American infant and maternal mortality in LA
17 county. But through that intersection, the initiative
18 launched with the goal of reducing the Black/White infant
19 and maternal mortality gap, (inaudible) percent five years.
20 and Dr. Allen covered that.
21 We are a coalition of LA County health agency,
22 including the public health, mental health, and health
23 service, First 5 (inaudible) or mental and health care
24 provider funders and community members. And we're united
25 in this one purpose.

1 Next slide please. So our movement is built on
2 core values that we all co-designed as a steering committee
3 and a collective by the members of the LA County
4 (inaudible) Prevention steering committee of which LA
5 County, as you see is a member of First 5 LA and backbone
6 organizations. And so values that are noted here -- and
7 it's something that we've all grounded in has been our
8 grounding point in terms of moving forward in our work
9 together and inspiring others to do that. And some of
10 these have been noted already. Racism as a root cause as a
11 frame. Black women Black people up front and leading in
12 the work. Fostering equity while fighting inequity.
13 Understanding and believing that we're all pieces of the
14 puzzle, that everyone has a part to play and can play a
15 part in making change. And the no-blame game. And as Dr.
16 Allen said, you know, not finger pointing at Black mothers,
17 but really looking at not transforming the person but
18 transforming the system.
19 So next slide, please. And so in terms of AAIMM
20 network structure -- and Dr. Allen referred to this as well
21 -- we really see ourselves as a collective of collectives
22 or a collaborative of collaboratives. We mentioned who the
23 steering committee consists of. In addition to the
24 community partners and community-based organizations, First
25 5 LA and health agencies, we also have representation from

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1 regional community action teams, from SPAs 1, 2, 3, 6, and
2 8. And you see those teams as circles along the side of
3 that center graphic, including March of Dimes, hospital
4 quality and improvement collaborative sits on the steering
5 committee, LA County AAIMM, doula advisory board, and
6 mentioned community based organizational leaders.
7 The steering committee has been structured in such
8 a way that the majority of representation identifies
9 members of the Black community. And in a county as vast as
10 LA, this structure has only helped us achieve and reach a
11 solid -- achieve solidarity, it helps us reach it, as well
12 it is a source of solidarity, a grounding point. It's not
13 a bureaucratic structure that's very horizontal. It's very
14 much grounded in the tenets of collective impact,
15 collective self-efficacy, and equity of belief and power.
16 And it serves as a powerful means of systems transformation
17 as every person across the collective has the opportunity
18 in some way to influence some part of some system to impact
19 these outcomes. And we like to think of them as systems
20 leaders creating fertile ground for sustained
21 transformation.
22 Next slide, please. Speaking of fertile ground,
23 what this collective effort, this initiative has created
24 together are seeds of impact and change. For example,
25 we've launched two awareness campaigns grounded in the

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1 messaging, codesigned by the steering committee and
2 community action teams, and informed by focus groups and
3 community conversations. Coinciding with the creation of
4 the first campaign, 400 years was enough, was the
5 development of foundational communications platforms,
6 including core messaging, a website, three social media
7 platforms, radio advertising, online advertising, and
8 community event partnerships. And I really wanted to
9 highlight the west side and both of media platforms as it
10 became kind of a centralized grounding place for some
11 various collective efforts throughout the county to land in
12 terms of content creation, sharing resources, sharing the
13 conversations, advocating together, and just really being a
14 collective in a virtual space.
15 The second campaign, which we are currently in, is
16 called, it take as a village. And it poses a call of
17 action on the part of the entirety of the community and
18 system engaged in supporting Black families to see
19 themselves as not only part of a Black family or person's
20 village, but also to see themselves as needing to transform
21 how they provide that support to Black families. Insofar
22 as a call to action for Black women and birthing
23 (inaudible), it's to activate their village with the
24 expectation that they are to be treated with respect,
25 cultural competency, and that their lives are valued. To

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1 date, these efforts have resulted in a reach of over
2 10.1 million people in Los Angeles county, primarily
3 African American.
4 Next slide. And what the initiative has also
5 created in sum total is forward momentum. As I mentioned,
6 these are some of the -- our wind, our outcomes and impact
7 to date, launch of the countywide steering committee, in
8 partnership with LA County Department of Public Health, the
9 AAIMM prevention initiative steering committee, and
10 committee action team coauthorized and I believe secured
11 four years of state perinatal equity initiative funds,
12 (inaudible) prenatal, father and preconception health.
13 Very instrumental groups throughout the collaborative in
14 passing Senate Bill 464, the Dignity in Childbirth Act,
15 which is around the device (inaudible) training thanks to
16 the advocacy of our Women's Policy Institute fellows, our
17 south LA, South Bay community action team, Black women for
18 wellness and a host of others throughout our network. We
19 were supported including First 5s and DPH doula program
20 launched and actually that number is now almost at 300
21 families. Black doula program, tech prep events our ground
22 so activity is (inaudible) awareness with collaboration and
23 life association of Black women physicians, collaborations
24 with insurers and others. And then we mentioned the
25 formation of the community action teams who are on the

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1 ground with innovative offerings such as the Black daddy
2 dialogue, an online virtually event in South LA, South Bay,
3 the village mental health support groups and mighty little
4 giants NICU support efforts in Antelope Valley. You know,
5 the community action teams really are a huge part of the
6 heart and soul of the collective initiative. Robust
7 appropriate communications platforms that never before
8 existed. So (inaudible) training of all county staff and a
9 launch of the village fund, codesigned with the steering
10 committee, an LA partnership for early childhood investment
11 which will be described later, a tremendous partnership
12 with cherished future, addressing hospital systems.
13 And, finally, as I head to the final week of my
14 fellowship and as we look forward to continue -- both what
15 the continued work looks like in the initiative, I really
16 would be remiss if I didn't express a deep gratitude for
17 Pritzker, my fellow fellows, the amazing change makers
18 leaders who make up the collaborative effort and who are
19 vital co-laborers in this work and many of whom have laid
20 the foundation of these efforts long before I even became
21 involved with them.
22 I'm also grateful to Dr. Barbara Ferrer and Dr.
23 Dansy Ellen of the Department of Public Health who have
24 quite literally changed the game so to speak when they
25 declared we would address this crisis firmly planted in the

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1 frame of racism as a root cause. And to you, First 5 LA
2 commission, for allowing this work to take place. To Kim
3 Belshe for your ongoing support, encouraging e-mails. And,
4 of course, my dear colleague (inaudible) Conner and Rena
5 Brander (phonetic) at the Department of Public Health, and
6 Brandi Sims here at First 5 LA who are absolute rocks in
7 this oftentimes very difficult work. And our team of
8 support efforts, Amelia, Tara, (inaudible) in the coms
9 department.
10 Plus I want to thank the many Black families who
11 have endured -- acknowledge them. The loss of a child or a
12 parent as a result of birth complications or the loss of
13 the birth experience they had dreamed of.
14 And finally, my former preemie baby girl and
15 original baby bosses and husband who are a reminder that,
16 even in the midst of courage there can be hope and healing
17 if we remain steadfast and courageous together.
18 And with that, I turn things over to my colleague,
19 Brandi Sims.
20 MS. SIMS: Thank you. Thank you, Dr. Allen and
21 Melissa for that overview of the AAIMM initiative and the
22 impact of the Pritzker Fellowship.
23 Good afternoon, commissioners. I'm Brandi Sims.
24 I'm First 5 LA program officer for the AAIMM initiative.
25 And I'm going to be sharing information about AAIMM's

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1 (inaudible) for our strategic plan, how First 5 LA is
2 utilizing partnerships and leveraged investments to
3 maximize our support of AAIMM, and today's request for
4 board approval of an investment in the AAIMM evaluation.
5 We all know that First 5 LA cannot reach our north
6 star if certain populations of children are not making it
7 past their first year in disparate rates. The AAIMM
8 prevention initiative is aligned to all four results for
9 children and families and falls within strategic priority
10 one, to strengthen public and community systems.
11 In support of these objectives, our priority with
12 AAIMM is adopting an equity lens, but also focusing on
13 sustainability, partnership, prevention, systems change,
14 evidence, and invasion in the areas where we have the
15 greatest potential for impact and using a wide range of
16 tactics.
17 In fiscal year 20-21, First 5 LA has committed
18 $1.4 million within the current First 5 LA programmatic
19 budget under the birth outcomes and disparities allocation.
20 This commitment includes $350,000 received from the
21 Los Angeles County Department of Public Health to lead the
22 AAIMM public awareness campaign which seeks to raise
23 awareness about birth disparities and the various
24 interventions being created, expanded, and improved to
25 address them, hopefully results in an increased utilization

1 and public and political will and sustainability of these
2 interventions.
3 It also includes our leading investment previously
4 approved by this board and the AAIMM village fund, which is
5 a full fund designed by the AAIMM initiative to support
6 community led efforts to reduce birth disparities. It
7 includes our efforts to support the integration of AAIMM
8 with other First 5 LA strategies and investments. It also
9 includes an earmark for today's request around financial
10 support of the AAIMM evaluation.
11 First 5 LA will continuously review and align our
12 policy and systems change contribution to improve facts and
13 services (inaudible) to meet the needs of LA County's
14 African American families and reduce disparities in birth
15 outcomes. Opportunities to improve services include
16 connections to maternal early identification intervention
17 and home visiting efforts, supporting AAIMM efforts to
18 engage hospitals and upstream, systems level interventions
19 to improve birth outcomes and experiences, and
20 collaborating with Best Start to increase African American
21 parent leader engagement in AAIMM and across First 5 LA
22 investments. All aligned AAIMM efforts are being reviewed
23 to determine necessary adjustments to better support this
24 target population and reduce the spread impacts in light of
25 Covid-19.

1 First 5 LA's investment in AAIMM leverages
2 contributions by a wide range of public, private, and
3 community partners. AAIMM has received more than $3 million
4 in local and state public funding, including California
5 state perinatal equity initiative in DHS core person care
6 funds, Over $400,000 in private investments for backbone
7 and programmatic support in which support from the LA
8 partnership for early childhood investment, we have raised
9 over $1 million for the AAIMM village fund. We also have a
10 wide range of community-based organizations, public
11 agencies, and private enterprises such as health plans and
12 hospitals providing in-kind support at the countywide
13 initiative through our steering committee, community action
14 teams, and AAIMM partnerships.
15 AAIMM's structure as a public-private community
16 partnership has allowed us to build a foundation of
17 authentic partnership, shared leadership, trust, and
18 accountability to the communities we serve. This
19 foundation is essential to the continued success and
20 sustainability of the effort.
21 A key (inaudible) to ensure optimization, scale,
22 and sustainability is a comprehensive evaluation of the
23 novel interdisciplinary and integrated intervention
24 strategies designed and implemented through the AAIMM
25 effort. AAIMM is funded in part through the California

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1 Perinatal Equity Initiative and the evaluation was used a
2 results-based accountability framework to ensure alignment
3 to the evaluation of PEI. This framework uses a
4 turn-the-curve process to capture the quality and impact of
5 services on well-being at both the client and population
6 levels.
7 First 5 LA is requesting approval from the board
8 of commissioners to establish a strategic partnership with
9 the LA County Department of Public Health and invest the
10 $400,000 in matching funds in support of the AAIMM
11 evaluation. Our goal is to evaluate AAIMM's strategies and
12 interventions, including those funded through the perinatal
13 equity initiative, the AAIMM doula program, and the public
14 awareness campaign which is led by First 5.
15 Funding will go to the Department of Public Health
16 who will lead the contract procurement and management of
17 the multi-year evaluation. We will be returning to the
18 board in October for authorization via contracts consent so
19 that procurement can start before the end of the calendar
20 year.
21 This concludes our AAIMM presentation. So I'm now
22 going to turn it back over to the chair for questions and
23 feedback.
24 COMMISSIONER ZEPEDA: Thank you, Brandi. And
25 thank you all presenters.

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1 Do the commissioners have any questions? I
2 haven't received any texts. Appears to be no questions.
3 I have a question. Well, it's more of a comment
4 and a question. When you were presenting -- I think it was
5 Dr. Allen and was mentioned by the other presenters as
6 well, is that, this is being led by Black women about Black
7 women. The idea that the people that are guiding this work
8 are actually the people on the ground who have lived these
9 experiences or have family members that have lived these
10 experiences. That is so important in my estimation. And
11 so I really -- that really stood out to me as a -- as a
12 real strength, what it is that you're doing. And so I just
13 wanted to point that out. And that's more of a comment.
14 It looks like I have a comment now from -- let's
15 see. From Dr. -- from Dr. -- from Commissioner Taylor.
16 Commissioner Taylor. I think you're on mute.
17 COMMISSIONER TAYLOR: Trying to get my mic back on
18 and get my face in there.
19 First of all, I want to thank that this is an
20 excellent presentation. Finally, we see where we are and
21 what we're doing. I really appreciate that. You guys are
22 doing a great job.
23 The only thing is, I think somewhere in here, so
24 you measure the outcome. We need to hear the voices of the
25 mothers that are being served so we can hear how this

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1 change has made a major difference in their lives in order
2 to reduce the stressors, help them to be well, and help
3 their child to be well. So they're nurturing and
4 understanding what needs to be done.
5 So I really appreciate this. And I let's make
6 sure that we focus on the doctors and the nurses and the
7 other people that engage these mothers so that they're not
8 turned off by the lack of empathy or the lack of hearing
9 their voice.
10 One of the things that so many things that I've
11 seen is that these ladies go in there, they tell them and
12 they complain, and the doctor just says, you're all right,
13 or the nurse says, you're all right. This is not me
14 speaking. It's them speaking. So I want to make sure
15 their voice is heard, we document that, and we understand
16 the shift that they understand they have a voice and
17 empower them so they get the help they need.
18 Thank you.
19 COMMISSIONER ZEPEDA: Thank you, Commissioner
20 Taylor.
21 Commissioner Heger -- Astrid, do you --
22 COMMISSIONER HEGER: I do. I love that fact that
23 they have my dad's name instead of my professional name on
24 my picture. It always makes me feel very good about where
25 I come from. And since we're talking about where we all

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1 come from, as some of you know, including Brandi, I'm very
2 interested in this whole concept about how we're going to
3 do this. This disturbed me for the long time. And the
4 first month I was on the commission, we talked about this.
5 I think I remember myself saying, it's racism. It's still
6 racism.
7 I'm wondering a couple things about this. Number
8 one, are we -- are we beginning to see any impact in the
9 two years that we've been working on this? That would be
10 interesting to know to see what kind of impact we're
11 having.
12 And I'm very action oriented. So Dr. Franklin, I
13 think one of the things would I love to see -- and I
14 mentioned this before to Christina -- a -- a really dynamic
15 aggressive Black-run clinic in an appropriate geographic
16 location in LA that actually provides the very best of
17 care. So what Romalis is saying is a doctor -- and I'm
18 going to tell you this is classic. You're going to be
19 fine, I don't need to hear what's wrong with you, et
20 cetera, and dismissive. That we have African American
21 doctors, clinic run by African American administrators,
22 African American nurses. We include a pediatric clinic.
23 We included an internal medicine clinic. We include a
24 community activist. Right, Brandi? We talked about this.
25 And that they're in the schools and high schools and that

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1 we actually demonstrate in 24 months a difference in
2 mortality rates.
3 I -- I'm -- I recognize stress is a huge factor in
4 African American population. My future daughter-in-law is
5 African American. You know, she tells me how she feels. I
6 think that we need to -- I just would like to know, are we
7 having an impact. And I have a number of African American
8 celebrity friends who would be very interested in investing
9 in this towards getting that kind of clinic and giving
10 bonus money to -- to doctors and nurses that work there.
11 So I'll just throw that out there.
12 COMMISSIONER ZEPEDA: Thank you, commissioner.
13 DR. ALLEN: I can dive in about the outcomes and
14 there. I almost feel like that's a softball question
15 because I know there is such a clinic that we have in mind.
16 The answer about evaluation is, there was a
17 decline. Unfortunately, our infant mortality data lags
18 because it's complicated the way it's calculated. But you
19 have to get to the end of the year in which the child might
20 die because it's considered a death during the first year
21 of life. So I can't -- so we are now just getting 2018
22 data. And there was a decline in Black infant mortality in
23 2018, but we really can't yet -- I mean, we'd have to look
24 at a trend over several years to be confident that isn't a
25 fluke. So as much as I'd love to claim that, I think we're

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1 really going -- what we will be able to see I think in the
2 shorter term is positive outcomes at particular programs on
3 a very micro level. So, for example, what are the outcomes
4 for women in the doula program that we have. But their
5 numbers won't be large enough for us to say we've changed
6 the infant mortality rate until we have a few years of
7 data.
8 So I think the focus will immediately be on, as
9 has been said, women's experience and the immediate
10 outcomes for women who are participating in particular
11 things. And it will take a little while before we can
12 really -- and we look for three years of data to be able to
13 say, you know, there's really been a change. So watch this
14 spot.
15 And I -- I'll turn it over to my colleagues to
16 respond to other parts of the comment.
17 MS. FRANKLIN: And we are, commissioner, in talks
18 regarding that very concept of a Black family-centered,
19 culturally relevant clinic or birthing center. So we're in
20 conversations with partners right now to work around that
21 and have really emerged right at beginning of Covid, and
22 looking at the need to really address the challenges of
23 Black women having to potentially deliver alone due to
24 certain hospital requirements and limitations of supportive
25 birthing person. So that is one area.

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1 And then the other is in our doula program where
2 we're tracking progress. Dr. Allen can speak to any
3 preliminary outcomes related to that.
4 COMMISSIONER ZEPEDA: Go ahead. You're muted.
5 DR. ALLEN: I with -- oh, I was reading a comment
6 and I missed the thing you -- just before you said I can
7 comment on it, Melissa. I'm sorry.
8 MS. FRANKLIN: It was the doula program progress
9 to date.
10 DR. ALLEN: Yes. This has been zero to 60 in one
11 year that it has gone as nonexistent to having served 300
12 women. And we're currently applying for State funds to
13 sustain it. We're hoping to get a grant of a million
14 dollars a year, which is -- this is a State initiative that
15 allows for expanded visions of home visiting. And what
16 we're trying to say is -- you know, our argument in the
17 proposal we're submitting is that doulas are the model of
18 home visiting. Even though it isn't usually framed as a
19 model of home visiting, it does do home visits. And it is
20 a model that is seen as very organically connected to the
21 Black community and has had tremendous success in
22 recruiting Black women, which is less true with some of the
23 other home visiting programs that have less of an organic
24 historic connection. So we're trying to sustain that and
25 build on that with this -- this State fund.

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1 COMMISSIONER HEGER: Deborah, there's an
2 additional comment on that, is that the women that are in
3 the homes doing the home visiting and helping with the
4 birthing in the Black community are primarily Black.
5 DR. ALLEN: They are all Black.
6 COMMISSIONER HEGER: There you and go. And the
7 doctors that are not in these specialized clinics are
8 predominantly not Black.
9 DR. ALLEN: That is correct.
10 COMMISSIONER HEGER: Okay. So I think -- I'm
11 commenting on the fact that my experience and dealing is
12 that's a real important differential in the issue of how we
13 treat our patients, how do we deal with the stress factor,
14 how do we understand the stress that they come in with.
15 That's why I'm always advocated for there being this super
16 duper Black clinic run by Black doctors and Black nurses,
17 and the whole thing is they actually can in fact experience
18 the experience. And I'm the ultimate old White female
19 doctor. So I have no right and I have no experience to
20 come from except what I see and -- in a medical profession.
21 And I'm very concerned about it, which is why I'm going to
22 tell you that if it's -- if it's run by Blacks, staffed by
23 Blacks, and they have that experience, you're going to see
24 the whole thing turn around.
25 COMMISSIONER ZEPEDA: Okay. Thank you,

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1 commissioner Heger.
2 Dr. Allen, did you want to respond?
3 DR. ALLEN: Other than to say I completely agree.
4 And this is a very exciting partnership.
5 Brandi, can I say who it's with?
6 MS. SIMS: Yes, you can.
7 DR. ALLEN: With Charles Drew University and a
8 coalition of Black doulas and Black midwives. So it's very
9 exciting. And they have developed a really robust work
10 plan for how to get it up and running and what its impact
11 is intended to be. It's really meant to be a center of
12 excellence, a model for what we would like care to be like
13 more broadly.
14 COMMISSIONER ZEPEDA: Do any of the other
15 commissioners have any other questions or comments?
16 COMMISSIONER GAREN: I have a comment. The
17 project that -- and the partnership that was just described
18 I think is really exciting, because I think to have this
19 bias towards action and to not do work that's so disperse
20 that it's hard to measure. But this center sounds
21 extremely compelling. And I think it's the kind of thing
22 that speaks to public-private partnership and is going to
23 be compelling and we should think about resourcing it from
24 the private sector as well. And so that -- that could be
25 -- you know, and it's meeting the moment in a way that I

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1 think is -- gives us an opportunity to, you know, use the
2 crisis to do good.
3 COMMISSIONER ZEPEDA: Thank you, Commissioner
4 Garen.
5 I don't see any other questions. I just think
6 that this is such an example of what First 5 is trying to
7 do with systems change and collaboration. And it -- and
8 it's showing more direct impact. I think sometimes we feel
9 like we're way -- so far way from the direct impact. And
10 this is quite concrete in many ways. And so I think that
11 this is a show -- I don't know if I want to call it a
12 showpiece, but it is a very good exemplar of what it is
13 that we're trying to accomplish in the commission.
14 So I'd like to end that.
15 Do we have any public comment on this, Jamie?
16 THE SECRETARY: We don't have any public comments,
17 but Romalis actually has a comment. I just saw that.
18 COMMISSIONER ZEPEDA: Sorry, Romalis.
19 THE SECRETARY: It's okay.
20 COMMISSIONER TAYLOR: I just want to say, this is
21 really outstanding. I think, like you said, Marlene, is
22 that we're showing the lead and the way. But it's very
23 important that we educate other providers who are not in
24 this network so that they understand how they impact
25 African American women and their children. And so out of

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1 this should become some training and sharing of knowledge
2 with other providers. And I think very important that we
3 publish in the medical journal the differences, and take
4 that and own the leadership that they're showing on that.
5 And I think that is going to be even more critical to show
6 and validate the outcome by putting the voice of those
7 ladies that are getting the help as a part of that outcome.
8 Because it's more powerful at the ground -- I keep talking
9 about the ground level. The people that are being
10 impacted, if they tell you it's good, it's good. If they
11 tell you it's bad, it's bad.
12 So we have to uplift that good work you're doing
13 by those that have successfully experienced it and are
14 happy with it and said how great it was. Then that
15 validates your publication of the message you're going.
16 Dr. Heger is dead on. And I mean, that's not a
17 joke. That's real what these ladies have been experiencing
18 and the children that have been passing because of what's
19 going on. I think these -- the way the team has outlined
20 that, the network they're building makes sense. I totally
21 support this. And so -- and I think the evaluation will
22 validate that. So we ought to put it in a medical journal
23 once we get through with this, and how great it is because
24 I'm really proud of what you've been doing. All our
25 partners, all our team, everyone, great job.

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1 Thank you.
2 COMMISSIONER ZEPEDA: Commissioner Garen, you had
3 a quick comment.
4 COMMISSIONER GAREN: My comment is really about
5 the nature of how terrific this presentation was and that
6 -- and that the whole board needs this kind of engagement
7 because this is real, and it's missing from our board
8 meetings. And, you know -- and I'm not suggesting that we
9 repeat the exact same presentation because I've -- I've now
10 experienced it. But I think there's something to be said
11 about thinking about the way we conduct our meetings and
12 what happens in subcommittee and what really could be -- to
13 getting into the balcony of the board as a whole and could
14 be exciting and energizing and involving, which is, you
15 know, what you really always want.
16 So just a -- you know, it's wanting more of this
17 in the group as a whole without it being redundant.
18 COMMISSIONER ZEPEDA: Thank you, Commissioner
19 Garen.
20 Okay. We have no public comment.
21 Item 6, commissioners, was an information item
22 about receiving some money from First 5 California for our
23 home visiting program. So if there's no questions on that,
24 we can go ahead and move to general public comment.
25 Okay. Jamie, do we have any general public

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1 comment?
2 THE SECRETARY: There is no general public
3 comments.
4 COMMISSIONER ZEPEDA: Well, with that said, I want
5 to thank all our presenters today. It was dynamite. It
6 was great. We haven't done this for months and so it was
7 nice to get into the weeds, so to speak, on these very
8 important projects that we're doing. So I congratulate you
9 on all the work you've done and accomplished, and I'm very
10 excited. This is what we should be doing. This is great
11 work.
12 So with that, I will adjourn the meeting. I don't
13 think I need to do -- get a first and second on Robert's
14 Rules. So I think we can go ahead and adjourn the meeting.
15 I wish you all a great weekend.
16 Thanks so much.
17 (At 3:34 PM the meeting was adjourned.)
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1 C E R T I F I C A T E

2

3 I, Heatherlynn Gonzalez, a Certified Shorthand

4 Reporter for the State of California, License

5 Number 13646, do hereby attest that:

6 The preceding is a true and accurate transcription

7 of the meeting of the organization named herein;

8 The meeting was taken down stenographically and

9 transcribed into English under my supervision and

10 authority;

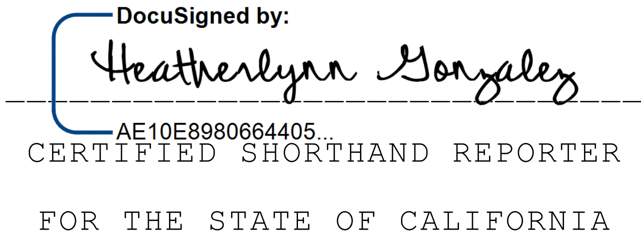
11 I have no interest, financial or otherwise, in any

12 of the parties, issues, or individuals who are involved in

13 this organization.

