



The Help Me Grow LA Pathways Evaluation

EXECUTIVE SUMMARY

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DEVELOPED BY



Introduction

In California, one in four children under age five 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

Recognizing the scale of this need underscores why early action matters. Early intervention is key to supporting a child's healthy development, particularly during the critical first five years of life. Research shows that acting as early as possible once a concern is identified improves outcomes and increases the effectiveness of intervention efforts.² A core part of this process is ensuring timely, closed-loop referrals that confirm when a child successfully connects to services and receives the support they need.³ 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.⁴ Disparities in screening and service access are even more pronounced when considering factors such as race, ethnicity, and type of health insurance.⁵

In response to these gaps, Help Me Grow LA launched HMG LA Pathways, a three-year countywide initiative to strengthen referral pathways, reduce disparities, and build more coordinated, family-centered systems of care.

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- 1 First 5 LA, 2012; Children Now, First 5 Association of California, & Help Me Grow California. (2014). Ensuring Children's Early Success: Promoting Developmental and Behavioral Screenings in California.
 - 2 Centers for Disease Control and Prevention. (2024, December 27). Why act early if you're concerned about development? Learn the Signs. Act Early. U.S. Department of Health and Human Services. <https://www.cdc.gov/act-early/families/why-act-early.html>
 - 3 Rahni, N. (2024, January 18). A path to successful closed loop referrals in Medi-Cal. Children Now. <https://www.childrennow.org/blog/a-path-to-successful-closed-loop-referrals-in-medi-cal/>
 - 4 KidsData.org. (2021-2022). Children Who Have Received a Developmental Screening. Retrieved from <https://www.kidsdata.org/topic/2205/developmental-screenings/table#fmt=2723&loc=2,364&tf=162&sortType=asc>
 - 5 Morgan, P. L., Hu, E. H., Woods, A. D., Gloski, C. A., & Wang, Y. (2023). Disparities in family-centered care among US children and youth with special healthcare needs. *Journal of Pediatrics*, 253, 297-303.e6. <https://doi.org/10.1016/j.jpeds.2022.09.024>

About Help Me Grow LA & The HMG LA Pathways Initiative

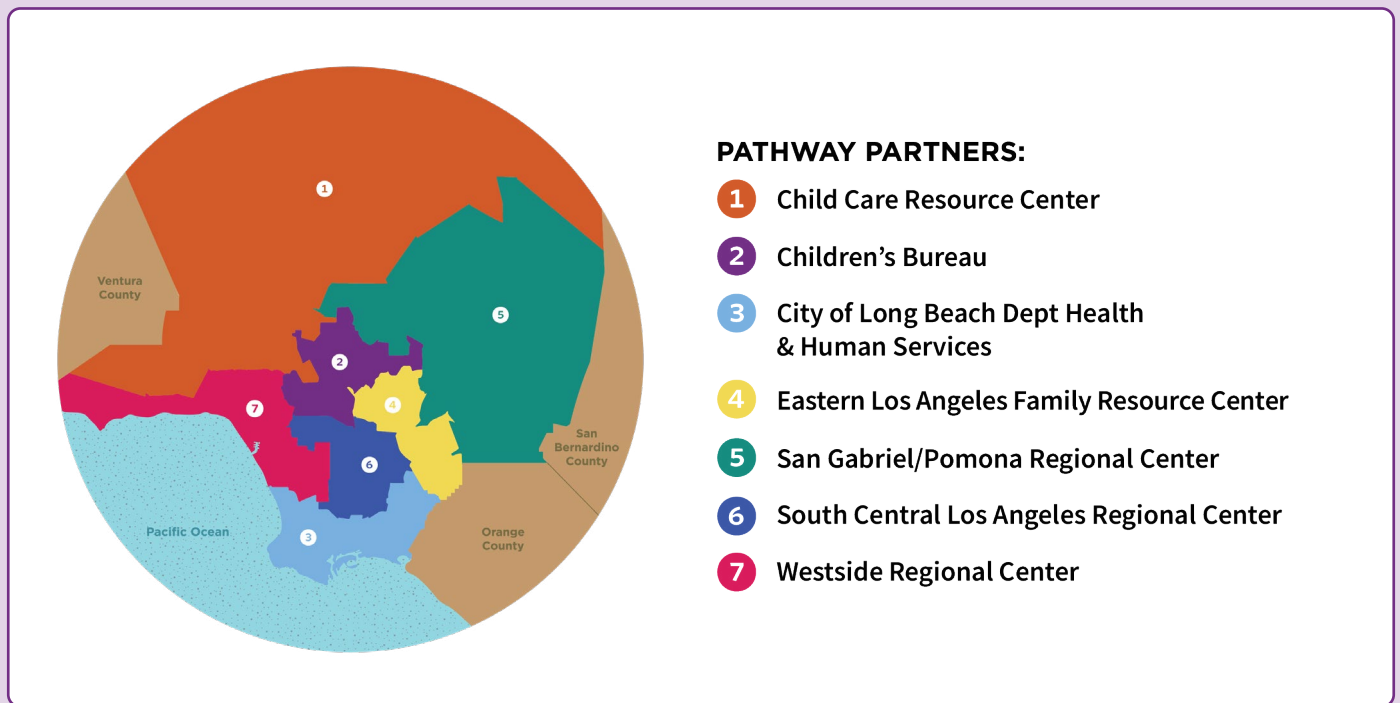
Help Me Grow LA (HMG LA) is the local implementation of Help Me Grow (HMG), a national systems change model designed to improve early identification and intervention (EI) by improving developmental screening rates, increasing awareness about developmental health, addressing stigma, connecting children to EI services, and collecting data for system improvement.

