Help Me Grow L.A.

Help Me Grow L.A. Pathways

Final Evaluation Report

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REPORT CREATED BY

first 5 la
Giving kids the best start

County of Los Angeles Public Health

VIVA social impact partners

Contents

Introduction

Why Strengthening Referral Pathways Matters

An estimated one in four children under age five in California is at risk for developmental or behavioral concerns. This proportion may be even higher in Los Angeles County, where local estimates suggest that 30% to 40% of young children could benefit from preventive and early intervention services.[1]

Early intervention and timely closed-loop referrals are essential to supporting young children's development, particularly during the critical first five years of life. A closed-loop referral means not only making a referral, but also confirming that the child successfully connects to the services, ensuring their needs are met.[2] Yet, despite this need, many children are not identified or connected to support until they enter kindergarten. In California, 48% of children with special needs have received developmental screening, compared to only 42% in Los Angeles County.[3] Disparities in screening and service access are even more pronounced when considering factors such as race, ethnicity, and type of health insurance.[4] For example, Latinx, Black, and Asian children in California are screened at lower rates than White children, contributing to delayed identification and fewer opportunities to access early support.[5]

In response to these issues, Help Me Grow Los Angeles Pathways is a countywide initiative designed to strengthen referral pathways, reduce disparities, and build more coordinated, family-centered systems of care. By focusing on equity, collaboration, and early connection to services, the initiative aims to ensure that all young children, regardless of race, language, income, or geography, have access to the support they need to thrive.

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Help Me Grow LA Pathways Background

Help Me Grow LA Overview

Help Me Grow (HMG) is a national systems change model designed to improve early identification and intervention (EII) by increasing developmental screenings, strengthening knowledge and awareness about developmental health, addressing stigma, linking children to early intervention services, and collecting data for continuous system improvement. Throughout the course of this evaluation, First 5 Los Angeles (F5LA), in coordination with the Los Angeles County Department of Public Health (LAC DPH), implemented Help Me Grow Los Angeles (HMG LA) to coordinate existing systems in Los Angeles County and connect young children to intervention services and supports.

Pathways Program & Unifying Agencies

HMG LA Pathways is a three-year initiative designed to support agencies and their referral partners in strengthening and expanding existing referral pathways in Los Angeles County. The program aims to ensure that all young children with or at risk of developmental and/or behavioral delays can access EII services.

To serve children across Los Angeles County, seven community collaboratives were formed. Each community collaborative consisted of one Unifying Agency (UA), a few subcontracted Collaborative Agencies that supported the implementation of strategies, and many Supporting Partners, community stakeholders responsible for providing feedback to inform planning, implementation, and sustainability of strategies. Each collaborative planned, tested, and refined strategies to make referral pathways more coordinated, integrated, and multidirectional, ultimately making it easier for families to find and access the support they need.

The participating Pathways communities aligned with Los Angeles County's seven Regional Center boundaries (or catchment areas) to ensure countywide reach, given the important role Regional Centers play in delivering the Early Start program to infants and toddlers. UAs were enrolled in the program in two cohorts, referred to as Wave 1 and Wave 2. The seven Unifying Agencies are presented below:

Wave 1 (October 2020 - December 2023)

- Child Care Resource Center, or CCRC (North LA County)
- Children's Bureau (Lanterman – Mid-Wilshire/Pasadena): Although the agency is now formally known as *All for Kids*, this report continues to refer to the agency as 'Children's Bureau' or 'CB' for consistency.
- Eastern Los Angeles Family Resource Center, or ELAFRC (Eastern LA)
- South Central Los Angeles Regional Center, or SCLARC (South Central LA)
- Westside Regional Center, or WRC (Westside)

Wave 2 (July 2022 - June 2025)

- City of Long Beach Department of Health & Human Services, or LB DHHS (Harbor)
- San Gabriel/Pomona Regional Center, or SGPRC (San Gabriel/Pomona)

This report focuses on both Wave 1 and Wave 2 UAs who completed the Pathways program.

Unifying Agency Strategies to Strengthen Referral Pathways

Throughout the project term, UAs selected and executed a number of strategies or approaches meant to strengthen and expand existing referral pathways in Los Angeles County.

Those approaches included the following efforts focused on leveraging technology to support referral processes:

1. Adopt and implement a third-party electronic referral platform that is accessible to families, providers, and referral partners (CB, CCRC, ELAFRC, LB DHHS).
2. Build a homegrown web-based electronic referral platform accessible to families, caregivers, and providers with children who may qualify for Regional Center services, including geographically specific resources and referrals for individuals not eligible for Regional Center services and conduct outreach to encourage use (WRC, SCLARC, SGPRC).
3. Build a web-based, electronic referral system component for children with moderate delays who are not eligible for Regional Center services (SCLARC).
4. Build an early childhood resource directory for families & providers (LB DHHS).
5. Equip a local call center to assist families with referrals to EII services (LB DHHS).
6. Enhance access to the regional center website with language and audio accessibility tools (e.g., ReciteMe web plugin) (SGPRC).

The following approaches focused on strengthening partnerships, community engagement, and capacity in UAs' communities:

7. Expand and strengthen partnerships with and among EII community partners serving families with young children (CB, ELAFRC).
8. Promote self-referrals by families and collect regular feedback on the current EII referral system (CB, SGPRC).
9. Provide educational opportunities and outreach for medical professionals and other supporting partners to increase awareness of available EII assessments and services (CCRC, ELAFRC, LB DHHS, SGPRC).
10. Use Promotoras to conduct culturally relevant community outreach and distribute early identification and intervention health information (SGPRC).

The following report summarizes the implementation of the above approaches and preliminary findings regarding the outcomes of those approaches on the EII system in Los Angeles County.

Evaluation Methodology

In partnership with F5LA, LAC DPH, and participating UAs, VIVA Social Impact Partners, the HMG LA Pathways Technical Assistance provider and project evaluator, developed a Data Collection, Evaluation, and Learning Plan for each UA that would support an evaluation of the HMG LA Pathways program (see Appendix 1a-b).

The Data Collection, Evaluation, and Learning Plans follow a continuous quality improvement (CQI) process, or an ongoing process that evaluates how an organization works and areas for improvement. The CQI framework implemented for this project was Plan-Do-Study-Act (PDSA). Through the PDSA cycle, UAs developed a plan to test or pilot their approaches (Plan); carry out the pilot (Do); observe, analyze, and learn from the pilot (Study); and determine what modifications, if any, to make for the next cycle (Act).

Data Collection and Submission

Each Unifying Agency was required to collect data to measure the implementation and outcomes of each of their approaches. As possible, data would be rolled up to support HMG LA Pathways program-level, HMG LA, and HMG National reporting and analysis. Core outcome indicators, to be tracked and reported on by all UAs, were finalized in March 2022 (see Appendix 2). Each UA was welcome to include additional outcome indicators in their evaluation plan. Data collection efforts were streamlined through data collection guidelines and templates, including three options for data submission to minimize complexity and time requirements for UAs.

UAs submitted implementation and outcome data during each evaluation cycle. The outcome-focused data was submitted to support analysis of progress toward achieving the HMG LA Pathways outcomes. The activities-focused data was submitted to support analysis of the implementation of the UAs' strategies. See Appendix 3 for an overview of the data collection periods and data sources.

Implementation Findings

This section provides an overiew of findings related to the UA's process of implementing the Pathways project activities. The following findings were determined through a systematic review of the project's data sources. UA experiences and key learnings from the following seven key areas are analyzed:

1. Selecting and finalizing Pathways approaches
2. Adopting or developing an online/customized portal
3. Pathways data collection efforts
4. Community engagement
5. Partnership building
6. Technical assistance

Selecting, Finalizing and Launching Approaches

INSIGHT SUMMARY: UAs took extended periods to finalize approaches due to the need for collaborative planning, online referral platform decisions, building upon existing infrastructure and community efforts, limited staff capacity, and sequencing with partnership building and community engagement. Wave 2 benefited from Wave 1's learnings, taking an average of 5 months to finalize their approaches compared to Wave 1's 8 months. The time it took was not merely a delay, but often a reflection of thoughtful, equity-centered planning that laid the foundation for stronger implementation.

Throughout the program, all Unifying Agencies (UAs) and their community collaboratives were expected to plan, implement, and refine a set of approaches designed to strengthen early childhood referral pathways in their communities. On average, Wave 1 UAs took approximately 8 months to finalize their approaches, while Wave 2 UAs took approximately 5 months.

For all UAs, approach generation began prior to the start of the HMG LA Pathways initiative. UAs were required to submit project proposals with an initial set of proposed approaches that they believed would support their communities. These approaches were born from UA's self-assessment of their communities' strengths, gaps, and opportunities.

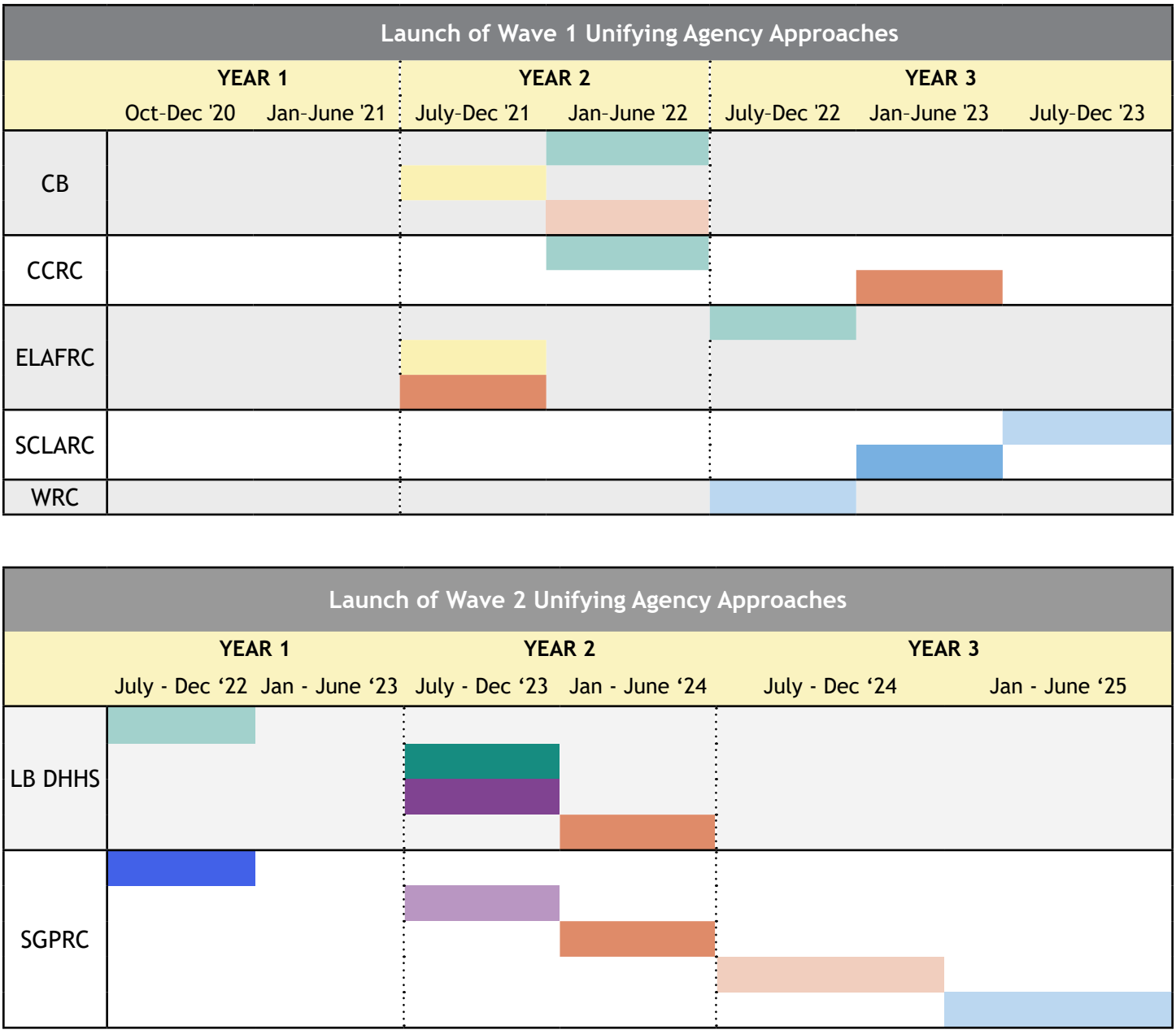
Across both Wave 1 and Wave 2, UAs experienced a range of factors that contributed to the length of time it took to confirm and finalize their Pathways approaches. While each agency's context

varied, several common themes emerged:

1. **Collaborative Planning with Partners:** All UAs emphasized the importance of engaging community partners, such as family resource centers, regional center staff, early educators, and health providers, in the selection and refinement of their Pathways approaches. Because many of these partners would be responsible for carrying out or supporting implementation, their feedback was critical to ensuring alignment and feasibility. UAs described this process of consultation, relationship-building, and consensus building as both necessary and time-intensive.
2. **Referral Platform Selection and Customization:** All UAs incorporated some form of web-based referral platform into their work, either through adopting existing systems (like Unite Us) or developing custom tools (such as agency-built portals).
    - Generally, regional centers chose to develop custom portals that could meet their agency's complex and specific needs, while non-regional centers opted to adopt an existing referral platform.
    - For UAs adopting an existing referral platform, choosing which platform to use was challenging, with primary concerns centralizing around: (1) cost and the ability to sustain use of the platform after grant funds ceased; (2) ease of use for partners and staff; (3) the ability to track closed-loop referrals; and (4) the ability to extract and analyze data.
    - For those developing a web-based referral system from scratch, the platform's ability to interact and exchange data with their other existing agency-required systems was key (e.g. SANDIS, CarelinQ).
3. **Building on Existing Infrastructure:** Rather than duplicating efforts, many UAs aimed to align their Pathways work with what already existed in their communities. This required time to map current resources, learn about partners' systems, and identify where Pathways funded approaches could fill gaps without causing duplication or confusion. For example, ELAFRC spent time with partners to level set - defining EII referrals, and clarifying each partner's existing referral processes - with the goal of developing a referral portal that both built on existing strengths and addressed local system gaps. Although this level of alignment sometimes caused delays, it ultimately led to more integrated and community-responsive strategies.
4. **Staffing Capacity and Competing Priorities:** During the early planning phases, many UAs and collaborative partners faced staff capacity constraints, turnover, and competing demands. These included COVID-19 pandemic response and recovery efforts (particularly for Wave 1, which launched months into the start of the pandemic), new agency-driven initiatives, or delayed re-openings of physical office spaces. As a result, some Pathways teams could not prioritize the project fully or hold regular planning meetings until several months into the grant period.
5. **Sequencing and Learning from Others:** Wave 2 UAs intentionally designed their planning process to begin with relationship-building and community engagement before finalizing elements of their approaches. They also took time to review their original proposals and had the privilege of learning from the experiences of the Wave 1 UAs. This strategic sequencing added time upfront but was seen as essential to ensuring the work was relevant, realistic, and well-aligned with agency and community goals.

Together, these factors highlight the importance of flexibility and responsiveness when piloting new approaches within complex, community-based systems. The time it took to finalize strategies was not simply a delay but often a reflection of thoughtful, equity-centered planning that set the UAs up for successful launch and implementation of their approaches (see figure 1).

Figure 1. Unifying Agency approach implementation timeline



Approach 1: Adopt and implement a referral platform from a third-party vendor, electronic referral platform that is accessible to families, providers, and referral partners (CB, CCRC, ELAFRC).

Approach 2: Build a web-based, electronic referral platform accessible to families, caregivers, and providers with children who may qualify for Regional Center services, including geographically specific resources and referrals for individuals not eligible for regional center services (WRC, SCLARC).

Approach 3: Build a web-based, electronic referral system component for children with moderate delays who are not eligible for Regional Center services (SCLARC).

Approach 4: Expand and strengthen partnerships with and among EII community partners serving families with young children (CB, ELAFRC).

Approach 5: Promote self-referrals to families and collect regular feedback on the current EII referral system (CB).

Approach 6: Provide educational opportunities and outreach for medical professionals and other supporting partners to increase awareness of available EII assessments and services (CCRC, ELAFRC).

Approach 7: Build an early childhood resource directory for families & providers (LB DHHS).

Approach 8: Equip a local call center to assist families with referrals to EII services (LB DHHS).

Approach 9: Enhance access to the regional center website with language and audio accessibility tools (e.g., ReciteMe web plugin) (SGPRC).

Approach 10: Use Promotoras to conduct culturally relevant community outreach and distribute early identification and intervention health information (SGPRC).

NOTE: The timeline above shows the time periods during which each of these approaches were officially launched or finalized; In most cases, however, UAs engaged in planning activities for each approach well in advance of its formal launch or finalization.

For Approach 4, all UAs were implementing partnership building activities very early in the project. The dates reflected in the timeline above show the periods during which those UAs formally expanded partnerships through MOUs, onboarded new partners to a referral platform or held a partnership-focused event.

Adopting or Developing an Online/Customized Portal

INSIGHT SUMMARY: All UAs adopted or built referral platforms. Successes included (1) stakeholder-informed design, (2) standardized workflows, (3) integration with other key EII functions, and (4) consistent data collection. Challenges included (1) staff turnover, (2) technical glitches, (3) data access issues, (4) cost to sustain, (5) limited closed-loop functionality, and (6) challenges accessing data.

Each Unifying Agency leveraged its project funding to implement and expand referral platforms or develop its own online portal. UAs fell into two categories:

1. Regional centers that leveraged software developers to create custom referral portals.
2. Non-regional center UAs that adopted existing portals, such as UniteUs, which include functions that can be used to collect patient data and track early childhood screenings and referrals. In one case, a UA that had already adopted UniteUs before the start of the project chose to focus on expanding its functionality and user base.

Successes: Successful aspects of the UAs' referral portal implementation and customization processes included:

- **Portals Were Informed by Diverse Stakeholder Input:** All UAs engaged their collaborative and supportive partners in the approach, design, and implementation of their referral portals. Additionally, several UAs conducted testing with intended users of the portal (e.g. intake staff and/or parents/caregivers).This resulted in user-friendly systems and functionality for providers, staff within the collaborative, and families.
- **Introduction of Referral Portals Standardized the UAs' Referral Processes:** Unifying agencies found that both adopted and built portals helped streamline referral processes and clarify roles and information needed from local referral partners. Their refined processes improved the timeline of submission and tracking of referrals.
- **Integration with Other Critical EII Functions**: Across both regional centers and community-based UAs, the referral platforms implemented under the Pathways initiative served as more than digital intake forms. They became access points that connected multiple elements of local EII systems. For many UAs, the referral portal functioned as the connective tissue across programs, people, and platforms.

- **Opportunity for consistent data collection:** Use of this technology also led to the collection of more complete and consistent intake data that could be aggregated and used to inform future decision-making related to the support and services available to families and their young children. Typically this data was also easier to extract afterwards for use in reports and data analysis.

INTEGRATION OF REFERRAL PORTALS WITH OTHER KEY EII FUNCTIONS

The following are examples of UAs using referral portals to support EII system building:

- At Long Beach DHHS, the UniteUs platform housed the referral form, the early childhood resource directory, and served as a core tool used by family partners operating the Resource Line. This all-in-one structure created efficiencies, sought to improve the family experience, and helped close referral loops.
- At SGPRC, the agency developed a universal self-referral form, used by both families and professionals, which was structured to feed into a new online portal capable of accepting medical and educational documentation, reducing duplication and easing the burden on families. In addition, it was hypothesized that such integration would improve internal workflows, and enhance communication with referring providers.
- At CB, the UniteUs platform was customized to better capture developmental screening data, when the collaborative found that while many screenings were taking place, only a small percentage of children screened resulted in an assessment score that required a referral for additional services. This led to ongoing discussions among the collaborative about the support that they could provide to families that do not qualify for intensive services through their local regional center and other entities.