14 Attested to on this 7th day of October, 2020.

15



16 ______________________________

17 CERTIFIED SHORTHAND REPORTER

18 FOR THE STATE OF CALIFORNIA

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Agenda Item: 03
Date: October 29, 2020

FIRST 5 LA

SUBJECT:
Home Visiting System Building Progress

BACKGROUND:

First 5 LA's long-standing commitment to supporting families through home visiting services is reinforced in the 2020-2028 Strategic Plan, which calls for First 5 LA to provide program and policy leadership to support the development and expansion of a universal system of voluntary home visiting that builds upon existing infrastructure. First 5 LA's ongoing engagement in home visiting system building efforts demonstrates the myriad of partnerships and strategies underway, as well as the adaptations necessary in response to the COVID-19 pandemic.

First 5 LA continues to support and build upon county-wide momentum to integrate home visiting as an important component of a coordinated, comprehensive system of care. Most recently, in response to a Board motion, the Department of Public Health, in collaboration with First 5 LA, Department of Health Services (DHS), Department of Mental Health (DMH), and Department of Child and Family Services (DCFS) reported on the unmet need for home visiting services, and strategies to expand programmatic options, diversify models of care, and funding needs to meet family's needs in L.A. County. As a result of the pandemic and the demands placed on County departments, First 5 LA has stepped into an interim leadership role in implementing and sustaining the current system and continuing momentum towards the long-term vision.

The October Special Board/Program and Planning Committee presentation will provide an update on First 5 LA's engagement in key areas of system building. Efforts include working closely with health plans to develop an infrastructure that will allow for automatic referrals of pregnant clients into home visiting services, as well as for reimbursement for enrolled members. Expanding partnerships into the health care arena would further ensure access and sustainability of home visiting services throughout the county. In an effort to further align to our Diversity, Equity, and Inclusion (DEI) value, First 5 LA continues to explore strategies to increase enrollment of underrepresented target populations, ranging from aligning language skills of outreach staff to hard-to-reach populations to researching African American staff and client experiences in home visiting. First 5 LA worked with the African American Home Visitation Workgroup to better understand the supports African American families need, who they trust, what criteria families use in deciding whether to accept home visiting, and program attributes that would better meet the needs of families.

First 5 LA's approach to data and learning is also evolving in response to the challenges – and opportunities – posed by the COVID-19 pandemic. First 5 LA has been guided by the Welcome Baby Learning Agenda, which identifies 30 priority learning questions related to program implementation and child and family outcomes, as well as strategies to answer these questions. Program monitoring and previous evaluation studies have generated key learnings that have guided refinements to the Welcome Baby program. Since the onset of the COVID-19 pandemic, program monitoring efforts have shifted to an intensive continuous quality improvement (CQI) model to support the rapid transition to virtual visits.

Prior to the pandemic, staff had completed preparations for the Welcome Baby Impact Study, a randomized control trial (RCT) which would establish an evidence base of the impacts of the Welcome Baby program on maternal and child outcomes. In response to programmatic shifts due to the pandemic, staff are shifting the focus of the study to address knowledge gaps on best practices and outcomes of virtual visits. These shifts leverage the existing study infrastructure and will result in insights into maternal and child outcomes of virtual visits, including variations in outcomes by

race/ethnicity, prenatal enrollment status, and risk-level. Additionally, the revised study will provide insights that will guide further programmatic refinements.

First 5 LA's ongoing work and leadership efforts in the key areas of coordination, workforce, funding and data provide critical support in countywide efforts to build an integrated, family-centered and comprehensive home visiting system. Strategies to address sustainability and engagement of health plans and increased enrollment among underrepresented target populations support and inform county wide improvements towards a more effective home visiting system. Given the constraints posed by the pandemic, First 5 LA's evaluation shift to a focus on virtual visits within Welcome Baby can also yield a significant contribution to the national field of home visiting at a time where limited data on virtual home visiting exists.

DISCUSSION:

The purpose of the October Special Board/Program and Planning Committee presentation is to provide an update on home visiting system progress, and to share First 5 LA's adaptations in response to the pandemic, including the shift in the Welcome Baby evaluation efforts. Reflections from Commissioners on learnings and insights will help guide future adaptations and inform First 5 LA's home visiting system building efforts.

Home Visiting System Building Progress

Diana Careaga, Family Supports

Agnieszka Rykaczewska, MLE

Program & Planning Committee Meeting
10/29/2020

Presentation Goals

Home Visiting System Building

Home Visiting System Building Progress Updates

Learning Approach

Overview of Learning Approaches and Welcome Baby Impact Study Modifications

Discussion & Questions

Discussion Questions

Strategic Plan 2020-2028

89

Strategic Priority: Strengthen Public Will & Community Systems

Improve, integrate and expand family-centered systems of early prevention, intervention and learning

Priority 1.1: *Provide program and policy leadership to support the development and expansion of a universal system of voluntary home visiting that builds upon existing infrastructure*

first 5 la
Giving kids the best start

Home Visiting System Building

Key areas for system change for realizing an optimal system of support:

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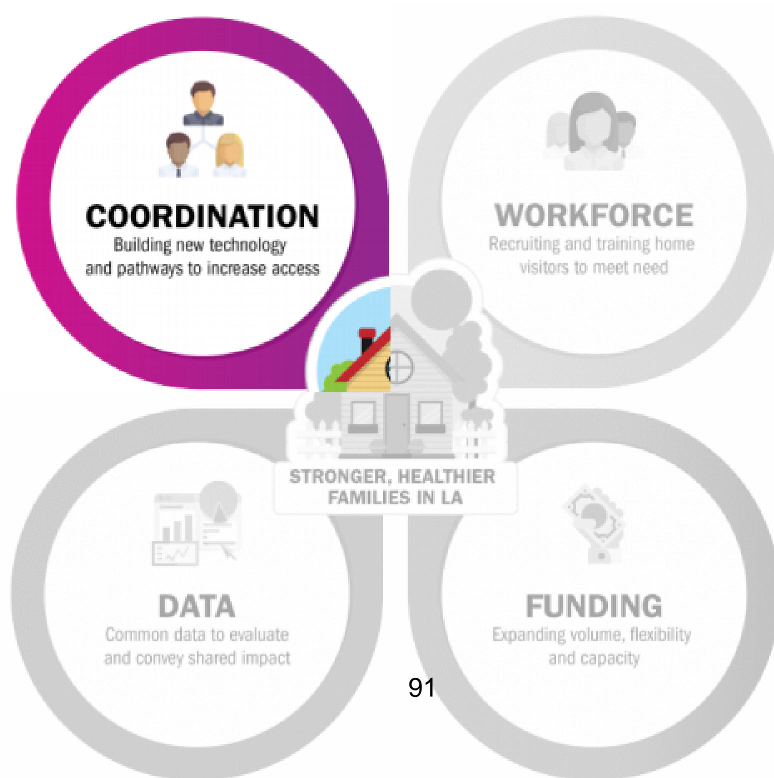
Home Visiting System Building



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Vision for Home Visiting in LA County

A universal system of voluntary, evidence-based family strengthening home visiting services for all Los Angeles families with children prenatal through age five to optimize child development, build parenting skills, and prevent the risk of adverse childhood experiences.

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Board of Supervisor Motion Response: Expanding Outreach and Increasing Diversity of Los Angeles County Home Visiting Programs To Improve Access for Women At Highest Risk

(August 2020)

- Affirmed commitment to creating a coordinated and broadened approach to home visiting
- Highlighted necessary capacity to serve families whose needs vary in type and intensity
- Emphasized that the diverse cultures and preferences in LA calls for programs with diverse modes of intervention
- Requested F5LA to assume governance and leadership role, given COVID demands on DPH

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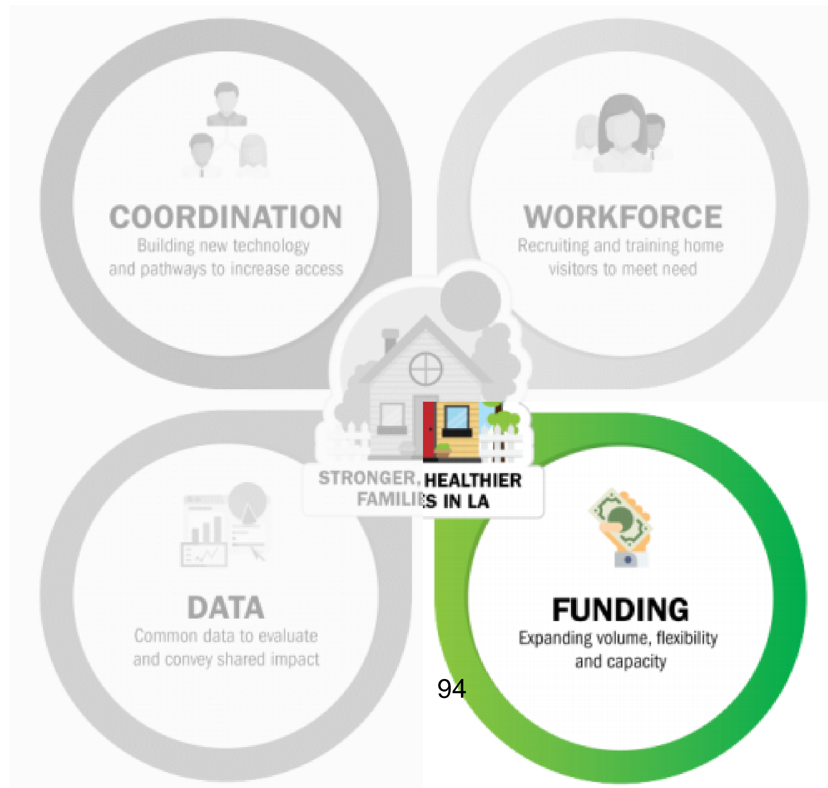

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Health Plan Engagement

- In December 2019 launched pilot with Promise Health for direct referrals of Promise members to home visiting
- Exploring expanded partnerships:
  - Implementation of similar referral strategy throughout County to maximize engagement of Promise members
  - Development of infrastructure to contract with Promise Health through outcome-based agreement
  - Initial explorations with Anthem and other managed care plans to develop referral pilot

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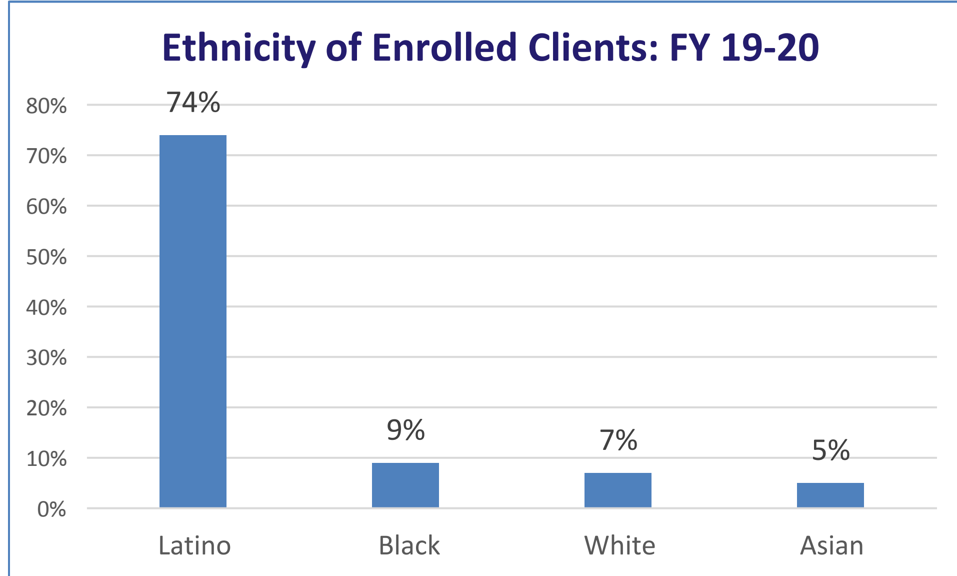
Target Population Outreach Efforts:



Challenges:

- Enrollment overwhelmingly represents Latino families
- Families lack familiarity with home visiting services - ongoing need to promote awareness of services
- Home visitor staffing diversity is limited (many sites require bilingual skills); need for increased cultural competency
- Outreach strategies specific to target populations

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Target Population Outreach Strategy Examples:

- Asian/Pacific Islander
  - Funded Khmer-speaking outreach staff in Long Beach

- African American
  - Provider initiated African American Home Visitation Workgroup
  - Research: Survey of close to 350 home visitors and 3 focus groups

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African-American Engagement in Home Visiting

- Research Finding Examples:
  - *Programmatic Modifications*
    - ➢ Flexible enrollment entry points, provision of concrete needs, parent connection opportunities
  - *Hiring Practices*
    - ➢ Hire culturally diverse providers
  - *Training*
    - ➢ Include implicit bias, DEI and cultural competency trainings, and increase staff awareness of birth disparities
  - *Outreach/Marketing*
    - ➢ Develop best practices and outreach specific for African American audience

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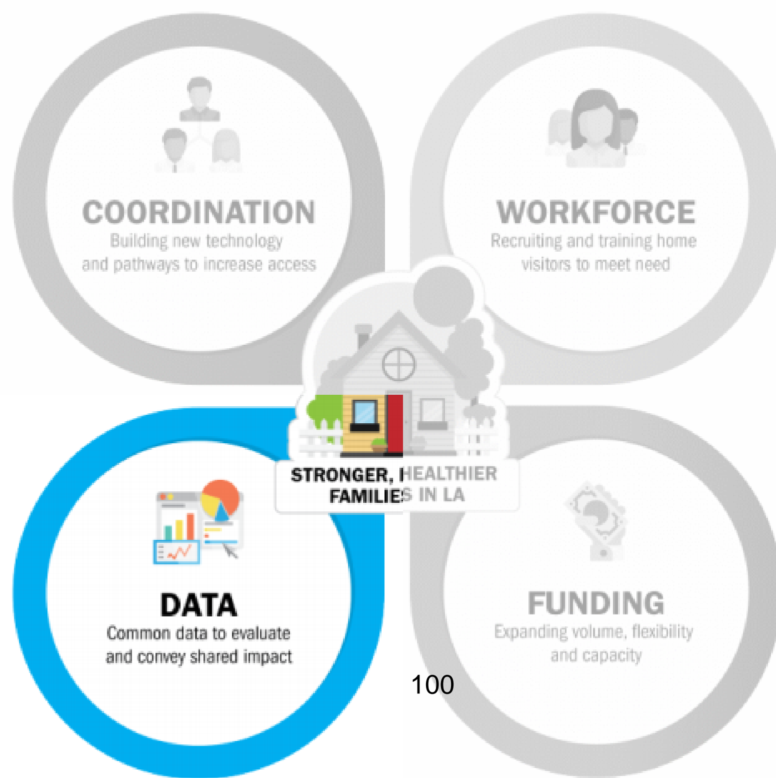

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Welcome Baby Learning Agenda

- Identifies priority learning questions and strategies for answering these questions

- 2 overarching categories of questions:

Programmatic Questions

- Services Provided
- Participant Demographics
- Program Model
- Referrals & Connections

Child & Family Outcome Questions

- Maternal Health
- Individual Child Health
- Child Welfare
- Family Environment

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FY 19-20 Programmatic Key Results

2,313 prenatal & 17,311 postpartum enrollments

74% Latinx,
9% African American,
7% Caucasian,
5% Asian

99.7% of mothers screened for depression

98.0% of children in Welcome Baby screened for developmental delays

13,450 successful referrals

6,922 Welcome Baby Graduations

Programmatic Findings from Past Evaluations

Study	Year	Key Sample Findings	Use
Psychometrics study on Modified Bridges Assessment	2017	• Tool was found to be valid and reliable. • Recommended practices to ensure reliable administration of the tool.	Welcome Baby protocols incorporated recommended practices, which staff regularly reference when administering the Bridges Assessment.
Implementation & Outcomes Study	2018	• Staff trainings focused on theoretical knowledge and lacked practical hands-on experience.	Increased role-playing and shadowing from and by more experienced staff during training period.

Child & Family Outcomes Findings from Past Evaluations

- Compared to national and regional benchmarks, parents who participate in Welcome Baby have:

Evolution of Learning Needs

- We will share two examples of the evolution in our approach to learning in response to the COVID-19 pandemic:
  - Evolving approach to program monitoring
  - Evolving approach to evaluation study

Evolution of Program Monitoring

- Continuous Quality Improvement (CQI) approach:
  - Bi-weekly surveys of Welcome Baby hospital leads
  - Monthly CQI meetings

- Results:
  - Increased video visits from an average of **11%** of visits to **76%** of visits
  - Clients report virtual home visiting met all my needs & expectations (**4.8/5**)

Evolution of Evaluation Study

- Background on Welcome Baby Impact Study (WBIS):
  - **Study Purpose***:* Establish evidence base of the impacts of the Welcome Baby program
  - **Method:** Longitudinal Randomized Control Trial over 18-months
  - **Questions:**

Do women and children who participate in Welcome Baby have better outcomes than those who do not participate?

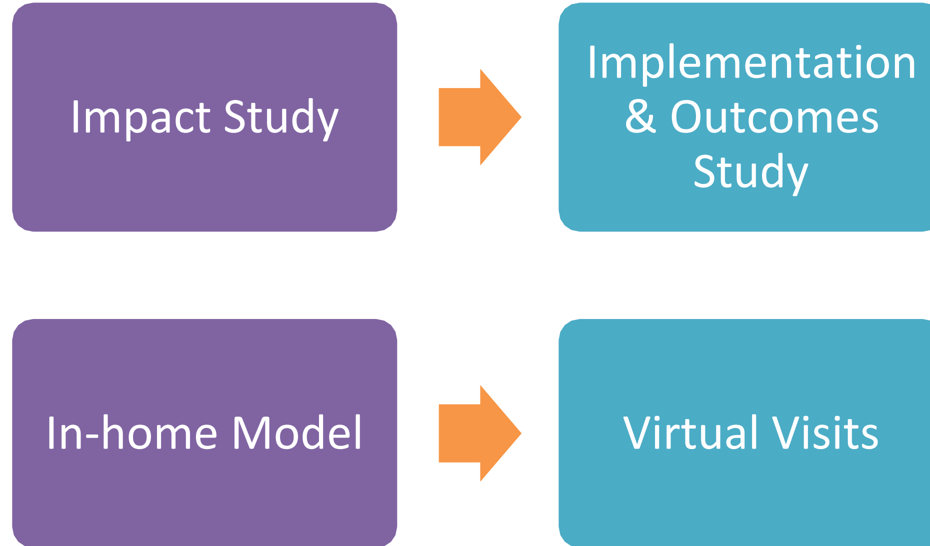
To what extent do benefits of Welcome Baby vary by risk levels and other demographics?

- Pre-COVID-19 Pandemic: Completed preparations to launch the study

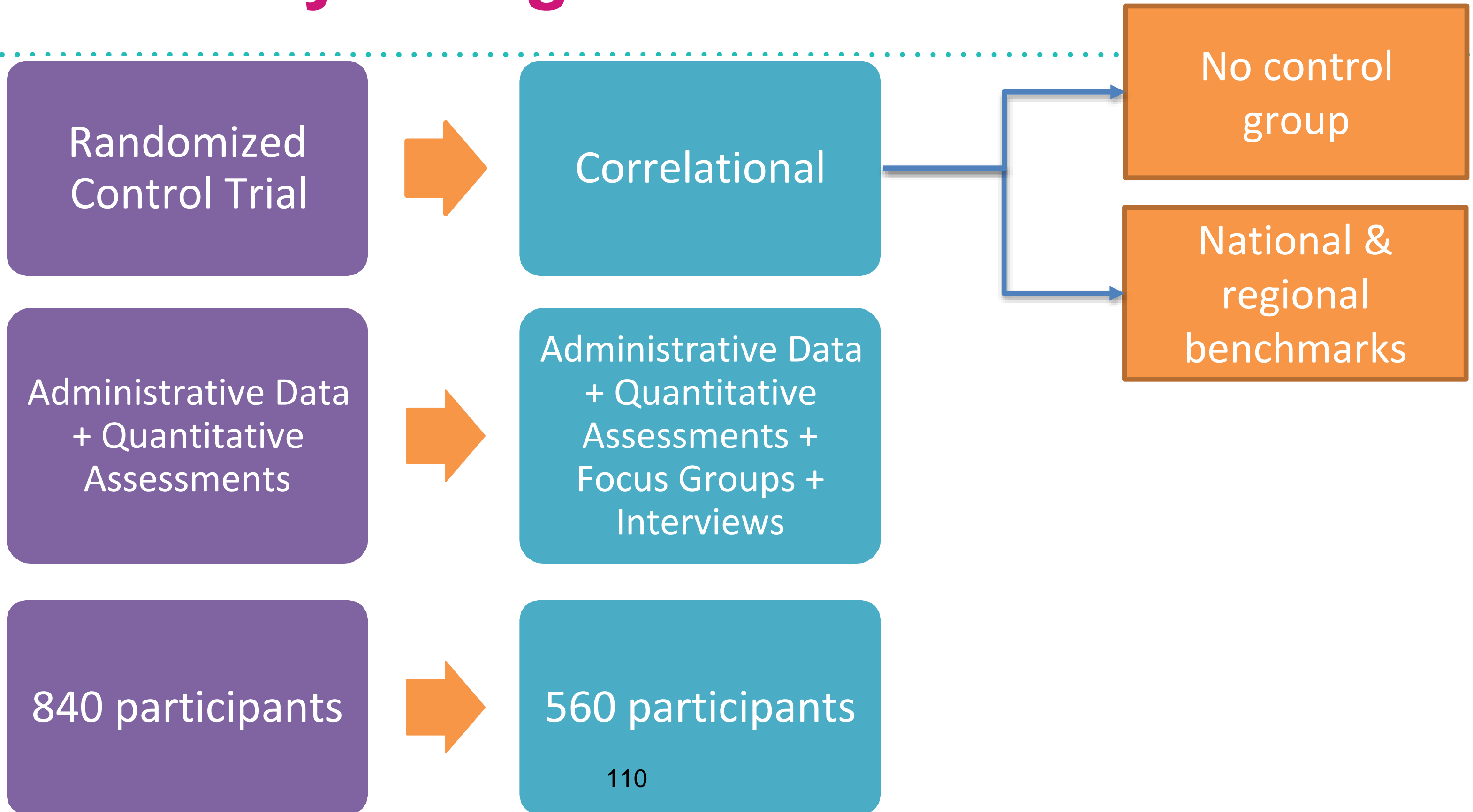
Impacts of COVID-19 Pandemic on Evaluation

- **Challenges:**
  - Evolution of program to virtual visits
  - Strain on both families and staff
- **Opportunities for Learning:**
  - Minimal data available on virtual home visits
  - What are the outcomes of virtual home visiting?
  - What are promising practices for quality virtual visits? What are challenges in implementing virtual visits?

