AGENDA

SPECIAL JOINT MEETING OF THE BOARD OF COMMISSIONERS AND THE BUDGET & FINANCE AND EXECUTIVE COMMITTEES

Budget & Finance Committee Chair: Robert Byrd

Thursday, February 28, 2019
1:30 PM

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

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1. **ACTION**
   Call to Order / Roll Call
   - Marlene Zepeda, Committee Chair

2. **INFORMATION** — 3
   Review Program & Planning Committee Meeting Transcript – January 24, 2019
   - Marlene Zepeda, Committee Chair

3. **INFORMATION** — 106
   Policy & Strategy Update: Early Childhood Priorities, Processes and Partnerships from Governor Newsom's Administration
   - Kim Pattillo Brownson, VP of Policy & Strategy
   - Kris Perry, Deputy Secretary of the California Health and Human Services Agency for Early Childhood Development and Senior Advisor to the Governor on Implementation of Early Childhood Development Initiatives, Office of the Governor of California

4. **INFORMATION** — 113
   Health Systems Outcome: Establish a Strategic Partnership with L.A. Care Health Plan for the Early Identification and Intervention Pilot and Authorize

COMMISSIONERS
Los Angeles County Supervisor Holly J. Mitchell, *Chair*
Brandon Nichols, *Vice Chair*
Judy Abdo
Robert Byrd, Psy.D
Astrid Heger, M.D.
Yvette Martinez
Summer McBride
Maricela Ramirez
Carol Sigala

EX OFFICIO MEMBERS
Barbara Ferrer, Ph.D., M.P.H., M.Ed.
Jacquelyn McCroskey, DSW
Deanne Tilton

EXECUTIVE DIRECTOR
Karla Pleitéz Howell

EXECUTIVE VICE PRESIDENT
John A. Wagner

First 5 LA staff to Execute New Agreement with L.A Care Health Plan
- **Cristina Peña, Senior Program Officer, Health Systems**
- **Alexandra Parma, Program Officer, Health Systems**

5. Break

6. **INFORMATION** **133**
Establish a Strategic Partnership with KPCC Southern California Public Radio (SCPR)
- Jennifer Pippard, Director, Strategic Partnerships
- Marlene Fitzsimmons, Manager, Communications

7. **INFORMATION** **170**
Strategic Plan Refinement Process (SPR4) Update
- Christina Altmayer, VP of Programs
- Steven LaFrance, Founder & CEO, Learning for Action

8. **INFORMATION** **183**
Families Outcome: Update on Welcome Baby Implementation and Outcomes Study Evaluation Findings (Written only)
- Armando Jimenez, Director, Measurement, Learning & Evaluation
- Melinda Leidy, Program Officer, Family Supports

9. **INFORMATION** **295**
Best Start Learning Agenda Update (Written Only)
- Antoinette Andrews Bush, Director, Communities
- Kimberly Hall, Manager, Evaluation & Learning
- Sandra Hilliard, Evaluation & Learning Analyst

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10. **INFORMATION**
Public Comment (For items not on the agenda)

11. **ACTION**
Adjournment

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

MEETING OF FIRST 5 LOS ANGELES PROGRAM AND PLANNING

Thursday, January 24, 2019

750 North Alameda Street, First Floor

Los Angeles, California 90012

REPORTED BY:
HEATHERLYNN GONZALEZ
CSR #13646

1 Thursday, January 24, 2019; Los Angeles, California
2 1:33 p.m.
3 -oOo-
4 COMMISSIONER ZEPEDA: Okay. Welcome to the
5 planning and program -- P and P meeting.
6 MS. BELSHE: There you go.
7 COMMISSIONER ZEPEDA: And happy new year to
8 everybody. I'm hoping that this year is going to be a
9 good one, with the focus on young children from the
10 governor. So we'll be hearing more about that today.
11 So welcome. So let's start with our roll call.
12 COMMISSIONER PLEITEZ HOWELL: Karla Pleitez
13 Howell, First 5, commissioner.
14 COMMISSIONER HEGER: Astrid Heger, commissioner.
15 COMMISSIONER CAGLE: Bobby Cagle with DCFS,
16 commissioner.
17 COMMISSIONER ARAGON: Linda Aragon with DPH.
18 COMMISSIONER ABDO: Judy Abdo representing Sheila
19 Kuehl's district.
20 MR. WAGNER: John Wagner, First 5 LA.
21 MS. COLMAN: Debra Colman, First 5 LA.
22 MS. PATTON: (Unintelligible) Patton, First 5 LA.
23 MS. PENA: Cristina Pena, First 5 LA.
24 MS. BROWNSON: Kim Pattillo Brownson, First 5 LA.
25 MS. PINEDA: Daniela Pineda, First 5 LA.