Challenges: Challenging aspects of the UAs' referral portal development and adoption process included:

- **Staff Turnover Resulting in Portal Retraining:** UAs reported that internally and among partners, staff turnover and inconsistent usage of the new portal in early stages of implementation necessitated frequent retrainings for those slated to use the portal. They also experienced challenges with staff turnover at the vendors, such as UniteUs and OneDegree, which caused UAs to feel like they were starting over in building relationships, selecting a platform, and learning about implementation.
- **Technical Mishaps and Glitches:** All UAs reported various technical glitches and setbacks that led to delays in implementing their portals. Regional centers reported challenges in creating data bridges between various software platforms (e.g., SANDIS, CASPIO) and their new intake/referral portals. Once bridges were established, updates to existing software platforms resulted in temporary user challenges. (Note: This was expected and was a key reason for the three-year project period, as F5LA anticipated that UAs would need ample time for implementation due to the nature of testing approaches/new technologies.)
- **Lack of Initial Buy-in from Users**: Some UAs found it challenging to gain buy-in from internal users, such as their intake departments, due to resistance to changes to their established workflows. UAs also navigated slow uptake and adoption among their partners. Two UAs reported challenges with securing required data sharing agreements in the early stages of

their portal adoption processes, which affected momentum. There were also reports that, although providers initially requested a shared platform, some were reluctant to adopt a new system due to competing internal workflows and agency-specific requirements. Despite these challenges, many UAs reported that 1:1 meetings with their partners, discussions during collaborative-wide meetings, and technical assistance sessions supported a significant increase in portal usage, and led to excitement and appreciation for the new referral workflows by the end of the project period.

- **Closed Loop Referral Challenges Resulted in Shifts in Platform Adoption and Expectations:** UAs adopting existing platforms (e.g., UniteUS and OneDegree) reported an inability to track closed-loop referrals. For example, ELAFRC initially pursued the OneDegree platform due to its alignment with the intended HMG LA Centralized Access Point platform[6], but found that closed-loop referral functionality was cost-prohibitive and unsustainable. As a result, they pivoted to enhancing their existing Salesforce system to support similar functions and lay the groundwork for future closed-loop referral capabilities.
- **Accessing data:** UAs who adopted referral platforms from third-party vendors initially had trouble accessing and using the data collected through their adopted platforms. For example, one UA manually entered data retroactively in UniteUs because they were not able to leverage the platform for data collection as referrals took place, while another UA reported being unable to access disaggregated data in UniteUs because of the cost of upgrading to access that data. Over time, UAs had more success accessing data, but experienced ongoing challenges in this area.

Each UA leveraged its project funding to implement and expand referral platforms or develop its own online portal. Despite the challenges listed above, the UAs reported that the investment in innovative technology improved their local early identification and intervention referral processes. The UAs, their collaborative partners, and community members, including families, felt the impact of these improvements.

6 Note: While LAC DPH intended to use OneDegree for the Centralized Access Point during the beginning stages of the Pathways Project, they later decided not to use an online referral platform, and instead to focus on providing resources and support through a centralized call line.

Data Collection and Submission

INSIGHT SUMMARY: Most UAs capacity for data collection and evaluation was limited, but improved over time through technical assistance supports.

Unifying Agencies were required to collect data to measure the implementation and outcomes of each of their approaches. The data collected throughout the project was used to help the UAs understand if their approaches were being implemented as intended, illuminate the barriers impeding progress, and identify needed refinements to their approaches and accompanying activities.

Data collection challenges, successes, and lessons emerged throughout the project lifecycle through the use of parent satisfaction surveys, submission of evaluation data, and use of data from the referral portals developed by UAs (see the Adopting or Developing an Online/Customized Portals section above). These efforts often stretched UA capacity, as all agencies reported limitations in both available time and evaluation expertise. Over the course of the project, UAs shared the following experiences:

Wave 1 UAs:

- One UA had internal evaluation expertise, but the Pathways project team had limited data experience.
- One regional center noted they were unfamiliar with grant-related data reporting, given their state funding model.
- Another UA expected partner support but had to rely on an internal staff member with limited experience.

Wave 2 UAs:

- One UA addressed gaps by hiring external consultants for evaluation support.
- Wave 2 UAs shared that receiving data tools two months in advance of data submission deadlines improved readiness for data submission.
- UAs felt their staff capacity and data fluency improved between Cycle 1 and Cycle 2 data submissions.
- Technical assistance support helped UAs add open-ended questions to parent satisfaction surveys, offering more nuanced insights.

Despite initial data collection challenges, throughout the project, the UAs' capacity for data collection and reporting was strengthened through modified strategies and ongoing technical assistance.

Metric	Wave 1	Wave 2
Number of families/caregivers surveyed on service access	4x increase from Cycle 1 to Cycle 2 (58 → 306 families)	16x increase from Baseline to Cycle 2 (18 → 305 families)
Number of families/caregivers surveyed on satisfaction with the referral process	121% increase from Cycle 1 to Cycle 2 (161 → 356 families)	1,594% increase from Baseline to Cycle 2 (18 → 305 families)
Number of children for whom age at referral was recorded	135% increase from Cycle 1 to Cycle 2 (2,800 → 6,577 children)	3% increase from Baseline to Cycle 2 (2,244 → 2,312 children)

Community Engagement

INSIGHT SUMMARY: UAs used mechanisms such as surveys and journey mapping to capture family insights and surface experiences of families navigating the EII system in Los Angeles County. In addition, place-based community events were leveraged to create real-time opportunities for EII screening and referrals. Success across community engagement efforts required strong outreach infrastructure, partner participation and effective timing.

UAs were expected to engage their local communities and families in an effort to support equitable planning and implementation efforts. Community members' lived experiences and insights, including from families of young children and system stakeholders, were celebrated as key to refining and strengthening the systems designed to support them. As a result, through various activities, UAs tested assumptions about family experiences and leveraged the insights of parents, families, and system stakeholders to strengthen their Pathways approaches.

Family Journey Maps: To better understand how families navigate EII systems, some UAs engaged in a process called family journey mapping. This approach uses in-depth interviews to document families' real-world experiences accessing services. The result is a visual or narrative map that outlines:

1. Key steps families took to access services,
2. Moments where things went well or broke down, and
3. How the process made parents and caregivers feel.

As a result, journey maps helped UAs test assumptions, validate known challenges, and identify new insights about system navigation from the family perspective. UAs that participated in the mapping process reported the following experiences:

- The process surfaced both barriers and bright spots in the EII system.
- UAs found value in comparing common themes and unique experiences across families.
- Individual family stories sparked new ideas for improving referral pathways.
- One UA engaged over 40 families through a months-long process and worked with partners to build trust and interest in participation.
- Journey mapping confirmed known challenges, particularly around interactions with medical providers, and shed light on areas requiring improvement. As a result, UAs identified a need for clearer communication with medical partners and stronger tools to support them in engaging with families.

Although all UAs expressed interest in conducting family journey mapping, four were unable to do so, in part due to capacity limitations. Even though the number of UAs participating in journey mapping was limited, all UAs engaged in some form of community engagement to capture community voice with the goal of strengthening the EII system.

Feedback Surveys: All UAs used surveys to gather satisfaction rates and experiences from parents and caregivers who were navigating the EII system with their young children. While this input was essential for equitable planning and implementation, UAs noted that meaningful community engagement through surveys required time, coordination, and staff capacity to support outreach, communication, and data collection.

Initially, when UAs first launched their parent satisfaction surveys, they found that response rates to the surveys were often low; however, after investing significant time and resources into their survey, UAs found success through a number of new strategies:

Unifying Agency Community Engagement	
Initial Challenges	**Successful Strategies**
• Using manually disseminated paper surveys that required time-consuming data entry after submission and often were not returned. • Families experienced survey fatigue and had limited time to respond. • Timing issues affected response rates—some surveys were sent too late after services, reducing relevance and responses.	• Integrating survey distribution into the service workflow (e.g., immediately after eligibility assessments). For example, CB and thier partners developed three surveys delivered at key timepoints: post-screening, post-referral, and post-service. • Dedicated staff followed up via email, reminders, and phone calls. • Incentives (e.g., gift cards) were offered to encourage participation.

Place-based Community Engagement Events: Several UAs used community events and workshops as hands-on opportunities to promote early developmental screening and connect families to services in real time. These gatherings went beyond awareness-building; they often created direct, trusted access points to the EII system.

In Long Beach, LB DHHS hosted on-site screenings and facilitated immediate referrals at high-visibility events like Celebration of the Young Child and Day of the Child. They also partnered with the public library to hold five parent workshops that supported navigation and built caregiver confidence. ELAFRC blended outreach, education, and screening at events like Holiday Breakfast and Playday in the Park, using interactive activities to introduce the ASQ developmental screening tool and normalize developmental conversations. SGPRC, through its promotora model, conducted outreach at 120 events, distributing multilingual and multicultural materials, and offering personalized guidance.

Across these examples, UAs demonstrated that direct, relational engagement, especially when paired with hands-on learning and trusted messengers, can effectively bring clarity to the referral process, build caregiver confidence, and support timely access to services.

Engagement Through Social Media & Marketing: In addition to reaching community through the feedback mechanisms described above, UAs used social media and email communication to engage with families and their local communities. One UA shared information about HMG LA via email blasts and social media on an ongoing basis. They also encouraged partners to share information using their social media accounts and/or printed flyers that could be distributed to families. Another UA used social media to manage an informational campaign about early developmental milestones and early intervention. They used messages produced for the HMG LA launch to inform the community about Help Me Grow. This UA's local family resource center also used Bright By Text to engage families with children ages 0-8 with easy-to-understand positive messaging about early childhood development.

CENTERING FAMILY VOICE IN SYSTEM DESIGN

UAs emphasized the importance of integrating family voice into their systems-building work. For example, ELAFRC engaged parents directly in workgroups, including in efforts to disseminate surveys and collect feedback from other families. This approach helped ensure that families were not just passive recipients of services but active contributors to system improvement. SGPRC also reflected on its community outreach and engagement as a core strategy that helped raise awareness and responsiveness to families' needs.

Partnership Building

INSIGHT SUMMARY: Strong cross-sector partnerships spanning community organizations, medical providers, regional centers, and school districts were foundational to the success of the Pathways project. All UAs expanded cross-sector partnerships and leveraged these collaborations to co-implement activities, strengthen referral pathways, and expand reach. While challenges in engaging medical providers and school districts were common, UAs found success through the development of formal agreements, clear expectations, and audience specific strategies.

Each UA worked closely with a network of community partners throughout this project to select, implement, and refine innovative approaches. To support this collaboration, UAs were also offered TA to identify partner needs, develop partnership strategies, and build and maintain partnerships to strengthen local referral pathways.

At the conclusion of the project, all UAs cited successful partnerships as key to refining and executing their Pathways approaches, as well as to data collection, learning, and quality improvement. UAs often relied on their collaborative partners to implement project-related activities, such as distributing parent surveys, submitting de-identified patient referral data, testing referral portals, and building knowledge and capacity related to EII in the community. Furthermore, UAs shared that building partnerships through Pathways created a ripple effect, each new relationship opened doors to additional connections, enabling them to engage more community partners and deepen their networks.

Prioritizing Partnerships From the Start: At the project's outset, all UAs expressed a desire to collaborate and form partnerships with medical clinics, early learning and care providers, and school districts; and throughout the project UAs were actively strengthening existing relationships and exploring new ones.

In addition, UAs in the Pathways project built on prior efforts to advance ongoing cross-sector collaboration. For example, ELAFRC, as the lead of its local interagency coordinating area (LICA), used Pathways to expand its governance model, adding subcommittees and engaging parents in decision-making.

Engaging Medical Professionals: Most UAs noted that engaging with the medical community is critical in local EII systems, for several reasons. Medical providers are often the first resource parents reach out to if they are concerned about their child's development, and are the primary source of developmental screenings. They are also positioned to connect children with the services they need to thrive if a need is identified. As a result, the UAs found an ongoing need to strengthen understanding of early childhood development, resources and screening protocols, and partnerships with local medical providers and clinics.

UNIFYING AGENCY SPOTLIGHTS - ENGAGING MEDICAL PROVIDERS

The following are examples of UAs that engaged medical providers in meaningful ways:

- CCRC successfully built partnerships with medical providers but found the process to be lengthy and complex, taking 6-8 months to onboard providers to the UniteUs referral platform. Challenges included coordinating across multiple clinic locations, onboarding staff individually, and navigating data-sharing and security requirements. Despite these hurdles, CCRC made meaningful progress by developing customized digital communications kits using materials from Help Me Grow National and First 5 LA, sharing promotional tools with providers, and investing in relationship-building with clinic staff and leadership.
- SGPRC focused on strengthening outreach and networking with medical providers, including local NICUs and a mental health services organization. These efforts led to improved referral processes and increased awareness of available supports. Looking ahead, SGPRC plans to build on this momentum by distributing informational flyers in medical office waiting rooms to connect more families with their services.

Engaging Regional Centers: UAs found that building strong partnerships with regional centers was critical, due to the central role of regional centers in providing services to young children, particularly at ages 0-36 months old. During CCRC's partnership building efforts, they faced hurdles in connecting with different regional centers, each with different processes for intake and consent. They stressed that each regional center is a separate entity requiring specific approaches to building and strengthening relationships. LB DHHS found success working with Harbor Regional Center to host and facilitate a child development training and also supported the Regional Center to build a relationship with Isabel Patterson Child Development Center to support increased access to developmental care.

Engaging School Districts: UAs and their collaboratives also noted the importance of building partnerships with school districts, which provide services to children ages 3 years old and up. Yet, they faced challenges making inroads with school districts for this project. For example, CB made efforts to engage with the Los Angeles Unified School District and hoped that strengthening that partnership would help them to build trust with other partners; however, they struggled with LAUSD's inconsistent participation in the collaborative.

Leveraging Funding and Formal Agreements to Support Commitment: Commitment and buy-in were further strengthened for UAs that decided to fund collaborative partners to complete activities. Even small amounts of funding helped support more consistent participation and stronger relationship-building among partners.

Some UAs also used formal structures like partnership agreements, memorandums of understanding (MOUs), and data share agreements to establish expectations for the duration of the project. While UAs found MOUs helpful, one UA noted that in the future, they will use stronger language and set clearer expectations to increase commitment from their partners.

In addition to the above efforts, UAs also strengthened partnerships by attending events that partners hosted and led, allowing them to show support for their partners and engage with critical community agencies.

Technical Assistance

INSIGHT SUMMARY: Technical assistance (TA) was key for UAs' implementation of many project components, including onboarding to new online referral platforms, data collection and participation in continuous quality improvement processes, community engagement, and partnership building. UAs especially valued tailored support, practical tools like templates, and the flexibility to adapt TA to their context and capacity.

UAs benefited from technical assistance in the following core areas:

Referral Platform Implementation: In Wave 1, UAs implementing online referral portals received hands-on onboarding support from portal developers.

- CCRC and CB credited the training and ongoing troubleshooting from UniteUs customer service managers as key to success.
- Weekly meetings with UniteUs technical support allowed CCRC to resolve issues in real time and improve partner adoption.
- A series of structured trainings facilitated by UniteUs and access to capacity-building materials helped build internal and partner confidence in using the platforms.

Resource and Referral Mapping: UAs shared data that was used by VIVA to build interactive referral network maps using the Kumu platform. These maps helped:

- Visualize referral pathways and network strength
- Identify gaps and underrepresented partner types
- Inform outreach efforts and strategic partnerships to pursue
- Spark internal conversations about system improvements

VIVA supported this effort by offering tools such as partner survey templates to collect meaningful feedback and input from their referral partners.

Data Collection and Continuous Quality Improvement: VIVA supported all UAs in their data collection and continuous quality improvement efforts by offering flexible and responsive technical assistance.

- Multiple data submission options were offered (e.g., raw files or standardized templates) to accommodate varying levels of data capacity across UAs
- Tools provided included sample referral portal data exports, user-friendly templates, and annual data submission guidance materials.
- One-on-one support sessions clarified expectations and reduced reporting burdens, ensuring accurate, consistent submissions.

These strategies helped streamline the UAs data submission process and support consistency and accuracy in the data submitted over the course of the project.

Community Engagement and Strategic Planning: VIVA also supported UAs with their community engagement objectives.

- ELAFRC and LB DHHS participated in TA trainings to support their ability to identify local events to increase awareness of community resources offered by their collaboratives.

- SGPRC received meeting facilitation tools to help guide partner meetings focused on identifying opportunities to better leverage staff and funding assets in support of their Pathways work.
- Most UAs participated in community engagement best practices training where they learned different approaches for ongoing community and family engagement, assessed their current practices and determined supports needed in order to achieve their desired future state of engagement with community.

These efforts deepened local knowledge of EII and created stronger connections between services and families.

WHAT UNIFYING AGENCIES VALUED MOST IN TA

UAs appreciated the structured check-ins and intentional lines of questioning provided during TA sessions, which created valuable space for reflection beyond their day-to-day responsibilities. These sessions encouraged UAs to think strategically about their long-term goals and provided opportunities to recognize milestones and accomplishments that might have otherwise gone unnoticed. UAs expressed appreciation for the TA provider's flexible approach to deliverable timelines, which was especially helpful as they navigated competing priorities. This flexibility was paired with consistent communication, creating a supportive and responsive working relationship. Additionally, the advance scheduling of meetings and trainings helped UAs plan ahead and align TA activities with their existing workflows.

Outcome Findings

This section provides an overview of findings related to the desired outcomes of the Pathways project. The following outcomes were determined by F5LA as part of the project development and initiation process:

1. Improved communication and tracking on referral status between referring agency and referral source
2. Reduction in wait times between screening and assessment, and between assessment and prevention or intervention services
3. Decrease in the age at which children are referred to services and begin services
4. Increase in access to EII services and supports[7]
5. Increase in parent/caregiver satisfaction with referral process and linkage to services

For each of the above outcomes, except 2. *Reduction in wait times between screening and assessment, and between assessment and prevention or intervention services,* VIVA, F5LA, and the UAs aligned on *core indicators,* for which each UA agreed to collect and report data. For Outcome 2, it was not possible to align on a core indicator for all UAs due to challenges in collecting wait time data. See Appendix 2 for the complete list of core indicators.

The following findings should be considered *preliminary*, as data collection processes and data quality were actively developed and strengthened throughout the project, and therefore were inconsistent over time and across agencies.[8] For that reason, additional evaluation efforts are required to further assess the ongoing impacts of the Pathways project. Additionally, differences in data strategies and referral volume across UAs means that some communities have a stronger representation in the findings below than others.

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7 The original language for Outcome 4 was "Increase in successful referrals (i.e. referrals appropriate based on screening results and families followed through on referrals) on first attempt." However, the core indicator that all Wave 1 UAs, First 5 and VIVA aligned on captures access to EII services, rather than the number of successful referrals. For that reason, the outcome language was updated in this report.

8 **Note:** The quantitative data used in this report came from the following data sources: (1) Collaborative Partner Surveys; (2) Meeting observations; (3) Administrative Data; (4) Parent/Caregiver Surveys. For all collaborative partner and parent/caregiver surveys, VIVA provided sample survey questions and resources for survey development and dissemination. However, surveys, questions, and dissemination approaches were not uniform across UAs. Wave 1 and Wave 2 UAs were evaluated in different timeframes and contexts. To avoid the risk of generating misleading results, the data from the two waves is not combined. Instead, findings are presented separately, with shared themes highlighted.