Shifts in Study Focus



Shifts in Study Design



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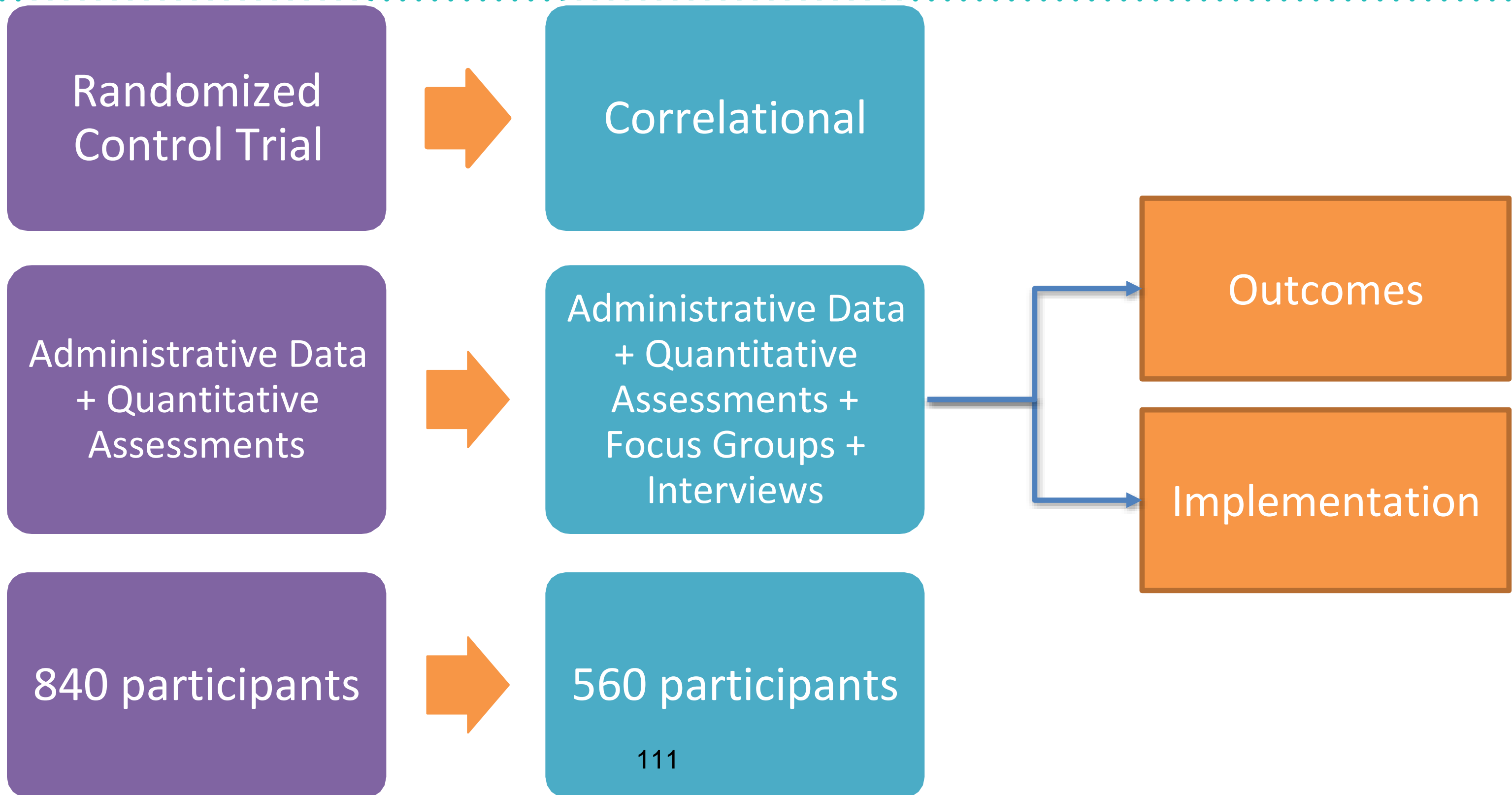
Shifts in Study Design



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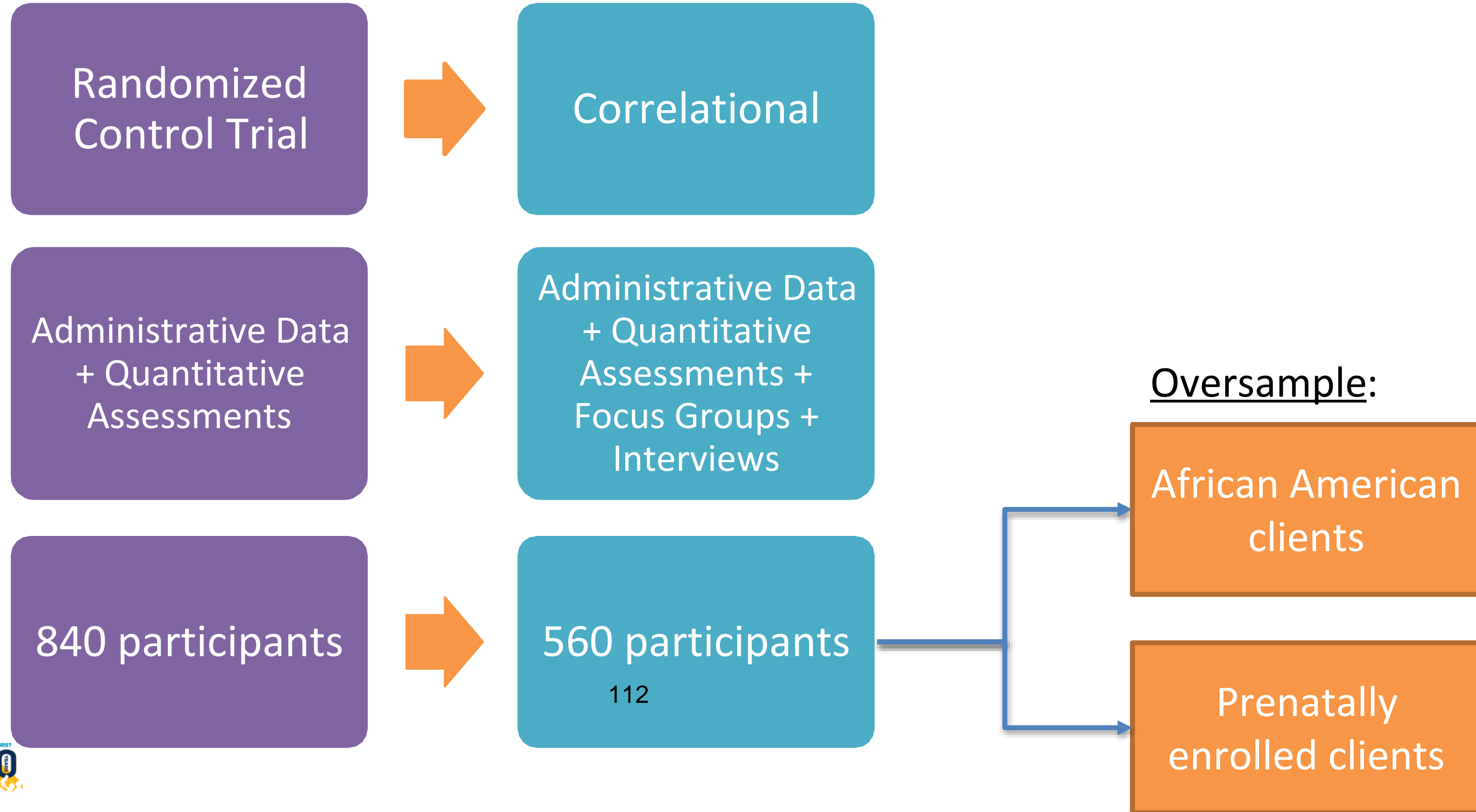
Shifts in Study Design



Benefits & Limitations of Evolved Approach

Benefits:

- Provides insights into **maternal and child outcomes** of virtual Welcome Baby visits, including into variations in outcomes
- Provides insights to guide further **programmatic refinements**
- Leverages **existing study infrastructure** (IRBs, data collection tools & protocols, etc.)

Limitations:

- Won't be able to attribute outcomes to participation in Welcome Baby
- Imperfect comparison data

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Discussion

1. What questions do you have about the system building process?

2. What questions or issues does the revised learning plan raise?

3. What additional questions or feedback do you have?

Thank you!

Appendix

Welcome Baby Learning Agenda Domains

Domain	Sample Learning Questions	Method
Services Provided	Did mothers accept the home visiting services that were offered? Did they participate in the services that they accepted?	Program monitoring Data linking
Participants	What are the demographic characteristics of those who accept Welcome Baby services? What is the risk profile of those who accept Welcome Baby services?	Program monitoring
Program outcomes Maternal Health	Do mothers who accept Welcome Baby appropriately utilize County entitlement services? Do mothers receive needed postpartum care?	Program monitoring Evaluation Data linking
Family Environment	Are family environments more supportive to positive child development? Are more children more likely to enroll in quality preschool or childcare?	
Individual Child Health	Are children more likely to be screened for developmental delays? Regularly?	
Child Welfare	Are families less likely to be reported to child welfare agencies? Does the program increase positive parenting behaviors?	
Systems Change	Are families connected to and receiving eligible entitlements?	Program monitoring Data linking
Program Model	Do outcomes for mothers and children vary by dosage?	Program monitoring Evaluation Data linking

FIRST 5 LA

SUBJECT:
Provide an update on Early Identification and Intervention efforts including implementation status of Help Me Grow LA.

BACKGROUND:
One of First 5 LA's four targeted results for children and families is "children receive early developmental supports and services". First 5 LA has been committed to strengthening early identification and intervention services (EII) for young children to ensure developmental and behavioral delays are detected early and children are connected to appropriate supports. Our system improvement efforts have including multiple efforts including policy change via state legislation and advocacy, as well as, advancing systems change through the planning and implementation of Help Me Grow LA (HMG LA) in partnership with the Los Angeles Department of Public Health (LAC DPH). This past year, staff has prioritized capturing and elevating learnings from our partnerships, such as the recently concluded First Connections evaluation, which will aid in sustaining and spreading best practices, as well as, further inform system change efforts.

As affirmed in the First 5 LA 2020-2028 Strategic Plan, First 5 LA is expanding upon its EII commitment with a focus on policy and data, practice transformation, and consumer demand to reduce health disparities and ensure all children in L.A. County enter kindergarten ready to succeed in school and life. First 5 LA will continue strengthening EII through various strategies, including implementing HMG LA to better coordinate systems that serve children to strengthen early identification and link children and their families to appropriate intervention services and supports.

Strategic Partnership with LAC DPH and the Co-Implementation of HMG LA
Since July 1, 2018, First 5 LA and LAC DPH have moved from planning to early implementation of key strategies and activities to bring the vision in the 2017 HMG LA Recommendation Report to life. As the organizing entity, LAC DPH is tasked with providing support, oversight and facilitation of broad system change activities while building out the necessary foundational infrastructure for HMG LA. LAC DPH will provide administrative and fiscal oversight necessary for long term system sustainability and expansion and lead ongoing continuous quality improvement. As we begin the third year of this partnership, First 5 LA and LAC DPH are moving toward testing multiple strategies to support HMG's four core components (Centralized Access Point, Child Health Provider Outreach, Community and Family Engagement, and Data Collection and Analysis) to meet LA county's needs and address our fragmented EII system.

HMG LA Countywide and Community Approach
The HMG LA Recommendation Report advised HMG LA adopt a "phased rollout that takes place in select communities" as "a means to identify, coordinate and build on existing early identification and intervention infrastructure." Intended to provide an opportunity to launch, test and refine strategies before scaling, this approach also allows HMG LA to better align to the needs of children and families.

The aim to focus select HMG LA activities and strategies at a countywide level while others at the community level was informed by multiple inputs during the implementation planning phase (2018-2019), including a deeper review of system barriers across the EII continuum; examination of documented inefficiencies experienced by other HMG state and California county affiliates; and findings from exploration with local key stakeholders (e.g.: QRIS/QSLA, Los Angeles based Regional Centers, First Connections, etc.). Additional considerations and criteria further informed the rollout and

selection of community and regions for HMG LA activities and strategies.[1] The vision of this approach is intended to allow a bi-directional, reciprocal relationship between the countywide and the community HMG LA features.

As part of the HMG model, certain core components such as the Centralized Access Point and Data Collection Analysis are distinctively "centralized" by design; therefore, taking on a countywide approach. Other activities such as Policy and Messaging also appear better suited for countywide reach. The remaining two other core components of the model, Community and Family Engagement and Child Health Provider Outreach align closely with a more "decentralized" or community approach. Current investments, including HMG LA Pathways and the partnership with L.A. Care Health Plan fall within this community approach.

Given L.A. County's scale and complexity, coupled with considerations of the geographic distribution of EII services, the community approach has been organized into 7 communities or regions, each overlapping with the 7 L.A. County Regional Center Catchment areas. Current HMG LA strategies that fall into the community approach include HMG LA Pathways. Launched earlier this month, HMG LA Pathways consists of community collaboratives representing diverse partners across different sectors (e.g.: health, mental health, early care and education, child welfare, schools, and community) that will work together to strengthen and expand referral pathways to be more coordinated, integrated and multi-directional. A total of 5 organizations were selected following a competitive solicitation process and on September 10, 2020, the First 5 LA Board of Commissioners approved partnerships with the following organizations to serve as the "Unifying Agencies" for their select collaboratives:

- *Community 1 (North LA County):* **Child Care Resource Center**
- *Community 3 (Lanterman):* **Children's Bureau of Southern California**
- *Community 4 (Westside):* **Westside Regional Center**
- *Community 5 (Eastern LA)*: **Heluna Health/Eastern Los Angeles Family Resource Center**
- *Community 6 (South Central LA):* **South Central Los Angeles Regional Center**

First 5 LA did not receive proposals for Community 2 (San Gabriel/Pomona) or Community 7 (Harbor) and anticipates releasing another solicitation focusing on these communities in the future. In addition, a competitive process to select a Pathways TA Provider also took place over the past 6 months and VIVA Strategies was selected. First 5 LA Board of Commissioners approved at the October 8, 2020 Commission meeting.

Important Learnings and Application

Multiple sources, including the First Connection Evaluation, the HMG LA advisory councils (System Synergy Council and Community & Family Engagement Council), and the evolving landscape have provided valuable learnings related to EII throughout the HMG LA implementation planning and early execution phase. Learnings span diverse themes including data collection and analysis; access to services; diversity and target audience; community and messaging; and capacity and technical assistance considerations, among others.

As part of the extension of the First Connections initiative,[2] First 5 LA partnered with Harder+Company Community Research in 2019 to implement a quantitative and qualitative evaluation of the initiative— including the perspectives of families, grantees and the technical assistance provider— to document the progress towards the goals of the First Connections strategy;

[1] E.g.: the density of the age 0–5 population, geographic distribution of services, complexity of different systems and the demonstrated need for developmental services.

[2] Formally known as Early Identification and Intervention of Autism and Developmental Delays Initiative, the First Connection initiative was extended by the First 5 LA Board of Commissioners in November 2017 for an additional two years to provide opportunity to glean best practices and important learnings to further inform HMG LA implementation.

inform implementation of HMG LA; and identify ways to strengthen and inform other systems change efforts. Over 50,000 developmental screenings were completed by the First Connections grantees between April 2014 to December 2019 and the evaluation examined screening data, along with demographic, referral and services data. Specific learnings related to strengthening linkage to community services include building mechanisms, such as interagency councils and networking activities, to help ensure referrals are appropriate and accessible. Others include developing formal partnerships for referral pathways and data sharing, as well as, incorporating both time and models (e.g.: promotoras, cultural brokers, etc.) to garner buy-in and trust when conducting community outreach. See Appendix A for the complete the evaluation report. First 5 LA and DPH are looking to apply this important learning to both the countywide (CAP and Data Collection/Analysis) and community (Pathways, LA Care pilot) level components of HMG LA.

DISCUSSION:

The purpose of the October Program and Planning Committee presentation is to provide an update on Help Me Grow LA implementation progress and share important learnings, primarily from the recently completed First Connections evaluation, that will be used to guide future programmatic planning and decisions. Feedback from Commissioners will help further inform First 5 LA's Early Identification and Intervention system change efforts.

First Connections Program Evaluation

Final Report

October 2020

harder + co community research

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Executive Summary

First Connections Program Overview Summary

The First Connections program is a critical component of First 5 LA's larger health strategy, based on their 2015-2020 Strategic Plan, to increase the effectiveness and responsiveness of early screening and intervention programs across health, behavioral health, and substance abuse service systems.[1] Six grantees participate in First Connections to provide developmental screenings and linkages for children birth through age 5 in Los Angeles (L.A.) County. They include three Federally Qualified Health Centers (FQHCs): AltaMed Health Services Corporation, Eisner Pediatric and Family Medical Center, and Northeast Valley Health Corporation; two family service agencies: Foothill Family and Allies for Every Child; and one Regional Center: South Central Los Angeles Regional Center. Technical assistance was provided by Children's Hospital Los Angeles (CHLA).

Through technical assistance, family engagement and resource navigation support, First Connections aims to: strengthen provider capacities to conduct developmental screenings, identify delays, and connect children and families to appropriate services; improve families' access to developmental screenings and early identification and intervention (EII) services; increase parents' knowledge about healthy development and developmental delays; and strengthen support for parents of children with special needs.

Evaluation Approach Summary

First 5 LA partnered with Harder+Company Community Research in 2019 to implement an evaluation of the First Connections program. The purpose of the evaluation was to collect quantitative and qualitative data – including the perspectives of families, grantees, EII system partners, and CHLA – to document the progress towards the goals of the First Connections investment; inform the development and implementation of Help Me Grow (HMG) LA which is a network to help families find child development services, and identify ways to strengthen and inform other systems change efforts as aligned to First 5 LA's new 2020-2028 Strategic Plan. In addition, First 5 LA intended for the evaluation to explore and strengthen the EII data available for L.A. County.

Three core areas of inquiry were identified for this evaluation: family access, knowledge, and support; systems learnings and implications; and technical assistance and provider capacity. To capture the information needed to address the three core areas of inquiry, the evaluation team relied on quantitative and qualitative analyses to synthesize and triangulate the multiple findings collected through the different data sources in this evaluation including data review, grantee data, journey mapping, focus groups and the First Connections Forum.

[1] First 5 LA. (2014). *Focusing for the future: First 5 LA strategic plan 2015-2020.* First 5 LA.

Primary findings for each area of inquiry include successes and challenges that could provide learnings for future improvements, as well as insights from the First Connections Forum held with grantees and other EII system partners in Summer 2020.

Key Takeaways

This report presents findings from the First Connections program evaluation by providing information about the implementation and effectiveness of the program that can inform the sustainability of First Connections, development and implementation of HMG LA, and strengthen EII practices across L.A. County. Findings are organized by the areas of inquiry and are informed by the experiences of grantees and parents/caregivers and through the grantee data review.

Family access, knowledge and support

The First Connections program works to engage families in discussions about healthy child development, supports them to navigate between programs and services across service sectors, and connects them to local Regional Centers, school districts, and community supports.

First Connections grantees conducted more than 50,000 developmental screenings with children birth through age 5 in L.A. County as part of the First Connections program. Slightly more than two-thirds (68%) of screenings suggested that screened children were "developing on schedule" at the time the screening was conducted, with 16% in the monitor range, and 17% in the referral range. When examining the individual domain results for screenings in the referral range, the most common area of concern was the Communication domain.

Overall, parents had positive experiences with the developmental screening process; although, some reported long wait times specifically related to scheduling appointments for further assessment. Parents also reported improving their knowledge of child development and developmental supports and learning about the importance of developmental screening and early intervention services through their participation in First Connections.

The main challenge families and grantees reported in this area is the stigma surrounding developmental delays. Some parents reported not always having support from family members. However, they reported that learning how intervention services would support their child's development gave them the motivation and confidence to advocate for their child. Parents also reported sometimes encountering gaps in communication or information when attempting to access services or resources, both within and outside of First Connections.

Systems learning and implications

First Connections program offers an important learning opportunity to leverage promising practices and lessons learned to advance and strengthen countywide EII system change efforts, such as Help Me Grow LA (HMG LA). Evaluation findings include outreach strategies to engage diverse families, the successes and challenges of developing external partnerships, and the critical role of care coordination in EII systems.

While grantees experienced some challenges engaging diverse families, they aimed to be responsive to the cultural nuances and needs of all the families in their catchment area. Grantees report often shifting their outreach strategies to better engage children and families of diverse backgrounds. Grantee data showed that First Connections screened American, Asian, Latinx, multiracial and White children and those of other race/ethnicities, with the vast majority of children screened identifying as Latinx (76%).

In addition to tailoring the outreach strategies, grantees indicated that having collaborative relationships with Regional Centers, school districts, and other mental and behavioral health providers is a critical component to ensure at risk children are connected to needed services. Grantees reported that developing relationships with external service providers requires frequent and consistent communication and follow-up, as well as garnering buy-in and trust with partners at the decision-making level.

Since most grantees generally rely on external partnerships for referrals and linkage, care coordination is another critical factor in guaranteeing that families are able to navigate the system and connect to needed intervention services and supports. Parents reported that care coordinators helped them connect to referral agencies when they did not hear back or when they needed to advocate for their child to receive services. Additionally, grantees reported implementing bridging services such as providing telephone education and support to the parents, providing families with developmental homework, and conducting ongoing follow-up to check-in on the child’s development to support families when a service gap existed.

Technical assistance (TA) and provider capacity

Understanding TA impact on grantee practices and workflow is foundational to evaluating the extent to which grantees were able to achieve family and system level outcomes. These findings can help inform the ways in which TA could benefit from better design investments upfront.

Grantees reported the most helpful aspects of TA were training, workflow development and refinement, as well as developmental screening tool selection. TA was also effective in building the capacity of grantees to facilitate both core and internally developed trainings on an ongoing basis.

Within the first three years, the TA team facilitated over 60 trainings with First Connections grantees designed to increase staff knowledge regarding developmental screening implementation, linkages to resources and services, and understanding developmental disabilities and interventions for young children. As grantees capacity increased, the TA team encouraged them to develop and utilize a “train the trainer” approach so grantee staff could deliver the basic trainings on their own with limited support.

Additionally, the TA team assisted grantees with developmental screening tool selection which led to grantees using the ASQ®:SE-2 to ensure that children who experience social emotional issues are identified, referred and connected to intervention services.

Though outside of the TA team’s scope for First Connections, grantees would have benefited from additional support related to trauma-informed care and grant reporting and data tracking, which impacted their ability to evaluate their programs.

Recommendations for HMG LA and EII Providers

As First 5 LA transitions the First Connections program and acts on their 2020-2028 Strategic Plan, they will begin to implement HMG LA, in addition to continuing to support EII providers in L.A. County more broadly, so that families optimize their child's development and children receive developmental supports and services as early as possible.[2] This evaluation provides an opportunity to translate key findings into actionable recommendations anchored to HMG LA’s core components:

Centralized Access Point (CAP) to help families and providers access needed resources

- Train staff to use **relationship-based, culturally responsive** approaches when working with children and families.
- Ensure that families are connected to **one consistent staff person** throughout the entire process
- Proactively plan for ways that staff will **stay connected with families** who are unable to access services or resources due to waitlists or delays.
- Develop pathways to help ensure referrals to EII providers are **appropriate and accessible**.
- Develop **formal partnerships** with MOUs for referral pathways and data sharing.

[2] First 5 LA. (2019). *2020-2028 strategic plan.* First 5 LA. https://www.first5la.org/2020-2028-strategic-plan/.

Community + Family Engagement (CFE) on child development and available resources

- Design **family engagement strategies** to reduce stigma via normalization, education, and awareness work that takes into consideration the needs of diverse families especially related to language and culture.

- Incorporate time to **garner buy-in and trust** when conducting outreach to community organizations.

- Provide **parent support and education** services, including peer groups.

Data Collection + Analysis (DCA) to measure success and improve the system for families

- Provide **education and ongoing support** to providers on the recommended data elements and provide **standardized definitions** to ensure consistency in data collection.

- Adopt or design a **countywide data system** that can integrate with, or be compatible with, other data systems that EII providers currently use.

- Develop **trainings and resources** to build the capacity of EII providers to collect and report data and evaluate implementation and outcomes in a consistent and meaningful way.

Child Health + Provider Outreach (CHPO) to support detecting delays and connecting families to resources

- Engage TA providers that have **deep expertise** and the ability to provide customized trainings, services and supports to work with a wide range of EII providers.

- Incorporate **trauma-informed practices** into EII provider outreach, training and TA.

- Aim to build the capacity and sustainability of EII providers by leveraging the "**train the trainer**" approach.

Introduction and Background

Why is Early Identification and Intervention important?

Critical development occurs between birth through 5 years of age

Early childhood is a critical stage for human development as almost 90 percent of the brain develops by age five.[3] The experiences and environment a child is exposed to during those early years lay the foundation for the rest of their lives.[4] For children with and at risk for developmental delays, early intervention can drastically impact their developmental trajectories.[5] Although research has shown that high-quality services provided to infants and toddlers before age three produce the highest return of investment (13 percent per child per year), many children with developmental concerns do not receive their first screening or intervention until after they enter the school system.[6,7] Given the importance of the earliest years of a child's life, it is imperative for early childhood systems to implement effective strategies to identify and address children's developmental needs, delays and challenges in order to better support their healthy development and long-term success.

EII services are key to reducing the adverse effects of developmental delays and disabilities and to providing support for families and children. Certain EII services are mandated by the Federal Government under Parts B and C of the Individuals with Disabilities Education Act (IDEA) and through health care plans under the Affordable Care Act (ACA) while others are offered in settings outside these federal mandates.[8] Research shows that early developmental screenings constitute the first step in identifying children who might need a formal development assessment[9] and are fundamental to connecting children to needed services and supports as early as possible.[10]

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[3] Koestner, L. (2015) *Effective systems in early identification of developmental delays.* First 5 Association of California.
[4] Shonkoff, J.P. & Phillips, D.A. (2000). *From neurons to neighborhoods: The science of early childhood development.* National Academies Press.
[5] Vaivada, T., Gaffey, M.F., & Bhutta, Z.A. (2017). Promoting early child development with interventions in health and nutrition: A systematic review. *Pediatrics, 140*(2). Doi: 10.1542/peds.2016-4308
[6] Hunt, N. (2020). *Identifying young children for early intervention in California*. Policy Analysis for California Education.
[7] Goode, S., Diefendorf, M., & Colgan, S. (2011). *The importance of early intervention for infants and toddlers with disabilities and their families*. The University of North Carolina, FPG Child Development Institute, National Early Childhood Technical Assistance Center.
[8] Ibid.
[9] Koestner (2015).
[10] Hunt (2020).

EII services in California and Los Angeles County

Despite the importance of developmental screenings and early intervention services, only 4.7% of California children birth through age 5 received early intervention services.[11] Additionally, only 3% of California's children receive early intervention services before age three even though 18% of children have a developmental delay or disability.[12] According to the American Academy of Pediatrics (AAP), children should be screened three times by age three. In California, only 26 percent of children are screened at the recommended frequency.[13] In addition to the lower screening rates in California, data show evidence of racial disparities. Screening rates are lower for Latino, African American and Asian children in California compared to their White peers.[14]

To address these gaps and inequities, various efforts have been implemented throughout the state as well as in L.A. County to improve coordination and communication between agencies and providers that serve young children and their families. Taking a systematic approach by coordinating between all providers serving children birth through age 5 maximizes effectiveness in addressing developmental delays and disabilities early and addresses needs at the family, provider and system level. The coordinated EII efforts of the system will contribute to the healthy social and cognitive development of the children served.[15] However, multiple barriers including lack of coordination and data sharing between agencies that provide EII services, eligibility requirements that are not straightforward, and complex referral process,[16] have prohibited children and their families from effectively accessing EII services. In 2014, the First Connections program emerged as an effort from First 5 LA to address these systematic barriers and decrease disparities in developmental screenings.

First 5 LA's EII Strategy

First 5 LA has been committed to investing in EII since 2005, beginning with the implementation of Early Developmental Screening and Intervention investment to empower physicians and early care and education providers, connect communities and create sustainable change (Exhibit 1). During implementation of the 2015-2020 Strategic Plan, First 5 LA outlined a focus on policy, advocacy and systems change via investing in systems, advocacy and policy work, and leveraging the strength and expertise of partners and others working towards shared goals for collective impact.[17] This focus continues with the new strategic plan that includes results for children and families that families optimize their child's development and children receive early developmental supports and services.[18]

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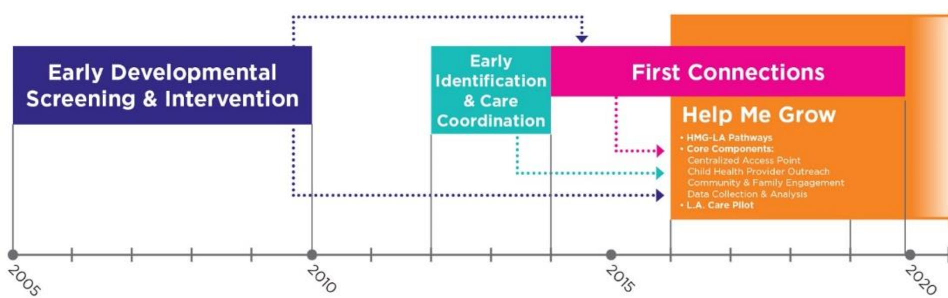
[11] First 5 LA. (2020). *Pathways to progress: Indicators of young child well-being in Los Angeles County.*
[12] Rosen, N., Parma, A., & Crow, S. (2020). *California's early identification and intervention system and the role of Help Me Grow*. First 5 Center for Children's Policy. https://first5center.org/assets/files/hmg-paper-v4-WEB.pdf
[13] Ibid.
[14] Parma, A. Peña, C. & Green, K. (2019). *Issue brief 1 – Early identification: Surveillance and screening*. First 5 LA.
[15] Guralnick, M. (2011). *Why early intervention works: A systems perspective*. NIH Public Access.
[16] First 5 LA. (2019). *Health Systems: Early Identification and Intervention*. First 5 LA. https://www.first5la.org/uploads/files/eii-summary_133.pdf
[17] Peña, C. (2019, July 18). *First Connections program evaluation kick-off meeting presentation*. First 5 LA.
[18] First 5 LA (2019).