1 COMMISSIONER WOODS: I am Keesha Woods,
2 Los Angeles County Office of Education.
3 COMMISSIONER TILTON: Hello. I'm Deanne Tilton,
4 the commissioner representing ICAN.
5 COMMISSIONER THOMPSON: Kip Thompson, DMH.
6 COMMISSIONER TAYLOR: Romalis Taylor,
7 representing Mark Ridley Thomas, commissioner.
8 COMMISSIONER SMITH: Wendy Smith, commissioner
9 representing the Commission For Children and Families.
10 MS. BELSHE: Kim Belshe, First 5 LA.
11 THE REPORTER: Heatherlynn Gonzalez, court
12 reporter.
13 SPEAKER: Amato (inaudible), First 5 LA.
14 MS. HILL: Linda Hill, First 5 LA.
15 SPEAKER: (Inaudible), First 5 LA.
16 MR. FARVA: Brian Farva, First 5 LA.
17 COMMISSIONER ZEPEDA: Okay. And Alice, since
18 you're over there.
19 SPEAKER: Oh, my God. Hi, everybody,
20 (Inaudible), First 5 LA.
21 MS. SWILLY: Sylvia Swilly, LA Commission
22 (inaudible).
23 MS. SHRINER: Kathy Shriner, executive committee
24 volunteer, Best Start Panorama City and Neighbors,
25 includes Van Nuys And Northhills East.

1 MS. DUBRANSKY: Barbara Andrade DuBransky, First
2 5 LA.
3 SPEAKER: Kaia Tith, First 5 LA.
4 Mr. BARTH: Peter Barth, First 5 LA.
5 MS. MARTIN: Charna Martin, First 5 LA.
6 MR. SANCHEZ: Gabriel Sanchez, First 5 LA.
7 MS. ALVARADO: Christina Alvarado, Childcare
8 Alliance of Los Angeles.
9 MS. RODRIGUEZ: Gina Rodriguez, First 5 LA.
10 SPEAKER: Miriam (inaudible), First 5 LA.
11 SPEAKER: (Inaudible), First 5 LA.
12 SPEAKER: (Inaudible), First 5 LA.
13 SPEAKER: (Inaudible), First 5 LA.
14 SPEAKER: (Inaudible), First 5 LA.
15 MR. LaFRANCE: Steven LaFrance, Learning For
16 Action.
17 SPEAKER: Manuel Fierro, First 5 LA.
18 SPEAKER: Alex Hilbrandt, Learning For Action.
19 MS. ANDREWS BUSH: Antoinette Andrews Bush, First
20 5 LA.
21 MR. GONZALEZ: Rafael Gonzalez, First 5 LA.
22 Speaker: (Inaudible), First 5 LA.
23 COMMISSIONER ZEPEDA: We got Rafael; right? I
24 couldn't see. There was blockage.
25 And I'm Marlene Zepeda, District 1 rep and chair

1 of the committee.

2 For our commissioners, Item 2, review of the

3 transcripts. Do the commissioners have any suggestions --

4 don't smile at me again -- for changes or modifications?

5 We were talking about this earlier.

6 COMMISSIONER TILTON: I think we should give an

7 award to the transcriber.

8 COMMISSIONER TAYLOR: Yeah, she's great.

9 MS. BELSHE: More than the chocolate chip

10 cookies?

11 COMMISSIONER ZEPEDA: Hearing none, we'll accept

12 them as is.

13 Moving on to Item 3, Early Childhood Priorities,

14 Gubernatorial Engagement, and Proposed California Budget.

15 This is going to be a positive report for us from Kim

16 Pattillo Brownson and Becca Patton.

17 MS. PATTILLO BROWNSON: So I'm going to actually

18 start by grounding -- should I be pointing somewhere else?

19 Or I can do it manually. Actually, I'll just start

20 actually by grounding this presentation in our north star

21 which we've talked about at this committee a number of --

22 MS. BELSHE: Let's hold just one second. Let's

23 get this pinned down.

24 MS. PATTILLO BROWNSON: There we go. We have

25 talked at this committee and at the full commission a

1 number of times about our north star, which is by 2028
2 that all children in LA County will enter kindergarten
3 ready to succeed in school and life. And I think it's
4 important to ground our gubernatorial engagement work and
5 our policy agenda in that result. Essentially, the surest
6 way to ensure that our policy and our budget priorities
7 reflect that is the legislature and the governor. Those
8 are the two sort of main roles and players that actually
9 influence our state government.
10 And so in the past, I think we have talked a
11 little bit -- and there's some new commissioners. I'll
12 just do a little refresher on this. In the past, we have
13 had a fairly willing partner in the legislature. There's
14 been a number of legislative champions I think who have
15 come out of early childhood and have put forth proposals
16 to actually move the ball forward for young children and
17 their families. We have had greater difficulty, however,
18 with finding an adequate dance partner for legislature.
19 And so focusing on gubernatorial engagement and looking
20 back and thinking about what we can do better matters a
21 lot.
22 When we originally brought forward a presentation
23 and an investment strategy with the Silicon Valley
24 Community Foundation on gubernatorial engagement, we
25 looked at a little bit of the history of prior