As part of the broader HMG LA initiative, First 5 LA launched HMG LA Pathways, a three-year effort to strengthen referral pathways and improve access to early intervention services for families. The initiative funded seven regional collaboratives - each led by a Unifying Agency (UA) with support from Collaborative Agencies and community-based Supporting Partners - to design, test, and refine strategies that promote coordinated, integrated, and multidirectional EI referrals. These strategies included technology-based solutions and efforts to enhance partnerships, community engagement, and local capacity.

UAs were enrolled in the HMG LA Pathways initiative in two cohorts, referred to as Wave 1 and Wave 2. The seven Unifying Agencies include:

Wave 1 (October 2020 - December 2023): Child Care Resource Center (CCRC), Children's Bureau (CB; recently renamed All for Kids), Eastern LA Family Resource Center (ELAFRC), South Central LA Regional Center (SCLARC), Westside Regional Center (WRC)

Wave 2 (July 2022 - June 2025): Long Beach Department of Health & Human Services (LB DHHS), San Gabriel/Pomona Regional Center (SGPRC)



Evaluation Approach

[VIVA Social Impact Partners](#) (VIVA) served as the HMG LA Pathways project evaluator and technical assistance (TA) provider. In this role, VIVA offered tailored support to UAs to help them implement and improve their strategies, such as guidance on data collection, opportunities for peer learning, and coaching aligned with continuous quality improvement (CQI) principles.

VIVA partnered with First 5 LA and the UAs to develop Data Collection, Evaluation, and Learning Plans grounded in a CQI framework. Each plan used the Plan-Do-Study-Act (PDSA) cycle to test and refine UA strategies over three years.

UAs collected and submitted both implementation and outcome data during each evaluation cycle. Core outcome indicators were tracked across all UAs, with the option to include additional measures tailored to local priorities. Data collection was standardized through guidelines and templates.

This executive summary highlights key findings from the implementation of participating UAs' approaches and shares preliminary insights into their impact on the EII system in Los Angeles County across Wave 1 and Wave 2 communities.

Key Findings

Implementation of Approaches:



SELECTING, FINALIZING AND LAUNCHING APPROACHES

UAs took extended periods to finalize their 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.

- ➔ UAs highlighted the importance of sequencing. Relationship building and community engagement often came before finalizing strategies.
- ➔ Capacity constraints, staff turnover, and competing priorities, including COVID-19 pandemic recovery for Wave 1 UAs, also contributed to the extended periods of time.



ADOPTING OR DEVELOPING AN ONLINE/CUSTOMIZED PORTAL

All UAs adopted or built online referral platforms. Successes included stakeholder-informed design, standardized workflows, integration with other key EII functions, and consistent data collection. Challenges included staff turnover, technical glitches, data access issues, cost to sustain, limited closed-loop functionality, and challenges accessing data.

- ➔ The evaluation found that stakeholder-informed design, plus testing with intended users such as intake staff and caregivers, produced more user-friendly systems.
- ➔ Referral portals were found to help clarify referral partner roles, standardize workflows, and improve referral submission and tracking. In addition, portals became connective hubs that linked multiple EII functions.