Exhibit 1. First 5 LA's History Strengthening EII[19]



To further this strategy, First 5 LA launched the First Connections program. Specifically, First Connections aimed to strengthen coordination between child and family serving organizations in the County, and to assist families in accessing timely screenings and early intervention services. The First Connections program partnered with six community-based providers to embed developmental screening and referral processes into their existing workflows. This approach intended to identify children who need early intervention services and support families and children to connect to appropriate services on cultural and linguistical needs.[20] This report describes the First Connections program elements and presents findings from an evaluation of the program after six years of implementation.

Connection to Help Me Grow LA (HMG LA)

In addition to implementing the First Connections program, First 5 LA partners with the Los Angeles County Department of Public Health to support the implementation of the national Help Me Grow (HMG) model in L.A. County. HMG helps families find services that can support their child's development and helps improve the coordination of programs and services in local communities. In recognition of the continued learning and promising practices that translate from First Connections program to HMG LA, First Connections program was extended to inform the planning and implementation of HMG LA. This collaboration between First 5 LA and other county partners and stakeholders is part of the systems and policy approach required to address the challenges families and children face when accessing early intervention services. The HMG model operates through four core components that aim to increase screening rates in L.A. County (Exhibit 2).[21]

[19] Ibid.
[20] First 5 LA. (2019).
[21] Parma, Peña, & Green (2019).

Exhibit 2. **HMG Four Core Components**[22]

First Connections Program Overview

Program description, goals, and intended outcomes

Established in 2014, the First Connections program is a critical component of First 5 LA's health strategy to increase the effectiveness and responsiveness of early screening and intervention programs across health, behavioral health, and substance abuse service systems. Six grantees participate in First Connections program including three FQHCs, two family service agencies, and one Regional Center (Exhibit 3). A technical assistance component was provided by Children's Hospital Los Angeles (CHLA) to provide each funded organization with assistance and trainings to support the implementation of the program. Through technical assistance, family engagement and resource navigation support, First Connections aims to:

- Strengthen provider capacities to conduct developmental screenings, identify delays, and connect children and families to appropriate services
- Improve families' access to developmental screenings and EII services
- Increase parents' knowledge about healthy development and developmental delays
- Strengthen support for parents of children with special needs

[22] Ibid.

The intended program outcomes include an increase in screening rates, changes to practices to strengthen EII within agencies and early childhood systems, and increase capacity of partners to embed developmental screenings and referrals into their workflow.[23] From April 2014 to December 2019, more than 50,000 screenings were completed for children ages 1 month to 5 years as part of the First Connections program. Children participating in the First Connections program were screened multiple times to track development over time. For more information about children and family outcomes see Family Access, Knowledge, and Support section starting on page 13.

[23] Peña (2019, July 18).

Description of grantees

To achieve these outcomes, First 5 LA funded six grantees (Exhibit 3) to expand their EII programming and partnered with Children's Hospital Los Angeles (CHLA) to provide each funded organization with technical assistance and trainings to support implementation.

As presented below, each type of grantee implemented developmental screenings through a unique approach to achieve their goals. Additional information about grantees is provided on Appendix B.

Exhibit 3. First Connections Grantees

Grantee type	Agency name	Services offered[24]	Screening tools[25]	Interventions[26]	Care Coordination Approach[27]	Agency Service Area
Federally Qualified Health Centers	AltaMed Health Services Corporation	Medical, Dental, Urgent Care, Pharmacy Integration, Senior Care, HIV services	ASQ®-3 and M-CHAT-R on tablet, integrated in electronic health record (developed own platform)	• Case management and follow-up • Spread and scale screening workflow to 3 additional sites • Trainings for providers and staff • Integration of screening tools into electronic health records (EHRs) • Data review and optimization of screening workflow at 6 sites	• Data tracking • Case management • Engagement with Regional Centers Community service providers • Follow-ups with pediatric providers	Countywide
	Eisner Pediatric and Family Medical Center	Medical, Dental, Vision, Behavioral Health, Enrollment and Benefits, Case Management	ASQ®-3 and M-CHAT-R on paper, completed in waiting room	• Case management into pediatric clinics • Expanded referral system and relationship building • Opened a new clinic with staff trained and a case manager on-site • Scaled to include children at Eisner Health Family Medicine Center at California Hospital	• Relationship building with pediatric providers, Regional Centers, and education attorneys specialized in Individualized Education Programs (IEPs).	South Los Angeles, Downtown LA, San Fernando Valley

[24] First 5 LA. (2019, June 11). *First Connections: Homegrown lessons and promising practices*. First 5 LA.
[25] Williams, M. Wheeler, B. Poulsen, M. Zamora, I. & Harley, E. (2018, April 3). *First Connections: Early identification and linkages to intervention for autism and other developmental disabilities in young children*. Children's Hospital Los Angeles. USC University Center for Excellence in Developmental Disabilities.
[26] First 5 LA (2019, June 11).
[27] Ibid.

Family Service Agencies	Northeast Valley Health Corporation	Medical, Dental, Specialty Services for Homeless and persons living with HIV/AIDS. Special programs and services: Health Education, WIC, Homeless outreach and health care services, DUI program, school-based clinics	ASQ®-3 and ASQ®:SE-2 on paper, mailed to home before appointment	• Expansion of the program to 6 health centers • Developing a pilot site • Offering trainings • Developing a workflow chart and referral algorithm	• Scripts for phone outreach • Follow-ups, and warm hand-offs • Strong relationships with external agencies	Service Planning Area (SPA) 2
	Foothill Family	Community-based behavioral health and social services to at-risk children and families	ASQ®-3 and ASQ®:SE-2 on tablet (Brooke's Publishing platform)	• Expansion to larger access models • Creation of Mental Health and Disabilities Program Assistant Position • Internal EHR updates for internal referrals	• Streamlined referral process • Community partnerships • Collateral visits with First Connections staff and referring staff	SPA 3
	Allies for Every Child	Early education programs (center-based, home based, licensed community-based providers), child welfare initiatives, developmental screenings and advocacy, IECMH consultations/therapy, health services, family/community hub	ASQ®-3 and ASQ®:SE-2 on paper	• Tailoring implementation procedures to be program-specific • Embedding protocol and monitoring in program requirements • Screenings and capacity building with community organizations	• Performance and quality improvement • Expertise to support staff in multiple areas • Collaboration with caregivers and internal behavioral health referrals	SPA 5, 6, 8
Regional Center	South Central Los Angeles Regional Center	Early Start, Lanterman Services, Case Management, and supportive programs such as respite, community integration, behavioral supports	ASQ®-3 and ASQ®:SE-2 on paper	• Screening to children using a network of community locations and partner programs • Support to caregiver for referrals, milestones information, and activities to support development • Connecting parents with support and education opportunities	• Staff to coordinate referrals and follow-ups with families • Parent follow-up timeline • Follow-up with service providers • Ongoing support for families to access services	SPA 6

Evaluation Approach

Evaluation goals and design

First 5 LA partnered with Harder+Company Community Research in 2019 to implement an evaluation of the First Connections program. The purpose of the evaluation was to collect quantitative and qualitative data – including the perspectives of families served, grantees and CHLA – to document the progress towards the goals of the First Connections strategy; inform the development and implementation of the HMG LA, and identify ways to strengthen and inform other systems change efforts. In addition, F5LA intended for the evaluation to explore and identify EII data available for L.A. County.

Based on the evaluation goals, Harder+Company identified three core areas of inquiry for this evaluation (Exhibit 4):

Exhibit 4. Core Areas of Inquiry

Family access, knowledge, and support. Understanding how First Connections grantees implemented family engagement practices and how they are working to improve parent access, knowledge, and support affects EII system efforts.

Systems learnings and implications. Understanding the promising practices and lessons learned of using a system-level approach to advance and strengthen countywide EII efforts.

Technical assistance (TA) and provider capacity. Understanding TA impact on grantee practices and workflow and the extent to which grantees have the knowledge and capacity to achieve family and system level outcomes.

Together, these areas constitute a holistic evaluation lens that supports a learning practice and orientation; accounts for the complexity, scale, and context at play in the First Connections program (e.g. at the different client, partner and system levels); and that considers the multiple barriers that providers and systems efforts face when implementing EII screening and referral systems.

Methods and Limitations

To capture the information needed to address the three core areas of inquiry, the evaluation team relied on the following sources: grantee background documents and reports, grantee performance data, data from grantee journey mapping sessions and focus groups with families, and sensemaking with EII providers during a virtual forum. Appendix A presents the methods used to capture the specific evaluation questions of each area of inquiry. The information below details each data source:

- **Document and data review.** The evaluation team conducted a review of key initiative documents including background information, performance matrices, and progress reports.
- **Grantee performance data.** Demographic, screening and referral data was analyzed to assess program outcomes within and across grantees.
- **Grantee journey mapping.** The purpose of journey mapping was to develop an in-depth perspective of the impact of First Connections activities on EII efforts, document changes to organizational processes and workflow, and identify successes and lessons learned. A total of six journey mapping sessions were conducted with various program staff (e.g. site leads, care coordinators, and physician champions), one session per grantee.
- **Family focus groups.** Findings from the focus groups helped capture families' experiences participating in the First Connections program by gathering information on the screening and referral process as well as the different activities agencies implemented to engage families, to normalize developmental screening and to support them with the services that parents need. The evaluation team conducted a total of four focus groups with parents of children participating in the First Connections program, one at each of the following sites: Allies for Every Child, Eisner Health, Northeast Valley Health Corporation, and South Central Los Angeles Regional Center.
- **First Connections Forum**. The First Connections Forum, held virtually on July 14, 2020 provided an opportunity for over 60 First Connections' grantees and EII service providers to hear preliminary evaluation findings and participate in small group discussions to "make sense" of and reflect on the findings in the context of their own practice. References to insights from EII partners throughout this report are based on the discussions held during the Forum.

The evaluation team conducted quantitative and qualitative analyses to synthesize and triangulate the multiple findings collected through the different data sources in this evaluation. Each type of analysis used by the evaluation team is explained below.

Qualitative Analysis

The evaluation team used Atlas.ti – a computer assisted qualitative data software program – to conduct the content analysis for all qualitative data sources. Content analysis is a systematic approach for organizing, analyzing and interpreting narrative data that is grounded in a primarily deductive framework. The evaluation team also developed comprehensive codebooks containing broad and specific codes used to identify themes and nuances within and across grantee journey mapping sessions and parent/caregiver focus groups. Limitations of the qualitative analysis include:

Uniqueness of grantees. Given that grantees are unique with respect to agency type, type of services offered, geographic location, and familiarity with early intervention services, the evaluation team ensured that findings generally spoke to the successes and challenges experienced across all grantees, as well as providing insight into the experience shared by subsets of grantees when similarities exist.

Low attendance to parent/caregiver focus groups. On average, four parents attended each focus group, which is much lower than the participant target of eight individuals. Although there was low attendance, parents were able to provide details of their journey accessing developmental screening services and receiving referrals and care coordination services. It is important to keep in mind that due to low attendance, experiences from parents cannot be generalized for all the families served by each grantee.

Quantitative Analysis

As part of the First Connections program, grantees conducted developmental screenings using The Ages & Stages Questionnaire®, Third Edition (ASQ®-3), The Ages & Stages Questionnaire®, Social Emotional (ASQ®-SE) and/or The Modified Checklist for Autism in Toddlers (M-CHAT).[28] To assess program outcomes, the evaluation team examined 52,656 ASQ®-3 developmental screenings completed from April 2014 to December 2019.[29] Given the retrospective nature of the evaluation, data availability limitations, and reporting inconsistencies, the ASQ®-3 data included in this report may include duplicate participants and does not represent the total number of screenings completed by grantees.[30]

Grantees extracted demographic, screening, referral and service data from their systems including EHRs, online data collection platforms and/or administrative records to share with the evaluation team. All extracted data was cleaned and checked for accuracy before being merged into one dataset. The resulting dataset was analyzed using Statistical Package for the Social Sciences (SPSS).

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[28] Based on the data shared by grantees, the ASQ®-3 was the most frequently tool used to assess the development of children engaged in the First Connections program.

[29] The evaluation team was unable to determine the total number of ASQ®-3 completed as grantees reported the combined number of ASQ®-3, ASQ®-SE, and M-CHAT screenings completed during the grant period in progress reports.

[30] The total number of children included in the evaluation may include duplicate participants as children engaged in the First Connections program could be screened multiple times at different points in time.

The quantitative analysis approach involved running descriptive analyses such as frequencies and mean calculations and comparisons (e.g. Chi-Squares and t-tests) to explore differences in screening and referral practices. Data stratifications were determined by data availability and sample size. Sample stratifications included the following:

- Age
- Race or ethnicity
- Gender
- Grantee type
- Fiscal year (July-June)

Statistical significance was assessed using the most appropriate test for the data and findings were considered to be significant if they achieve *p*-value less than or equal to 0.05, meaning the probability of the finding occurring by chance is less than or equal to 5 percent. Limitations include:

Missing Data. All variables were reviewed to determine the amount of missing data. In order to increase our sample size, we included all data available for the analyses.

Data Availability. The data available for the evaluation varied greatly by grantee:

- Screening results were available for five of the six grantees: 2 FQHCs, 2 family serving agencies and 1 Regional Center.
- Referral data did not distinguish between internal and external referrals and was only available for four of the six grantees: 2 FQHCs, 1 family service agency and 1 Regional Center.
- Service data was only available for three of the six grantees: 1 FQHC, 1 family service agency and 1 Regional Center.

Reasons for limited data included:

- Grantees had varying levels of capacity to access and provide the data needed for the evaluation.
- Screening and referral data was available in different formats (paper and electronic). The evaluation only analyzed data available electronically.
- Variables of interest were not collected or were not linked to screening and referral data.
- Grantees varied in the way they documented or defined connection to services.
- COVID-19 pandemic impacted the ability of grantees to secure and share their referral and service data.

- This evaluation report only includes data received by 4/17/20.

The data available for the evaluation limit our capacity to assess differences across grantees.

Report Overview

This report presents findings from the First Connections program evaluation by providing information about the implementation and effectiveness of the program that can inform the sustainability of First Connections, development and implementation of HMG LA, and strengthen EII practices across L.A. County as aligned to First 5 LA's new 2020-2028 Strategic Plan. Findings are organized by the areas of inquiry: family access, knowledge, and support; systems learnings and implications; and technical assistance and provider capacity and are informed by the experiences of grantees and parents/caregivers and through the grantee data review. In addition to the primary findings, each area of inquiry includes successes and challenges that could provide learnings for future improvements, as well as insights from the First Connections Forum held with grantees and other representatives from EII systems consisting of early childhood providers, health plans, and county agencies.[31] The final section includes lessons learned and recommendations.

[31] The First Connections Forum was held on July 14, 2020 with over 60 EII systems partners.

Family Access, Knowledge, and Support

EII screening and referral efforts often focus on engaging providers more than families,[32] and family engagement is often measured via referral tracking alone. Research suggests that the most impactful EII system efforts expand family engagement to include educating families on how to navigate EII systems and addressing family risk factors, such as perinatal depression and family stress, to provide more holistic family support.[33,34]

The First Connections program works to engage families in discussions about healthy child development, supports them to navigate between programs and services across service sectors, and connects them to local Regional Centers, school districts, and community supports. Family engagement, education, and support are critical to HMG system efforts.[35] It is important to understand how First Connections grantees implemented these family engagement practices and how working to improve parent access, knowledge, and support affects EII systems efforts.

Key Findings

- Grantees conducted more than 50,000 developmental screenings for children birth through age 5 in L.A. County as part of the First Connections program.
- Parents increased their knowledge of age appropriate child development and developmental supports and resources.
- Children demonstrated improvements in skills and abilities, most notably communication and social skills, after receiving developmental services.
- The strategies implemented by grantees, namely relationship development, education and awareness building, were important to help parents overcome the stigma associated with special needs.
- Parents sometimes encountered gaps in communication or inconsistent or inaccurate information when attempting to access services or resources, both within and outside of First Connections, such as lack of consistent information about resource availability or having to repeatedly follow-up with referral organizations.

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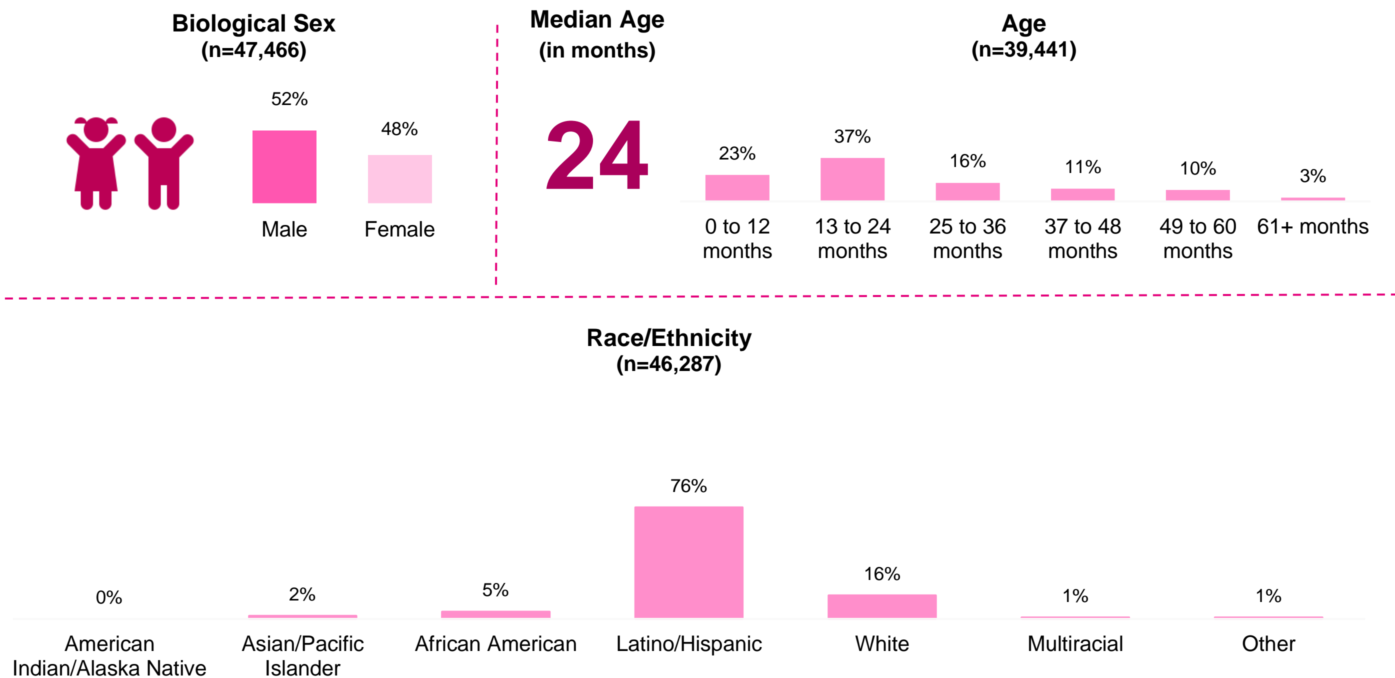
[32] Spark Policy Institute. (2013). *Early childhood health integration evaluation brief report #4: Screening and referral systems for early childhood health.* http://www.coloradotrust.org
[33] Ibid.
[34] Kaye, N. & Rosenthal, J. (2008). *Improving the delivery of health care that supports young children's healthy mental development update on accomplishments and lessons from a five-state consortium.* National Academy for State Health Policy. https://www.commonwealthfund.org
[35] Harder+Company Community Research. (2018). *Early identification and intervention systems in California: Bright spots and lessons learned.* https://www.packard.org/wp-content/uploads/2018/03/Early-Identification-and-Intervention-Systems-in-CA-Full-Report.pdf

As part of this efforts, First Connection grantees conducted developmental screenings using ASQ®-3, ASQ®-SE and/or the M-CHAT. Across grantees, the ASQ®-3 was the most commonly instrument used to screen for develvopemental delays. Findings presented in this section are based on ASQ®-3 screenings.

More than 50,000 screenings were conducted through First Connections. The ASQ®-3 is designed to assess children's development at specific age points across five domains: communication, gross motor, fine motor, personal/social and problem solving. From April 2014 to December 2019, 52,656 ASQ®-3 screenings were completed for children ages 1 month to 5 years. Children participating in the First Connections program may have been screened multiple times to track their development over time. This practice aligns with the AAP's recommendation of three developmental screenings by the age of three.[36] Additionally, children at risk of developmental delays may be screened more often than the recommended discrete ages (i.e., at 9, 18 and 30 months) to monitor their development. ASQ®-3 best practices suggest rescreening children that score in the monitoring zone in 2 to 3 months from their last screening.[37] Due to this practice as well as diferences in data reporting across organizations, the total number of unduplicated children screened was unable to be determined.

Exhibit 5 provides an overview of the characteristics of screened children. Further analysis of the race and ethnicity of children screened through First Connections is included in the Ensuring Equitable Service Delivery section starting on page 22.

Exhibit 5. Demographics of Children Screened with ASQ®-3[38]



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36 Lipkin, P., & Macias, M. (2010). Promoting optimal development: Identifying infants and young children with developmental disorders through developmental surveillance and screening. *Pediatrics*, *145*(1), 1-19. https://pediatrics.aappublications.org/content/145/1/e20193449

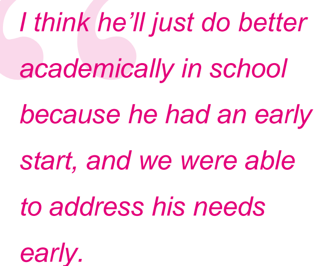
37 Ages and Stages. (2015). Kids in the monitoring zone: What to do next. https://agesandstages.com/wp-content/uploads/2017/04/Kids-in-the-monitoring-zone.pdf

38 Sample sizes for demographic characteristics of screened children varied by indicator due to differences in data availability.

Parents learned about the First Connections program through multiple channels. When asked how they learned about the developmental screenings and referral services offered by First Connections grantees, parents reported a wide variety of sources, such as through community events, healthcare providers, staff at social service agencies, childcare providers, teachers, social workers or therapists. In some cases, parents initiated conversations about developmental concerns with doctors, specialists or staff before being offered developmental screening services. Other times, parents learned about the services while receiving other routine services with First Connections grantees, such as well-child visits.

Overall, parents had positive experiences with the developmental screening process; however, some reported long wait times specifically related to scheduling appointments for further assessment. Parents appreciated that grantees provided information during and after the screening services. They shared that grantee staff explained the developmental domains measured by the screening tool as well as how developmental services, such as speech therapy, can be beneficial for their child's development if a delay is identified. Parents reported screening results were usually shared with parents in-person or over the phone, and the time frame for receiving results varied from immediately following the screening to one or two weeks later. However, some parents expressed frustration with the process for scheduling appointments for follow-up developmental assessments. In some cases, it took days, weeks or more than a month for referral organization staff to call them to schedule these appointments.

Parents' improved their knowledge of child development and developmental supports through their participation in First Connections. Through the screening process and subsequent services (e.g. speech classes and therapy), several parents reported learning which behaviors might be indicative of developmental delays. Based on these behaviors, parents reported learning how to stimulate their children to make progress on milestones. Parents also reported paying more attention to their child's development with more patience and a better understanding of the appropriate stages of child development.



I think he'll just do better academically in school because he had an early start, and we were able to address his needs early.

– Parent/Caregiver

Parents also reported learning about the importance of developmental screening and early intervention services. This increase in knowledge led to parents taking initiative and advocating for screening and services for their children earlier on, instead of waiting to receive guidance from providers (psychiatrists, teachers, therapists, etc.). Finally, several parents reported learning about services and resources available in their communities, eligibility requirements, costs and even changes in state laws that affect their ability to access to services.

EII partners agree that prioritizing parent education about child development plays a large role in determining whether parents accept services for their children. EII partners also recommend providing opportunities for families to meet and bond with each other, share resources, and overcome stigma.

Stigma surrounding developmental delays is difficult to overcome. Some parents reported not always having support from family members – especially those unfamiliar with developmental delays or EII services. However, parents reported that learning how screening services and therapies to address delays would support their child's development, as noted above, gave them the motivation and confidence to advocate for their child.

Grantees shared that shifting stigma related to development delays is a time-intensive process. They acknowledged it is important that staff interact with families in a way that does not cause them to be reluctant to seek services. They shared the importance of considering education and awareness when communicating with parents to ensure they understand their child's development and the positive outcomes that could result from seeking developmental services. Grantees also worked to reassure parents that their child would not be labeled or stigmatized if they had a developmental delay or special need. Grantees found that investing time to develop trust and rapport with a family helped encourage those who were hesitant to accept a referral.

EII partners recommend holding active listening sessions to hear directly from parents about what they are going through and what is important to them as it relates to developmental concerns and to use the session as an opportunity to answer questions before providing screening services. This will help promote buy-in from families from the beginning and help providers better understand the specific barriers and stigma that the families are facing. EII partners also suggest sharing successful stories of children and families engaging in developmental services, working with faith-based organization or cultural champions, and including male figures in marketing materials as best practices for normalizing EII services and shifting stigma.