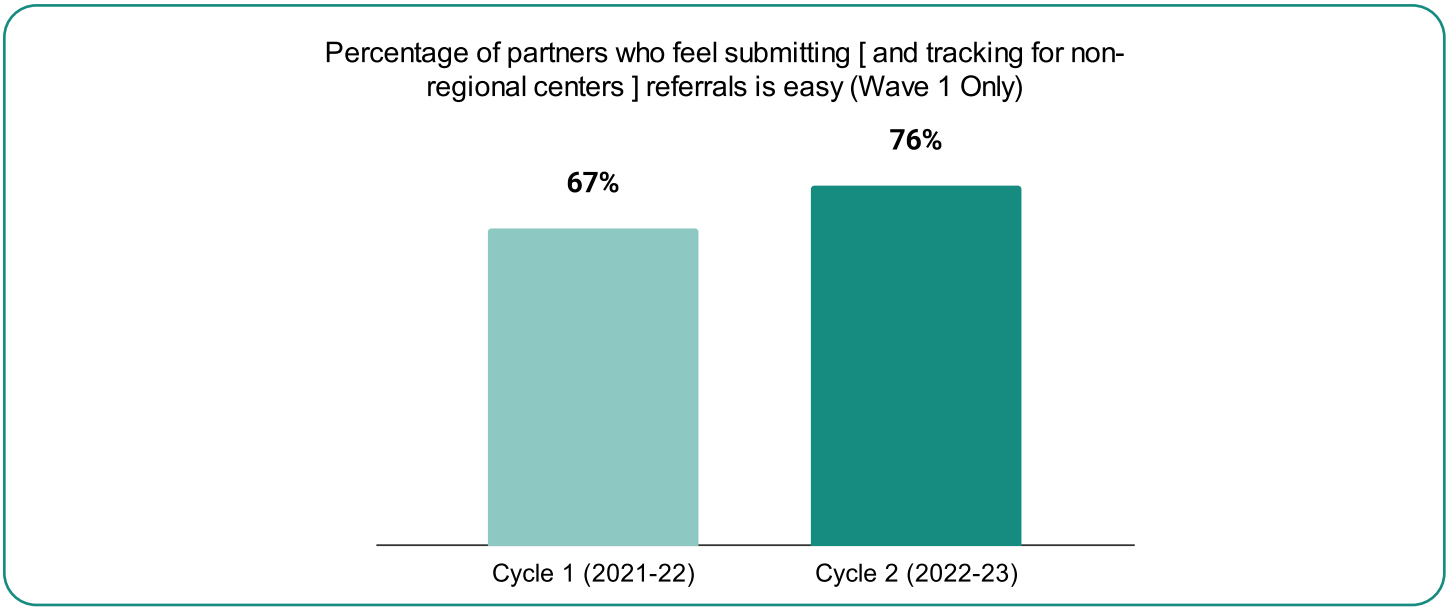
Outcome 1: Improved communication & tracking on referral status between referring agency and referral source

INSIGHT SUMMARY: Partner referral portal usage and ease of use increased over time throughout participation in the Pathways initiative.

Wave 1 Findings

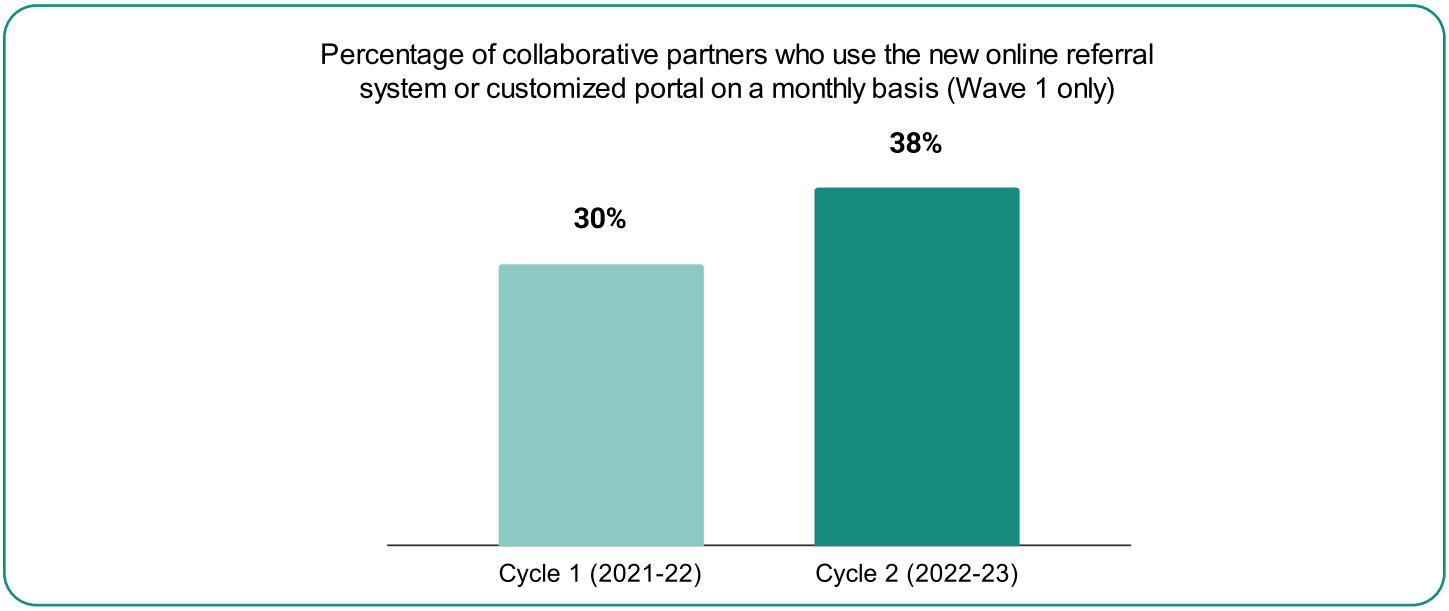
From Cycle 1 to Cycle 2, the percentage of collaborative partners who used the new online referral system or customized portal on a monthly basis **increased by 8 percentage points.**[9]

Over the same period, the percentage of partners who felt submitting and tracking referrals is easy **increased by 9 percentage points.**



N = 40 partners for Cycle 1; N = 34 partners for Cycle 2

9 Data Source: Collaborative partner surveys/polls for all 5 UAs in Cycle 1 and 4 out of 5 UAs in Cycle 2. In Cycle 2, one UA's data source was email communication and discussions during collaborative partner meetings. Data was shared with VIVA via data template for some agencies and raw survey data for some; Total N = 40 for Cycle 1; 34 for Cycle 2.



N = 12 partners for Cycle 1; N = 30 partners for Cycle 2

STRENGTHENING CROSS-SECTOR COLLABORATION

Several UAs pointed to enhanced collaboration and relationship-building as a defining outcome of their Pathways participation. Children's Bureau emphasized the importance of the strong relationships it built with partner agencies, noting that maintaining open communication and having a shared North Star helped ground the work and move it forward collectively. CCRC described how their work under Pathways helped de-silo internal operations and foster more intentional collaboration across departments and with external partners. Regular meetings and partner engagement were essential to sustaining these connections. ELAFRC also used the project to deepen relationships with community partners by developing a referral-focused community of practice and by integrating this work into broader agency initiatives, which supported long-term sustainability.

Wave 2 Findings:

From Baseline to Cycle 2, the percentage of collaborative partners who used the new online referral system or customized portal on a monthly basis **increased by 18 percentage points.**[10]

Over the same period, the percentage of partners who felt submitting and tracking referrals is easy **remained at 100%.**[11] Further, the percentage of LB DHHS partners who were satisfied with using the online referral system to submit and track non-regional center referrals during Cycle 2 was 100%, surpassing their target of 75%.[12]

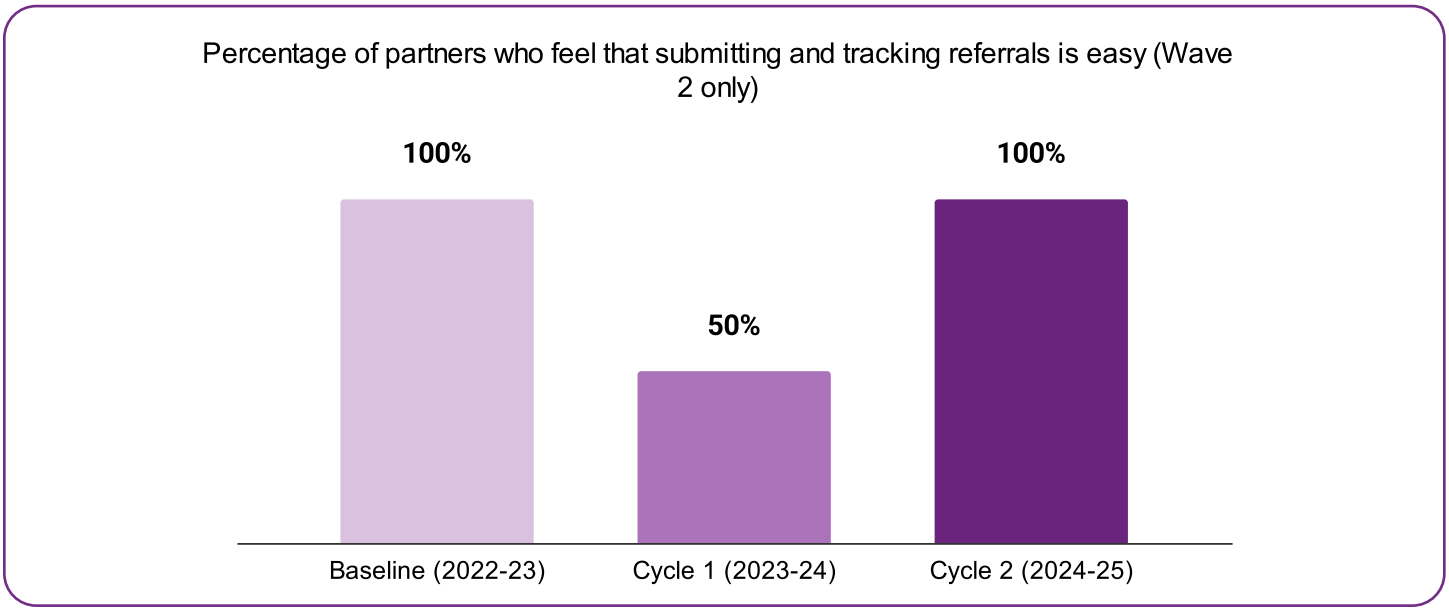
For Wave 2 UAs, this data only reflects the outcomes for LB DHHS as SGPRC did not launch their

10 Data Source: Collaborative partner survey administered by LB DHHS; Total N= 9 for Baseline, 16 for Cycle 1, 7 for Cycle 2.

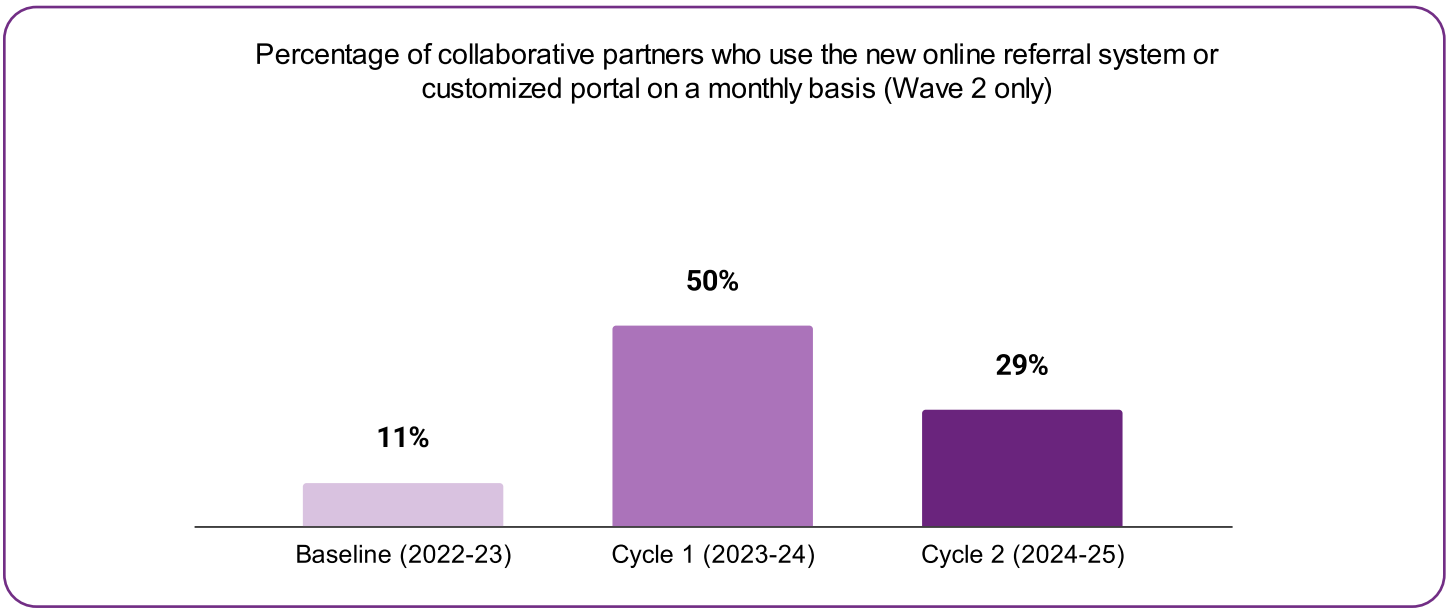
11 Data Source: Collaborative partner survey administered by LB DHHS; Total N= 1 for Baseline, 8 for Cycle 1, 2 for Cycle 2.

12 Data Source: Long Beach Department of Health and Human Services Report from April 1, 2024 - March 30, 2025. N = 2.

online portal during the evaluation period. It is important to note that the online referral system usage as well as the experience using the system fluctuated throughout the evaluation period. There was an increase to 50% of partners using the UniteUs system and a dip to 50% of partners feeling that submitting and tracking referrals is easy during Cycle 1.



N = 9 partners for Baseline; N= 16 for Cycle 1; N= 7 for Cycle 2



N= 1 partners for Baseline; N= 8 for Cycle 1; N= 2 for Cycle 2

LEVERAGING TECHNOLOGY TO IMPROVE REFERRAL PROCESSES

UAs pointed to the successful design and launch of digital referral portals as key outcomes of their participation in the Pathways Initiative. For example, WRC developed a comprehensive portal that allows families and providers to submit applications, share documents, and connect with the Westside Family Resource and Empowerment Center. This system has streamlined the intake process and saved families time due to the inclusion of user-friendly design features. The success of the portal was made possible by strong collaboration with both community partners and internal intake teams, who played a hands-on role in shaping the system and adapting workflows.

South Central Los Angeles Regional Center (SCLARC) took a collaborative approach to designing, testing and piloting their portal, ensuring it was accessible to their predominantly Spanish-speaking community. By incorporating feedback from local partners and understanding the needs of both intake staff and leadership, they were able to build a system that increased access and lowered barriers for families. Meanwhile, CCRC piloted a new technology platform across its agency, which not only supported EII referrals but also aimed to strengthen connections between subsidized child care and developmental services. In each case, dedicated funding and shared commitment among partners were cited as critical enablers of success.

Outcome 2: Reduction in wait times between screening and assessment, and between assessment and prevention or intervention services

INSIGHT SUMMARY: Some UAs tracked referral wait times and turnaround times between when a referral was made and when it was received or closed. However, not all UAs tracked this outcome, and those who did assessed wait time in a variety of ways.

Wave 1 Findings:

While there were no core indicators associated with this outcome, two UAs elected to report on indicators related to this outcome to support their continuous quality improvement.

Wait times for regional center services: For ELAFRC, in Cycle 2, the regional center in their community (Eastern Los Angeles Regional Center) initiated services within 45 days of parent(s) signing the Individualized Family Service Plan (IFSP) for 84% of 2,147 eligible children.[13]

Partner collaboration: For CB, in both Cycle 1 and 2, all 4 collaborative partners engaged in data analysis and recommendations to reduce the amount of time it takes for children to be screened and connected to prevention and intervention services.[14] CB shared that this was possible due to consistent participation in collaborative partner meetings, which resulted in ongoing information sharing. In particular, it was important for their local regional center (Lanterman Regional Center) to be at the table as a key partner.

Wave 2 Findings:

Referral Confirmations: For SGPRC, in Cycle 2, the average number of days between sending an outbound referral and receiving a confirmation of referral from partners using an online portal was 2.5 days, surpassing their target of 10-20 days.[15]

Referral Closures: For LB DHHS, the average number of days between referral creation and closure decreased from 5.1 in Cycle 1 to 4.6 in Cycle 2.[16]

13 Data Source: Eastern Los Angeles Regional Center Early Start Report for October 1, 2022 - September 30, 2023. Submitted via data collection template.

14 Data Source: Children's Bureau observations during collaborative partner meetings. Submitted via data collection template.

15 Data Source: San Gabriel Regional Center April 1, 2024 - March 30, 2025. Submitted via data collection template. N = 1682

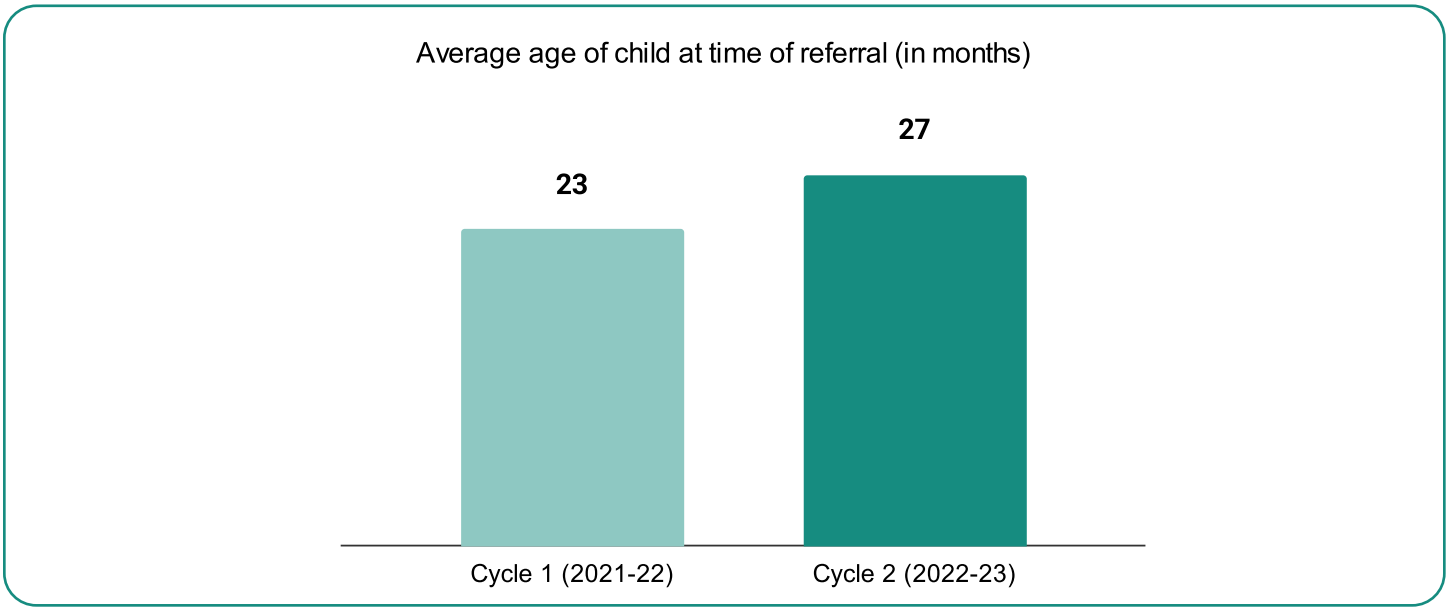
16 Data Source: Long Beach Department of Health and Human Services Report from April 1, 2024 - March 30, 2025. N = 20

Outcome 3: Decrease in the age at which children are referred to services and begin services

INSIGHT SUMMARY: Wave 2 UAs saw a 4-month reduction in average age at time of referral from Baseline to Cycle 2. Across all UAs, disparities remained by race and gender. Boys were referred later than girls, on average, for both waves. Black/African American and American Indian/Alaska Native children for Wave 1 and Latino, Filipino, and Asian children for Wave 2, were referred later than other racial groups.