1 gubernatorial elections and looked back at Meg Whitman and
2 Jerry Brown, having then been candidates, and were -- I
3 can say I was personally pretty startled to find that
4 early childhood did not at all register on their radar.
5 It did not make their top ten list. It did not make their
6 top 20 list. And that is in the same way that we think
7 about preventable harms for young children, there are
8 preventable harms in policy snafus that need not happen.
9 And so our strategy here was to, essentially, get
10 to the candidates early, educate them, help them
11 understand sort of what the dire shortages and needs and
12 reforms are that are necessary in our field, and make sure
13 that they understand that it not just a nice to have when
14 you are flushed with surplus, but a vital necessity.
15 So what part of the education campaign was about
16 media. We had the very first televised gubernatorial
17 debate that actually had several early childhood
18 questions. We also had individual funder and donor
19 candidate forums where, as opposed to sort of doing the
20 high level for TV, there were a pepper of sort of
21 questions being -- coming towards each of the candidates,
22 so they had to be reasonably conversant and be able to
23 present their views on the issue.
24 We also highlighted polling showing that the
25 public is with them, that the public wants investments in

1 young children in priorities in the budget. And we also
2 shared messaging data around sort of what the path forward
3 would look like.
4 The last part -- and this is the last bullet that
5 you will see on your screen or page -- is around the
6 blueprint. And we've heard great feedback that, again,
7 with our partner in the Silicon Valley Community
8 Foundation, there was a 90-day rollout plan that was very
9 concrete. There was immediate actions that could be
10 taken, many of which have now actually come into fruition.
11 There are gubernatorial staff appointments that did not
12 previously exist in Governor Brown's administration around
13 a senior policy advisor on early childhood development, a
14 -- a deputy secretary of health and human services who was
15 just actually named on Monday, who is Chris Perry, who is
16 also an alumni of the First 5 family. And also there are
17 now additional appointments that have been seated with
18 many of the priorities. Nadine Harris who is from San
19 Francisco -- many of you know her from her trauma-informed
20 work -- has just been named surgeon general.
21 And so these are innovations that did not exist
22 in the past administration that I think are very exciting
23 to see again coming to fruition.
24 We also understood that in order -- we couldn't
25 just come up with good policy recommendations, but that we

1 also needed to put pressure on and create the surround
2 sound so that the candidates who would know that there is
3 a chorus of supporters who are awaiting good policy making
4 and decision making. So we have broached -- and I'll
5 acknowledge Gabe Sanchez, who's over there -- into new
6 areas of communications covering Cal Matters, Capitol
7 Weekly, the San Jose Mercury News, the LA Times, KABC,
8 KPCC, KNX Radio, California Public News and Service. And
9 all of this is designed to essentially both ensure that
10 our electeds know that this is a safe place to tread, but
11 also a worthwhile one to invest.
12 The last thing I'll just get to is what are the
13 actual results in the budget. And so on January 10th, we
14 were very much delighted to see that not only did Gavin
15 Newsom as a candidate talk about young children as
16 priorities, but his budget reflects a high watermark. We
17 did an analysis of other gubernatorial pronouncements in
18 their first budget and then their proposed investments in
19 young children. And outside of a court-mandated
20 settlement in New Jersey, this is the single-largest
21 budget package of any sitting American governor. That is
22 actually a pretty exciting thing and it is -- it is an
23 opening volley in a conversation with the legislature, but
24 it absolutely gives us a toe hold to be strong
25 negotiators.

1 What's also noteworthy is the comprehensiveness
2 of the package which mirrors again how our policy
3 prescription rolled out, which was to say that, although
4 there's been great and forward moving motion on early care
5 and education in the budget in past years, what young
6 children need to thrive is not just a one-shot vaccine of
7 ECE. What this budget really reflects is a comprehensive
8 view that I think reflects an understanding that children
9 don't live in silos and that they need multiple wraparound
10 services. So there are family strengthening investments,
11 over hundred million in home visiting between the CalWorks
12 home visiting initiative, as well as the match for the
13 federal MIECHV money. There is an economic strengthening
14 component with a CalWorks investment to build off of last
15 year's investment, as well as a enlarging of the EITC, the
16 Earned Income Tax Credit. There's an expansion of paid
17 family leave proposal from six weeks to six months, which,
18 again, would make us a front runner among the states.
19 And then in health, there's important work -- and
20 I want to acknowledge Charna and Peter who are smiling
21 proudly in the back, because AB-11, which was our first
22 bill -- our very first legislative baby here out of First
23 5 LA, is very much influencing how this new governor is
24 actually thinking about the importance of developmental
25 screenings and developmental delays, and is shored up by

1 $60 million proposal in terms of developmental screenings.
2 In addition, there's a $8 million investment in
3 black infant health, building on much of the work of our
4 partners in the county from last year. And then in early
5 care and education, the highlights are 500 million for
6 facilities and workforce development, a 125 million to
7 expand targeted universalism, which means serve all
8 low-income eligible four-year olds, and then the creation
9 of a road map between the Department of Education, the
10 Department of Social Services, and the Department of
11 Finance.
12 I'll just close by saying, these are all very
13 exciting new waters that First 5 LA is swimming in. I
14 think we've already sort of provoked a little tidal wave,
15 which is really exciting. But we are early in our
16 legislative process, and so I think we are very much
17 buoyed and optimistic about what's ahead, but also very I
18 think sober about what work is ahead because there will be
19 a lot.
20 So one thing I'll just flag for commissioners'
21 consideration and for your calendars that, it is important
22 to not just for them to hear from us but also from and
23 you. So April 30th, I will ask to flag for your calendars
24 as First 5 advocacy day. You all have been incredibly
25 impactful in the past, and we would love to have your

1 again.