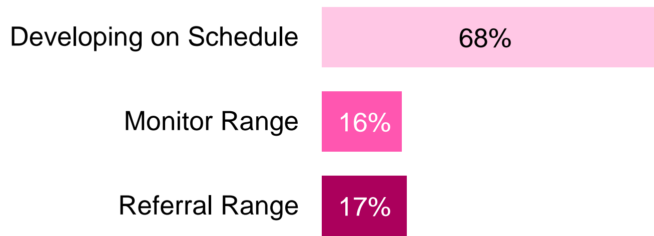
Developmental Screening Results and Referrals

Slightly more than two-thirds of screenings conducted as part of the First Connections program suggested that screened children were "developing on schedule" at the time the screening was conducted. ASQ®-3 scores fall into one of the following 3 categories: developing on schedule, in need of monitoring, or in need of referral for additional assessment and services. Out of the 41,695 screenings for whom overall results were available, 68% fell in the developing on schedule category, 16% in the monitor range, and 17% in the referral range. While the majority of screenings indicated that screened children were on track developmentally at the time of screening, a third (33%) of the screenings identified children with or at risk for developmental and behavioral delays (see Exhibit 6).[39] The total percentage of screenings that fell in the monitor or referral range is within the range of children estimated to be at risk for developmental delays in in L.A. County. Approximately 30 to 40% of children residing in L.A. County would benefit from early intervention services and support.[40]

[39] A child is considered to be in the referral range if she or he scores below the cutoff score (2 standard deviations below the mean performance) for at least one of the five ASQ®-3 domains. The monitor zone includes scores that are between 1 and 2 standard deviation below children's mean performance in each developmental area. Being in the referral range indicates that further assessment is recommended to identify developmental delays but does not necessarily indicate a diagnosis or eligibility for EII services.

[40] Campbell, H. (2012). *Early developmental screening and intervention initiative (EDSI): Lessons learned*. First 5 LA.

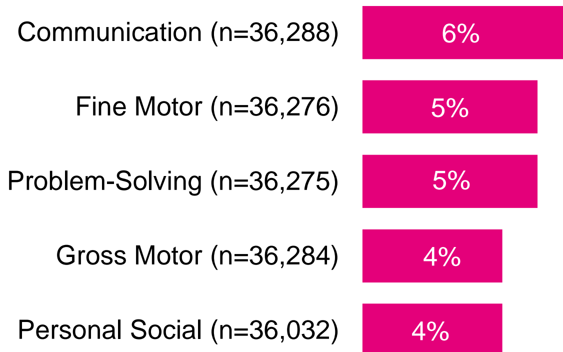
Exhibit 6. Overall ASQ®-3 Results (n=41,695)*



* Due to rounding percentages may not add up to 100%

Communication was the most common area of concern on the ASQ®-3. When examining individual ASQ®-3 domain scores of screenings, 6% of screenings had concerns in two or more domains.[41] Based on individual domain results, the most common area of concern was communication (Exhibit 7). This finding is lower than the prevalence of communication disorders reported in other studies. Research has shown that the communication disorders affect 11% of children ages 3 to 6 in the United States.[42]

Exhibit 7. ASQ®-3 Domains in the Referral Range



Most referrals were made to Regional Centers or Early Head Start/Head Start. In addition to sharing and explaining screening results, grantee staff discussed with families the need for further assessement and intervention services with families of children that scored in the referral range. Referral organizations included Regional Centers, school districts, Early Head Start/Head Start, behavioral health and health services (e.g. occupational, physical therapy).[43]

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[41] ASQ®-3 individual domain results were not available for one of the FQHCs and the Regional Center. "More than one domain" category is inclusive of any of the ASQ®-3 individual domains (i.e., communication, gross motor, fine motor, problem solving and personal social).

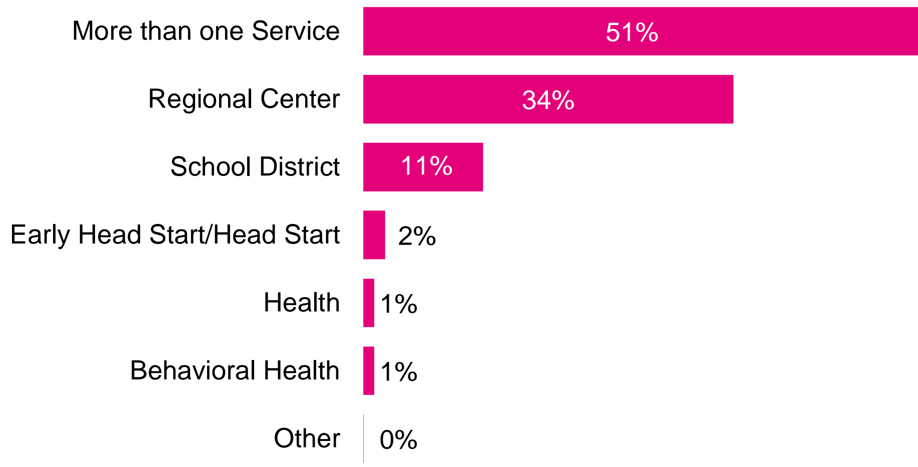
[42] Black, L.I, Vahratian, A. and Hoffman, H.J. (2015). *Communication disorders and use of intervention services among children aged 3 -17 years: United States, 2012.* NCHS data brief (205). Hyattsville, MD: National Center for Health Statistics. https://www.cdc.gov/nchs/products/databriefs/db205.htm#children_age

[43] Referral data was available for two FQHCs, one family serving agency and Regional Center.

Across all grantees for whom referral data was available, over half (55%) of the screenings in the referral range resulted in referrals.[44] The proportion of screenings that resulted in referrals aligns with the percentage reported by pediatricians. In 2016, pediatricians reported referring 59% of children at risk for developmental problems.[45] Many factors impacted referral rates including families not being receptive to services; services not being available; and children being already connected to services. Some families were not ready to seek services, in which case grantees continued to monitor the child's development and advocate for the need for additional services. Additionally, some of the families resided in areas where early intervention services such as Head Start or Early Head Start were not available or were planning to move out of the County or the State.

Children could be referred to multiple services depending on the areas of concern identified during their screening. Approximately half (51%) of the referrals were to two or more services, followed by 34% to Regional Centers solely and 11% school districts solely (see Exhibit 8). Of the screenings that resulted in two or more referrals, 89% included referrals to Regional Centers and 65% to Early Head Start or Head Start. The large number of referrals to the Regional Center reflects the age distribution of screenings with scores in the referral range, as approximately four-fifths (79%) of screenings were conducted with children 3 years of age or younger and the Regional Centers are designated as the agencies that serve children under the age of 3 with special needs.[46]

Exhibit 8. Referrals to Early Intervention Services by type of service (n=2,598)[47]



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[44] Please interpret referral and service data findings with caution as children participating in the First Connections program could have been screened multiple times during the grant period but may have only been referred to a particular resource once.

[45] Lipkin, P., Macias, M., Chen, B., et al. (2020). Trends in pediatricians' developmental screening: 2002-2016. *Pediatrics*, 145(4). https://pediatrics.aappublications.org/content/pediatrics/145/4/e20190851.full.pdf

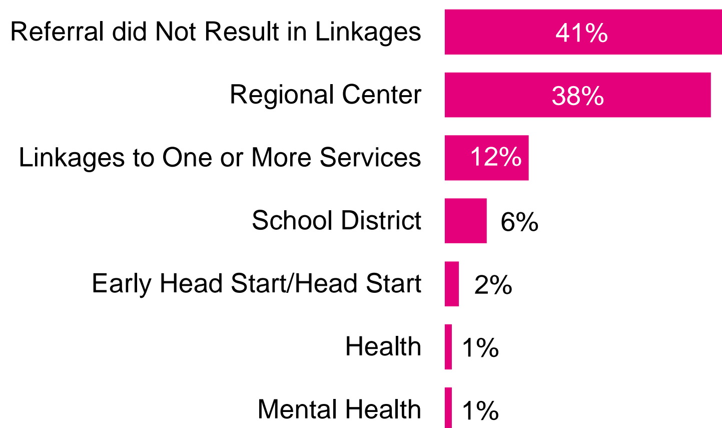
[46] Legislative Analyst's Office. (2018). *Evaluating California's system for serving infants and toddlers with special needs*. https://lao.ca.gov/Publications/Report/3728

[47] "More than one service" category is inclusive of any of the following services: Regional Centers, school districts, Early Head Start/Head Start, health, behavioral health and other intervention services.

Linkages and Access to Developmental Services

Success of linkages to early intervention services varied by referral type. For the purpose of this evaluation, successful linkage to services refers to referrals made by First Connection Grantees for children in the referral range that resulted in being found eligible for and/or receiving at least one early intervention service. On average, 59% of referrals resulted in linkages to at least one early interventions service.[48] Exhibit 9 below shows the percentage of referrals that resulted in linkages to a specific early intervention service. Parents who partcipated in focus groups shared the following reasons for not linking to services: stigma, parent disagreeing with results, lack of understanding, lack of financial resources, lack of time, long waiting lists, and limited availablility of local resources.

Exhibit 9. Referral Outcomes by type of service (n=2,598)[49]



Parents sometimes encountered gaps in information or communication when attempting to access services or resources. Parents reported feeling like they had to advocate for their children, both within First Connections and with organizations external to First Connections. They shared that some grantees and service providers did not always willingly share the services or resources they knew of or had access to unless parents asked for them specifically. In other instances, parents felt as though they had to push the process and repeatedly contact the service providers they were referred to in order to make progress towards scheduling an appointment and accessing services. Parents also expressed that more accurate and complete information needs to be disseminated about available developmental services and resources in the community, eligibility requirements for services (e.g. Medical, IEP) and the process to access services for children.

I didn't know that they learn about [using] scissors [at that age]. I do like knowing where he's behind and where I can help him to also progress.

– Parent/Caregiver

[48] The reported percentage of successful linkages does not reflect instances where, upon further assessment, the child is found to be developing typically and does not require intervention services.
[49] Service data was only available for one FQHC, one family serving agency and Regional Center.

Attending services can be both time and resource intensive for families, which was a challenge for parents – especially for those who work. Parents reported facing several challenges in accessing needed services, including not being able to fit appointments into their work schedules, having to drive long distances for an appointment, and the cost of services for parents accessing intervention services through private insurance who have the additional financial burden of co-payments for services. Parents also shared they would prefer longer-term coordinated services that do not require their child to be moved around based on eligibility (e.g. ECE providers, Regional Center, school system) to avoid changing routines for children and schedules for parents.

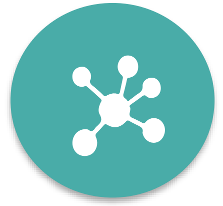
Children improved their communication and social skills after receiving developmental support services. Children who were able to be successfully linked to services demonstrated improvements as a result of the early intervention they received. For example, some parents noticed their children enhanced their vocabulary, improved their social skills at school and the park, and expressed less frustration when trying to communicate. Many parents also felt the services helped their child prepare for school and succeed in the next stage in their lives. Parents expressed confidence that their children will do better at school because their needs were addressed earlier and felt hopeful about the long-lasting benefits of early intervention services in their child's future.

First Connections Forum Highlights

The First Connections Forum, held virtually on July 14, 2020 provided an opportunity for over 60 First Connections' grantees and EII service providers to "make sense" of preliminary evaluation findings and reflect on the findings in the context of their own practice. After discussing the positive outcomes and challenges children and families experienced in First Connections, attendees were asked to share best practices for successfully engaging families. Grantees and service providers shared the following strategies:

- Share successful stories of children and families engaging in services.
- Hold active listening sessions to hear from parents what they are going through and what is important to them as it relates to developmental concerns and use the session as an opportunity to answer questions before providing screening services – which will help promote buy-in from families from the beginning.
- Provide opportunities for families to meet and bond with each other, share resources, overcome stigma.
- Prioritize parent education about child development – this plays a large role in determining whether parents accept services for their children.
- Work with faith-based organization or cultural champions to reduce stigma, develop trust, and help connect families to services.
- Include male figures, such as fathers and grandfathers, on marketing, communication, and education materials, especially for Asian and Latinx communities, to help normalize services and reduce stigma.

System Learnings and Implications



First Connections is one of a series of First 5 LA investments contributing to the advancement of system and practice change efforts, including HMG LA.[50] First Connections offers an important learning opportunity to leverage promising practices and lessons learned to advance and strengthen LA's countywide EII efforts. EII pilots and demonstrations, such as First Connections, have proven fertile grounds to inspire and test policy and practice changes.[51]

The systems learnings and implications from First Connections can inform the activities, spread, and scale of future EII efforts in L.A. County.

Key Findings

- Overall, First Connections grantees screened children of varying racial and ethnic backgrounds. Grantees attempted, with varying level of success, to engage children and families of diverse backgrounds. However, more information is needed to determine if all the diverse families in their catchment area are able to access developmental screening services.

- Care coordination is key to guaranteeing that families are able to navigate the system and connect to needed services.

- Multiple grantees reported developing approaches to providing bridging services, such as telephone education and developmental homework, when a service gap existed. These services helped build relationships and helped parents better understand their child's development, often resulting in connecting their children to needed services.

- Grantees reported varying levels of success with developing external partnerships for the purposes of generating referrals and linking families to needed services. New partnerships required trust and buy-in, and engaging champions and key decision makers.

- When possible, grantees took advantage of in-house programs for referrals, such as Early Start, Head Start, Early Head Start and medical specialists.

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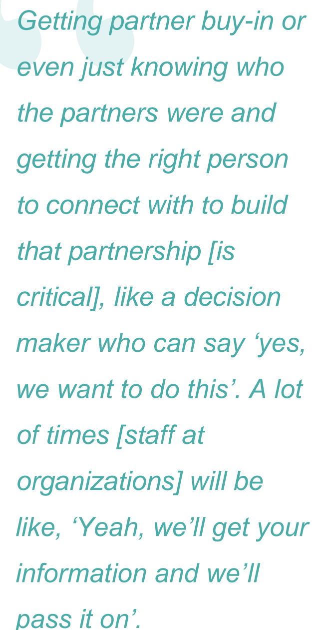
[50] For example, Early Developmental Screening and Intervention Initiative and the Early Identification and Care Coordination Project (see https://www.first5la.org/files/HelpMeGrow-LA%20Recommendation%20Report.pdf)

[51] Kaye & Rosenthal (2008).

Background

The evaluation of the First Connections program will inform the HMG LA model by identifying system-level lessons learned based on the innovative approaches that First Connections grantees have used to strengthen, embed and expand EII practices in their organizations. The findings that follow illustrate systems-learning and implications meant to inform planning and implementation of HMG LA in the future, based on findings from providers' journey mapping sessions, caregiver focus groups, and grantee performance data. This section outlines systems learnings and implications with respect to 1) equity in serving children and families from diverse backgrounds, 2) service referrals and care coordination, and 3) partnerships and collaboration in the EII system.



Getting partner buy-in or even just knowing who the partners were and getting the right person to connect with to build that partnership [is critical], like a decision maker who can say 'yes, we want to do this'. A lot of times [staff at organizations] will be like, 'Yeah, we'll get your information and we'll pass it on'.

Ensuring Equitable Service Delivery

Overall, First Connections grantees conducted ASQ®-3 screenings with children of varying racial and ethnic backgrounds. Based on the data available,[52] across all grantees, the largest proportion of ASQ®-3 screenings were with Latinx children, accounting for 76% of the overall total screenings completed from 2014 to 2019 (see Exhibit 10). The race/ethnicity for children 0-4 years old in L.A. County in 2019 is included in Exhibit 10 as a comparison point. This analysis, which is intended to shed light on equity in screening practices, is not without limitations. For example, the overall racial and ethnic background of screened children would suggest an underrepresentation of African American, Asian/Pacific Islander, Multiracial and White children served by First Connections when considering the demographics of L.A. County[53]; however, the specific geographical catchment areas that each grantee serves may have a different racial/ethnic makeup than that of the overall County. Further analysis is needed to understand whether the racial/ethnic make up of children screened through First Connections mirrors the racial/ethnic make up of their catchment areas more generally. While the available race/ethnicity data of screened children indicates that the findings from the First Connections program may not be generalizable to all families across the full spectrum of L.A. County's racial and ethnic make-up, the high proportion of Latinx children screened for developmental delays reflects the proportion of Latinx individuals being served at grantee organizations (67% to 84%).

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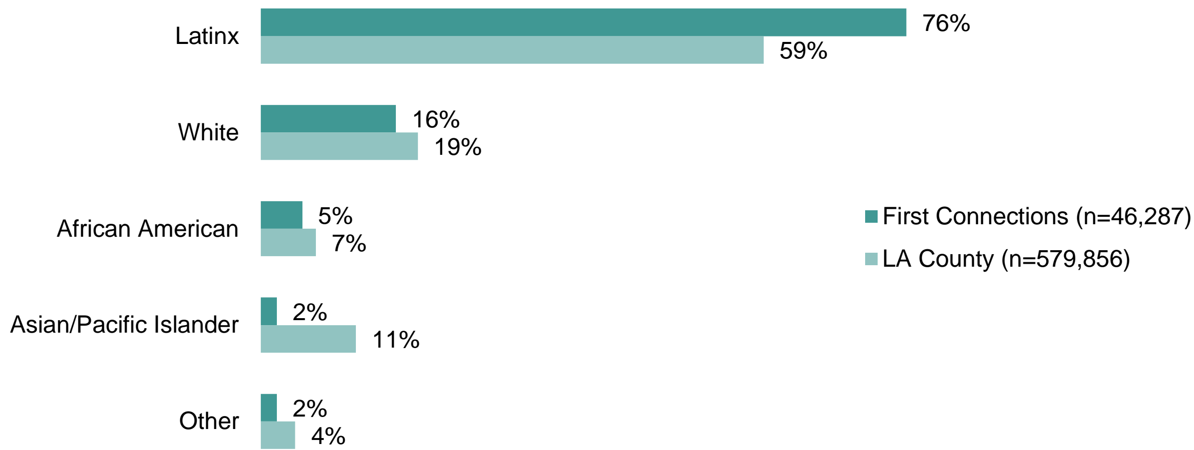
[52] The screening data presented does not include every ASQ®-3 screening completed through the First Connections grant. Race and ethnicity data was not available for one of the family serving agencies and ASQ®-3 results were not available for one of the FQHCs.

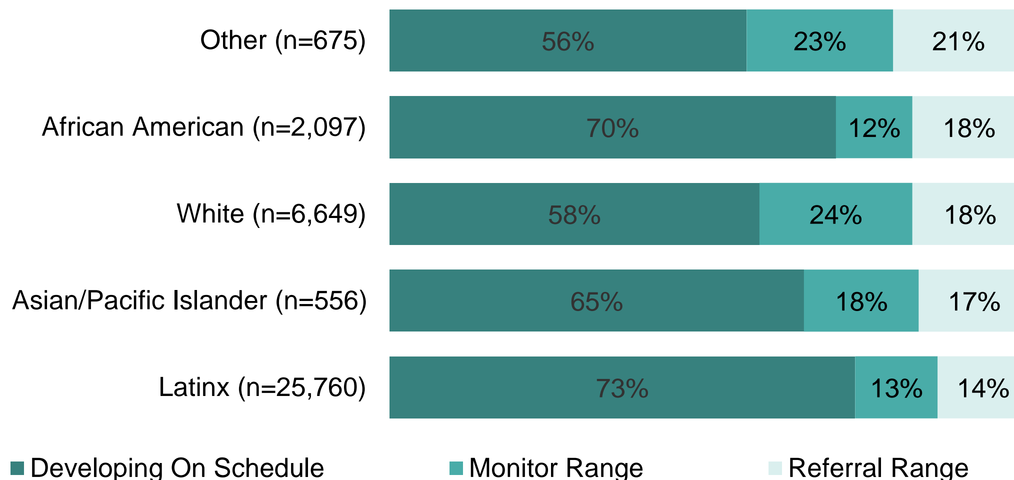
[53] U.S. Census. (2019). Annual county resident population estimates by age, sex, race and Hispanic origin: April 1, 2010 to July 1, 2019. Retrieved from https://www.census.gov/newsroom/press-kits/2020/population-estimates-detailed.html

Exhibit 10. Race/Ethnicity of Children Screened by First Connections and L.A. County Children[54]



Overall, screenings conducted with Latinx children were significantly less likely to fall in the referral range.[55] When examining the ASQ®-3 screening results for each of the racial and ethnic categories, screenings of African American children (18%), White children (18%) and children of other racial and ethnic categories (21%) had higher proportions of results falling in the "referral" range than Latinx children (see Exhibit 11).

Exhibit 11. ASQ®-3 Overall Screening Results, by Child's Race/Ethnicity[56]



[54] As a point of comparison, race/ethnicity for children under 5 (0-4) residing in L.A. County in 2019 is shown in this graph. Other race/ethnicity category includes multiracial children, American Indian/Alaska Native and non-specified other race and/or ethnicity.

[55] *p*-value < 0.01

[56] Screening results by race/ethnicity were not available for slightly less than a third of screened children (32%, n=16,919). This was due to race/ethnicity data not being linked to their screening results or race/ethnicity information not being captured in the dataset. Other race/ethnicity category includes multiracial children, American Indian/Alaska Native and non-specified other race and/or ethnicity.

There were significant differences in the proportion of ASQ®-3 domains that fell in the referral range based on the race and ethnicity of screened children, with screenings of Latinx children being significantly less likely to be identified as needing further assessment and referral than White children in each of the ASQ®-3 domains (Exhibit 12).[57]

- **Communication:** Screenings conducted with Asian (9%) and White (8%) children were significantly more likely to be in the referral range than those completed by African American (5%) and Latinx (5%) children.

- **Gross Motor:** Screenings conducted with White (7%) children were significantly more likely to be in the referral range than those completed by African American (4%) and Latinx (3%) children.

- **Fine Motor:** Screenings conducted with Asian (7%), White (7%) and African American (6%) children were significantly more likely to be in the referral range than screenings of Latinx (4%) children.

- **Problem Solving:** Screenings conducted with Asian (9%) and White (7%) children were significantly more likely to be in the referral range than those completed by African American (5%) and Latinx (3%) children.

- **Personal Social:** Screenings conducted with Asian (7%), White (6%) and African American (4%) children were significantly more likely to be in the referral range than screenings of Latinx (3%) children.

Exhibit 12. Percentage of ASQ®-3 Screenings with Domain Results that Fell in the Referral Range, by Child's Race/Ethnicity

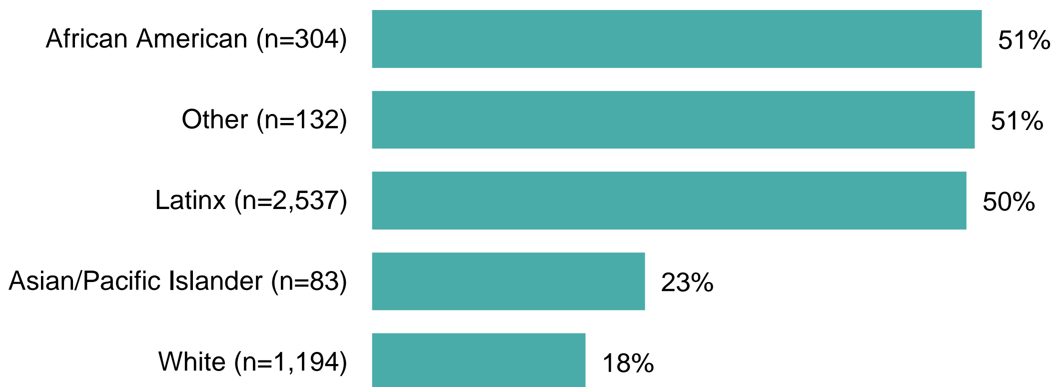
Race/Ethnicity	ASQ®-3 Domain Results in the Referral Range				
	Communication	Gross Motor	Fine Motor	Problem Solving	Personal Social
African American/Black (n=1,715 - 1,729)	5%	4%	6%	5%	4%
Asian/Pacific Islander (n=517 - 523)	9%	6%	7%	9%	7%
Latinx/Hispanic (n=21,690 - 21,776)	5%	3%	4%	3%	3%
White (n=6,377 - 6,520)	8%	7%	7%	7%	6%
Other (n=460 - 466)	7%	4%	4%	7%	5%

[57] *p*-value < 0.01

While the specific reasons for these racial differences in screening results between First Connections participants are unknown, research has shown that African American and Latinx children are less likely to be diagnosed for behavioral and developmental conditions.[58] A possible factor related to these findings for Latinx children is a common complaint that the Spanish translation of the ASQ®-3 is inaccurate, as discussed further below. Linkage data was not reliable enough to analyze by race/ethnicity.

Higher proportion of screenings of African American, Latinx and children of other races and ethnicities that fell in the referral range resulted in referrals to the Regional Center when compared to screenings of Asian and White children. On average, 44% of children who were identified as needing further assessment and/or referral were referred to the Regional Center. Based on the referral data available, there were significant differences in the percentage of children referred to the Regional Center across racial and ethnic groups. Compared to Asian (23%) and White (18%) children in need of further assessment and intervention services, African American children (51%), children of other races and ethnicities (51%) and Latinx children (50%) were significantly more likely to be referred to the Regional Center (see Exhibit 13).[59]

Exhibit 13. Referrals to Regional Center, by Child's Race/Ethnicity[60]



Higher proportion of screenings of Asian and White children fell in the referral range resulted in referrals to the health intervention services such as occupational and physical therapist when compared to screenings of Latinx children. Based on available data, 4% of children who were identified as needing further assessment and/or referral were referred to services such as physical therapy and occupational therapy. There were significant differences in the percentage of children referred to health intervention services such as occupational therapy, physical therapy, and medical specialists (e.g., audiologist) across racial and ethnic groups. Asian (11%) and White (8%) children were significantly more likely to be referred to this type of services than Latinx (3%) children (see Exhibit 14).[61] Referrals to other organizations could not be analyzed by race/ethnicity due to small sample size.