Wave 1 Findings

From Cycle 1 to Cycle 2, the average age of child at the time of referral increased by 4 months, on average, across all UAs.[17]



N = 2,800 for Cycle 1; N = 6,588 for Cycle 2

However, it is important to note that the total number of children included in the sample increased 135% during this time, from 2,800 to 6,577 children. Additionally, each UA captured this data differently. For example, regional centers included children referred through the Early Start program, excluding any children over the age of 36 months. Other UAs included any children referred to their agency for Early Identification and Intervention-related purposes.

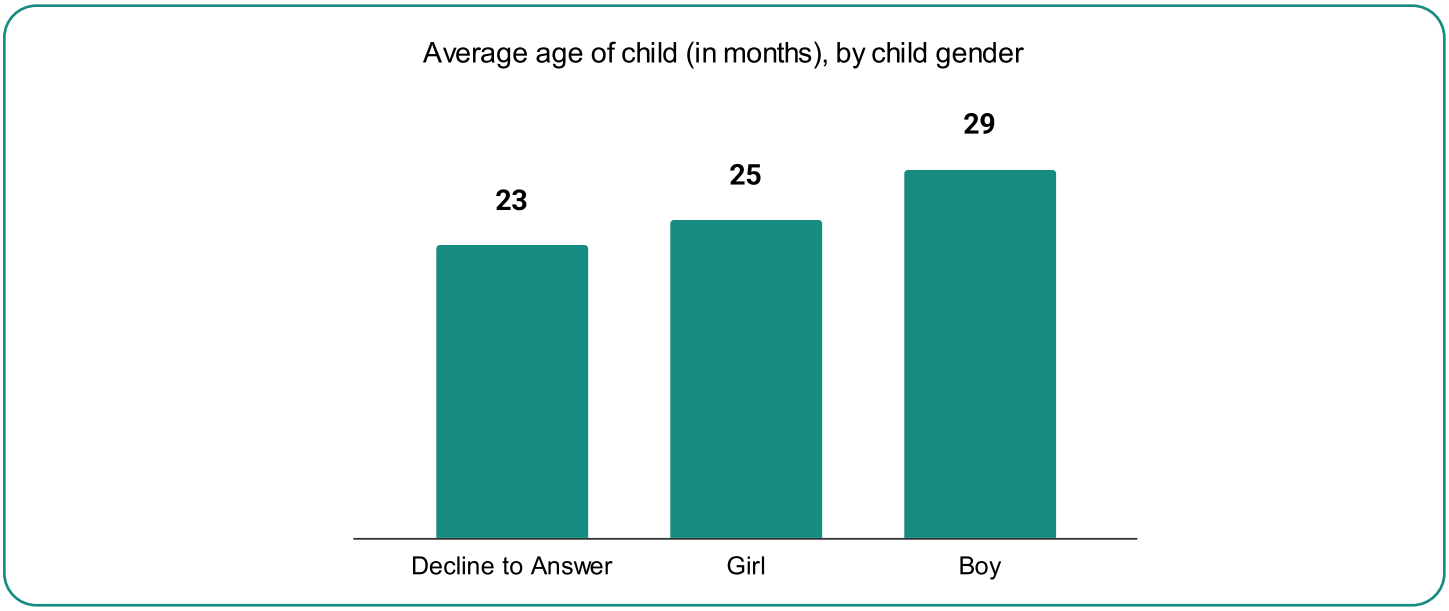
For the above reasons, insights are limited regarding change over time between Cycle 1 and Cycle 2. In addition, any comparisons between UAs/communities are unreliable given the differences in data collection process and parameters. However, the following charts show average age by

17 Data Source: Administrative data from 5 UAs for Cycle 1 and 4 UAs for Cycle 2; Total N = 2,800 for Cycle ; 6,588 for Cycle 2.

Note: Administrative data collection processes and parameters for inclusion differed from agency to agency. UAs determined parameters for inclusion (age range, programs, types of referrals, etc.) based on the most helpful information for their collaborative's learning and growth.

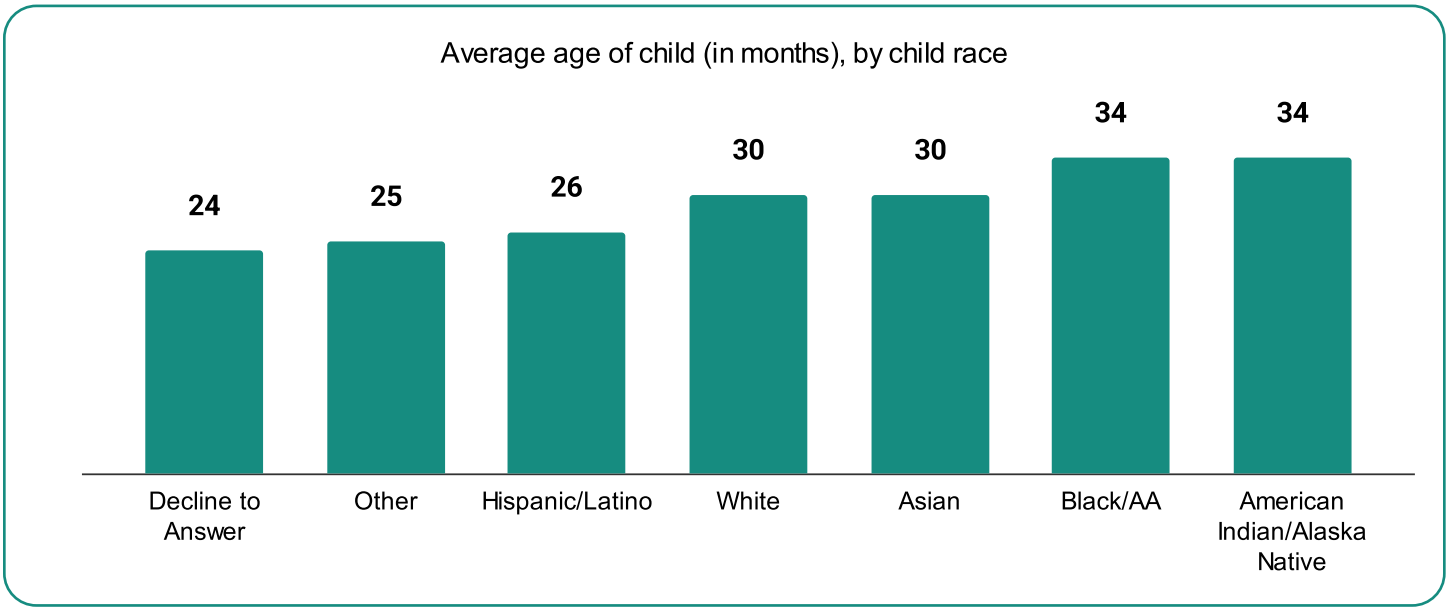
demographic categories in Cycle 2, allowing for analysis of this outcome by child gender, race, and home language.

On average, boys were 4 months older than girls at the time of referral.



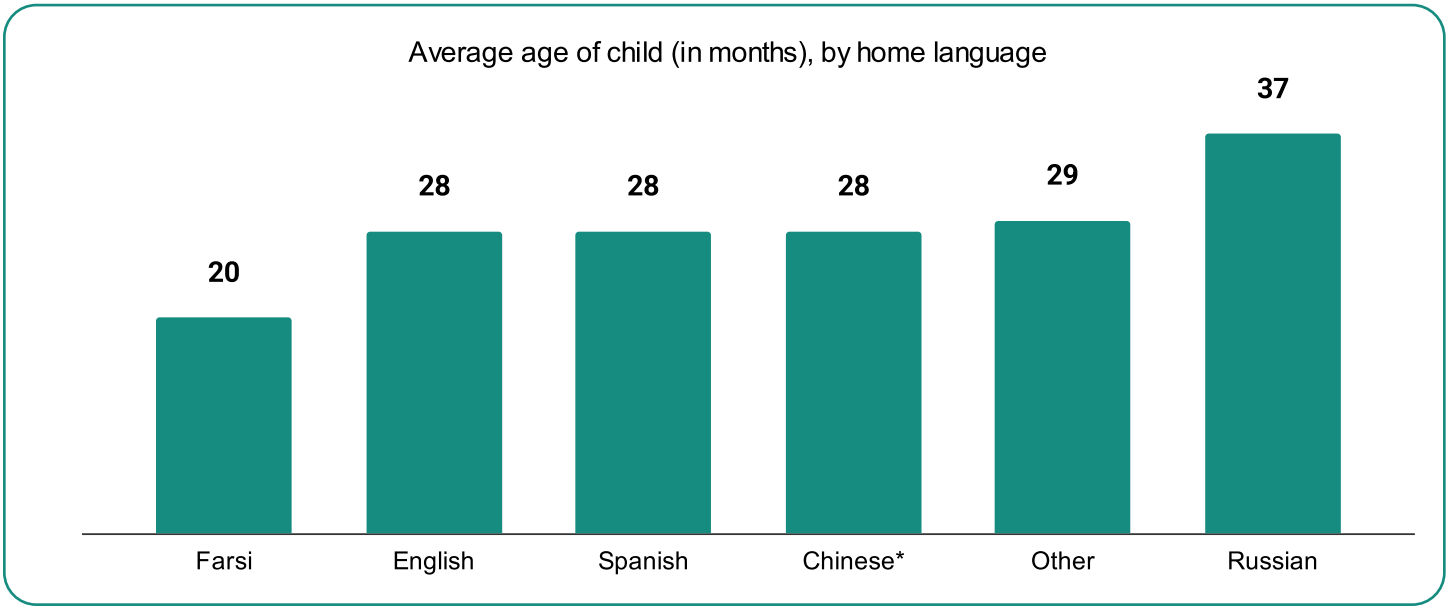
N = 37 Decline to Answer, 2,351 Girls, 4,187 Boys; Cycle 2 (October 1, 2022 - September 30, 2023) only

Black/African American and American Indian/Alaska Native children were the oldest at the time of referral, each with an average age of 34 months. Hispanic/Latino children and those who identified as Other race were the youngest at the time of referral (aside from those who declined to provide race data), with average ages of 26 and 25 months, respectively.



N = 94 Decline to Answer; 733 Other; 3,853 Hispanic/Latino; 709 White; 210 Asian; 931 Black/African American; 11 American Indian/Alaska Native. Chart only includes demographic categories for which there were 10+ children. Cycle 2 (October 1, 2022 - September 30, 2023) only.

The average age at time of referral was highest for children in homes where Russian is the home language (37 months), followed by Other languages (29 months), and English, Spanish, and Chinese, including Cantonese and Mandarin (28 months each). The average age was lowest in homes where Farsi is the home language (20 months).

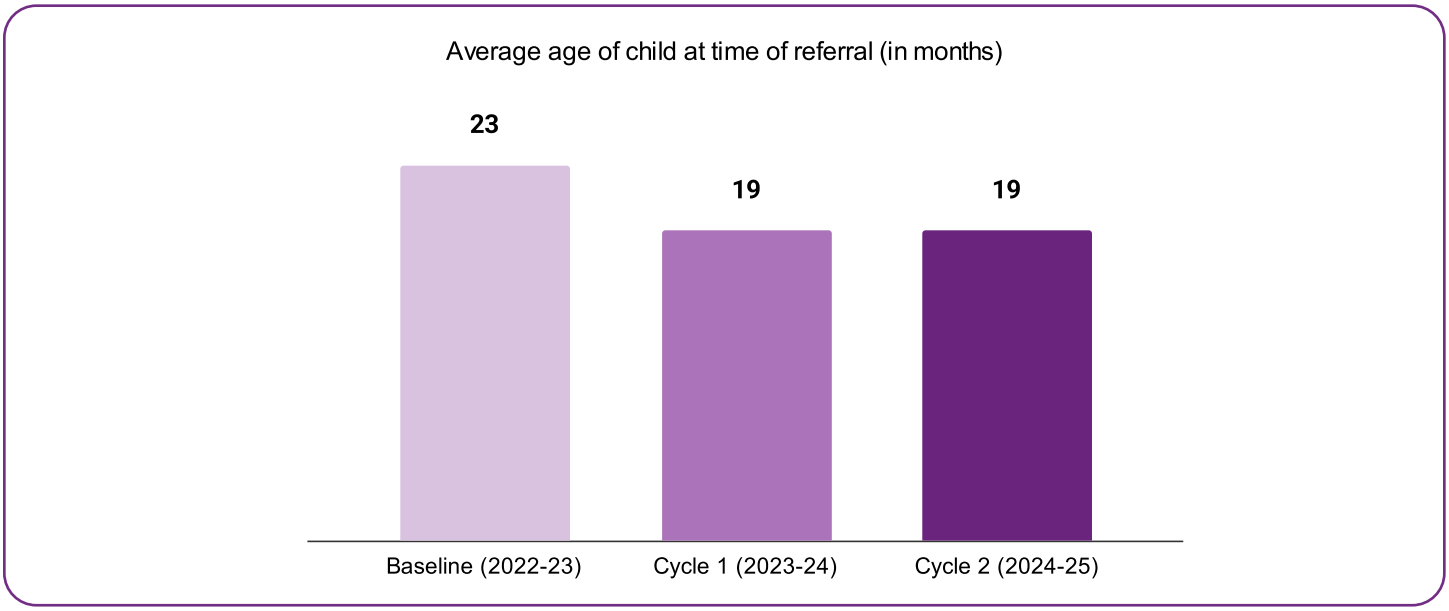


N = 17 Farsi; 4,914 for English; 1,398 Spanish; 41 Chinese; 74 Other; 13 Russian. Chart only includes demographic categories for which there were 10+ children. Cycle 2 (October 1, 2022 - September 30, 2023) only.*

**includes Cantonese and Mandarin*

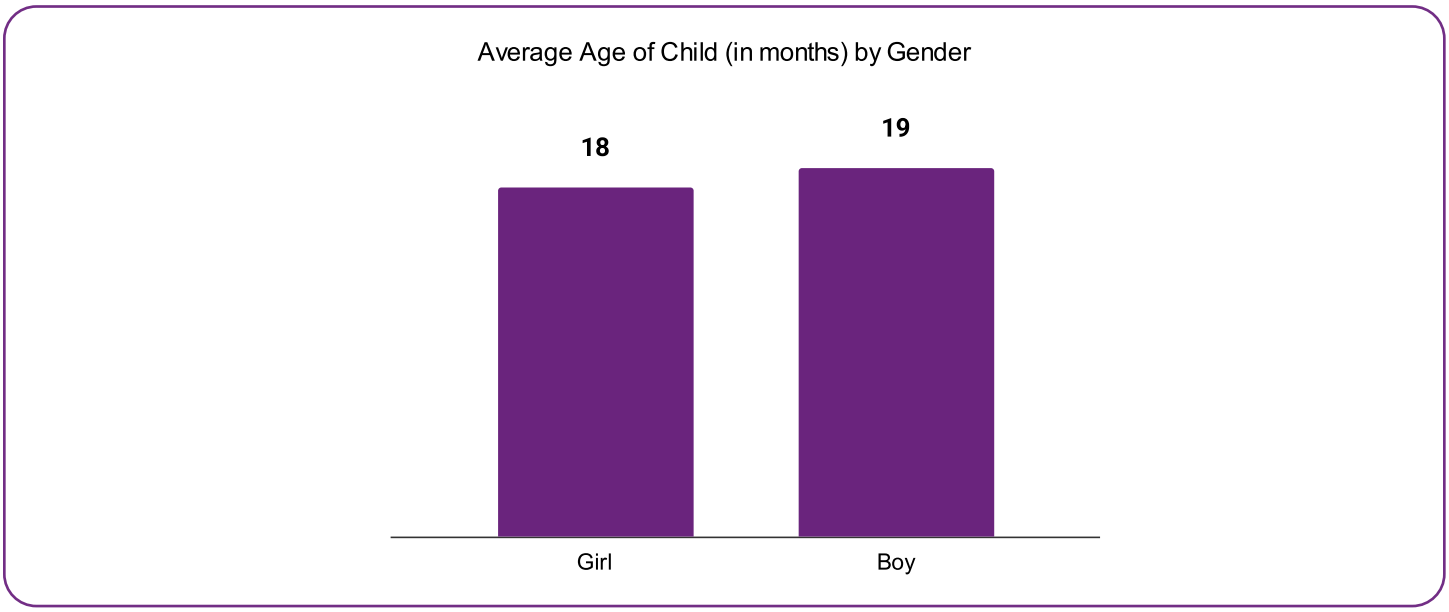
Wave 2 Findings:

From Baseline to Cycle 2, the average age of child at the time of referral decreased by four months across UAs.[18]



N = 2,244 for Baseline; 2,412 for Cycle 1; 2,312 for Cycle 2

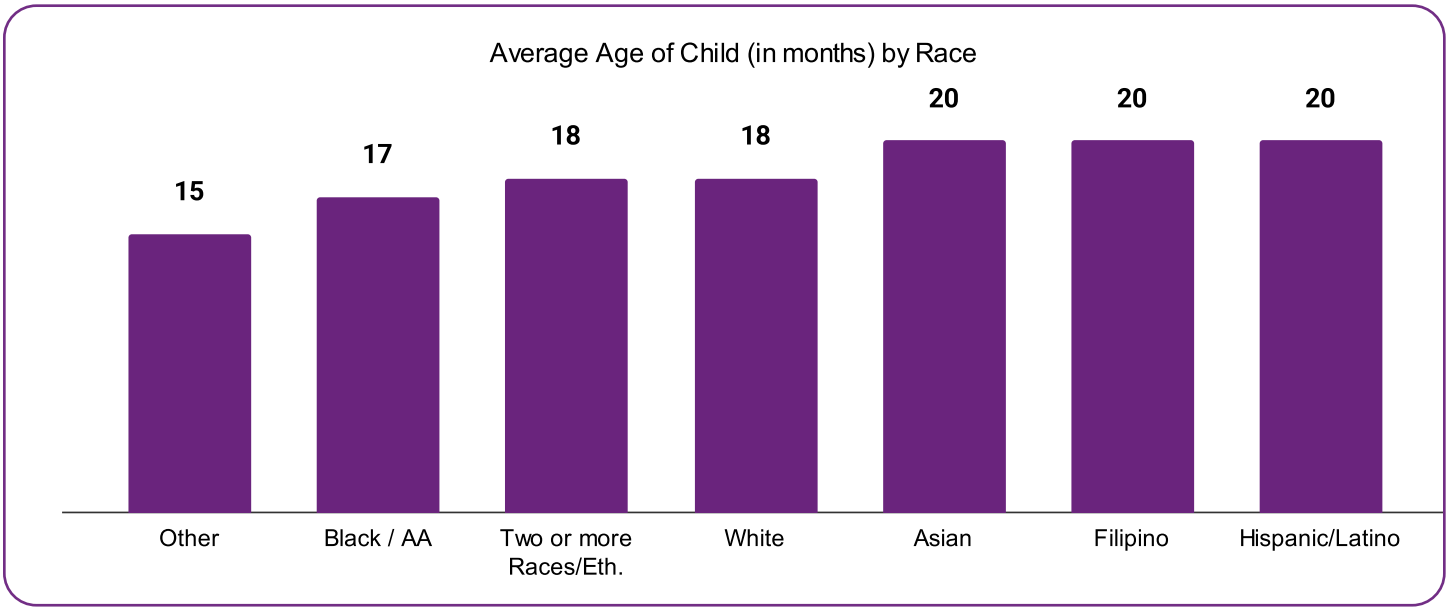
On average across UAs, boys were slightly older than girls at the time of referral, with boys averaging 19 months and girls 18 months.