2 And with that, we'll transfer back.

3 MS. BELSHE: So I guess the question here is, do
4 we want to pause for a moment and see if there are any big
5 pictures comments or questions that commissioners have
6 before we go into what we're characterizing as the deeper
7 dive on early care and education proposals of the
8 governor's budget? Is that right, Kim or Becca?

9 MS. PATTON: Yeah. We could pause now for
10 questions, if there's sort of --

11 MS. BELSHE: Any kind of big picture, level
12 settling questions?

13 COMMISSIONER ZEPEDA: Any questions,
14 commissioners, on this?

15 COMMISSIONER TAYLOR: I don't have a question as
16 much as a comment. I think the governor put his foot down
17 real strong in talking about his own personal experience
18 and the fact packet that he, as well as his own children,
19 could not have succeeded if it was not for the early
20 assessment for the difficulty they had. I'm not going to
21 talk about what that is. But he comes with cred as to --
22 I always say street cred. He already had the creds for
23 experiencing this. And if it wasn't for the intervention
24 he would not have succeeded as even now as a governor if
25 it wasn't for the assessment that his parents struggled to

1 get for him. So he -- you know, he adds a lot of
2 credibility to what we're trying to do. And that's a very
3 powerful thing when you're talking to someone that doesn't
4 have that credibility, like the legislators. Most of them
5 don't know that. But he can speak from experience. So
6 that's very powerful. I'm excited.
7 Congratulations on all your hard work. And I'm
8 there for the April 30th. My boss says she'll mention me.
9 COMMISSIONER ZEPEDA: Other questions or comments
10 on this part of the presentation?
11 Do -- I have a question. You said that he has a
12 cabinet position. I don't know if you called it a cabinet
13 position for early childhood. Has that person been
14 appointed?
15 MS. PATTILLO BROWNSON: That is Janina Perez, who
16 used to be at Children Now and is a former First 5 LA
17 grantee. And she is absolutely very well steeped in this
18 field and has worked in State policy for over a decade.
19 And we have had initial meetings with her, and then we'll
20 be meeting with the full team in the next couple of weeks.
21 COMMISSIONER ZEPEDA: So some of these items are
22 proposals. They're not set -- they're not -- they're --
23 they still have to pass muster with the legislature.
24 MS. PATTILLO BROWNSON: That's right. All of
25 these are proposals. The January high watermark is

1 essentially the governor's vision document, and then the
2 legislature decides how they want to play ball.
3 COMMISSIONER ZEPEDA: That's why I can see it
4 would be very important.
5 Wendy.
6 COMMISSIONER SMITH: So at our commission
7 meeting, you mentioned the vacancies also on the State
8 Board of Ed and the desire to get someone from, you know,
9 early childhood on there. Has anything happened there?
10 MS. PATTILLO BROWNSON: The State board meets
11 again I think the second week of February. So there are
12 three termed-out former appointees. Mike Crist (phonetic)
13 is one of them. He has taken his name out of contention.
14 I think there are ongoing negotiations as to whether the
15 other two are drafting to be reappointed. One is from a
16 military charter school in the Bay area and one is the
17 former publisher of Ed Source. Excuse me. Not Ed Voice,
18 which is another organization, and she's based out of San
19 Diego.
20 But so before that second week of February, we'll
21 know how many appointments are going to be available and
22 who those people will be.
23 COMMISSIONER ZEPEDA: And there is some
24 discussion at the -- the Commission For Teacher
25 Credentialing to have an early childhood person on there,

1 finally. So we'll see what happens with that.
2 MS. PATTILLO BROWNSON: I should have actually
3 started here. I apologize for not having done so. This
4 is a new space of advocacy and engagement with candidates
5 that First 5 LA has not undertaken before. So really my
6 very first thing that I should have said is, thank you,
7 because this is a new space that we're entering into.
8 It's a grant of trust and it is a privilege to do this
9 work. You did not have to say yes. We're delighted that
10 you did and hope to continue to earn your trust in this
11 work.
12 COMMISSIONER ZEPEDA: Commissioner Taylor.
13 COMMISSIONER TAYLOR: I just want to state that
14 we should be visible somewhere at the table up north. So
15 I wanted to put it on the table that I support someone
16 from our group, kind of mention it to the boss there, that
17 we should put somebody up there to represent us and give
18 us voice at the State level. And so we, as commissioners,
19 who get behind whoever she wants to put forward and give
20 that full-throated support to that person whether it be
21 her or someone else.
22 MS. BELSHE: Are you saying, Romalis, in terms of
23 having staff deployed or --
24 COMMISSIONER TAYLOR: Whatever you think needs to
25 be done. You've come up with great strategy, but I think