DATA COLLECTION AND SUBMISSION

Most UAs' capacity for data collection and evaluation was limited, but improved over time through TA support. Specifically, TA contributed to the following improvements in data collection across Waves 1 and 2:

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

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.

- ➔ Journey mapping findings underscored the need for clearer communication and tools for medical partners and the role of trusted EII system navigators.
- ➔ Place-based events turned outreach into direct access: LB DHHS conducted on-site screenings and immediate referrals at community celebrations; ELAFRC paired interactive education with ASQ screenings; and SGPRC's promotoras reached families across 120 events with multilingual materials. UAs also leveraged email, social media, and text messaging services to extend reach and reinforce developmental messages via trusted channels.



PARTNERSHIP BUILDING

Strong cross-sector partnerships spanning community organizations, medical providers, regional centers, and school districts were foundational to the success of the HMG LA 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.

- ➔ Cross-sector partnerships were foundational to selecting, implementing, and refining the UAs' approaches. Partners distributed parent surveys, shared de-identified referral data, tested portals, and helped build local EII capacity.
- ➔ Engaging medical providers required sustained effort. CCRC, for example, spent 6-8 months onboarding clinics to Unite Us due to multi-site coordination, staff training, and data/security protocols. Similarly, partnering with regional centers was essential but complex, given their varied intake and consent processes.



TECHNICAL ASSISTANCE

TA was key for UAs' implementation of nearly all components of the project, 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.

- ➔ Data submission TA offered flexible submission pathways (raw files or templates), sample exports, clear guidance, and one-on-one sessions, which reduced burden and improved accuracy and consistency.

Project Outcomes:⁶

- 1. Communication & tracking on referral status between referring agency and referral source:** The evaluation found partner referral portal usage and ease of use increased over time throughout participation in the HMG LA Pathways initiative.
 - Wave 1:** From Cycle 1 to Cycle 2, Wave 1 partners using online referral portals monthly increased by 8 percentage points; those reporting that referrals were easy to track increased by 9 points.
 - Wave 2:** Wave 2 partners saw an 18-point increase in monthly portal use from baseline to Cycle 2. Within the LB DHHS community, 100% of partners found referrals easy to track in Cycle 2.
- 2. Wait times between screening and assessment, and between assessment and prevention or intervention services:** 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:** At ELAFRC, 84% of 2,147 children began Regional Center services within 45 days of IFSP signing in Cycle 2. In Cycles 1 and 2, CB convened all four of its collaborative partners to analyze data and identify strategies to reduce screening-to-service wait times.
 - Wave 2:** SGPRC reduced the average time to referral confirmation to 2.5 days, surpassing its target of 10-20 days in Cycle 2. LB DHHS shortened referral closure time from 5.1 days in Cycle 1 to 4.6 days in Cycle 2.
- 3. Age at which children are referred to services and begin services:** Wave 2 UAs saw a 4-month reduction in average age at time of referral. Across all UAs, disparities remained by race and gender. On average, boys were referred later than girls 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:** 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. This increase coincided with a 135% increase in sample size, rising from 2,800 to 6,577 children. Boys were referred 4 months later than girls on average, and Black/African American and American Indian/Alaska Native children were the oldest at the age of referral, averaging 34 months (n=11), compared with 25 months for Hispanic/Latino (n=3,853) and 26 months for those identified as “Other” race (n=733). Referral age also varied by home language, ranging from 20 months in Farsi-speaking households (n=17) to 37 months in Russian-speaking households (n=13).

⁶ The 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. Additionally, 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.

Wave 2: Across Wave 2 UAs, the average referral age decreased by 4 months from Baseline to Cycle 2. Boys were referred at 19 months compared to 18 months for girls. Latino, Filipino, and Asian children were referred later, averaging 20 months compared with 15 months for children identified as “Other.” Differences were also seen by home language, with Chinese-speaking households reporting the highest referral age (20 months, n=113) compared with 19 months for English (n=1,792) and Spanish-speaking households (n=378).

4. **Access to EII assistance:** Findings from parent surveys showed that, across all UAs, parents/ caregivers of Black or African American children and girls were least likely to report that they were able to access the EII assistance they were seeking. Parents from Spanish-speaking households reported higher rates of accessing assistance for their child compared to those from English-speaking households.