N = 1,448 Boys; 862 Girls; Chart only includes demographic categories for which there were 10+ children. Cycle 2 (April 1, 2024 - March 30th, 2025) only.

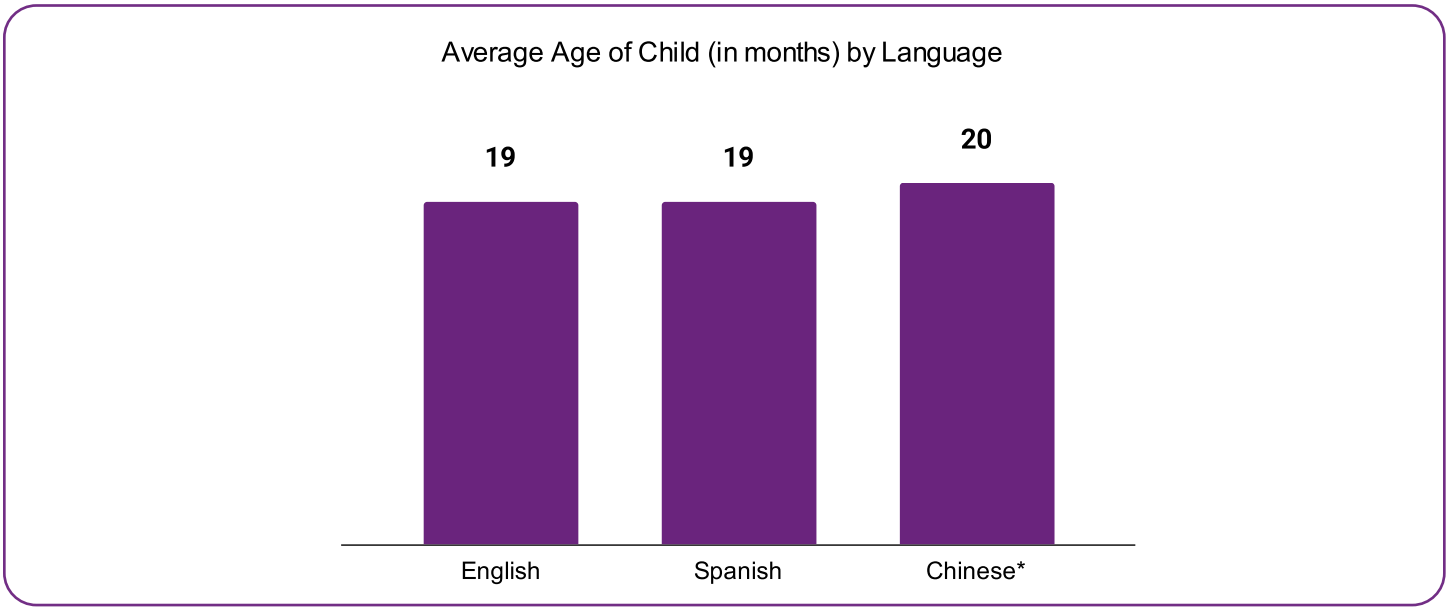
18 Data Source: Administrative data from 2 UAs for Baseline through Cycle 2; Total N = 2,244 for Baseline; 2,412 for Cycle 1; 2,312 for Cycle 2. **Note:** LB DHHS tracked referral data through its online portal, which had low partner usage. Most data for this outcome reflects children served by SGPRC.

Across most racial and ethnic groups, those who identified as Hispanic/Latino, Filipino, and Asian had the highest age at the time of referral (20 months). Those who identified as Other had the lowest age at the time of referral (15 months).



N = 48 Other; 47 Black/AA; 397 Two or more Races/Ethnicities; 124 White; 291 Asian; 27 Filipino; 1,365 Hispanic/Latinx; Chart only includes demographic categories for which there were 10+ children. Cycle 2 (April 1, 2024 - March 30th, 2025) only.

The average age at time of referral was highest for children in homes where Chinese (including Cantonese and Mandarin) is the primary home language (20 months) followed by Spanish and English (19 months).



N = 1,792 English; 378 Spanish; 113 Chinese. Cycle 2 (April 1, 2024 - March 30th, 2025) only*

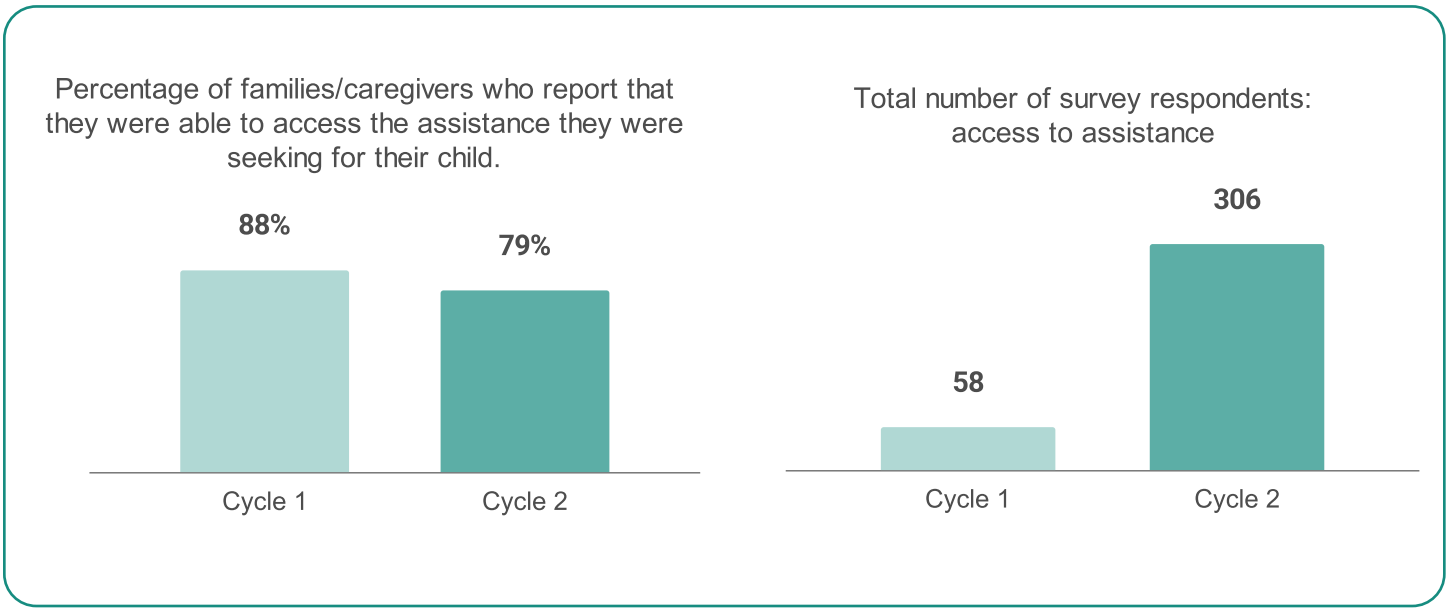
**Includes Cantonese and Mandarin*

Outcome 4: Increase in access to EII services and supports

INSIGHT SUMMARY: Across all UAs, access to EII assistance was lowest for Black or African American children and girls. Parents from Spanish-speaking households reported higher rates of accessing assistance or their child compared to those from English-speaking households.

Wave 1 Findings:

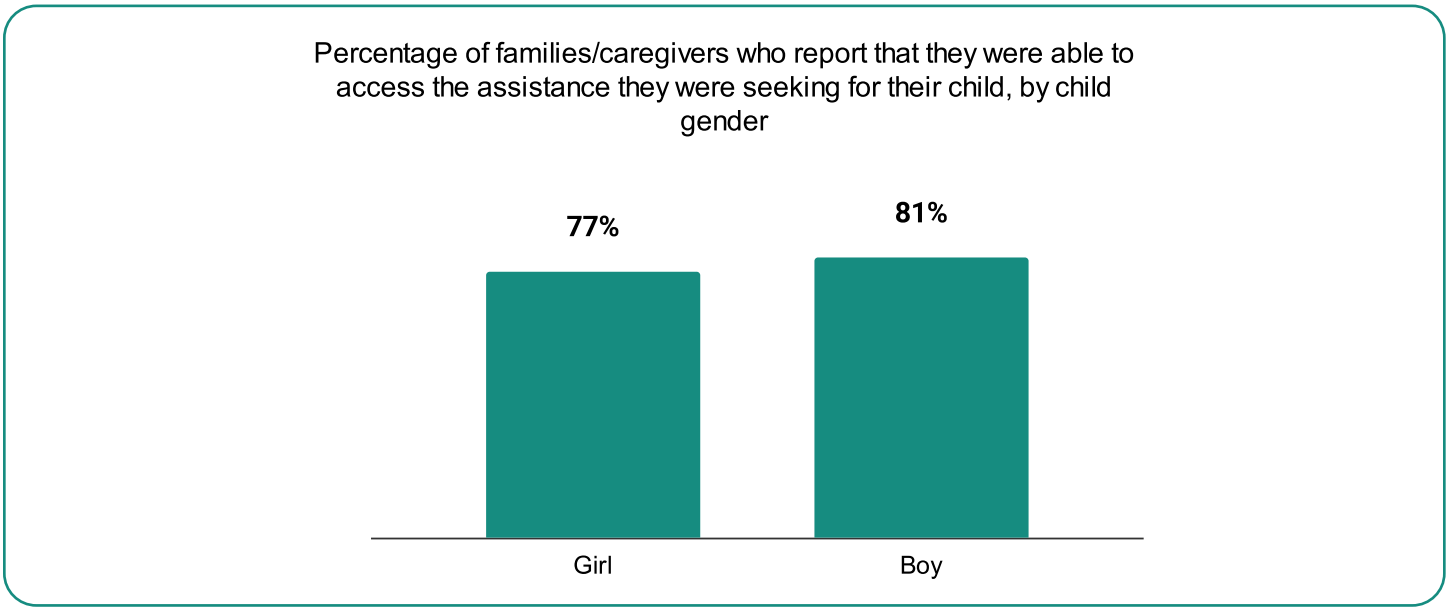
While the percentage of families/caregivers who report that they were able to access the assistance they were seeking for their child appears to have decreased over time19, the total number of families/caregivers included in the sample increased by more than 400% during that time. This indicates strengthened data collection processes over time and limits the value of comparisons between Cycle 1 and Cycle 2 results. In fact, multiple UAs indicated that they changed their approach to parent/caregiver satisfaction surveys between Cycles 1 and 2. For that reason, the demographic analyses below include only Cycle 2 results.



N = 58 for Cycle 1; N = 306 for Cycle 2

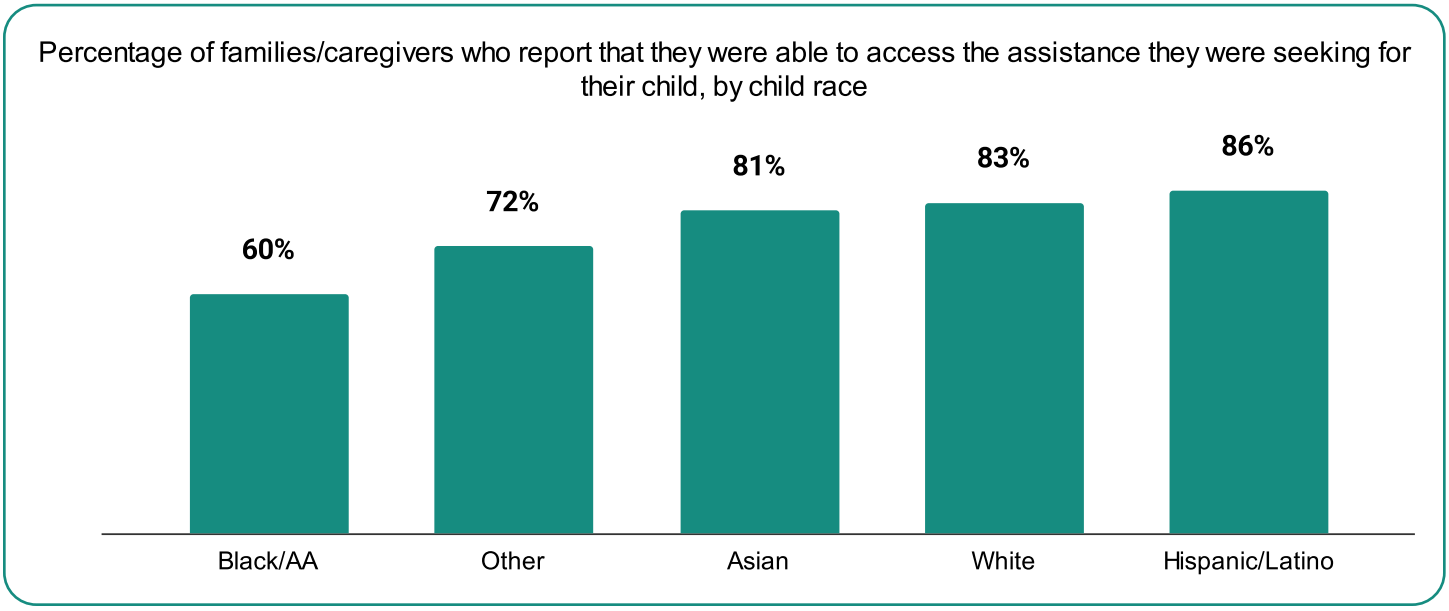
19 Data Source: Parent/caregiver surveys. Each UA developed and disseminated their own survey. VIVA provided suggested survey question language; however survey language was not identical for each UA. Data submitted via data collection template or by sending raw data; N = 58 for Cycle 1; 306 for Cycle 2.

Access to assistance was higher for parents/caregivers of boys (81%) than girls (77%) .



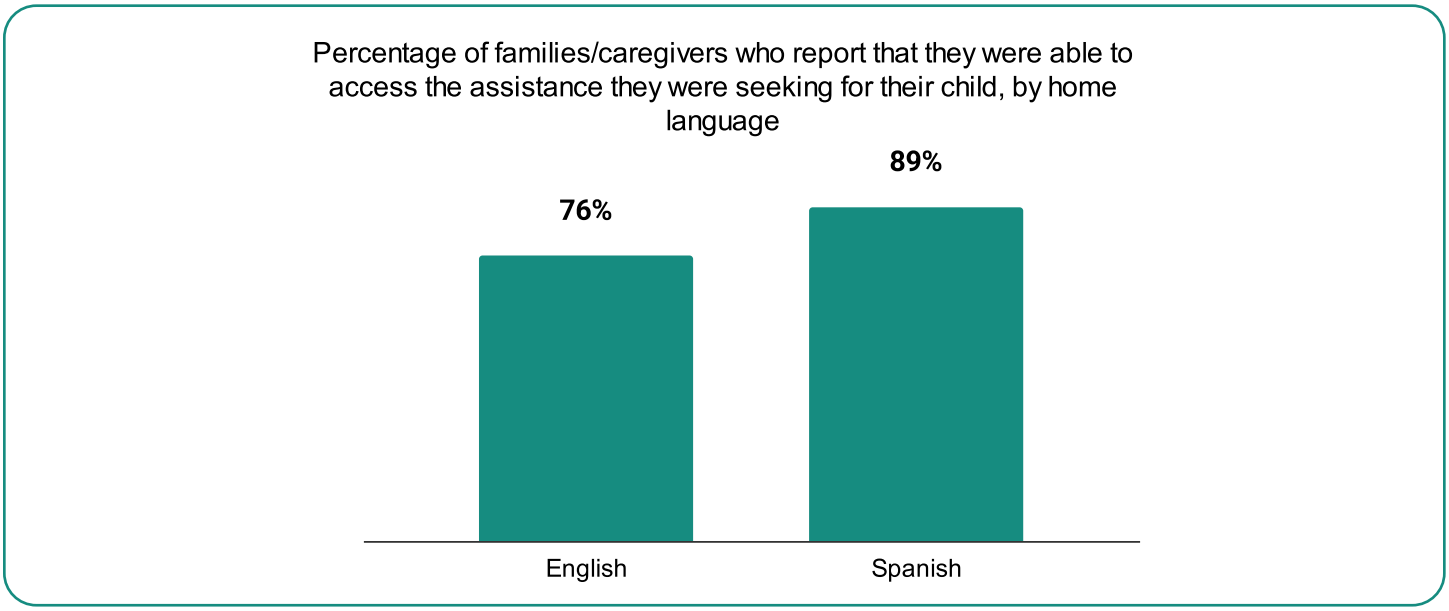
N = 177 boys, 116 girls; Chart only includes demographic categories for which there were 10+ respondents. Cycle 2 (October 1, 2022 - September 30, 2023) only.

Among racial groups, access was lowest for parents/caregivers with Black or African American children, with 60% reporting that they were able to access the assistance they were seeking for their child. In comparison, access was highest for Hispanic/Latino families, with 86% reporting access to the assistance they were seeking.



N = 34 Black/African American; 18 Other; 21 Asian; 48 White; 153 Hispanic/Latino. Chart only includes demographic categories for which there were 10+ respondents. Cycle 2 (October 1, 2022 - September 30, 2023) only.

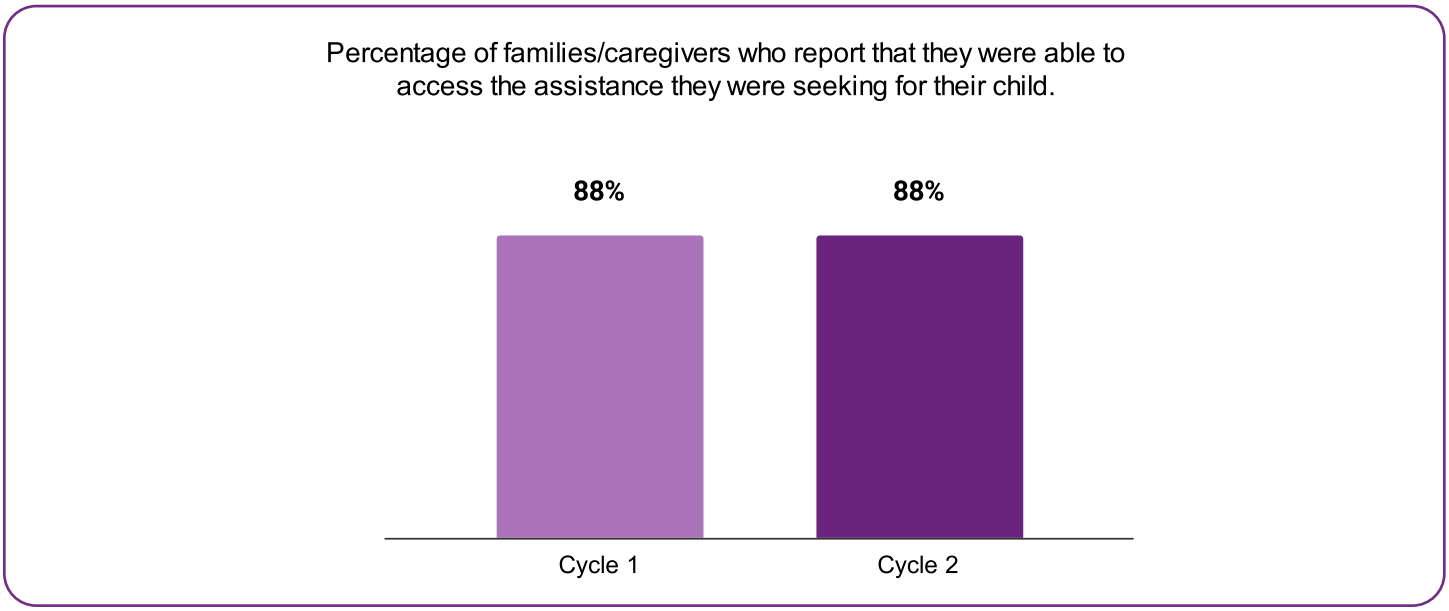
Families or caregivers from homes where English is the home language reported accessing the assistance they were seeking for their child at a lower rate (76%) than families/caregivers from homes where Spanish is the home language (89%).