1 we need to have a visibility there. When they're making
2 these decisions about what they're going to do, I think --
3 I trust your thinking on this and this organization's
4 thinking because we've been forward thinking about where
5 we should go with this, and a lot of these changes
6 happened because of our forward thinking. That's why we
7 support you. So the ideas is that, what can we do to
8 support whoever you want to put forward, whether it be
9 yourself or one of your team, to be in a pivotal decision
10 making position that says, we can help guide, support, and
11 strengthen the direction of this state.
12 MS. BELSHE: Yeah. And so I appreciate you
13 raising that, and it's an opportunity to echo Kim's
14 comments of thanks, not just for the commission support of
15 the gubernatorial engagement work, but really support of
16 the staff broadly because we are there. We are very
17 present. And it's been lovely and fabulous and exciting
18 to see First 5 LA's visibility elevated, partnerships that
19 we're helping convene and advance moving forward, and to
20 see this new administration understanding. Not only does
21 Governor Newsom get the importance of a comprehensive,
22 whole child approach that Kim just spoke to and put his
23 money -- at least his proposed budget where is vision and
24 mouth is, but he and his team also understand First 5s and
25 see the value of First 5s, and are eager to hear from

1 First 5s. So actually First 5 LA, at the invitation of
2 governor's office, is facilitating a meeting with the
3 chief of staff and senior leaders from the governor's
4 office in the next couple weeks of First 5 LA First, First
5 5 California, and the association.
6 So there are different ways that we are engaging
7 and will engage. We also have California Strategies with
8 the board's support that is our boots on the ground on a
9 daily basis. And the resources that you all have
10 supported to build that capacity out has been enormously
11 powerful. And then the team that Peter has developed and
12 deployed across multiple issues. We're going to go more
13 deeply into ECE in a moment.
14 So I think we're very well resourced and very
15 present and investing your dollars both in terms of
16 contract consultants and staff very, very wisely. Now we
17 have an opportunity with this new governor and
18 administration who gets the contributions First 5s can
19 make, and First 5 LA specifically, to really up our game
20 in the field and the results we see. So we're very
21 visible.
22 COMMISSIONER HEGER: On the health issues I think
23 there's a really unique opportunity to transfer just
24 saying, this is a budget proposal and we're going to ask
25 for money, into it being an expectation of all

1 pediatricians that they would do the screenings and
2 developmental screening. I guess what I would ask, if
3 it's possible for staff, I would love to work with them,
4 but the idea of, what is the compensation -- since we're
5 always talking about billing and money and who gets the
6 money, what's the compensation value to a general
7 pediatrician in the community to do these -- to do both
8 the developmental screening and -- because that's -- and
9 the ACEs score because those are going to be things that
10 they say, well, that takes an additional 15 minutes or
11 another 20 minutes. So the idea of looking at it being a
12 sustainable part of every pediatric evaluation is
13 critical.
14 And then I think also in talking with the First
15 District with Supervisor Solis, she's very interested in
16 getting Gavin Newsom and his wife to come to LA and look
17 at what we're doing and talk about my -- my one note, the
18 idea of screening these kids for FASD at the same time
19 since we know half the kids in foster care have FASD. So
20 the idea being that of bringing them down here and ask
21 them to invest. But I'm always into sustainability, and
22 if we create a standard of care for all pediatricians, we
23 can do it for maybe LA County, but maybe for the state
24 would be awesome. Then we set a standard for the nation
25 and that they then get reimbursed for the time they spend

1 doing that is critical.

2 COMMISSIONER ZEPEDA: Thank you.

3 Okay. Let's go ahead and move on, Becca, for the

4 second half of the presentation.

5 MS. PATTON: Thank you and good afternoon. Just

6 want to thank Kim for that very timely and exciting

7 update.

8 So I'm going to take a moment this afternoon to

9 do a little bit of a deeper dive into the early learning

10 portion. So both what is happening at the State and then

11 what are we doing locally.

12 So the ECE team has been working to bring sort of

13 greater alignment and integration between our programmatic

14 and policy work. So we're working to advance State policy

15 priorities but we're also ensuring that our local ECE

16 system and landscape is not only informing the development

17 of that state policy, but that it is prepared to take the

18 advantage of the opportunities we know are on the horizon.

19 So we're going to go through sort of what that

20 work has looked like, confirm our priorities for next year

21 and discuss anticipated next steps and really hope to

22 engage the commissioners in a robust discussion about

23 what's on the horizon.