Wave 1: Access to assistance was higher for parents/caregivers of boys (81%, n=177) than girls (77%, n=116). By race, access was lowest for parents/caregivers with Black or African American children (60%, n=34) and highest for Latino families (86%, n=153). Spanish-speaking households reported higher access (89%, n=92) than English-speaking households (76%, n=196).

Wave 2: Access to assistance was slightly higher for parents/caregivers of boys (89%, n=190) than for girls (86%, n=114). Black/African American families reported the lowest access (80%, n=10), while families identifying as Two or More Races had the highest (98%, n=50). By language, English households reported lower access (87%, n=265) compared with Spanish (90%, n=137) and Chinese-speaking households (94%, n=31).

5. **Parent/caregiver satisfaction with referral process and linkage to services:** Findings from parent surveys showed that, 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: Satisfaction declined slightly over time, though survey response size increased by more than 120%. Parents of boys were more satisfied (77%, n=176) than girls (71%, n=116). By race, Black/African American families reported the lowest satisfaction (60%, n=35), while “Other” racial group reported the highest (80%, n=18). Families from Spanish-speaking households (77%, n=91) reported slightly higher satisfaction than English-speaking households (73%, n=196).

Wave 2: Satisfaction increased by 13% from Cycle 1 to Cycle 2. Gender gaps disappeared, with both groups averaging 93%. Black/African American families reported 100% (n=10) satisfaction, while Hispanic/Latino families reported the lowest (90%, n=157). Chinese-speaking households reported 100% satisfaction (n=31), compared with 94% English-speaking (n=265) and 91% Spanish-speaking households (n=137).

6. **Sustainability:** At the project's conclusion, all UAs felt prepared to sustain a majority of the approaches developed through the HMG LA Pathways project. Planned strategies for sustainability included embedding project 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. One year after the HMG LA Pathways grant period ended, Wave 1 UAs reported progress in sustaining portals, transforming their collaborative partnerships, and leveraging data tools (e.g., dashboards, and heatmaps) for internal system strengthening efforts. However, they also identified challenges, including technology costs, staffing limitations, navigating the end of ongoing TA support, and loss of formal collaborative structures.

Lessons Learned

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

1. **Time:** Building partnerships and referral systems requires significant time. Adjustments to expectations were needed, particularly for Wave 1 UAs impacted by COVID-19. More time is often necessary to achieve desired outcomes.
2. **Funding:** Project funding was critical to success, enabling partner participation, cross-agency collaboration, testing of referral platforms, and centering community voices in system design.
3. **Cross-Sector Partnership & Collaboration:** Strong collaboration across sectors, especially with medical practices, regional centers, and schools, is essential, though it requires substantial time and resources.
4. **Data Capacity:** UAs strengthened their ability to collect and analyze data, including disaggregated data by race, language, and zip code. This capacity is critical for identifying disparities and informing outreach and programming.
5. **Referral Platforms/Portals:** Investment in referral platforms improved efficiency, but success depends on aligning tools with partner workflows and allowing design flexibility.
6. **Community Engagement:** Engaging families through diverse modalities built trust and provided valuable feedback.
7. **Technical Assistance:** Ongoing TA and VIVA's adaptability were critical in supporting UAs and sustaining progress throughout the project.

Recommendations for Future Efforts

Based on the above insights and learnings gleaned through the implementation of HMG LA Pathways activities and evaluation efforts, VIVA recommends the following:

- 1. Further examine and address existing disparities:** Prioritize further examination of disparities in EII access, satisfaction, and referral timing, especially for Black, American Indian/Alaska Native children, girls, and other underserved groups, to inform targeted strategies for reducing barriers.
- 2. Offer support and incentives for consistent data collection, data sharing, and collective learning:** Invest in the infrastructure, funding, and incentives needed for regular data collection, disaggregation, and data sharing across partners. Promote family and partner feedback loops as a standard practice to drive continuous improvement.
- 3. Create a countywide portal/referral system:** Create a countywide referral portal that integrates with existing systems (e.g., regional center portals, medical EHRs) and supports closed-loop referrals. Provide ongoing training, outreach tools, and shared data protocols to promote adoption and use.
- 4. Target medical partners to engage in the EII System:** Sustain targeted outreach, education, and collaboration with medical providers to strengthen developmental screening and referral practices—acknowledging their role as key entry points for families.
- 5. Center community and family experiences:** Ensure ongoing investment in strategies that elevate family and community perspectives. Financial and technical assistance are critical to making engagement authentic, equitable, and actionable.