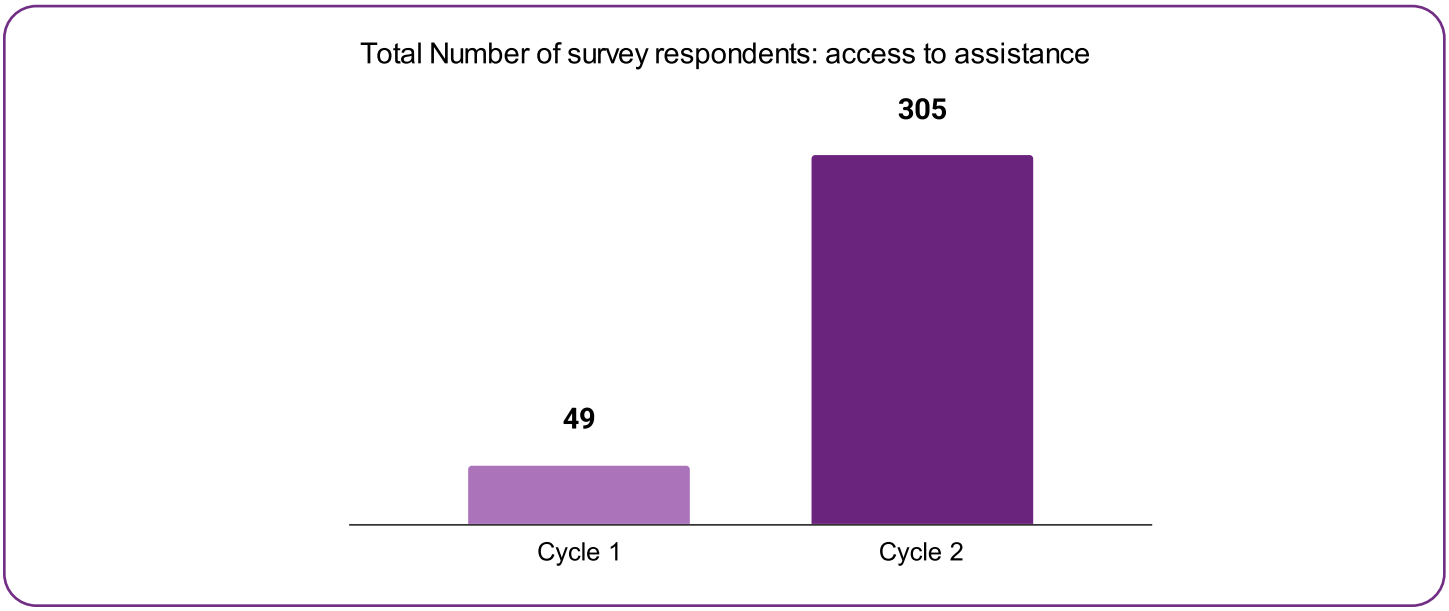


N = 196 English, 92 Spanish. Chart only includes demographic categories for which there were 10+ respondents. Cycle 2 (October 1, 2022 - September 30, 2023) only.

Wave 2 Findings

While the percentage of families/caregivers who report that they were able to access the assistance they were seeking for their child remained the same over time[20], **the total number of families/caregiver included in the sample increased by more than 522% during that time.** This indicates strengthened data collection processes over time.

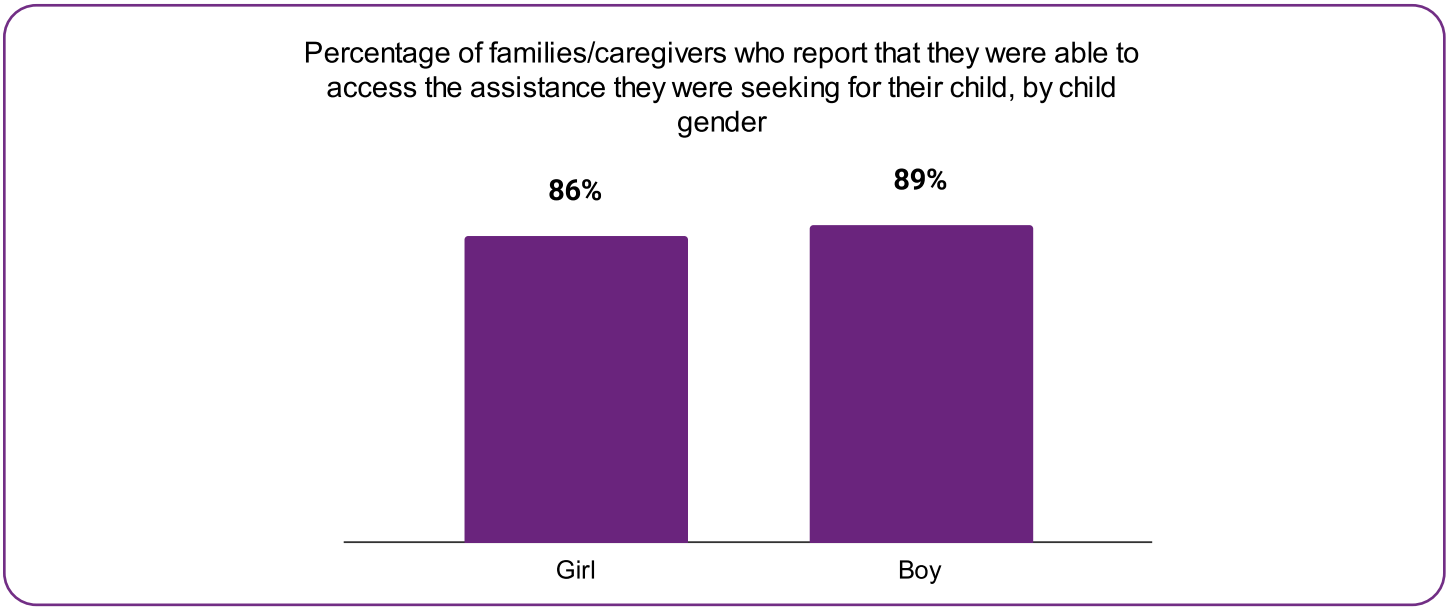




N = 49 for Cycle 1; N = 305 for Cycle 2

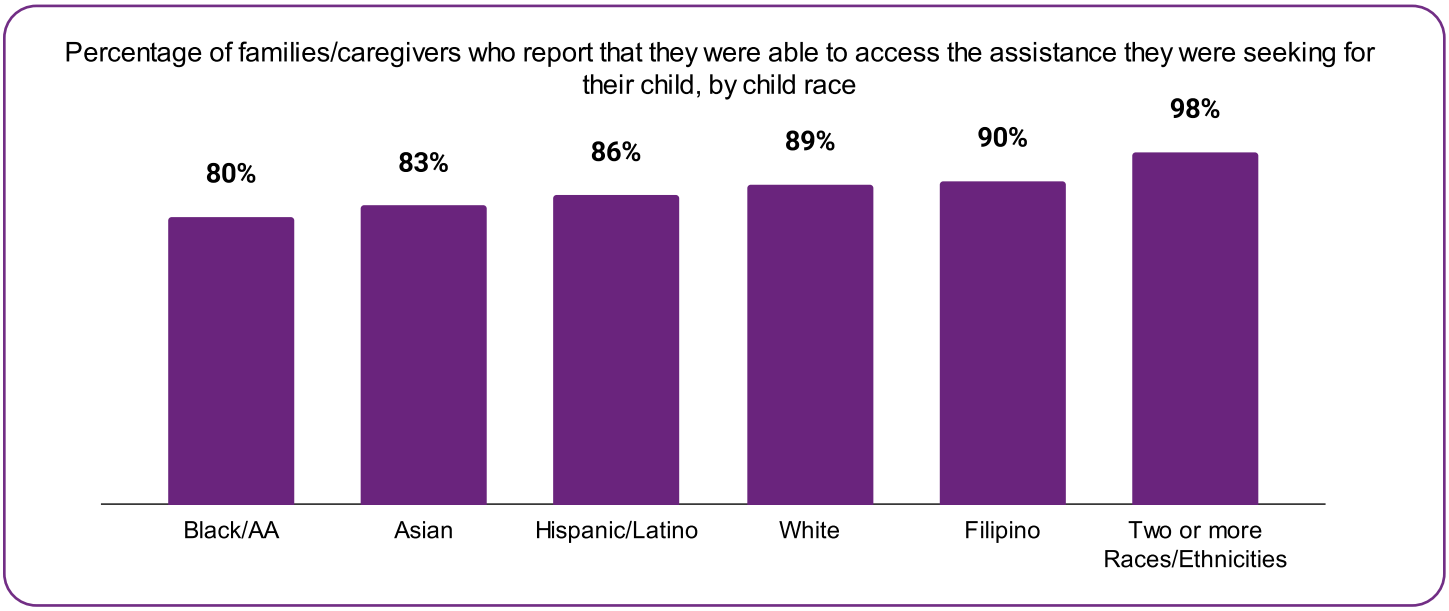
Access to assistance was slightly higher for parents/caregivers of boys (89%) than girls (86%).

20 Data Source: Parent/caregiver surveys. Each UA developed and disseminated their own survey. VIVA provided suggested survey question language; however survey language was not identical for each UA. Data submitted via data collection template or by sending raw data; N = 49 for Cycle 1; 305 for Cycle 2.



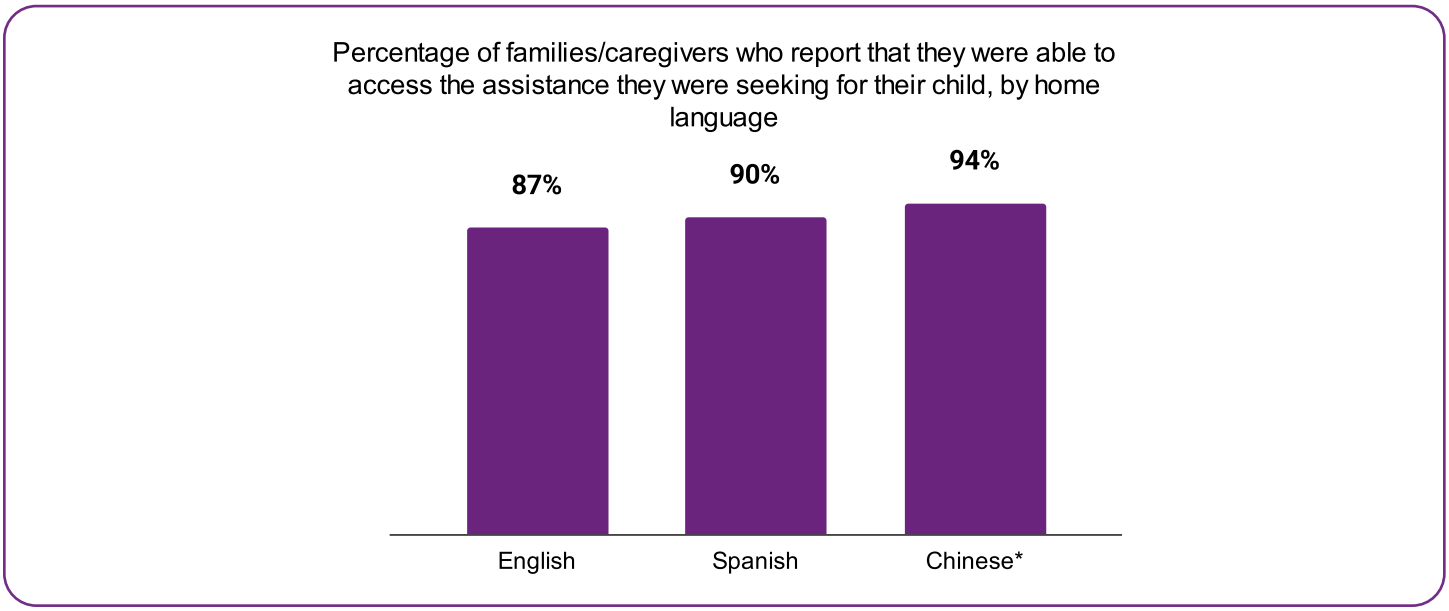
N = 190 boys, 11 girls; Chart only includes demographic categories for which there were 10+ respondents. Cycle 2 (April 1, 2024 - March 30, 2025) only.

Among racial groups, access was lowest for parents/caregivers with Black or African American children, with 80% reporting that they were able to access the assistance they were seeking for their child. In comparison, access was highest for Two or more Races/Ethnicities, with 98% reporting they were able to access the assistance they were seeking.



N = 10 Black/AA; 10 Filipino; 26 White; 46 Asian; 50 Two or more Races/Ethnicities; 157 Hispanic/Latino. Chart only includes demographic categories for which there were 10+ respondents. Cycle 2 (April 1, 2024 - March 30, 2025) only.

Caregivers where English is the home language reported accessing the assistance they were seeking for their child at a lower rate (87%) than families/caregivers from homes where Spanish is the home language (90%) and where Chinese (including Cantonese & Mandarin) is the home language (94%).



N = 265 English, 137 Spanish; 31 for Chinese. Chart only includes demographic categories for which there were 10+ respondents. Cycle 2 (April 1, 2024 - March 30, 2025) only.

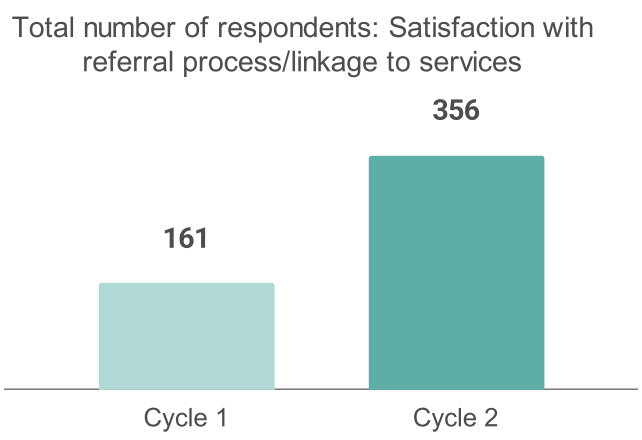
**Includes Cantonese and Mandarin*

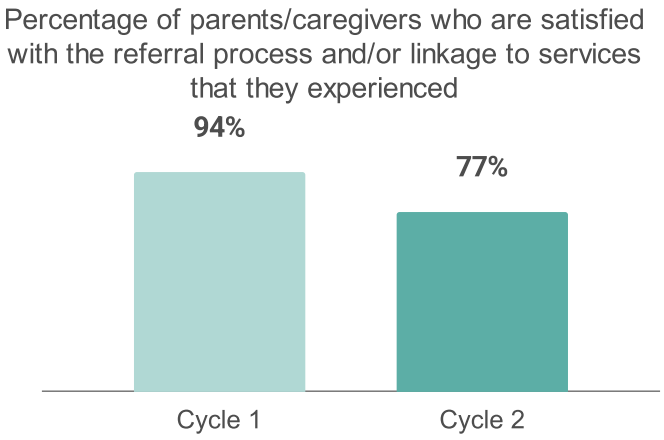
Outcome 5: Increase in parent/caregiver satisfaction with referral process and linkage to services

INSIGHT SUMMARY: For Wave 1 UAs, caregiver satisfaction with the referral process and/or linkage to services was lower for caregivers of girls compared to boys. By race, satisfaction was lowest among caregivers of Black or African American children and highest among those identifying their children as "Other" race. In contrast, Wave 2 data showed the highest satisfaction among caregivers of Black or African American children and the lowest among caregivers of Hispanic/Latino and Filipino children.

Wave 1 Findings:

While the percentage of families/caregivers who report that they were satisfied with the referral process and/or linkage to services appears to have *decreased* over time,[21] **the total number of families/caregivers included in the sample increased by more than 120%** during that time. Similar to the above findings on access, this indicates strengthened data collection processes over time and limits the value of comparisons between Cycle 1 and Cycle 2 results. Again, multiple UAs indicated that they changed their approach to parent/caregiver satisfaction surveys between Cycles 1 and 2. For that reason, the demographic analyses below include only Cycle 2 results.

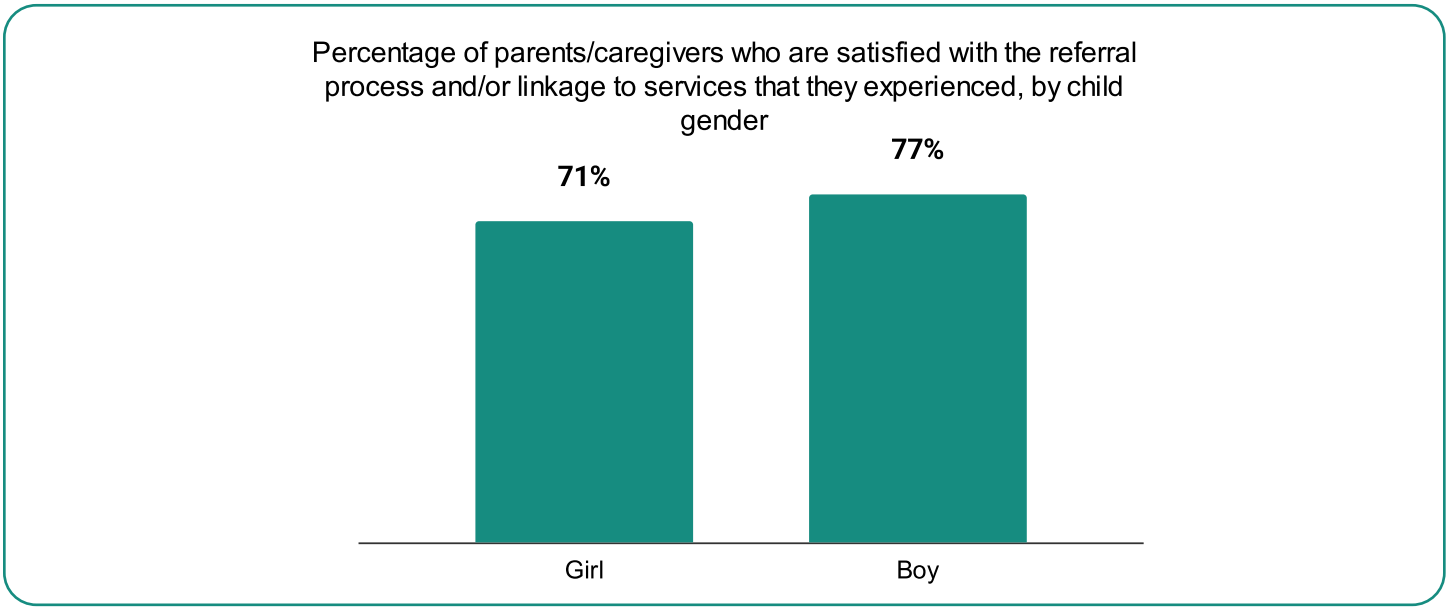




N = 161 for Cycle 1; N = 356 for Cycle 2

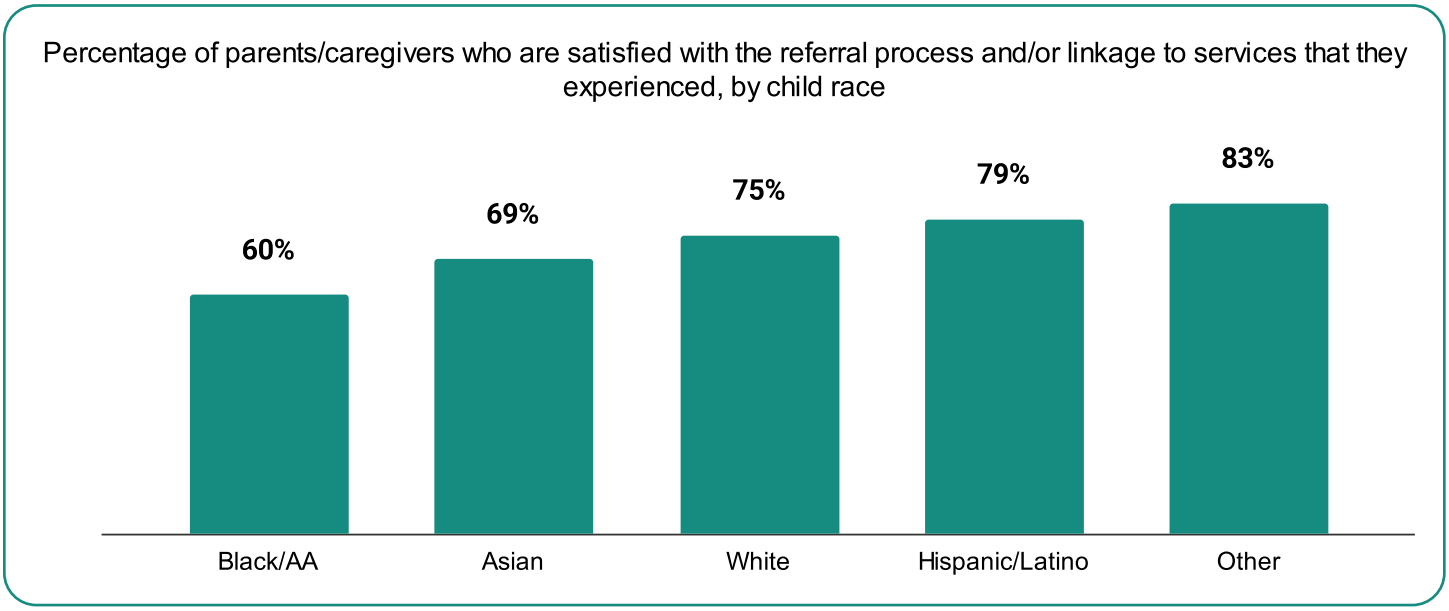
21 Data Source: Parent/caregiver surveys. Each UA developed and disseminated their own survey. VIVA provided suggested survey question language; however survey language was not identical for each UA. Data submitted via data collection template or by sending raw data; N = 161 for Cycle 1; 356 for Cycle 2.