24 As Kim mentioned, as we continue to refine and

25 shape our work, we have our north star guiding us. So by

1 2028, we want all children in LA County to enter
2 kindergarten ready to succeed in school and life.
3 Additionally, we also have our results for children and
4 family that commission approved in November and our policy
5 agenda from November 2017 that provides us a framework as
6 we continue to guide and prioritize our work for the
7 coming months.
8 So our first priority for 2019 is looking at
9 increasing access for early learning. So we know
10 Los Angeles county faces an overall lack of capacity in
11 early learning programs. Governor Newsom set a goalpost
12 of expanding our California state preschool program so we
13 can serve all eligible four-year olds by 2022. So we
14 applaud this expansion for four-year olds while also
15 acknowledging that there's still severe shortages for
16 children zero to three. So to ensure increased access for
17 children zero to three, the ECE coalition is going to once
18 again ask for a billion dollar investment in access.
19 As commissioners will recall our state ECE
20 collision is comprised of advocates, providers, and other
21 stakeholders in the field, and they come up with a unified
22 budget ask each legislative season. This coalition is
23 jointly funded by us here at First 5 LA. I want to thank
24 commissioners for your support. It's funded by First 5
25 California. And there's also going to be an investment by

1 the Heising-Simons Foundation to support communication
2 strategy for the coalition overall.
3 Currently, Assembly Bill 194 by Assembly Member
4 Eloise Reyes is the bill vehicle for the coalition's
5 request around access.
6 In addition to the state level work we know that
7 our local system building work also needs to be in lock
8 step with our larger policy work. So we're also
9 supporting increased access at the local level for
10 engaging ongoing work with LAUSD's leadership so they
11 prioritize ECE both with their own investments and through
12 drawing down further funds for the California State
13 Preschool Program.
14 So in addition to funding spaces for access,
15 there actually has to be a physical location for those
16 spaces, which means that we have also a dire need around
17 facilities throughout LA County and the State. So, once
18 again, our state policy advocacy will also mirror our
19 local systems building.
20 So Governor Newsom, as Kim mentioned, proposed
21 500 million for facilities and workforce development. The
22 ECE coalition is currently exploring the best use of that
23 $245 million set aside for facilities. We're examining
24 the merits of what is the current revolving loan fund and
25 how this fund can be reshaped to better meet the needs of

1 ECE providers.

2 Locally, with partnership and leadership from

3 Advancement Project, we're also engaged with the babies

4 and toddlers campaign which highlight the grave need for

5 more access for babies and toddlers within Los Angeles

6 county. A first step in this process was a partnership

7 with the County in the form of a board motion. This

8 motion is looking at currently county-owned facilities and

9 examining which of these facilities might be ripe to be

10 turned into ECE spaces.

11 In order to achieve our results for children and

12 families, which we are steadfastly committed to. It's not

13 enough to just ensure children have access to early

14 learning, but that early experience must be one that is

15 enriching and fosters healthy child development. However,

16 our current system disincentivized quality throughout the

17 system because providers who have to meet higher quality

18 standards often receive a lower reimbursement rate

19 throughout the state.

20 In addition, California's current quality rating

21 improvement system is only serving 14 percent of

22 providers, and it's unclear how many providers are

23 accessing other funding streams around quality improvement

24 efforts.

25 So in order to ensure that early learning

1 experiences are enriching for young children, we're
2 pursuing state policy around reimbursement rate reform.
3 We are also aligning other investments in quality and
4 looking at strategies around workforce development. In
5 addition, we are currently building and building out our
6 current system locally for quality improvement, Quality
7 Start Los Angeles, and have two investments around
8 workforce development that really use the framework of our
9 early childhood educator competencies as the bridge to
10 ensure that we have a unified system for professional
11 development in higher education.
12 So I'm going to dive deeper into these strategies
13 in the next slide. So we want to right size the
14 reimbursement rate structure for providers. We are hoping
15 to take what is now currently a two separate bifurcated
16 reimbursement rate system into a single reimbursement rate
17 system that is both regionalized so it can reflect the
18 different cost of living throughout the state, and
19 actually has a built-in structure that incentivizes and
20 pays for the true cost of care, including providing higher
21 quality care.
22 Currently, Assembly Bill 125 by Assembly Member
23 McCarty is the bill vehicle, and this will also be part of
24 the ECE coalition's ask this year. There will also
25 probably be a separate Senate bill that will be running

1 simultaneously. Once that is done, we'll let commission
2 know.
3 Additionally our team, in partnership with others
4 in the field, is actually doing a deep dive into what are
5 the other quality improvement funding streams available to
6 providers through the State. The California Department of
7 Education has a quality improvement fund; however, it's
8 unclear how many providers are impacted by this fund, are
9 taking advantage of this fund, and how effective these
10 funding streams are. So we're doing an analysis to figure
11 out what is the impact and effectiveness and how can we
12 better align these funding streams, both with each other
13 and the State's investment in the quality rating and
14 improvement system.
15 Again, in addition to our state policy advocacy,
16 we're also doing our local systems building. So across
17 the state, there continues to be effort to increase the
18 number of providers in our state's quality rating and
19 improvement system. As you'll recall, since 2015 First 5
20 LA has been working collaboratively with various partners
21 to develop, refine, and improve what was a previously
22 bifurcated quality rating and improvement system in LA
23 County into one single system. This currently now unified
24 system is Quality Start Los Angeles.
25 We're continuing to convene our partners, which