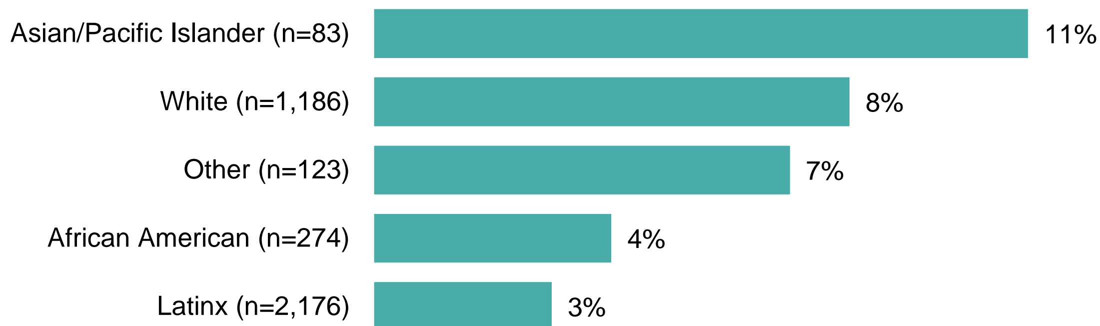
[58] Zuckerman, K., Mattox K., Sinche, K., Blaschke G., & Bethell, C .(2014). Racial, ethnic, and language disparities in early childhood developmental/behavioral evaluations: a narrative review. *Clinical Pediatrics* (Phila). 53(7):619–631. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3955219/

[59] *p*-value < 0.01

[60] Other race/ethnicity category includes multiracial children, American Indian/Alaska Native and non-specified other racial category.

[61] *p*-value < 0.01

Exhibit 14. Referrals to Health Intervention Services, by Child's Race/Ethnicity[62]



Grantees shifted their outreach strategies to better engage children and families of diverse backgrounds. While grantees experienced challenges engaging all families, they aimed to be responsive to the cultural nuances and needs of all the families in their catchment area – especially as it is related to race, ethnicity and language. For example, one grantee reported initial challenges engaging the African American community, thus they adjusted their outreach and communication strategy to increase the opportunities to engage with families in spaces they frequently visit, such as partnering with specific community resource centers that serve higher proportions of African American families. Similarly, another grantee reported challenges in reaching the local Asian American population, thus they incorporated ways for the entire organization to be more embedded and connected to that community, such as conducting additional outreach efforts and bringing in staff who speak Chinese and Vietnamese. Grantees acknowledged that engaging certain populations in EII was often more difficult than others and required them to be thoughtful and creative. These efforts further demonstrated their commitment to serving children and families of diverse backgrounds and aligned with EII partners recommendations to hire specialists that speak the native languages present in the surrounding community and partner with other organizations to conduct outreach to under-engaged populations.

Grantees experienced challenges engaging children and families of with diverse cultural and linguistic needs. Multiple grantees reported challenges engaging Latinx, African American, and Asian American families. Barriers included stigma related to child development issues, fear of engaging with providers and public agencies due to issues such as immigration, as well as grantees not having a strong presence in certain communities. Two grantees also reported challenges working with Spanish-speaking parents and parents with low literacy levels. They reported that education and language barriers can create challenges since the Spanish version of the ASQ®-3 was described as "not great" by parents and required them to read and respond to various items that do not translate well conceptually. This lowers willingness to engage honestly because it made parents feel uncomfortable and likely relates to the findings above around the lower likelihood of Latinx children falling in the referral range. One grantee responded to diverse child and family needs by modifying the workflow to spend more time with parents who needed more assistance completing the screening due to language barriers or low literacy levels.

EII partners recommend developing a parent education model that considers cultural and linguistic differences to help break down stigma and get parents to understand the importance of developmental services, as well as providing tools and maps for providers to understand the demographics of the areas they serve.

[62] Other race/ethnicity category includes multiracial children, American Indian/Alaska Native and non-specified other racial category.

First Connections Forum Highlights

The First Connections Forum provided an opportunity for First Connections grantees and EII service providers to "make sense" of preliminary evaluation findings and reflect on the findings in the context of their own practice. After discussing the demographics of children and families served by First Connections, grantees were asked to share their best practices for engaging underrepresented groups. Grantees and service providers shared the following insight or strategies:

- Hire specialists who speak native languages present in the surrounding community and partner with other organizations to conduct outreach to under-engaged populations.
- Develop a parent education model that considers cultural and linguistic differences to help break down stigma and get parents to understand the importance of developmental services.
- Develop tools for providers to understand the changing demographics of the surrounding areas, for example, develop maps that show the real time changes in the racial/ethnic makeup of an organization's catchment area.

Impact of Service Referrals and Care Coordination

Care coordination is key to guaranteeing that the referral for developmental services is successful. Grantees reported that referral, linkage and care coordination is generally a time and resource-intensive process, but worthwhile for ensuring that children and families are connected with appropriate supports after a developmental delay has been identified. Some grantees reported care coordination most often consists of assisting the parent in reaching out to an external service provider and following up to ensure they were moving towards receiving services. Some grantees reported their care coordinators followed up directly with the referral organizations as well, although some organizations, such as most Regional Centers, required the parent to initiate an initial assessment and consultation.

Parents felt supported by grantees when attempting to access external services. Parents reported that grantees supported them in connecting to other agencies when they did not hear back or when they needed to advocate for their child to receive services (i.e. when children fell in the "gray" area on the ASQ®). Parents reported feeling as though staff at grantee organizations were generally helpful when it came to referrals and care coordination and were persistent in following up to ensure a linkage had been made.

EII partners agree that a point person for families is key for successful communication, warm handoffs and follow through to maintain feedback loop between agencies and among children and families. They also advocated for embedding care coordination or parent navigators into the EII infrastructure, rather than an add on that depends on level of funding.

"When we first started, our care coordination was even more robust. [We helped] parents fill out Regional Center applications. This assured it was sent in, and then we tried everything to hear from Regional Center about what services they received. Overtime, we realized that we were not able to access their records, so we would ask the parents [instead]."

–Grantee

Grantees took advantage of programs internal to the organization for service referrals, when possible. Some grantees, specifically the Regional Center and family service agencies, reported leveraging internal programs such as Early Start and Early Head Start for referrals when appropriate. One grantee noted that, looking back, more planning work would have been beneficial for "really mapping out a flow of how we want things to look, and then putting procedures in place to follow that flow" to increase efficiency between internal programs. This reiterates the fact that it is important to ensure First Connections is integrated within the organization's core programs and services to have maximum impact.

Multiple grantees provided bridging services when a service gap existed. Grantees acknowledged that children and families are not always able to access services due to general lack of availability or ineligibility. In other cases, parents are hesitant to accept a referral for services due to stigma or fear their child will be labelled. Grantees reported implementing bridging services such as providing telephone education and support to the parents, providing families with developmental homework, and conducting ongoing follow-up to check-in on the child's development to support families in those situations. Grantees reported that providing these bridging services helped staff develop rapport and trust with parents, and in some instances, parents who refused a referral previously would accept it later down the road after becoming more comfortable with grantee staff.

First Connections helped parents connect with each other. In addition to the support from their care coordinators, parents shared appreciation for the opportunity to meet and learn from other parents with similar experiences. For example, parents who had successfully navigated services would share their experiences, such as information on how to request additional services from different agencies. This knowledge sometimes resulted in parents successfully accessing services using the "tips and tricks" they learned from each other. EII partners emphasized the need for parents to be supported in order for their children to succeed.

The inability to share data and receive timely follow-up information from referral organizations was a major barrier to care coordination. Grantees acknowledged that obtaining information about the status of a referral for the purpose of care coordination is incredibly difficult. One grantee noted that this was due to lack of responsiveness on the referral organization's end, which resulted in shifting their practice to follow-up with parents instead. Grantees reported that establishing data sharing agreements and practices with commonly referred to organizations would have made it much easier to ensure children and families are linked to services. Although some grantees were able to develop MOUs with partners, others shared difficulties in coordinating an MOU with partners and there was limited information about whether the formal agreements made the partnerships more effective.

Parents reported wishing for a centralized resource with accurate service and eligibility information given that sometimes referrals were not successful, and they ended up going to multiple places and wasting time and resources. Similar to care coordinators, and as discussed in the referral section above, parents reported feeling like they had to be persistent and frequent in their attempts to connect with organizations they were being referred to. In some instances, parents felt as though they had to push the process and repeatedly contact the external providers they were referred to in order to make progress towards accessing services – either because the provider was unresponsive or because progress towards initiating services, such as an intake, was not scheduled in a timely fashion.

Parents reported that they would like to have a faster and more centralized process from the time of referral, given the urgency of wanting to enroll their child as soon as possible in services to begin addressing their child's developmental delays. For example, two parents reported they would like to be referred to a single entity that held all of the accurate service information related to developmental interventions for their child. This would avoid situations where parents would reach out to multiple organizations and receive conflicting information about the services available and the intake process. In response to this finding, EII partners also recommended co-locating care coordinators or similar roles across organizations that commonly share referrals (e.g. school district and Regional Center) to streamline the care coordination process.

First Connections Forum Highlights

The First Connections Forum, held virtually on July 14th, 2020, provided an opportunity for EII system partners to discuss the implications of preliminary evaluation findings and reflect on ways that the findings might be relevant beyond the scope of First Connections. After discussing findings related to the successes and challenges with developing partnerships and the impact of care coordination, system partners were asked to reflect on the implications these findings have for the design and implementation of similar investments and/or strategies to embed developmental screening and linkages into practice. System partners shared the following insight:

- A point person for families is key for successful communication, warm handoffs and follow through to maintain feedback loop between agencies and among children and families.
- Co-locate care coordinators or similar roles across organizations that commonly share referrals (e.g. school district and Regional Center).
- Supporting the whole family is key – for example, parents might be struggling with behavioral health issues such as maternal depression or substance abuse which can affect the whole family. Parents are essential partners to their children's success.
- Make care coordination or parent navigators part of the infrastructure, not an add on that depends on level of funding.

Developing Partnerships and Collaboration in the EII System

Grantees reported varying levels of success with developing external partnerships. Since most First Connections grantees rely on external partnerships to connect children with needed intervention services and supports, having collaborative relationships with referral organizations such as Regional Centers, school districts, and other mental and behavioral health providers is critical step in ensuring successful referrals and linkages. Grantees reported that developing relationships with external service providers is usually not an easy or fast process, as it requires frequent and consistent communication and follow-up, but can certainly be done. Most grantees reported having established relationships with several of the organization types mentioned previously, and even having some formal partnerships in place via memorandums of understanding (MOUs) or other written agreements.

EII partners recommend that EII providers should not hesitate to overcommunicate with new potential partners, for example sending follow-up emails and reminders, which can demonstrate commitment to establishing a relationship and expanding referral pathways.

Garnering buy-in and trust from external partners can help tremendously with partnership development and eventually program implementation. Grantees reported that developing partnerships and strong working relationships with external organizations was much easier when there was acceptance of, and willingness to, support the goals of First Connections, as well as trust among all parties. This inevitably required extensive communication, education and awareness work on the issue of EII and timely developmental screening, referral and linkage, as well as relationship-building to ensure external partners understood the significance of First Connections and its potential to positively impact children and families. One grantee also reported that having direct communication with a decision maker at the external organization is helpful for expediting partnership development.

School districts, that's been the hardest one. To this day, I am waiting for an MOU […] They've been very challenging to establish a relationship with in order to create a referral pathway for kids who are aged out of Regional Center early intervention. I think it's low on their priority list.

–Grantee

EII partners recommend identifying a point-person at partner agencies to maintain streamlined and consistent communication when in the initial stages of partnership development.

Some grantees reported already having partnerships with external organizations in place, which allowed them to very easily partner for the purpose of First Connections. Grantees reported leveraging relationships that were in place prior to receiving the First Connections grant, such as relationships with FQHCs, clinics, and pediatrician's offices. Since grantees had already established relationships with key staff at these organizations, they were more likely to commit to supporting the initiative without having to go through a formal outreach and education process to explore what a First Connections partnership might look like.

Nearly all grantees reported having challenges with engaging and building relationships with new partners, despite investing significant time and resources to expand their referral pathways. Many grantees noted that external organizations, most often certain Regional Centers or school districts, can be especially challenging to establish relationships with, and even sending and coordinating referrals, following up on the status of a referral or obtaining data on whether children were assessed and connected to services is often times difficult to nearly impossible. Grantees reported that challenges developing external partnerships include a variety of factors such as lack of responsiveness, difficulty gaining buy-in around the issue or identifying a single point person and decision maker**.**

EII partners recommend reinstating interagency councils where cross sector representatives come together to share updates, keep each other informed of changes in services or resources, and build trusting relationships with each other that would improve system coordination.

First Connections Forum Highlights

First Connections Forum participants discussed the challenges grantees experienced with building partnerships and referral pathways and shared the following recommendations for approaching partnership development with new organizations:

- Identify a point-person at the agency to maintain streamlined and consistent communication when in the initial stages of partnership development.
- Be aware that developing a partnership with an external agency usually requires buy-in from decision makers at higher levels. If that buy-in is not gained with decision makers, the partnership is not likely to succeed.
- Don't hesitate to overcommunicate with new potential partners, for example sending follow-up emails and reminders, which can demonstrate commitment to establishing a relationship and expanding the referral pathway.
- Reinstate interagency councils where cross sector representatives come together and form relationships that would improve system coordination.

Technical Assistance (TA) and Provider Capacity

Developmental screening, care coordination, referral and tracking require multiple implementation systems.[63] Providers face many organizational and time demands that might impede effective implementation of required systems, and research has found that "implementation of a screening and referral system […] requires training for the providers, ongoing support materials, and other types of support, such as direct assistance with redesigning office workflow."[64] TA providers must be knowledgeable about the field, comprehend organizational context, and effectively address stakeholder needs in order to gain buy-in and influence practice.

Understanding TA impact on grantee practices and workflow is foundational to evaluating the extent to which grantees were able to achieve family and system level outcomes. This area of inquiry aimed to understand which aspects of TA were most impactful on grantees and their capacity to implement the program as well as what aspects are areas of opportunity to support providers in the future. These findings can help inform the ways in which TA could benefit from better design investments upfront.

Key Findings

- Within the first three years, the TA team facilitated over 60 trainings with First Connections grantees.
- Core trainings were effective for laying the foundation for program implementation.
- TA beyond training, especially with workflow development and tool selection, supported grantees' implementation of First Connections.
- Some grantees did not understand the full scope of TA supports and did not realize additional support was available.
- Although outside the scope of First Connections' TA, grantees would have benefited from support with grant reporting and data tracking.

[63] King, T., Tandon, S., Macias, M., Healy, J., Duncan, P., Swigonsky, N., Skipper, S., & Lipkin, P. (2010). Implementing developmental screening and referrals: Lessons learned from a national project. *Pediatrics,125*(2), 350-360. https://pediatrics.aappublications.org

[64] Kaye & Rosenthal (2008).

Background

As the first and largest pediatric hospital in Southern California and a recognized leader in the field of developmental disabilities, Children's Hospital Los Angeles (CHLA) provided training, education and ongoing TA for the First Connections grantees. The TA approach included:

- Training First Connections grantee staff to conduct developmental screening with children ages birth to 5 years using ASQ®-3, ASQ®:SE-2, and M-CHAT-R
- Developing workflows and algorithms[65] to ensure universal screening and linkage for underserved and ethnic minority children living in poverty
- Supporting grantees to provide parent education, using Centers for Disease Control and Prevention's Learn the Signs Act Early, ZERO TO THREE publications, and other materials
- Developing relationships between medical and family service providers, family-run resource agencies, and ethnic minority parent organizations
- Developing strategies to link young children with early intervention and reduce access barriers

Early Screening, Better Outcomes: Developmental Screening & Referral Toolkit for Pediatric Medical Clinics. The "Early Screening, Better Outcomes: Developmental Screening & Referral Toolkit for Pediatric Medical Clinics", authored by USC's University Center of Excellence in Developmental Disabilities at Children's Hospital Los Angeles, was developed as part of the First Connections initiative and builds on the work of First Connections' FQHC grantees.

This toolkit is designed as a practical guide to support pediatric medical clinics in accurately implementing or refining a high-quality approach to developmental screening and linkage.

Although developed for providers in California, most of the information provided in the toolkit is relevant to other states and can be adapted to fit a range of settings. The toolkit is designed to be useful to clinics that are implementing a new developmental screening initiative, as well as for clinics that already conduct developmental screening but want to review and refine their program.

This toolkit was published in July 2020, and can be found at: first5la.org. As of September 2020, toolkits for Family Serving Agencies and Family Resource Centers are also in the process of being developed.

[65] Workflows or algorithms refer to the articulated process and steps that each organization follows to implement developmental screenings.

The findings that follow speak to the implementation and outcomes of TA on provider capacity to implement the First Connections program, based on provider report during journey mapping sessions and an interview with the TA provider. This section outlines TA and provider capacity outcomes with respect to 1) supports accessed by grantees, 2) TA successes and 3) challenges and areas of opportunity to support grantees.

Technical Assistance and Provider Capacity Findings

Supports Accessed by Grantees

Within the first three years, the TA team facilitated over 60 trainings with First Connections grantees. These trainings were designed to increase staff knowledge regarding developmental screening implementation, linkages to resources and services, and understanding developmental disabilities and interventions for young children. While a core set of trainings was offered to all grantees, the TA team tailored the content to the audience, using a different approach depending on the participants (e.g. medical providers, medical assistants, preschool teachers, home visitors, behavioral health professionals, etc.), number of attendees, experience with the screening tool(s)/subjects, as well as specific agency needs. In addition to core content, the TA team also provided grantees with a list of topics on which training was available and encouraged them to generate other requests for training to meet their agency's unique needs.

[The technical assistance team] was really good, if something came up and I had a question that I needed to get answered, they would get back to me very quickly. That was incredibly helpful.

–Grantee

Grantees levels of engagement with the TA team varied over the span of the First Connections grant. Most grantees reported receiving more support from the TA team at the beginning of the grant, with engagement tapering off as grantees built their internal capacity to facilitate their own trainings and solidified their program implementation. Grantees also reported leveraging the TA team with various levels of intensity based on their needs at any given point in time. For example, some grantees reported the TA team provided training supports (especially in the initial phases of First Connections), but there was less overall engagement in other areas such as workflow development and refinement. Another grantee reported already having EII expertise in-house when the grant was initially received, thus they did not need as much support upfront.

[The technical assistance team] came out and did our [initial] training. That expertise being transmitted to providers was really powerful and valuable, so that was really important.

–Grantee

Technical Assistance Successes

Grantees reported having overall positive experiences with the TA team. Grantees described the team as "wonderful", "friendly", "consistent" and "approachable". It was evident that the TA team was successful at creating positive relationships and rapport with the grantees, to the extent that one grantee even consulted with them outside of the scope of First Connections at various points in time.

Trainings were effective for laying the foundation for program implementation and building internal capacity of grantees. Grantees reported the core trainings, which were initially focused on the technical aspects of developmental screening implementation, connecting with community resources, and strategies for developing culturally-friendly parent education materials, ensured that program and agency staff had baseline knowledge for implementing First Connections' core activities. One grantee reported it was helpful for the initial trainings to be delivered by a team with such deep expertise on the subject matter, which made the trainings more powerful.

Grantees noted ongoing training and support for frontline staff as important mechanisms for ensuring the program was being implemented with quality and fidelity. Grantees most often cited ongoing training as essential for reinforcing the importance of developmental screening, ensuring staff understand the technical aspects of implementing screening, and helping prepare staff to have sensitive developmental conversations with parents and families. During the second year of First Connections, the TA team encouraged grantees to develop and utilize a "train the trainer" approach so grantee staff could deliver the basic trainings, such as administering the ASQ®-3, ASQ®:SE-2, M-CHAT-R, on their own with limited support. Grantees reported the TA team helped First Connections staff develop internal trainings based on their organization's unique needs and helped build their capacity to facilitate both the core and internally developed trainings on an ongoing basis. EII partners agreed that the "Train the Trainer" approach is a good idea for future TA practices to build provider capacity, especially since staff turnover is something that organizations experience on a regular basis, thus the need for training is ongoing.

Grantees Capacity to Screen Increased over Time

Across all grantees, the number of ASQ®-3 screenings conducted increased over time, with slightly over a quarter (26%) of the total screenings conducted during the 2018-2019 fiscal year.

TA, especially as it related to screening tool selection and workflow development and refinement, supported grantees' implementation of First Connections. Some grantees reported the TA team consulted on how best to integrate developmental screening into their core services and identifying the best tools to conduct developmental screening for different age groups. A few grantees also reported the TA team assisted with developmental screening tool selection – particularly as it relates to the added benefit of using the ASQ®:SE-2 for children over the age of two, since the ASQ®-3 is not likely to detect certain behavioral health or social-emotional issues for this group of children. This recommendation from the TA team shifted some grantees' workflow to incorporate the ASQ®:SE-2 to ensure identification of children who experience social emotional issues, even if they do not show concerns on the ASQ®-3.

Technical Assistance Challenges and Areas of Opportunity to Support Grantees

Some grantees were not aware of the full scope of TA supports. Some grantees reported they did not realize the TA team could support them in other ways, thus they solely relied on the team for conducting training. One grantee mentioned it was not clearly communicated what additional support, outside of training, the TA team could offer, which would have probably increased the extent to which they engaged the team on various aspects of program design, implementation, and evaluation.

I don't know that their role – the technical assistance team – was ever fully explained, everything that they could do. I took it as just that they were available for trainings.

–Grantee

Grantees identified a few additional areas of support that would have been beneficial. Grantees reported there were a few areas that, in hindsight, the TA team may have been able to help them with but were not a focus of the support they received. Grantees mentioned the identification and vetting of existing written resources and materials to share with families, since this can promote parents' understanding of child development, age appropriate milestones, and ways to stimulate their child at home. One grantee specifically mentioned identifying and assessing the quality of written resources and developmental homework for Spanish-speaking families, which makes up a large portion of the families they serve.

Additionally, there were certain elements of TA support that could not be provided because of scope of work limitations. For example, one grantee reported they would have liked support with identifying the link, both conceptually and in practice, between developmental screening and trauma-informed care – which happened to be an organization-wide focus and goal for their practice. TA related to trauma-informed care was considered during contract renewals in 2018, but was ultimately deemed to be outside of the scope of First Connections by First 5 LA.

A lesson learned, and this is still a challenge, is to figure out a way to incorporate the [First Connections] data you want to collect into the existing databases – that would be ideal.

–Grantee

Grantees could have benefited from capacity building support with grant reporting and data tracking from First 5 LA. Some grantees reported feeling unclear about the metrics or information required for grant reporting and accountability to First 5 LA, which made it difficult to develop robust systems to track data earlier in the life of the grant. Grantees would have appreciated having more guidance on the contract monitoring required, in addition to the performance matrices, as well as support with developing or adapting systems to capture data over time.

Nearly all grantees reported challenges throughout the life of the grant with capturing and utilizing data more generally. Some grantees attempted to use a more sophisticated approach to tracking, such as integrating First Connections data elements into their EHRs or client information system. Some grantees reported there were challenges with getting the appropriate fields integrated into the existing health records or client information system or that the system could not support the ideal method of data input, which led to "work arounds" – for example, uploading a PDF version of the completed ASQ® screener, which made pulling or analyzing that data impossible. Other grantees reported using Excel templates to track program implementation and client results, which evolved over time as the need to track new elements or track existing elements differently became a necessity.

Limitations with respect to data tracking left some grantees without the means to pull data in an efficient manner or in a desired format, which impacted their ability to successfully evaluate program performance and outcomes. Some grantees reported it would be ideal to integrate developmental screening, referral and linkage data into systems that their organization already uses, but also acknowledged that it can be challenging to configure existing systems to capture this information. EII partners discussed the importance of developing and maintaining robust systems for keeping records and data that is consistent and easily able to be aggregated at an EII system-level in the future.

First Connections Forum Highlights

First Connections Forum participants discussed grantees' experience with the First Connections TA component and reflected on the implications these findings have for the design and implementation of similar investments and/or strategies to embed developmental screening and linkages into practice. System partners shared the following insight:

- The "Train the Trainer" approach is a good idea for future TA practices to build provider capacity.
- The "Train the Trainer" approach is important, especially since staff turnover is something that organizations experience on a regular basis, thus the need for training is ongoing.
- Developing and maintaining robust systems for keeping records and data that is consistent and easily able to be aggregated will be important at an EII system-level.
- Trainings that help prepare staff to build trust and have difficult conversations with parents are a high

Conclusion and Recommendations

Key Learnings

First Connections offered a valuable opportunity to learn about developmental screening, referral and linkage best practices which further inform and strengthen EII practices across the County. The insight gained from this evaluation resulted in the following key learnings:

Family Access, Knowledge, and Support

Overall, children and families experienced positive outcomes as a result of their participation in First Connections. In addition to receiving developmental screenings, referrals and linkages to developmental services, parents reported noticeable improvements in their child's communication and social skills, as well as increases in their own knowledge and awareness of child development. While parents reported overall positive experiences with First Connections and their engagement with grantees, they also reported challenges such as gaps in communication with referral organizations and receiving inconsistent or inaccurate information about accessing intervention services and resources, overcoming stigma associated with developmental delays, and finding it challenging to access services due to logistical challenges.

Systems Learnings and Implications

Overall, First Connections helped uncover learning about three key systems level topics including 1) equitable service delivery, 2) care coordination, and 3) partnerships.

Ensuring equitable service delivery. While analysis of grantee data showed that grantees were able to screen and refer children and families of varying racial and ethnic backgrounds, grantees reported challenges with engaging diverse families. Stigma, fear of engaging with professionals and systems, as well as cultural and linguistic barriers all impacted grantees ability to effectively engage families of all types.

Impact of service referrals and care coordination. Grantees and parents alike reported that care coordination is important for ensuring families are connected to developmental services and resources. While care coordination was reported to be time and resource intensive on the grantee's end, parents benefited immensely from having a staff member who could help them navigate the complexities of the EII system.