Parents/caregivers of boys were satisfied with the referral process/linkage to services at a higher rate (77%) than parents/caregivers of girls (71%).



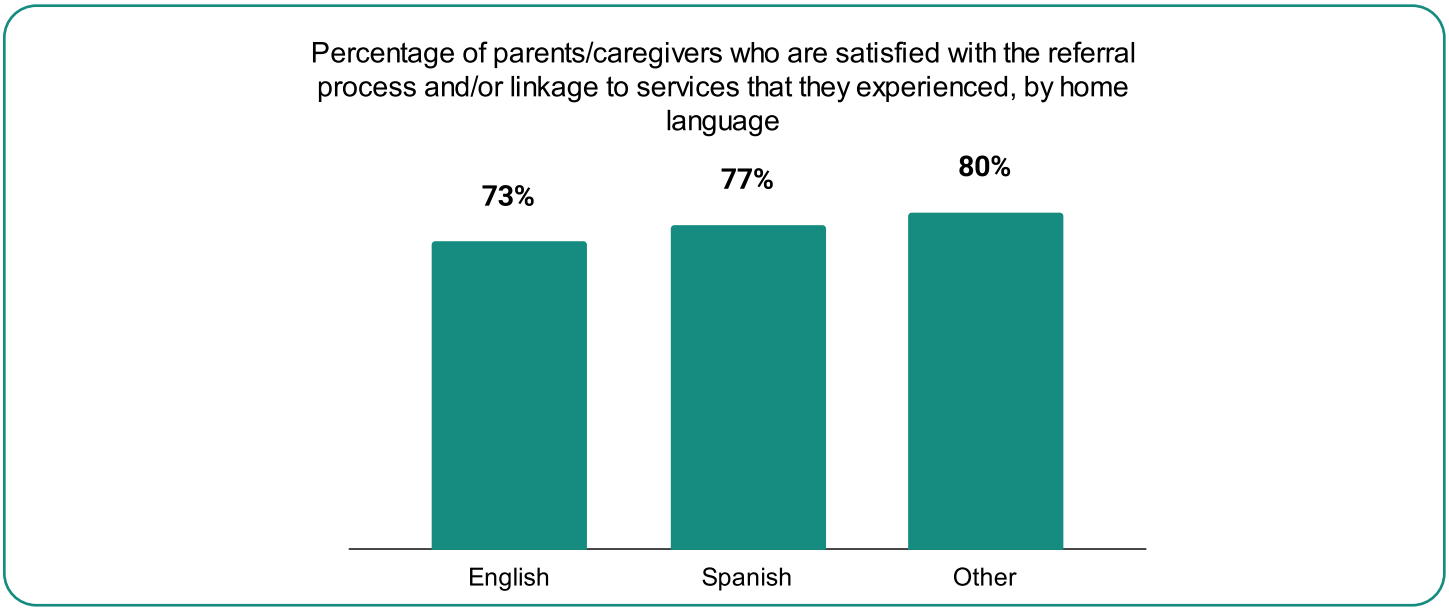
N = 116 girls, 176 boys. Chart only includes demographic categories for which there were 10+ respondents. Cycle 2 (October 1, 2022 - September 30, 2023) only.

Parents/caregivers of children who identified as Other race had the highest rate of satisfaction while parents/caregivers of Black or African American children reported satisfaction at the lowest rate (60%).



N = 35 Black/African American; 18 Asian; 48 White; 153 Hispanic/Latino; 18 Other. Chart only includes demographic categories for which there were 10+ respondents. Cycle 2 (October 1, 2022 - September 30, 2023) only.

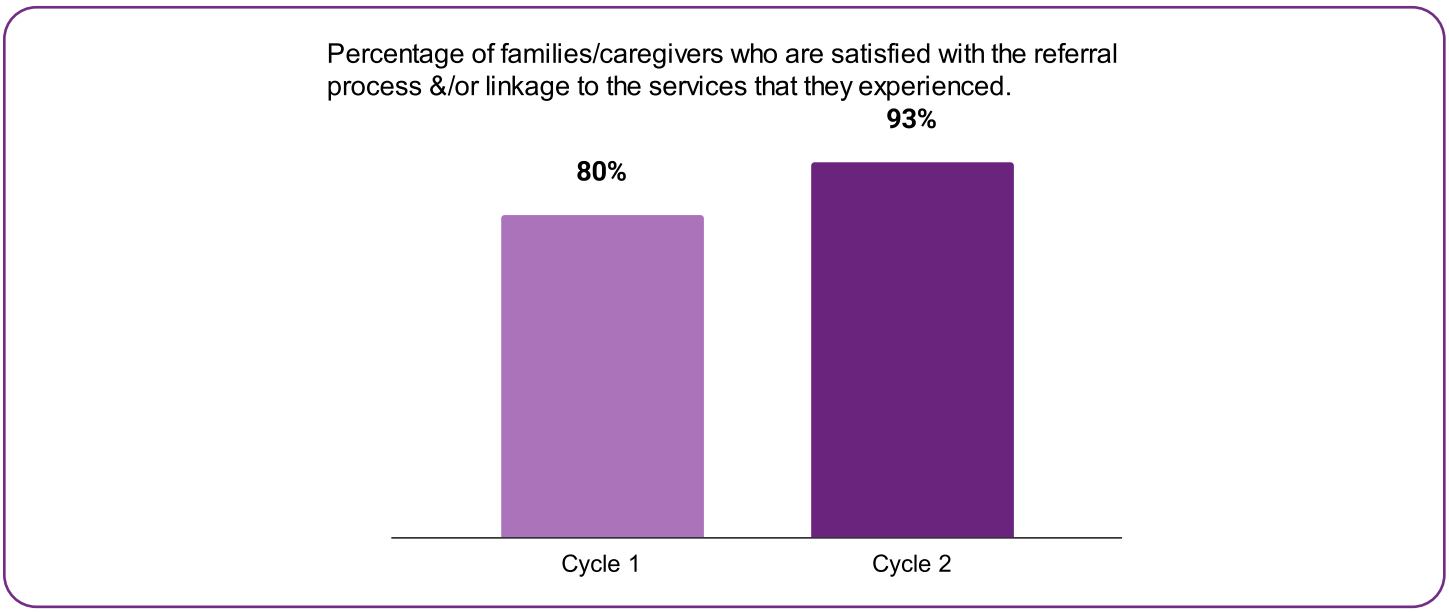
Families or caregivers from homes where English is the home language reported satisfaction with the referral process and/or linkage to services at a lower rate (73%) than families/caregivers from homes where Spanish is the home language (77%) and other languages (80%).

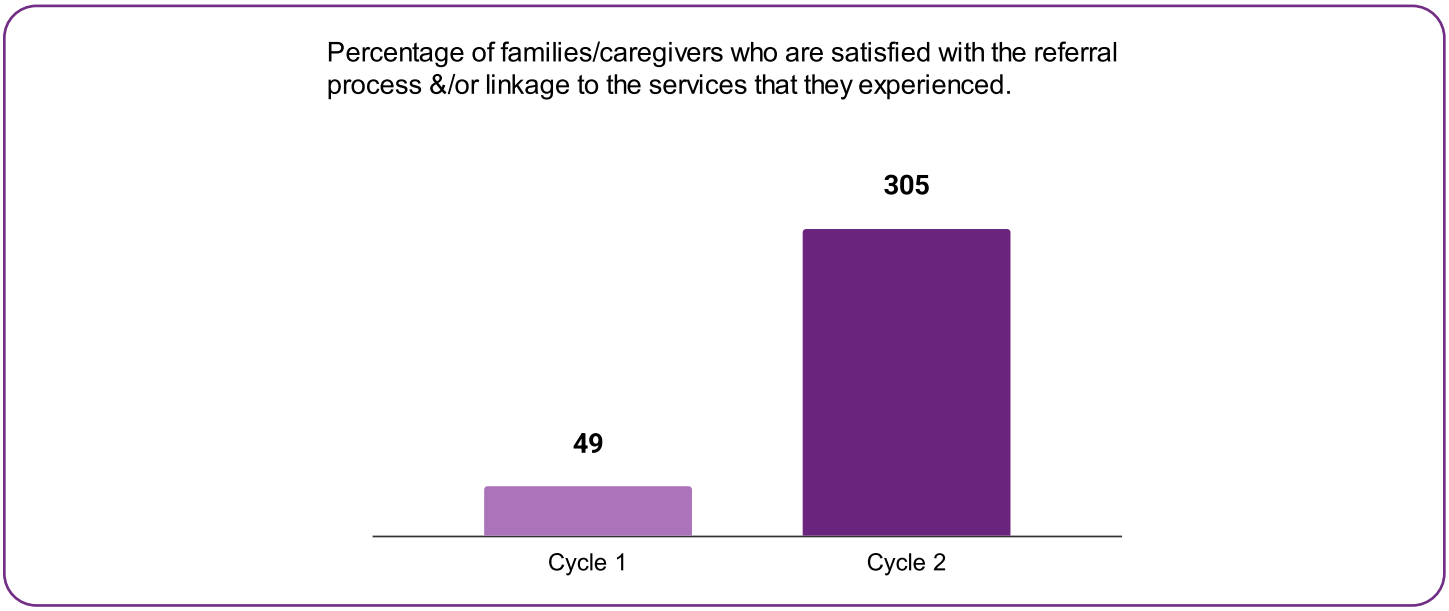


N = 196 English; 91 Spanish; 10 Other. Chart only includes demographic categories for which there were 10+ respondents. Cycle 2 (October 1, 2022 - September 30, 2023) only.

Wave 2 Findings

The percentage of families/caregivers who report that they were satisfied with the referral process and/or linkage to services **increased over time by 13%.** The total numbers of families who responded to the survey also **increased over time by 522%**[22] This indicates strengthened data collection processes over time. This also limits the value of comparisons between Cycle 1 and Cycle 2 results, as only one UA reported results in Cycle 1. For that reason, the demographic analyses below include only Cycle 2 results.

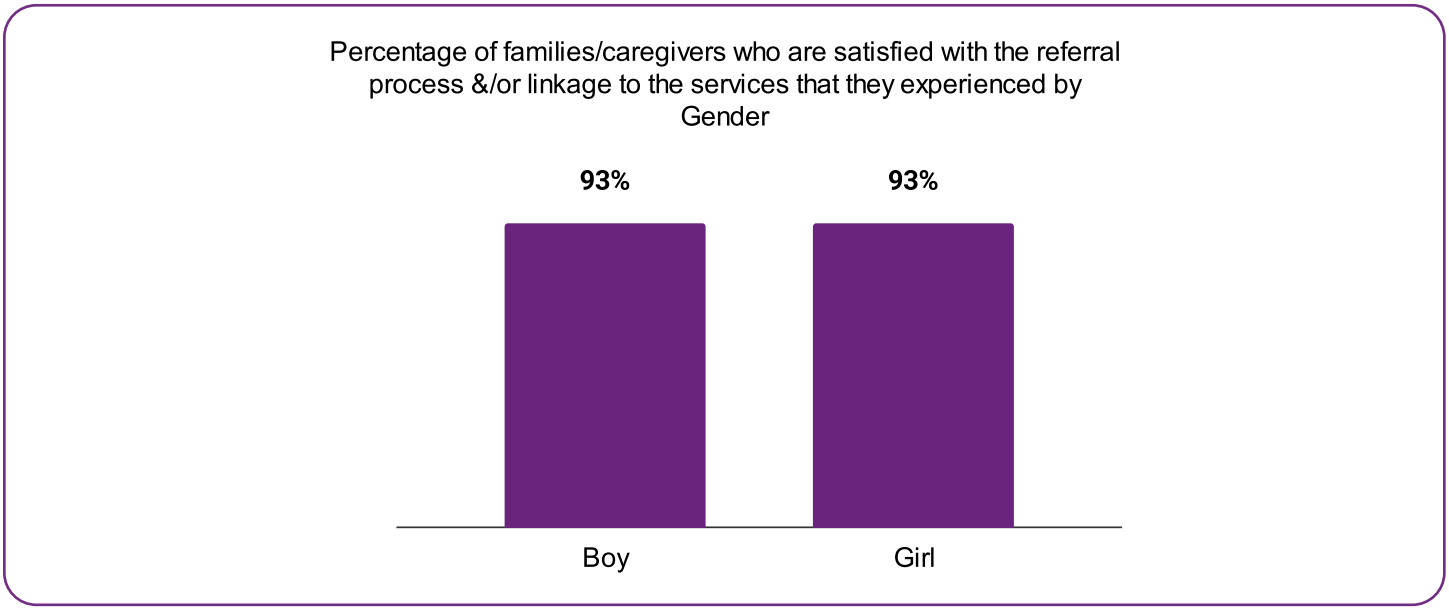




N = 49 for Cycle 1; N = 305 for Cycle 2

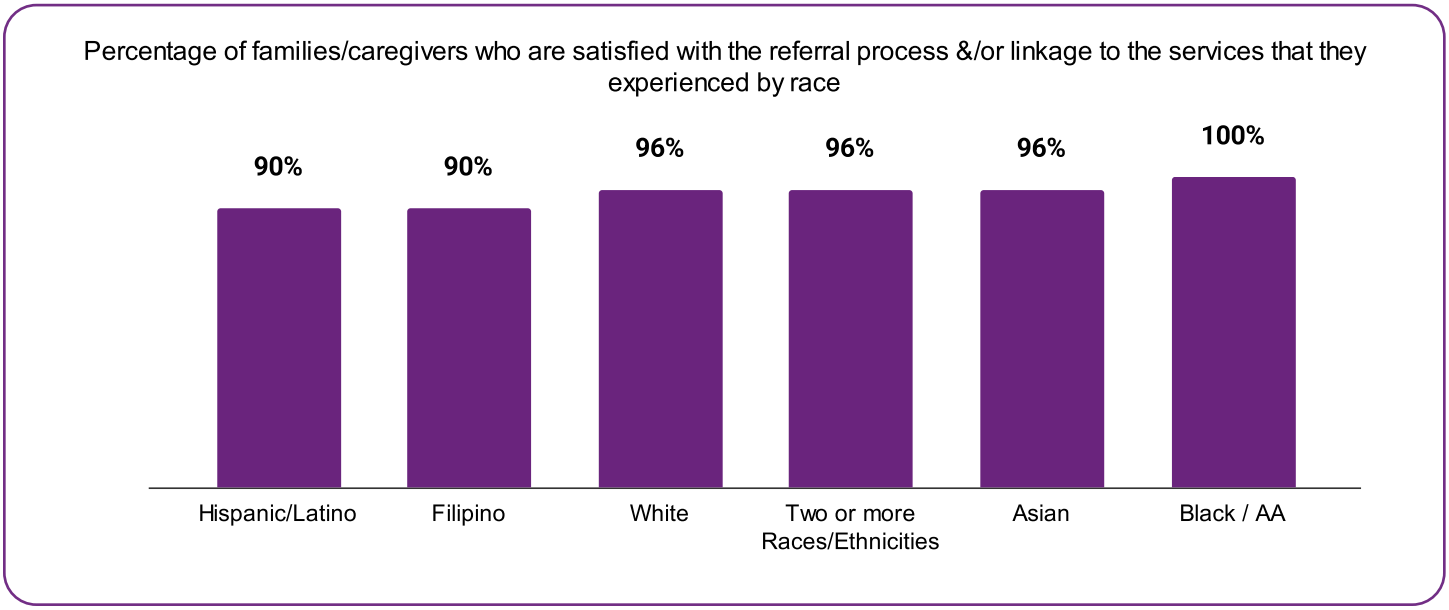
22 Data Source: Parent/caregiver surveys. Each UA developed and disseminated their own survey. VIVA provided suggested survey question language; however survey language was not identical for each UA. Data submitted via data collection template or by sending raw data; N = 49 for Cycle 1; 305 for Cycle 2.

There were no gender differences in parent/caregiver satisfaction with the referral process or service linkage, with both groups reporting an average satisfaction rate of 93%.