1 includes the Los Angeles County Office of Education, Child
2 360, the Child Care Alliance of Los Angeles, the County of
3 Los Angeles Child Care Planning Committee, PEACH, and the
4 Office for the Advancement of Early Care and Education.
5 Want to make sure we have all our partners in there.
6 So these partners are currently in the process of
7 finalizing the local governance structure for this quality
8 improvement system. So this governing structure right now
9 includes a funders circle and a leadership council which
10 provides an overall vision for a countywide quality
11 improvement system and separate committees to make local
12 implementation level decisions around Quality Start
13 Los Angeles.
14 Additionally, our team is currently exploring the
15 opportunity to braid and blend the different funding
16 streams supporting Quality Start Los Angeles. We want to
17 make sure that we're created greater efficiencies
18 throughout the system and expanding the reach of our
19 Quality Start Los Angeles system.
20 Workforce undergirds both access and quality. So
21 we know that we need to both retain the current workforce
22 we have in order to maintain access, make sure we have a
23 robust pipeline into our workforce to increase access, And
24 that that workforce is well educated and prepared to offer
25 the best quality for our children.

1 So we're -- we know workforce members with more
2 professional development and education can provide
3 children with better quality of care, but our current
4 workforce is undercompensated. In addition, they are not
5 able to access opportunities that could improve their
6 skill set.
7 So, again, at the state level, part of the ECE
8 coalition's budget ask includes legislation to reimagine
9 and expand the AB 212 program. This is an existing
10 program that is designed to retain early educators within
11 our workforce. This program provides stipends to early
12 educators who are either pursuing professional development
13 or higher education. And, again, this is another bill
14 vehicle for the Governor Newsom's proposal around the 245
15 million set aside for work force development.
16 Also at the state level there is an effort to
17 revise and improve the child development permit matrix.
18 PEACH is a coalition of college and university faculty
19 working to strengthen our early educator preparation
20 system. A first step in this revision of the matrix is
21 creating the teacher performance expectations. So PEACH
22 is working across the field to galvanize the field and
23 make sure that they are offering input into this crucial
24 first step and revising the matrix.
25 Once again, our state policy advocacy has to be

1 near to our local systems building. So another approach
2 to strengthening our workforce can be found in the
3 California early childhood education competencies,
4 shorthand known as just competencies. These were
5 developed by both the California Department of Education
6 and First 5 California ten years ago, and can provide a
7 unified framework by which to develop the workforce. Our
8 current workforce has two pathways to develop their
9 skills, both within community-based trainings and within
10 our higher education system, and the competencies can be
11 the through line through both systems.
12 So locally we're invested in two strategies to
13 embed the competencies as a framework in both systems. So
14 the early childhood educator competencies initiative
15 integrates these competencies into community-based
16 training programs. Currently, we have seven
17 community-based training programs, and they're meeting
18 regularly to collaborate, connect, and leverage resource
19 around the competencies, and over the next year they will
20 begin to develop and trust trainings that actually do
21 embed these competencies within their in training program
22 for our workforce.
23 Again, the mere strategy is PEACH's work around
24 embedding competencies within course work throughout our
25 higher education system. So, again, using the

1 competencies as a framework, this strategy aligns ECE
2 courses throughout 23 different community colleges and
3 universities within LA County.
4 In addition PEACH is using the data gathered in
5 mapping these courses to inform decisions about future
6 course offerings. For example, during the mapping
7 process, PEACH discovered that a large oversight was the
8 lack of courses offered in supporting dual language
9 learners. So this lesson learned is going to be used to
10 inform future advocacy around what courses are actually
11 offered within our higher education system.
12 So 2019 is going to be a busy year.
13 I also want to talk a little bit about not only
14 the work we're currently engaging in, but what foundation
15 are we laying for what's on the horizon and how are we
16 using our current efforts to inform our future work. So
17 in addition to our current priorities, we're engaged in a
18 number of efforts to further understand both the current
19 needs of Los Angeles county's children, but also our
20 statewide and local ECE system. So California was a
21 recipient of the federal preschool development grant. One
22 of the first projects of this planning grant was to
23 conduct a needs assessment for children zero to five to
24 truly understand what the needs are around the access
25 throughout the state. There are also initial

1 conversations happening around unifying existing
2 kindergarten readiness assessment efforts to better
3 understand the impact and potentially lay the groundwork
4 for a statewide kindergarten readiness assessment. That's
5 at the state. And, again, locally, we also have our
6 investment, which the commission is familiar with, around
7 the kindergarten readiness assessment.
8 This will -- this information and understanding
9 around child development, based on our KRA results, will
10 help shape and refine our decisions in investment so we
11 can meet children and communities where they are and
12 ensure that we are investing in the best ways to support
13 them.
14 Additionally, First 5 LA's conducting a fiscal
15 assessment of ECE providers and supporting the countywide
16 fiscal assessment that is currently under way. Data from
17 these assessments will paint a better picture of not only
18 the funding streams flowing into Los Angeles county that
19 support ECE, but the effectiveness by which we draw down
20 and spend these funds.
21 You know that currently we are under spending a
22 lot of the funds that are actually allocated to
23 Los Angeles county, and we're hoping information from both
24 these assessments will allow us to better utilize existing
25 resources.