Developing partnerships and collaboration in the EII system. Grantees reported that developing external partnerships for the purposes of expanding referral pathways was possible but did require a large investment of time and effort. Grantees reported that garnering buy-in and trust among decision makers are key to developing new partnerships.

Technical Assistance and Provider Capacity

Overall, TA was effective in helping grantees lay the foundation for embedding developmental screening, referral and linkage practices into their organizations' services. Grantees reported the most helpful aspects of TA were training, workflow development and refinement, as well as developmental screening tool selection. TA was also effective in building the capacity of grantees to facilitate both core and internally developed trainings on an ongoing basis. Though outside of the TA team's scope for First Connections, grantees would have benefited from additional support related to trauma-informed care and grant reporting and data tracking, which impacted their ability to evaluate their programs.

Recommendations for HMG LA and EII Providers

As First 5 LA transitions the First Connections program and pivots to implementing HMG LA and supporting EII providers in L.A. County more broadly, this evaluation provides an opportunity to translate key findings into actionable recommendations anchored to HMG-LA's core components: Centralized Access Point (CAP), Community and Family Engagement (CFE), Data Collection and Analysis (DCA), and Child Health and Provider Outreach (CHPO). The following table highlights recommendations for funders, providers, and system partners of EII efforts in LA, including the implementation of HMG LA, based on the evaluation findings.

Recommendation	Description
Centralized Access Point (CAP)	
Train staff to use a relationship-based, culturally responsive approach when working with children and families.	Grantees reported that developing relationships with parents was a key strategy for reducing stigma, and in some instances, helped move parents to accepting a referral they had initially declined. Consider intentional ways that staff can build rapport with parents early in the process (especially for HMG LA, since communication through the CAP will largely be virtual).
Ensure that families are connected to one consistent staff person throughout the entire process – from entry into the EII system to accessing services and through follow-up.	Grantees, as well as EII partners, emphasized that connecting families with a consistent staff person throughout the screening, referral, and linkage process was important. Consider designing staff caseloads so families are in contact with a single staff member throughout the process and embed care coordinators/patient navigators into the system permanently, when possible.
Proactively plan for ways that staff will stay connected with families who are unable to access services or resources due to waitlists or delays.	Grantees reported the success of providing "bridging services", such as telephone-based education or developmental homework, for families who either decline a referral or were not able to access services due to waitlists. Consider how staff will keep connected to families who cannot access services more immediately to ensure they do not "fall through the cracks".

Build processes to help ensure referrals to EII providers are appropriate and accessible.	Parents reported that not all referrals were appropriate nor accessible for their family. For example, some referrals required driving long distances or the service modality (for example, virtual speech therapy) was not appropriate for the child. Consider how HMG LA and EII providers throughout the County will inventory and stay updated on EII services and resources to ensure they are appropriate and accessible for families in terms of service type, modality, geographic location, cost, etc. Interagency councils or other regular network building activities may help the staff stay updated on the available resources.
Develop formal partnerships or MOUs for referral pathways and data sharing.	Grantees shared the difficulties of developing new partnerships with external organizations due to lack of responsiveness and lack of buy-in from decision makers. Support the EII providers who are part of HMG LA, as well as those who are not, in developing formal partnership agreements and referral pathways by bringing together the decision makers at those organizations and understanding the value add for all involved.
Community + Family Engagement (CFE)	
Design family engagement strategies to reduce stigma via normalization, education, and awareness work.	Grantees reported that education and awareness work regarding child development and developmental delays with parents takes time and often repeated follow-ups to normalize their experience. Consider how family engagement strategies can most effectively build parents' knowledge and awareness, but also normalize developmental delays using consistent and repeated messaging and "family friendly" language. EII partners recommended holding active listening sessions as an opportunity to answer questions before providing screening services and to hear about parents' experiences. EII partners also suggested sharing successful stories of children and families engaging in developmental services, working with faith-based organization or cultural champions, and including male figures in marketing materials as best practices for normalizing EII services and shifting stigma.
Develop family engagement strategies that consider the needs of diverse families especially related to language and culture.	Grantees reported challenges engaging diverse families due to a variety of reasons. Consider ways that family engagement strategies will account for the needs of diverse families with respect to language and cultural beliefs, such as hiring staff who speak native languages, creating educational materials that feature images of diverse families, and creating consistent messaging to address commonly held beliefs about developmental delays across cultures.
Incorporate time to garner buy-in and trust when conducting outreach to community organizations.	Grantees reported that developing successful external partnerships requires garnering buy-in and trust. Consider incorporating models such as promotoras and cultural brokers/champions to ensure that outreach to community organizations is culturally appropriate and factors in time for ongoing conversations to develop relationships with point-persons and decision makers.
Provide parent support and education services, including peer groups.	Both parents and grantees reported the value of increasing parents' knowledge about age appropriate child development in decreasing stigma and committing to getting their child to needed services. Consider investing in evidence-based parenting curricula that focuses on child development as well as provides opportunities for parents to build relationships and support networks with each other.
Data Collection + Analysis (DCA)	
Provide education and ongoing support to providers on the recommended data elements and provide standardized definitions to ensure consistency in data collection.	Grantees and the First Connections TA provider reported that grantees could have benefited from additional support with grant reporting and data tracking, such as guidance on what metrics to track, how to commonly define those metrics and how best to capture them. Consider how to provide education and ongoing support to providers to make sure metrics are tracked correctly and consistently.

Adopt or design a countywide data system that can integrate with, or be compatible with, other data systems that EII providers currently use. If that is not possible, create a process to streamline the sharing and transfer of data.	Grantees expressed a desire for data integration with systems they already use at their agency, such as EHRs and client information systems. Consider adopting or designing a platform that is compatible with systems already in use to reduce burden on providers. If this is not possible, consider developing backend solutions such as periodic data transfers to stay updated while avoiding double data entry.
Develop trainings and resources to build the capacity of EII providers to collect and report data and evaluate implementation and outcomes in a consistent and meaningful way.	Grantees reported that limitations with data tracking sometimes left them unable to evaluate their programs in meaningful ways. Consider developing ongoing trainings and resources to support providers with program evaluation and quality improvement efforts that will ultimately help improve the quality of their services and interactions with families.
Child Health + Provider Outreach (CHPO)	
Engage TA providers that have deep expertise and the ability to customize their approach to the wide range of EII providers.	Grantees expressed gratitude for the deep knowledge and expertise of the TA team, especially in their delivery of core trainings. Engage experts to deliver TA to EII providers that is both consistent, yet tailored to each providers' settings, knowledge level, and previous experience with EII services/resources.
Incorporate trauma-informed practices into EII provider outreach, training and TA.	Some grantees expressed the desire to further explore trauma-informed care via TA, however that was not possible due to contract limitations. Consider how trauma-informed practices can be incorporated into the outreach, training and TA that EII providers will receive.
Aim to build the capacity and sustainability of EII providers by leveraging the "train the trainer" approach.	Grantees reported that the CHLA TA helped build their internal capacity to facilitate core trainings by leveraging the "train the trainer" approach. Consider how to continue to leverage this approach to build the capacity of EII providers, especially since they are susceptible to experiencing staff turnover thus have an ongoing need for training.

Appendices

A. Matrix – Evaluation areas of inquiry, questions and methods (from evaluation framework)

Area of Inquiry	Evaluation Questions	Document + Data Review	Grantee Performance Data	Grantee Journey Mapping sessions	Parent/ Caregiver Focus Group
Family access, knowledge and support	What impact did activities have on families (e.g. knowledge, support, access to services)? To what extent have First Connections services been responsive to the diverse needs of children and their families? What challenges did agencies face when connecting with and engaging parents? How did they navigate those? What worked and what did not when trying to address those challenges?	X	X	X	X
Systems learning and implications	What proved effective to address different organizational capacity needs and close service gaps within the network of EII service providers? What cross-sector collaborative relationships were built and how? How have grantees navigated and shaped system dynamics as they've experimented with new practices, approaches and partnerships?	X	--	X	--
Technical assistance and provider capacity	In what ways did TA strengthen the capacity of grantees to implement multiple EII systems? To what extent did TA help elevate issues, influence engagement, mobilize grantees, and shift organizational practices and workflows?	X	--	X	--

B. Additional information about First Connection Grantees

Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) screen children during well-child visits and connect families and children to community resources when assessment results indicate a possible developmental delay. FQHCs follow-up with families to monitor subsequent visits over time.[66] The following three grantees are part of this group:

AltaMed Health Services Corporation. AltaMed Health Services Corporation provides multiple services including pediatric care, developmental screening and referrals to Regional Centers[67] and other community agencies. This grantee uses health information technology for staff to implement and track developmental screening results. Their implementation of the program included:

- Integration of screening tools into electronic health records (EHRs)
- Trainings for providers and staff on dynamic screening workflow at three clinical sites
- Early intervention referrals with case management and follow-up
- Spread and scale screening workflow to 3 additional sites
- Data review and optimization of screening workflow at 6 sites

Their approach to care coordination and linkage to services included data tracking, case management, engagement with Regional Centers, community service providers, implementing innovative contracting for services, and follow-ups with pediatric providers.[68]

Eisner Health. Eisner Pediatric and Family Medical Center is a nonprofit community health center dedicated to improving the physical, social and emotional well-being of children and families within the communities they serve, regardless of income. Eisner Health provides multiple pediatric services including individual and family therapy, trauma-focused cognitive behavioral therapy and parenting programs. Their implementation program approach included:

- Integration of case management into pediatric clinics
- Expanded referral system and relationship building
- TLC Speech Therapy provided on-site through warm hand-off and visit with parents
- Opened a new clinic in 2015 with staff trained on the Ages & Stages

[66] Williams, M. (2019, May 29). *First Connections/Children's Hospital Los Angeles.* AAP-CA2 and First LA Strategic Forum. First 5 LA.
[67] Regional Centers are nonprofit private corporations that contract with the California Department of Developmental Services (DDS) to provide or coordinate services and supports for individuals with developmental disabilities. https://www.dds.ca.gov/RC/
[68] First 5 LA (2019, June 11).

Questionnaire® (ASQ®) and a case manager on-site

- Scaled to include children at Eisner Health Family Medicine Center at California Hospital

Their approach to care coordination and linkage to services included relationship building with pediatric providers for buy-in, with Regional Centers to familiarize with intake coordinators, through pre-existing relationships (e.g. TLC Speech Therapy), and with education attorneys specializing in Individualized Education Programs (IEPs). Eisner Health also developed the BRIDGE program to help parents navigate the early intervention system.[69]

Northeast Valley Health Corporation. Northeast Valley Health Corporation is a community health center that provides dependable health care to medically underserved residents of L.A. County, particularly in the San Fernando and Santa Clarita Valleys. Northeast Valley provides health services to children, including developmental screening and age-specific education regarding child development and growth. The implementation approach of the program included:

- Developing a pilot site
- Offering trainings to pediatric providers to identify and refer children and families to early intervention services and support
- Developing a workflow chart and referral algorithm
- Expansion of the program to 6 health centers

Their approach to care coordination and linkage to services included developing workflow, roles and responsibilities, scripts for phone outreach, follow-ups, warm hand-offs, and strong relationships with external agencies.[70]

Family Serving Agencies

Family Service Agencies implemented First Connections program through screenings for all children from birth to 5 at intake and every 6 months; and linking families to community resources and to other agencies.[71] Two grantees are part of this group.

Foothill Family. Foothill Family Services is committed to improving infant, child, youth, and family development by providing comprehensive behavioral health care, early childhood development and social services. In addition to conducting developmental screenings, Foothill Family provides parent education, home visiting services and family therapy. Their implementation approach of First Connections included:

- Starting small with their internal Early Head Start Program, Developmental, Individual-differences, Relationship (DIR)/Floor time and FQHCs before expanding to larger access models including all internal

[69] Ibid.
[70] Ibid
[71] Williams (2019, May 29).

birth through age 5 programs

- Creation of Mental Health and Disabilities Program Assistant Position
- Internal EHR updates for internal referrals
- Large community outreach and building partnerships

Their approach to care coordination and linkage to services included having a streamlined internal First Connections referral process, building community partnerships, and having collateral visits with First Connections staff and referring staff. [72]

Allies for Every Child. Allies for Every Child provides critical, high-quality early education programs, interventions to strengthen families at risk of abusing or neglecting their children, foster care and adoption services, and multiple integrated services, including developmental screenings/advocacy, parenting classes and pediatric health consultations. Their First Connections implementation approach included:

- Tailoring implementation procedures to be program-specific
- Embedding protocol and monitoring in program requirements
- Screenings and capacity building with community organizations

Their approach to care coordination and linkage to services included a disabilities team, performance and quality improvement, support to staff in multiple areas such as nutrition, social work, among others, collaboration with caregivers, and internal behavioral health referrals.

Regional Center

Family Resource Centers screen children under age 3 when families reach out to a Regional Center, facilitate the connection with Early Start and other resources, and conduct screenings in multiple settings such as libraries, health fairs, among others.[73] One First Connections grantee is part of this group.

South Central Los Angeles Regional Center. The South Central Los Angeles Regional Center, co-located with a Family Resource Center that provides support and referrals to families, provides a wide range of services including one-to-one peer counseling support for families and caregivers, ongoing outreach and public awareness in the community, parent support groups and a range of other services. Their implementation of the program included:

- Providing developmental screening to children ages birth to five using a network of community locations and partner programs. From 2017-18, grantee shared information about the importance of developmental screenings through 16 resource or health fairs.

[72] First 5 LA (2019, June 11).
[73] Williams (2019, May 29).

- Reviewing results with caregiver and discussing needed referrals, providing milestones information as well as age-appropriate activities and tips to support development

- Connecting parents with support and education opportunities

Their approach to care coordination and linkage to services included dedicated staff to coordinate referrals and follow-ups with families to ensure connection to services, developing a parent follow-up timeline that includes summary letters within a week of the screening, calls to parents within 2 weeks, following up with service providers, and providing ongoing support for families to access services.[74]

[74] First 5 LA. (2019, June 11).

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Early Identification and Intervention: Strengthening Linkage to Community Supports

Program and Planning Committee

October 29, 2020

Presentation Objectives

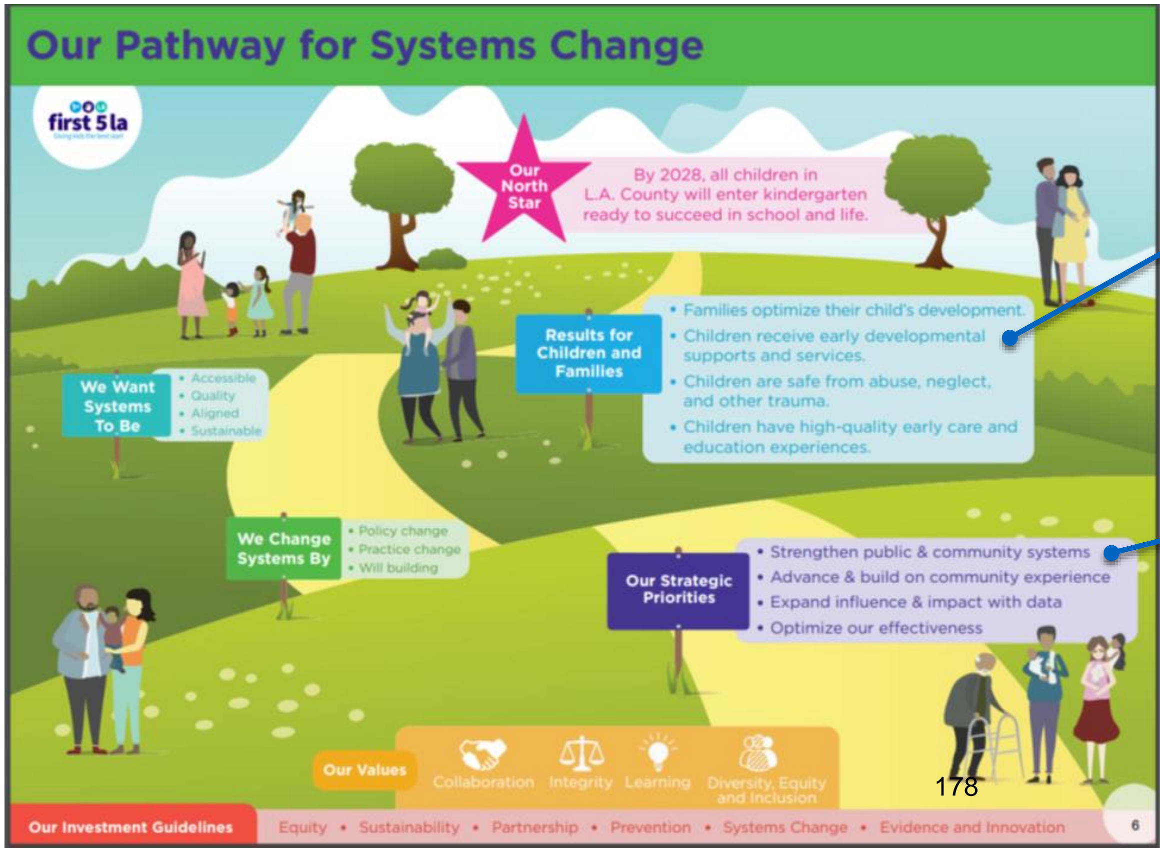
Help Me Grow Updates

Learning Approach

Discussion

- Help Me Grow LA Early Implementation Updates
- Important Learnings and Application
- Comments & Questions

Strategic Plan 2020-2028



Result: Children receive early developmental supports and services

Strategic Priority: Strengthen public and community systems

first 5 la
Giving kids the best start

FIRST 5 20 YEARS OUR KIDS OUR FUTURE

Problem Statement: Underutilization/Stats

- 40% drop for vaccination rates due to reduction in well-baby/child visits
- 40% drop in referrals to Regional Centers (peaking in May and June)
- Anecdotal reports of families and pediatricians believing Regional Centers were closed
- DPH staffing reassigned to support COVID-19 response

Adjustments:

- Telehealth: allowances for some components of well-child visits to occur virtually
- Early Start directive allows Regional Centers to provide services to children over 3 years old while transitioning to school services on a temporary basis
- CA Dept. of Developmental Services (DDS) producing a PSA and flyer to communicate Regional Centers are open and offering virtual services
- DDS distributes MHSA funding to Regional Centers for projects focused on prevention, early intervention and family support

first 5 la Giving kids the best start
FIRST 5 20 YEARS OUR KIDS OUR FUTURE

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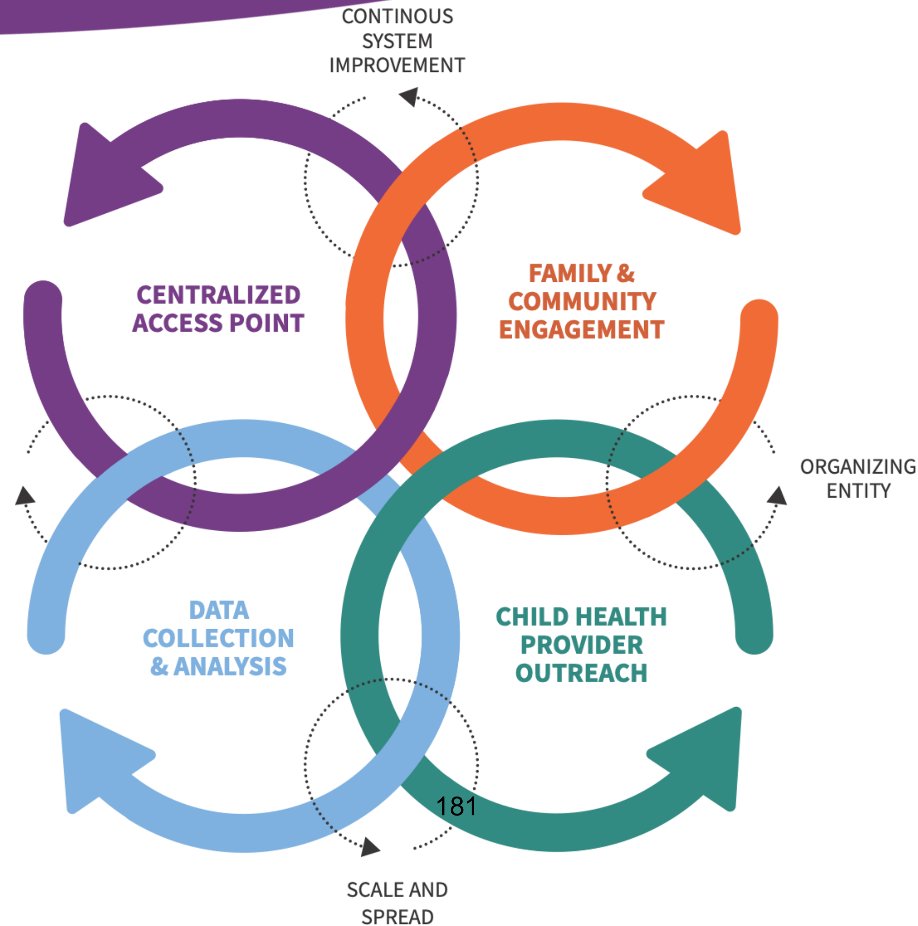
HELP ME GROW LA

Help Me Grow LA is implemented in collaboration between First 5 LA and Los Angeles County Department of Public Health.

first 5 la
Giving kids the best start

County of Los Angeles Public Health

HMG LA: Core Components



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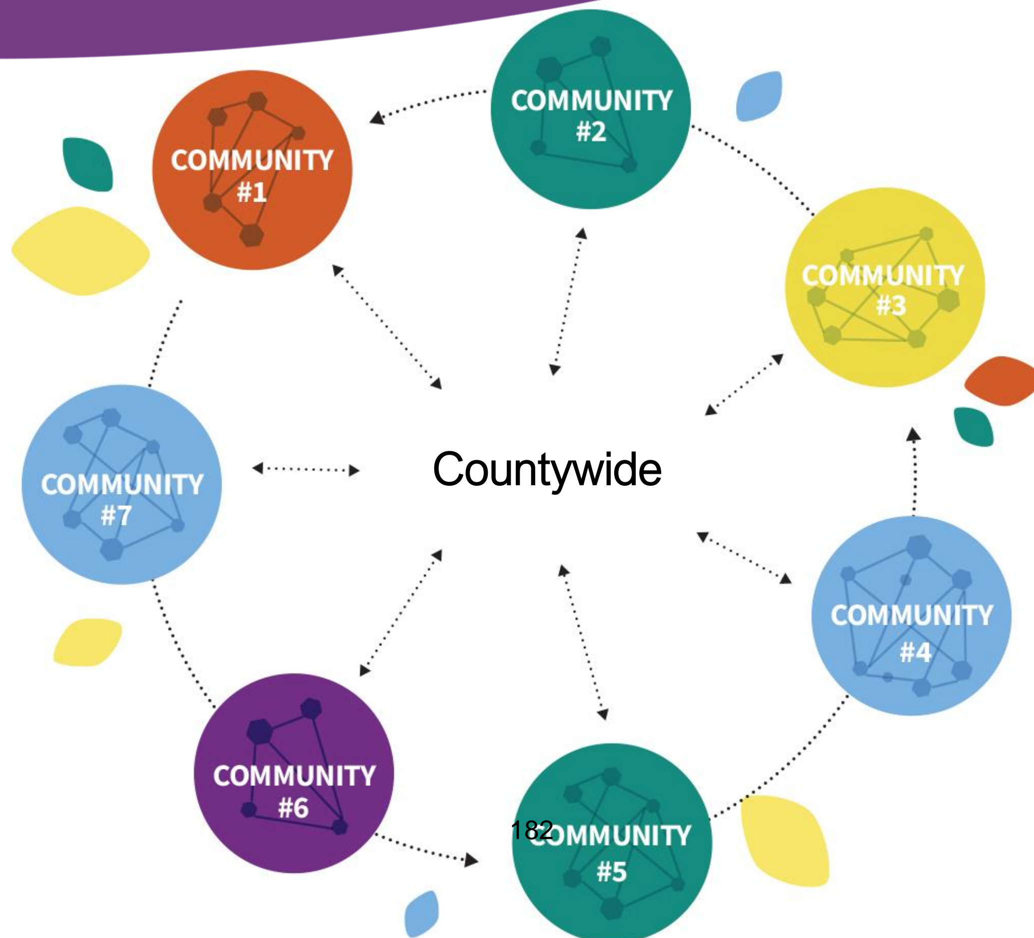
HMG LA: Countywide & Community Approach



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Learnings Related to Linkage to Community Supports

Help Me Grow LA

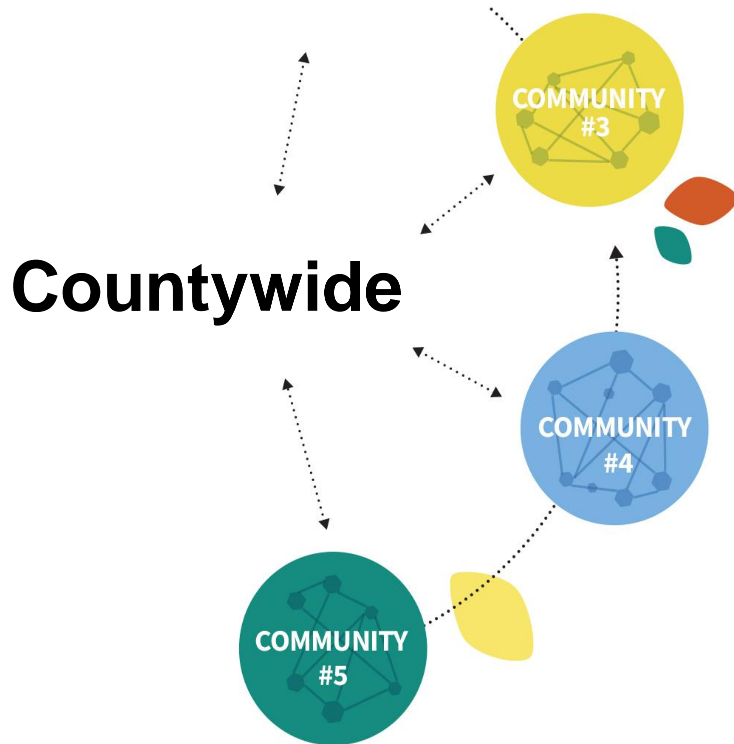
First Connection Evaluation Findings:

- Over 50,000 ASQ-3 screenings conducted (April 2014- Dec. 2019)
- 16% fell in monitoring range and 17% fell in refer range
- Increased parent knowledge of child development & overcome stigma associated with special needs
- Children demonstrated improvements in skills and abilities after receiving developmental services

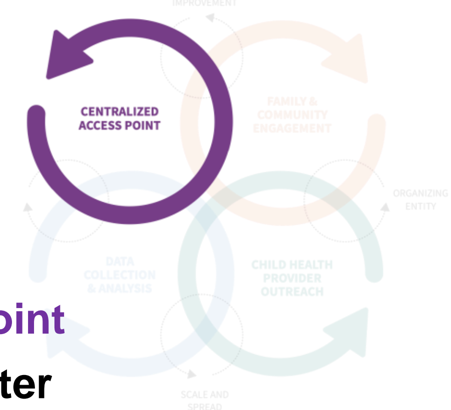
Important Learnings for Linkage to Community Services:

- ➢ Build mechanisms to help ensure referrals to EII providers are appropriate and accessible
- ➢ Develop formal partnerships or MOUs for referral pathways and data sharing
- ➢ Incorporate time to garner buy-in and trust when conducting outreach to community organizations

Help Me Grow LA



Countywide



Centralized Access Point

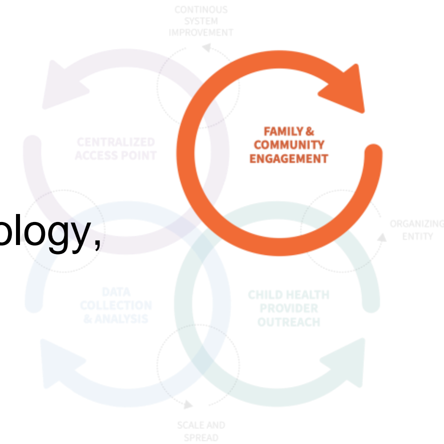
- Web and call center

Application of learnings

- Resource Liaisons provide assistance, find resources, and make linkages based on client needs
- One Degree Information and Referral pilot

Help Me Grow LA is implemented in collaboration between First 5 LA and Los Angeles County Department of Public Health.

first 5 la — Giving kids the best start
County of Los Angeles Public Health



HMG LA Pathways: Community collaboratives testing innovative approaches to strengthen and expand referral pathways via technology, Infrastructure, and/or practice

Intended Outcomes:

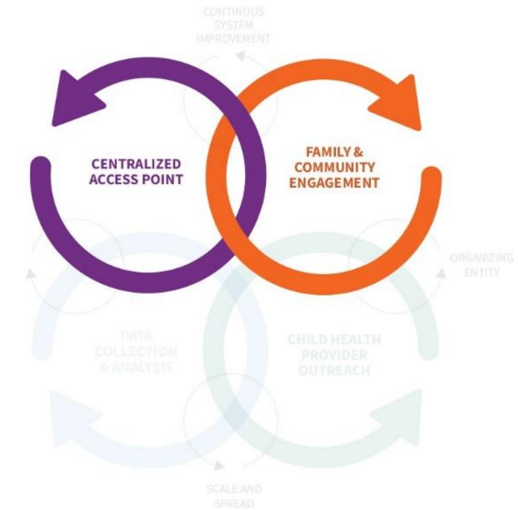
- Improved communication and tracking on referral status
- Reduction in wait times
- Decrease in the age at which children are referred
- Increase in successful referrals on first attempt
- Increase in parent/caregiver satisfaction

Help Me Grow LA is implemented in collaboration between First 5 LA and Los Angeles County Department of Public Health.