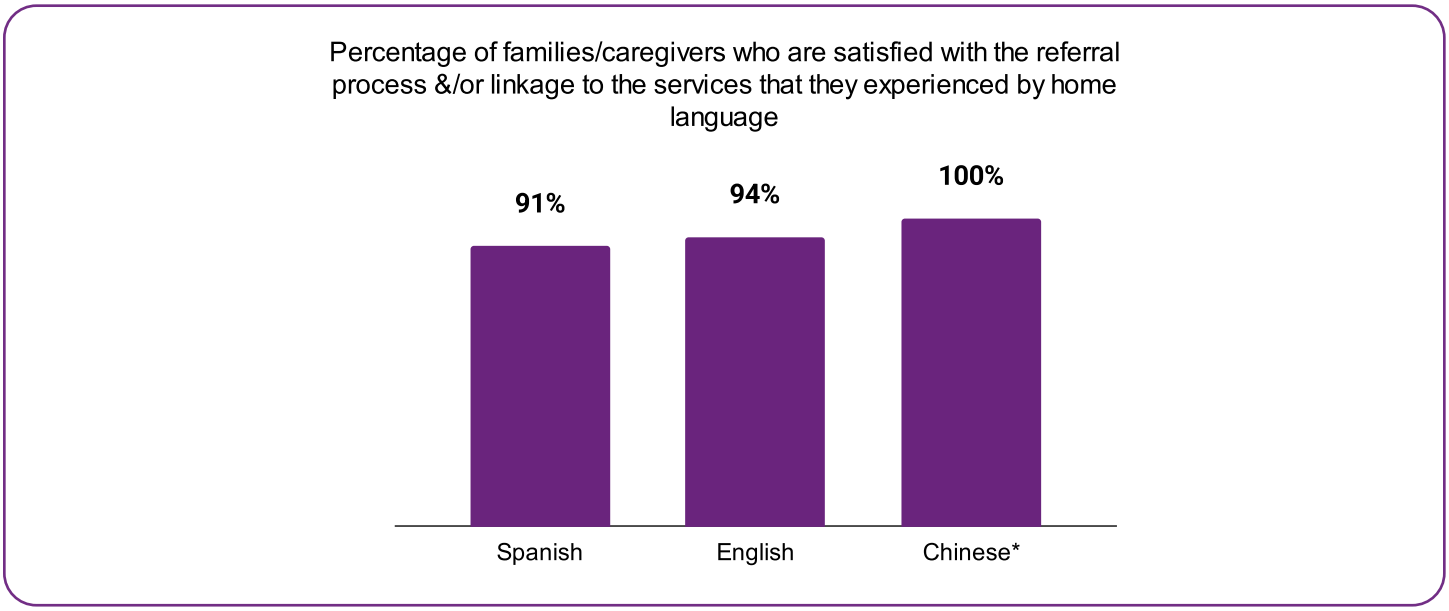
N = 190 boys; 114 girls. Chart only includes demographic categories for which there were 10+ respondents. Cycle 2 (April 1, 2024 - March 30, 2025) only.

Across races, parents/caregivers of children who were Black/African American had the highest rate of satisfaction (100%), followed by Asian (96%) and Two or more Races/Ethnicities. Parents of Hispanic/Latinx children reported satisfaction at the lowest rate (90%).



N = 157 Hispanic/Latino; 10 Filipino; 26 White; 50 Two or more Races/Ethnicities; 46 Asian; 10 Black/AA. Chart only includes demographic categories for which there were 10+ respondents. Cycle 2 (April 1, 2024 - March 30, 2025) only.

Families or caregivers from homes where Chinese (including Cantonese & Mandarin) is the home language reported satisfaction with the referral and/or linkage to services at the highest rate (100%), followed by English (94%) and Spanish (91%).



N = 137 Spanish; 265 English; 31 Chinese (including Cantonese & Mandarin). Chart only includes demographic categories for which there were 10+ respondents. Cycle 2 (April 1, 2024 - March 30, 2025) only.

**Includes Cantonese & Mandarin*

UA REFLECTIONS ON KEY PATHWAYS OUTCOMES

Toward the conclusion of their time in the Pathways project, all UAs reflected on the impact of their participation in the Pathways initiative, not only within their own organizations but across the broader EII system. Several key themes emerged from these reflections, including highlighting achievements such as strengthened cross-sector partnerships, expanded use of technology to streamline referrals, increased community and provider awareness of EII, and deeper integration of family voice in system design.

Collectively, these reflections illustrate how the Pathways project supported grantees, in implementing practical, values-aligned improvements that strengthened referral systems, deepened partnerships, and laid the groundwork for more responsive and equitable early intervention services. The UAs' collective experiences point to the importance of funding, collaborative structures, and intentional inclusion of family and community voices in advancing systems change.

Sustainability

A key outcome of the UAs' participation in the Pathways project was the establishment of approaches that continue to be sustained, and in some cases evolved into deeper work, to strengthen EII referral systems in Los Angeles County.

INSIGHT SUMMARY: At the project's conclusion, all UAs felt prepared to sustain a majority of the approaches developed through the Pathways project. Planned strategies for sustainability included embedding Pathways approaches into existing systems and their agency's emerging priorities and funding opportunities.

For Wave 1 UAs, referral processes, partner collaborations, and data-informed outreach continued beyond the grant term, with several UAs deepening their efforts through integration into existing systems and advisory structures.

During the final six months of their participation in the Pathways project, all UAs developed sustainability plans to guide the continuation of their efforts beyond the grant period. These plans were designed to help UAs assess which core activities, approaches, and partnerships established through the Pathways initiative could be sustained, adapted, or phased out after the project concluded[23]. The following table summarizes the approaches that most UAs intended to sustain, as well as the corresponding strategies for sustaining those approaches:

Approach	Intended Sustainability Strategies
Collaborative Partnerships *Intended to Sustain: All 7 UAs*	• Hold meetings at preferred frequency • Maintain agreements and extend MOUs with collaborative partners • Leverage funds from existing federal and state partners, in-kind time from partners, and grants (DDS, grant funds for upcoming projects, etc.) to support partnerships • Collaborate with community partners to establish and track community needs and develop future efforts plans • Use collaborative communication and project management software and/or email communications
Web-based Referral Portals *Intended to Sustain: All 7 UAs*	• Leverage support and buy-in from agency leadership as well as intra-agency coordination support and funding to ensure continued use of portals • Use UniteUs customer engagement/success team to support continued implementation. • Continue IT/software support for regional centers' custom portals • Continue to promote and expand portal and resource directory components to enhance value and useability among community members, EII professionals, and families

23 For Wave 1 UAs, the project was termed in December 2023, while Wave 2 UAs concluded the project in June 2025.

Approach	Intended Sustainability Strategies
Data Collection & Evaluation *Intended to Sustain: 5 UAs*	• Embed data fields developed for the Pathways evaluation in referral portals • Maintain and update parent surveys as needed and work with internal/ external champions to ensure continued dissemination • Leverage data collected through online referral portals, parent surveys, and partner agencies to inform programmatic decisions • Utilize sensemaking discussions and data briefs from the Pathways evaluation to support continuous quality improvement
Outreach & Education *Intended to Sustain: 5 UAs*	• Use referral heatmaps that were provided through the Pathways evaluation to inform outreach approaches and priorities • Apply communications and social media strategies received through Pathways technical assistance • Continue exploring new approaches to reach medical partners • Implement community navigator programs • Purchase marketing materials to support outreach to new potential partners • Participate in community networking events to promote EII resources and connection to services • Leverage agency staff to disseminate informational materials about EII services and supports. • Promote parent surveys via flyers with easy to access QR codes (supports online distribution and promotion of the parent survey) • Host EII training events and workshops for ECE professionals and parents / caregivers in partnership with local organizations.

While both waves of UAs expressed a commitment to sustaining core components of their work, there are some differences between the way Wave 1 and Wave 2 UAs are sustaining their Pathways approaches. Wave 1 UAs primarily focused on integrating Pathways activities into existing systems and structures to ensure continuity beyond the grant period. For example, WRC intended to embed its referral portal into internal intake workflows, SCLARC intended to integrate referral and charting functions into its existing electronic system, and ELAFRC intended to sustain collaborative efforts through its long-standing Partnership Council. These agencies emphasized institutionalization through system alignment, ongoing use of data, and existing advisory structures.

In contrast, Wave 2 UAs emphasized strategic adaptation and alignment with new initiatives. Long Beach, for instance, is positioning its Pathways work to continue under a newly awarded Early Childhood Mental Health grant that will fund the organization's early childhood efforts moving forward, while SGPRC intends to expand its outreach team and pilot new strategies such as QR code-enabled parent surveys. Rather than embedding into fixed systems, Wave 2 UAs focused on evolving their strategies to fit within emerging priorities and funding opportunities.

Sustainability Learnings & Future Intentions: Reflections from Wave 1 UAs

In December 2024, one year after their project period ended, all five Wave 1 UAs participated in post-grant conversations to reflect on the project's lasting impacts and the extent to which each UA's Pathways approaches had been sustained. These conversations highlighted shared progress and areas where local context shaped continued implementation and sustainability of approaches.

Sustainability Successes: UAs cited several positive and successful experiences in their effort to sustain their approaches:

1. **Referral Infrastructure:** WRC, ELAFRC, and SCLARC successfully sustained their referral systems, with some agencies seeing continued increases in early intervention referrals. WRC described its new portal as one of the most ambitious projects it had undertaken, and SCLARC fully embedded its portal into staff workflows to improve efficiency and family experience.
2. **Cross-Sector Collaboration**: Some UAs institutionalized their Pathways partnerships. CCRC integrated its collaborative into the Head Start Community Health Advisory Council, creating a platform for child health discussions. ELAFRC maintained its Partnership Council and LICA, continuing partner engagement in outreach and advocacy.
3. **Data Use and Strategic Outreach**: WRC and ELAFRC continue to use heatmaps and dashboards to inform community engagement strategies, such as NICU outreach and targeted advertising. These tools have also supported grant writing and planning efforts.
4. **Family Engagement**: ELAFRC expanded parent leadership roles and connected families to broader equity initiatives. SCLARC used informal feedback gathered through its intake platform to identify system barriers and improve workflows in real time.

Sustainability Challenges: Despite this progress, Wave 1 UAs faced several barriers to sustaining areas of their work.

1. **Technology Costs and Platform Fit**: While some UAs maintained their portals locally, others found the cost or functionality of platforms like UniteUs prohibitive. CB discontinued use of its UniteUs portal while CCRC sought alternatives, such as FindHelp. ELAFRC has faced portal development delays, but has secured funding to continue.
2. **Staffing Constraints**: Limited staffing made it difficult to maintain workflows and partner engagement. For example, SCLARC delayed launching a new workflow due to hiring delays, while WRC and ELAFRC lacked sufficient infrastructure or grant-writing capacity to fully sustain momentum.
3. **Loss of Formal Collaborative Structures**: Though individual partnerships often remained, many of the structured cross-agency collaboratives that were key to Pathways were not sustained. Without formal MOUs or meeting structures, coordination across agencies proved difficult.
4. **Reduced TA Support Post-Grant**: As expected, technical assistance and Help Me Grow LA engagement decreased after the project ended. Some UAs found this transition difficult and expressed a desire for more intentional follow-up and continued partnership.

Looking Ahead - Wave 1 Priorities: Despite challenges, all five UAs articulated clear and forward-looking plans for the year ahead, with many building on the foundation laid by the Pathways project.

- CCRC is exploring new infrastructure through the FindHelp platform and is developing additional Family Resource Centers in Sylmar, Victorville, and at local shelters. They are also

launching a maternal mental health workshop series and are interested in aligning Pathways lessons with broader agency planning.

- CB is launching Padres Poderosos, a DDS-funded initiative focused on Latino and Black families. The program includes workshops, coaching, and advocacy training, and is being supported by new staff hires and deeper regional center partnerships.
- WRC is using portal data to identify outreach gaps and will expand efforts to reach under-referred populations, such as NICU families. They are also working on a Language Access & Cultural Competency Plan and hope to elevate their portal model statewide through presentations and peer learning.
- ELAFRC is finalizing its Salesforce-based portal and continuing its focus on family leadership and co-design. They are planning a 2025 advocacy summit and deepening community outreach through targeted media and partnership strategies.
- SCLARC is onboarding new staff and enhancing its portal with improved accessibility options (e.g., in-lobby kiosks). They are also continuing their involvement in DDS equity workgroups and considering how to strengthen support for parent partners and families navigating early intervention systems.

These efforts reflect a continued commitment to the principles of Pathways, particularly collaboration, equity, family voice, and data-driven systems change, and suggest that, while the grant period has ended, the momentum and impact of the work continue to evolve.

Lessons Learned & Recommendations

Lessons Learned

Throughout the Pathways project, there have been several important lessons learned:

1. **Time:** Building partnerships and strengthening referral systems with parents and community members at the center requires time. Throughout the course of the project, all partners had to adjust expectations on what was possible over three years. This was apparent from the very beginning, when the process for finalizing approaches to pilot took much longer than expected. It also took significant time for the collaboration and capacity building required for the UAs to consistently collect the data included in this report. For Wave 1 UAs, this was exacerbated by the impacts of the COVID-19 pandemic on the UAs and each of their communities, especially during the first year of this project. It is likely that additional time is required to see progress towards achieving the desired outcomes for this project.
2. **Funding:** Providing financial resources allowed UAs to pilot approaches and build infrastructure designed for sustainability. In addition to direct resource costs (e.g. software licenses, outreach materials), UAs used project funding for the following components, each of which were key to the project's success:
    - Partner participation: Providing funding for partners ensured consistent participation throughout the project, and for unifying agencies to provide robust coordination and support.
    - De-siloing work within agencies: UAs were able to use funding as leverage for collaboration and inter-agency partnership that otherwise was not possible.
    - Testing different approaches and technologies: UAs were able to invest time and resources trying different referral platforms and/or iterations of custom portals in order to land on the best technology(ies) for their referral systems.
    - Centering community: UAs shared that they would not have been able to spend the time and resources required to collect feedback and partner with community members in developing and implementing their approaches without the funding to do so. It was crucial for the UAs to hear from end users as they developed and refined systems.
3. **Cross-Sector Partnership & Collaboration:** Most UAs shared that collaboration with partners across sectors is critical, and full participation and buy-in from certain partners, such as medical practices, regional centers, and school districts is key. Establishing and maintaining those partnerships requires substantial time and resources for relationship building and EII

capacity building.

4. **Data Capacity:** All UAs faced challenges collecting data for the Pathways project, including data disaggregated by zip code, child race, child gender, and home language. Through this project, each UA built capacity in data collection, reporting, and analysis. Without the structure and support provided through this project, it is difficult for UAs to prioritize this type of data collection. However, this data allows analysis that is crucial for identifying and addressing disparities in access to early intervention, and can be used for UA decisions related to messaging, outreach, programming, and more.
5. **Referral Platforms/Portals:** All UAs invested significant resources in developing or adopting online referral systems or portals. While the uptake and/or development processes were involved, most UAs have found that the resulting system has added efficiency. UAs found that success in this area depends on aligning platform tools with partner workflows and readiness as well as allowing flexibility in timeline and design of these tools. Still, UAs noted that having several different referral platforms/portals operating in Los Angeles County creates confusion.
6. **Community Engagement:** Community engagement is crucial to building effective EII systems and supports. UAs leveraged a diversity of modalities (e.g., texts, social media, surveys, events, etc.) in order to both share information and collect feedback from families. They found that parents are engaged and grateful for opportunities to connect.
7. **Technical Assistance:** UAs shared that the technical assistance and capacity-building tools provided throughout the project were critical to their success. They also shared that VIVA's adaptability was very important as needs changed throughout the project.

Recommendations for Future Efforts

Based on the above insights and learnings, VIVA recommends the following:

1. **Further examine and address existing disparities:** The findings above point to disparities in access to EII services, satisfaction with referrals and linkage to services, and age at time of referral, especially for Black children and families. To address these disparities it is important to first understand them. We recommend further exploring the sources of these disparities and explicitly addressing and reducing systemic barriers that limit access to early identification and intervention (EII) referrals and services for Black and African American, American Indian/Alaska Native children and families, girls and any other group facing inequities.
2. **Offer support and incentives for consistent data collection, data sharing, and collective learning:** The UAs strengthened their data infrastructure throughout the course of this project, allowing for ongoing data collection, learning, and continuous quality improvement. In particular, regularly collecting family and partner feedback was new for most UAs, and some shared that this is difficult to continue without ongoing support/funding. Furthermore, data must be disaggregated to allow for analysis of disparities and inequities within the system. One UA shared that this project opened up the opportunity to begin data sharing between their collaborative and the local regional center in a way that was not possible prior to participation in the project. Referral partners must be supported to continue developing and maintaining these data practices.

3. **Create a countywide portal/referral system:** UAs had a hard time selecting a referral system and reported confusion due to different systems existing across agencies/communities. The countywide referral system would be strengthened if there were one central portal that allowed for referrals across sectors. While this will require a significant effort to encourage adoption of the portal, it will open up opportunities for a more streamlined system and shared resources that can be used for outreach and education about portal usage. It will also allow for consistent data sharing and learning (see Recommendation 2 above.) Alongside the centralized portal, it will be important to offer ongoing training, resources and guidance on referral protocols. This system should:
    - Build on and/or integrate with the regional centers' custom intake portals and medical partners' electronic health records (EHR) systems
    - Include a mechanism for closed loop referrals
4. **Target medical partners to engage in the EII System:** For systems to be sustainably strengthened, key partners must be bought in as consistent participants. Because families and children may enter the EII system through many different doors, all partners must be at the table to ensure that all families can access the services they need. UAs experienced barriers engaging with medical partners and shared that additional education and alignment with those partners regarding developmental screening and referral practices is important.
5. **Center community and family experiences:** UAs expressed the impact of centering family experiences throughout the Pathways project and shared that this would not be possible without the financial and technical assistance offered through the project. This must be continued to build equitable EII systems.

Conclusion

This evaluation revealed valuable insights into the HMG LA Pathways initiative, which was designed to strengthen EII systems and referral pathways in communities throughout Los Angeles County. This work is crucial to the well being of children and communities, ensuring that all families with young children have access to the services they need for their children's development.

Systems change work requires long-term commitment and evolves over time. As the project concluded, Wave 2 UAs reported fewer family referrals and lower attendance at community events—reflecting a broader climate of fear in immigrant communities due to shifting federal immigration policies. In response to this reality in California communities, the Department of Developmental Services issued a directive to regional centers and other service providers to make developmental services flexible and accessible to all, including offering remote options for service delivery.[24] These shifts underscore the need for systems to continually evolve in order to meet the changing needs and realities of the communities they serve.

The partnership and community engagement established through this project are essential to strengthen as the landscape evolves, ensuring systems remain responsive to community needs. We hope this report offers insights and recommendations to guide the continuation of this important work.

Funded by First 5 LA's Pathways investment, part of Help Me Grow Los Angeles, a collaboration of First 5 LA and Los Angeles County Department of Public Health.

Help Me Grow LA

first 5 la
Giving kids the best start

County of Los Angeles Public Health

24 California Department of Developmental Services. (n.d.). Message to the community: Protecting access to services and supports for all Californians. Retrieved July 17, 2025, from https://www.dds.ca.gov/newsletter/message-to-the-community-protecting-access-to-services-and-supports-for-all-californians-2/

Appendix

1. UA Evaluation Plans

a. Wave 1 UA Evaluation Plans
b. Wave 2 UA Evaluation Plans
c. HMG LA Pathways Evaluation Core Indicators
d. HMG LA Pathways Data Collection Periods and Data Sources

2. UA Data Dashboards

a. Wave 1 Cycle 1 & Cycle 2 Tableau Data Dashboard
b. Wave 2 Baseline, Cycle 1 & Cycle 2 Tableau Data Dashboard

3. UA Data Briefs

a. Wave 1 Cycle 1 Data Briefs
b. Wave 1 Cycle 2 Data Briefs
c. Wave 2 Cycle 1 Data Briefs
d. Wave 2 Cycle 2 Data Briefs

4. Wave 1 Zip Code Heat Maps

a. Wave 1 UA Combined Cycle 1 Zip Code Heat Map
b. Wave 1 UA Combined Cycle 2 Zip Code Heat Map
c. WRC Cycle 2 Heat Map
d. CCRC Cycle 2 Heat Map
e. ELAFRC Cycle 2 Heat Map
f. SCLARC Cycle 2 Heat Map
g. CB Cycle 2 Heat Map

5. Wave 2 Zip Code Heat Maps

a. Cycle 1 Heat Maps
b. Cycle 2 Heat Maps

6. Family Journey Maps

a. CB Family Journey Map
b. CCRC Family Journey Map
c. SGPRC Family Journey Map
d. Wave 1 Resource & Referral Maps
e. Wave 2 Resource & Referral Maps