HMG LA: County & Community Integration

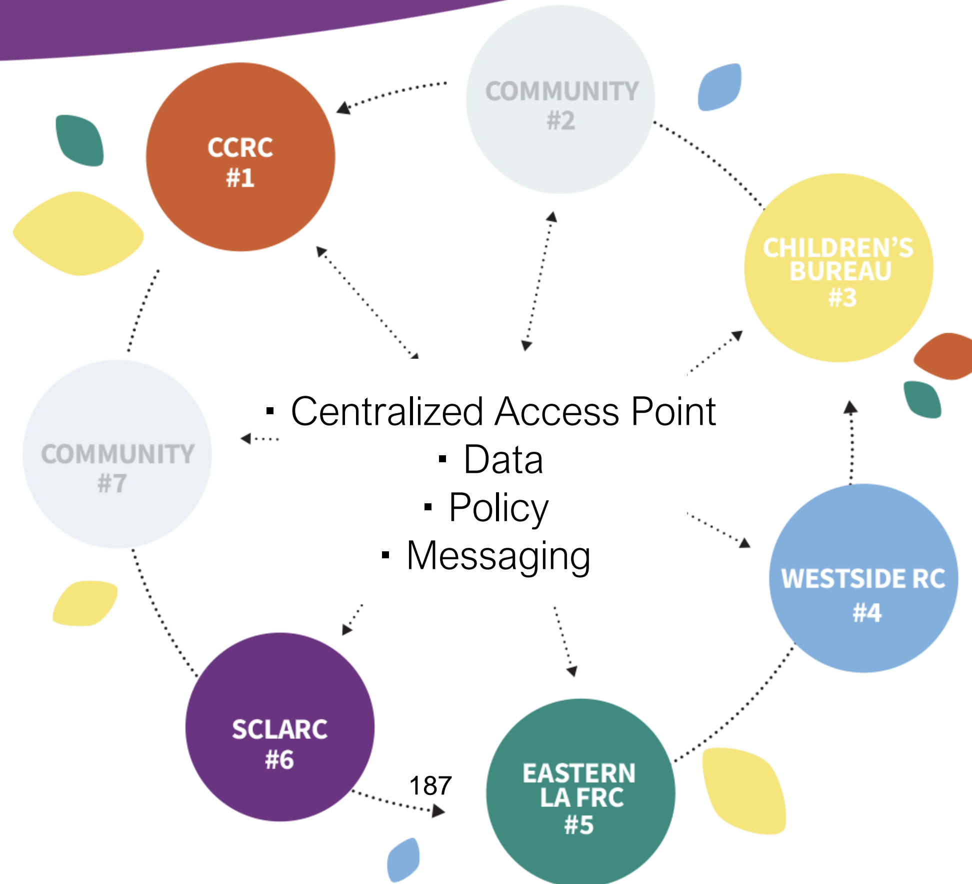
CAP & Pathways:

- Test innovative approaches to strengthen referrals
- Map local EII services and supports
- Incorporate parent/family experience and needs
- Inform and pilot Countywide & Community features:
  - Information & Referral
  - Data Collection
  - Communication & Messaging
  - HMG LA Resources



Help Me Grow LA is implemented in collaboration between First 5 LA and Los Angeles County Department of Public Health.

HMG LA: Countywide & Community Approach Applied



Help Me Grow LA is implemented in collaboration between First 5 LA and Los Angeles County Department of Public Health.

Comments and Questions

first 5 la
Giving kids the best start
County of Los Angeles Public Health

FIRST 5 LA

SUBJECT:
Establish Strategic Partnerships with the Los Angeles County Office of Education (LACOE), the Child Care Alliance of Los Angeles (CCALA), and Child360 for a combined total not to exceed $1,887,676 for the implementation of Quality Start Los Angeles' Dual Language Learner (DLL) Pilot Study Expansion for 13 months.

RECOMMENDATION (PROVIDED AS INFORMATION):
This memo is provided as information for the Board's consideration at the October 29, 2020 meeting of the Special Board/Program and Planning Committee meeting. First 5 LA staff recommends that at the November 12, 2020 Commission meeting, the Board approves the following:

- Establish a Strategic Partnership with LACOE an amount not to exceed $695,892 through December 31, 2021;
- Establish a Strategic Partnership with CCALA in an amount not to exceed $595,892 through December 31, 2021;
- Establish a Strategic Partnership with Child360 in an amount not to exceed $595,892 through December 31, 2021.

BACKGROUND:
First 5 LA is pending an award for the DLL Pilot Study Expansion funds from First 5 CA, the third phase of the statewide DLL Pilot Study that was launched in 2015. This item is being brought forward for information due to funds being anticipated in November 2020. We will be returning for action at the November 12, 2020 Commission meeting. Approving these strategic partnerships will allow First 5 LA to execute contracts quickly with partners starting December 1, 2020 and will allow First 5 LA to expend funds by December 31, 2021, as required by F5CA. Under resolution 2020-03 First 5 LA was granted authority to accept additional funds from F5CA for QSLA. Los Angeles County plans to integrate the DLL Expansion Project in coordination with Quality Start Los Angeles (QSLA), LA County's Quality Rating and Improvement System (QRIS). The consortium is comprised of First 5 LA, the Los Angeles County Office of Education (LACOE), Child Care Alliance of Los Angeles (CCALA) and Child360. These partner organizations will be leading the DLL Pilot Expansion in Los Angeles County. The Los Angeles DLL expansion project will include partners collaborating to utilize, adapt, and align existing resources to develop a QSLA comprehensive "menu" of training and professional development opportunities for providers, coaches, and families that are available virtually and address COVID19 response needs. Additionally, QSLA leadership will integrate dual language learning supports into all QSLA does for staff, families, and children. This includes imbedding DLL learning supports within the leadership committee's goals, priorities and activities, training for QSLA staff, participating providers and creating consistent messaging to the field.

The partners will work collaboratively to implement the pilot expansion as follows:

First 5 LA will administer grant funds and contracts and oversee completion of the pilot consistent with the funding award from First 5 California.

- **LACOE** will lead train-the-trainer support for QSLA rated-providers and other providers which includes center-based and Family Child Care Homes (FCCH), and Family Friend and Neighbors (FNN) using California Preschool Instructional Network (CPIN) professional development curriculum, and other researched-based materials with local customizations for the provider type. Using the LA County PreK to Kindergarten Transition Systems Alignment Framework, LACOE will also focus on providing joint professional development with pre-schools and school districts in LA County to support school transition efforts.
- **CCALA** will lead the development of a series of family education workshops and a family engagement train-the-trainer curriculum for providers aligned with the CPIN professional

development curriculum. They will train providers, so they are able to deliver the curriculum to parents and families. Additionally, they will coordinate access to professional development training for FCCH, FFN and center-based providers through their network of resource & referral agencies.

- **Child360** will leverage their own DLL professional development training expertise and resources and develop an infant-toddler focused training series in English and Spanish. They will also create a public awareness campaign to promote the importance and value of supporting Dual Language Learners both at home and in early learning environments across LA County. Child360 will also lead the evaluation of the DLL expansion phase activities.

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 these Strategic Partnerships to comply with this policy.

GOVERNANCE GUIDELINES #5 AND #6 (SUSTAINABILITY AND LEVERAGING):

QSLA will integrate dual language learning supports into the fabric of all that QSLA does for staff, providers, families, and children. This includes imbedding supports within the leadership committee's goals, priorities and activities; training for all staff and providers messaging to the field. QSLA recognizes dual language learners are the majority of children 0-5 in Los Angeles County. As such, QSLA is accountable to make sure DLLs are at the center as decisions are made about quality, equity, access, sustainability & budget. Therefore, ongoing DLL quality supports will be sustained through block grants, IMPACT and incoming QCC funding. Additionally, QSLA has consistently worked to make its model more sustainable. Modifications included, but were not limited to, reducing coaching services at highly-rated sites and reducing the frequency of formal assessments – in line with directive from the state. In addition, QSLA is currently doing more digital engagement with providers, reducing the costs of operations (decreased travel expenses, more time allowed to work directly with participants, etc.) Together with other IMPACT Regional Hubs, we explore lessons learned and share resources to ensure the long-term sustainability of our statewide early learning and care quality improvement work.

In addition, because QSLA is now funded through a single solicitation released by Quality Counts California (QCC), these strategic partnerships allow us to seamlessly blend and braid funding. We are also able to leverage the experience and resources available within our partner agencies to enhance the work of QSLA, to recruit participants, and to offer supports to providers representing the mixed-delivery early learning and care system in LA County. By administering through a single agency, First 5 LA, we are also able to reduce reporting requirements and centrally manage the work of QSLA's implementing agencies, LACOE, CCALA and Child360.

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.

These Strategic Partnerships can provide a demonstrated level of ability or expertise that is only available in the community through the proposed Strategic Partnership.

These three organizations are the only ones in Los Angeles County that implement Quality Start Los Angeles, LA County's Quality Rating and Improvement System (QRIS). Therefore, they are the only organizations in LA county with expertise in QSLA that is required to implement this project.

LACOE leads and supports educators, preschool through TK-12th, in the areas of curriculum, instruction, and assessment, family engagement and career-college readiness. LACOE is also one of the largest Head Start grantee agencies in the country, co-lead of the county's Quality Rating and Improvement System Consortium, and the lead for the state-funded California Preschool Network (CPIN), Region 11 serving early learning providers in the Los Angeles County. LACOE's Early Learning consultants are well versed and experienced in adult learning and coaching strategies using a variety of modalities such as in-person, online, blended, synchronous and asynchronous. They have a wealth of knowledge and skills in a variety of early learning content areas, including the Preschool Learning Foundations and Preschool Curriculum Framework, and in particular have expertise in dual language development, and culturally and linguistically appropriate practices.

CCALA has 40 years of experience in professional development, information dissemination, technical assistance and support for early learning educators. They have a unique and significant partnership with ten-member agencies, the LA County resource & referral and alternative payment agencies that serve communities at the local level. Because of this network they are able to quickly and effectively disseminate county-wide professional development for a diversity of providers and families.

Child360 has extensive experience in marketing and developing multimedia campaigns to reach families and early learning professionals. They co-chair the QSLA communications workgroup which is charged with marketing and communicating with the early education field and families served. Their recent projects include launching an extensive social media and marketing focus on the 2020 Census targeting hard to reach communities. Besides having expertise in evaluation and program assessment, Child360 worked with F5CA on the second phase of the DLL in-depth study which included identifying effective professional development, intentional teaching, and family engagement strategies in LA County. They are familiar with overall evaluation of the DLL Pilot Study and have the existing relationships with the F5CA evaluator of the state project, the American Institute of Research (AIR).

Lastly, the 2020-2028 Strategic Plan contains four (4) results for children and families. The DLL Pilot Study Expansion aligns with one of the results we seek for LA County's children "to have high-quality early care and education experiences." As such, F5LA is committed to work towards a comprehensive and aligned system under the Quality Start Los Angeles (QSLA) umbrella to support quality improvement and workforce development across the diversity of early learning settings and provider types

<u>NEXT STEPS</u>:
Staff anticipates returning to the Board for action on the Strategic Partnership and approval of the contract at the November 12, 2020 Board Meeting.

Agenda Item: 07
Date: October 29, 2020

FIRST 5 LA

SUBJECT:
Establish a Strategic Partnership with the Los Angeles County Office of Education (LACOE) in the Amount of $6,349,422 to implement Quality Start Los Angeles' (QSLA) IMPACT 2020 award from First 5 CA for the period of November 1, 2020 through June 30, 2023

RECOMMENDATION (PROVIDED AS INFORMATION):
This memo is provided as information for the Board's consideration at the October 29, 2020 Meeting of the Special Board/Program and Planning Committee. First 5 LA staff recommends that at the November 12 Commission meeting, the Board approve the establishment of a Strategic Partnership with LACOE for an amount not to exceed $6,349,422 for the period of November 1, 2020 through June 30, 2023. Funds for FY 2020-2021 are included within the current First 5 LA Programmatic Budget under IMPACT 2020, which was approved by the Board of Commissioners in June 2020. Beyond FY 2020-21, funds will be pulled for the assigned fund balance which will be brought to the Board of Commissioners for approval in June of the corresponding fiscal year. At the time of budget approval, requested resources will shift from the Assigned resource category of the fund balance, dedicated for broad Strategic Plan purposes, to the Committed category, amounts dedicated for a more specified purpose via resolution.

BACKGROUND:
First 5 LA was recently awarded IMPACT 2020 funds from First 5 CA, building off the work conducted under the Improve and Maximize Programs so All Children Thrive Initiative (IMPACT) that ended on June 30, 2020. IMPACT 2020 places less emphasis on rating early learning and care sites and more emphasis on providing quality improvement services, with a particular focus placed on settings that have had less opportunity to quality improvement supports (e.g., Family, Friend, and Neighbor care, Family Child Care homes, and center-based care without a state preschool contract). Quality Start Los Angeles is an umbrella for Los Angeles County's Early Care and Education Quality Improvement initiatives, and is implemented by several agencies, including LACOE. Because LACOE administers the other quality improvement funding streams that fund QSLA, staff recommend the establishment of a Strategic Partnership with LACOE since they are in a unique position to leverage, blend, and braid these funds with the other public dollars that make up QSLA's funding. In addition, LACOE has the skills and resources needed to adhere to state reporting and compliance requirements – a role they have managed for QSLA for many years.

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 $6,349,422 to comply with this policy.

GOVERNANCE GUIDELINES #5 AND #6 (SUSTAINABILITY AND LEVERAGING):
QSLA serves as an umbrella for publicly funded local quality improvement initiatives; and LACOE administers other funding from Quality Counts California, making them uniquely able to blend and braid public funding for quality improvement initiatives In addition, QSLA is currently doing more digital engagement with providers, reducing the costs of operations (decreased travel expenses, more time allowed to work directly with participants, etc.) Together with other IMPACT Regional Hubs, we explore lessons learned and share resources to ensure the long-term sustainability of our statewide early learning and care quality improvement work.

We are also able to leverage the experience and resources available within our partner agencies to enhance the work of QSLA, to recruit participants, and to offer supports to providers representing the mixed-delivery early learning and care system in LA County. By administering through a single agency, we are also able to reduce reporting requirements and centrally manage the work of QSLA's implementing agencies, the Child Care Alliance of Los Angeles (CCALA) and the Los Angeles County Office of Education (LACOE).

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.

LACOE's role as current QSLA administrator of public quality improvement funds make them uniquely qualified to administer IMPACT 2020 funds. They have extensive experience with state reporting requirements, including the submission of the Common Data File (CDF) to the state and have coaches with QSLA's implementation partners that can be amended with these dollars. Moreover, LACOE has robust oversight and accountability mechanisms to ensure compliance with all relevant guidelines and procedures. Having been a crucial administrative partner for five years with QSLA, LACOE's experience and history with our unified Quality Rating and Improvement System (QRIS) means that LACOE is ready to execute programming upon contract execution. LACOE's deep and trusted relationship with our partner implementation agencies uniquely qualifies them to conduct this work, having previously been successful in a competitive solicitation for IMPACT funds in 2019. IMPACT 2020 is but one piece of QCC's Local Consortia and Partnership Grant, the other pieces of which are also managed by LACOE. This management structure will place LACOE in a position to easily blend and braid other future public funding for Quality Start Los Angeles, and our strong and long-standing partnership will help QSLA in applying for future funding opportunities.

Lastly, the 2020-2028 Strategic Plan contains four (4) results for children and families. One of these is that "[c]hildren have high-quality early care and education experiences." The work conducted under this proposed strategic partnership is imperative toward achieving that result, and builds off years of quality improvement work in Los Angeles County.

NEXT STEPS:

Staff anticipates returning to the Board for action on the Strategic Partnership and approval of the contract at the November Board Meeting.

Agenda Item: 8
Date: October 29, 2020

SUBJECT:
Establish a Strategic Partnership with California Health Foundation and Trust, fiscal sponsor for the Hospital Alliance of Southern California (HASC) and Communities Lifting Communities (CLC) in the Amount of $250,000 to implement Cherished Futures for Black Moms and Babies 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 October 29, 2020 Special Meeting of the Board of Commissioners & Program and Planning Committee. First 5 LA staff recommends that at the November 12, 2020 Commission meeting, the Board approve the establishment of a Strategic Partnership with the California Health Foundation and Trust for an amount not to exceed $250,000 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. At the time of budget approval, requested resources will shift from the Assigned resource category of the fund balance, dedicated for broad Strategic Plan purposes, to the Committed category, amounts dedicated for a more specified purpose via resolution.

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. A comprehensive update of the AAIMM Initiative was shared at the September 24th, 2020 Special Programs and Planning Commission Meeting including an overview of aligned First 5 LA investments

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.
4. First 5 LA is a leading funder of the AAIMM Prevention Initiative evaluation alongside LACDPH. 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.

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; and (2) 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.

Cherished Futures for Black Moms & Babies

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 key partner in this effort is Cherished Futures for Black Moms and Babies, a hospital quality improvement effort led by the Hospital Association of Southern California (HASC), Communities Lifting Communities (CLC) and the Public Health Alliance of Southern California (Alliance).

Cherished Futures is a unique, multi-sector collaborative initiative that aims to reduce Black infant mortality and improve patient experience and safety for Black mothers and birthing people. The project is currently centered in South Los Angeles, South Bay, and the Antelope Valley-- the regions of the county with the highest rates of adverse outcomes for Black families, though the need exists throughout the region. Guided by the data and grounded in Black women's experiences, Cherished Futures brings together decision makers from local birthing hospitals, public health departments, health plans, and AAIMM Community Ambassadors from the priority communities to co-design upstream, systems-change solutions at the clinical, institutional, and community levels. The hospitals participating in the current Cherished Futures pilot cohort include Antelope Valley Hospital, Cedars-Sinai, Centinela Hospital Medical Center, Dignity Health California Hospital Medical Center, and Providence Little Company of Mary Medical Center Torrance. Collectively, these five hospitals accounted for one-third of all African American hospital births in Los Angeles County in 2016.

In December 2020 this pilot cohort will complete a capacity building and planning year having co-designed actionable, community-informed implementation plans with interventions at each system level. First 5 LA seeks to partner with Cherished Futures to leverage private and public funding to the 2021 Pilot Cohort Implementation Year. Cherished Futures will provide multi-layer support for the hospital teams as they initiate the self-selected systems-level interventions identified in the capacity building year by hosting collaborative convenings, providing individual technical assistance to assist hospital teams in implementing selected interventions, conducting evaluations, and disseminating key learnings and strategic communications.

The contract will include the following objectives:

- Facilitate at least three convenings to support ongoing learning, strategy development, and implementation of selected strategies to improve African American birth outcomes;

- Provide at least six technical assistance sessions to each hospital team to support the successful implementation of quality improvement interventions at the clinical, institutional and community levels that improve African American birth outcomes;
- Cultivate stronger regional communication and collaboration between hospitals, Black birthing families and other key partners to facilitate greater coordination of resources and strategies that improve African American birth outcomes;
- Evaluate hospital progress in implementation plan completion and improvements in birth outcomes for African American mothers;
- Identify and implement sustainable quality improvement models and strategies in partnership with hospital QI departments, refining the process as necessary;
- Develop and expand Cherished Futures communications to elevate the stories, lessons learned, and successes of the project through various channels such as media coverage, a year-end webinar or in-person meeting, or other opportunities through related birth equity initiatives

Cherished Futures 2021 Implementation Year budget is $475,000. First 5 LA's proposed funding for this 1-year timeframe is $250,000 and will leverage LACDPH funds in the amount of $200,000. Additionally, California Health Care Foundation (CHCF), will be contributing resources for this in 2021 and 2022; the total amount is in development but expected to match First 5 LA's investment of $250,000. This represents a new partnership for First 5 LA. CHCF is a grantmaker focused on improving California's health care delivery system with emphasis on Medi-Cal. First 5 LA and CHCF will work closely together to affirm focus and priorities as well as track progress and learning. Finally, this investment leverages current funding from Health Net Health Plan who has primarily supported the pilot cohort's planning and capacity building in 2020.

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 $250,000 to comply with this policy.

GOVERNANCE GUIDELINES #5 AND #6 (SUSTAINABILITY AND LEVERAGING):

Sustainability: First 5 LA's support to Cherished Futures for Black Moms and Babies will build evidence for the interventions and strategies of the hospital quality improvement effort, serving as a catalyst for additional adoption, scale and sustainability of interventions and strategies.

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, $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, and $400,000 of First 5 LA funds contributed to LACDPH for the AAIMM Evaluation. This effort also leverages First 5 LA investment in home visitation and Best Start as three of the participating hospitals in the Cherished Futures cohort implement the Welcome Baby program and serve Best Start communities. Potential opportunities for these hospitals include connecting on how to better engage their AA patients to increase referrals into Home Visiting. Lastly, each hospital is expected to identify a community engagement intervention alongside their clinical intervention, potential exists to connect and collaborate with Best Start.

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 can provide a demonstrated level of ability or expertise that is only available in the community through the proposed Strategic Partnership:

The Public Health Alliance of Southern California is an existing collaborative of local health departments in Southern California, including Los Angeles, Long Beach and Pasadena. Collectively, Alliance members have statutory responsibility for the health of 50% of California's residents. They focus on multi-sector policy, systems and environmental change to improve population health and equity.

Through their work establishing the Cherished Futures for Black Moms and Babies first hospital quality improvement cohort they have the demonstrated resources, ability and expertise to implement the objectives listed above in cooperation with the Commission, and consistent with our Strategic Plan. Cherished Futures for Black Moms and Babies is the only hospital quality improvement effort that is a partner in the AAIMM Initiative and has secured the participation the five hospitals that accounted for one-third of all African American hospital births in Los Angeles County in 2016.

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 and CHCF funds to support Cherished Futures for Black Moms and Babies. LACDPH's contribution totals approximately $200,000 for the 2021 Implementation Year. Health Net provided $$484,000 in funding for the 2020 Capacity Building and Planning Year. Private funders such as California Health Care Foundation are determining funds to contribute to the multi-year project (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* and 1.2-3 *Increased accessibility, quality and responsiveness of hospital and health plan systems to reduce disparities in Black infant and maternal mortality*. 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.

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 Cherished Futures for Black Moms and Babies is a co-investment with public and private 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 the Strategic Partnership and approval of the contract at the November 12, 2020 Board Meeting.