1 In partnership with the county, we're also
2 supporting the Office For the Advancement of Early Care
3 and Education. As you all know, in July 2018 this office
4 moved from the CEO's office to the Department of Public
5 Health. And this provided a moment-in-time opportunity to
6 strategically think about the office's contribution to the
7 overall well-being of children and families in LA County,
8 with a particular focus and lens on public health policy.
9 With our support and partnership, that office is currently
10 engaged in strategic planning process to both reimagine
11 the office but also the structure and contribution of the
12 county's policy roundtable and the county's child care
13 planning committee.
14 Finally, we have our own strategic plan
15 refinement process which offers all of us a moment-in-time
16 opportunity to think reflectively and critically about our
17 own contribution to policy and systems change and how we
18 want to proceed with this work in the future.
19 Commissioners will receive a more robust update on our
20 strategic plan process later in this meeting by Christina.
21 So I know that was a lot. So I will pause here
22 for questions. And just want to thank you for your
23 support the past few years and as we enter into 2019.
24 COMMISSIONER ZEPEDA: Thank you, Becca.
25 Questions for Becca on the early childhood

1 approach?

2 Commissioner Smith.

3 COMMISSIONER SMITH: I have just a couple of

4 concrete kind of questions, which I now can't find.

5 One of them has to do with the rate reform

6 efforts. I -- I wasn't clear whether the bill, AB 125, is

7 the bill that contains whatever the mechanism for

8 incentivizing.

9 MS. PATTON: Yeah. So that bill contains sort of

10 the policy outline of how to bring those two reimbursement

11 rate systems together into one rate structure that would

12 then differentiate reimbursement rate levels for providers

13 based on the current cost of living where they are

14 regionally and also what standards they're meeting around

15 quality.

16 COMMISSIONER SMITH: And it will weigh out

17 measures the way in which that's to be --

18 MS. PATTON: At this point, it doesn't get that

19 detailed. But there is a rate reform work group that is

20 being convened by First 5 California of which First 5 LA

21 is a participant, and they should be finalizing that in

22 the next few months.

23 COMMISSIONER SMITH: The other question I had had

24 to do with the -- I'm going to find it -- sorry.

25 Does the one billion ask from the coalition, how

1 does that relate to the 500 million that the Governor
2 proposed? Is that a separate matter or is that just
3 upping it?
4 MS. PATTON: It is upping it. So we just are
5 trying to underscore the importance of increasing access
6 for children zero to three, and want to set a marker that,
7 if we a goalpost for access to children that are
8 four-years old by 2022, that we have a goalpost that's
9 also mirrored for children zero to three. So it is a
10 billion dollar ask, but the budget process is a
11 negotiation. And it's really just to try to set a goal
12 mark of how much will we increase access for children zero
13 to three by 2022.
14 MS. BELSHE: So if I can -- just because I think
15 it's important for the commissioners to understand where
16 we are right now given what the Governor's proposed. ECE
17 -- say a word about the ECE coalition in terms of its
18 colors and the facilities piece and the quality piece that
19 are in the Governor's budget and the pieces that are not.
20 Because the billion is really getting into the slots that
21 are not a part of what the Governor has put on the table.
22 So break that down.
23 MS. PATTON: For sure. Yes. So ECE coalition
24 comes up with a unified budget ask each year, and it is
25 usually reflective and also responsive to the Governor's

1 budget proposal which happens in the beginning of January.
2 So the ECE coalition this year has developed a budget ask
3 that essentially contains four pillars. The first pillar
4 is increase in spaces, which is that additional billion
5 dollar investment on top of what the Governor has
6 proposed, in particular focused on children zero to three.
7 The second piece of that is the rate reform proposal, so
8 making sure that we do that undergirding of that
9 foundation piece of how we actually reimburse providers so
10 that we have stability throughout the system. The last
11 two pieces are actually just providing clarification
12 potentially to the Governor's proposal. So one is around
13 facilities. So his $245 million set aside, we're
14 currently looking at maybe reshaping the revolving loan
15 fund, and then that could be the vehicle of how that money
16 is distributed throughout the system. And same with
17 workforce is the fourth pillar and looking at the 245
18 million set aside that the Governor proposed in January
19 and using the existing partnership AB 212 as the vehicle
20 to distribute those funds.
21 MS. BELSHE: And, Kim, maybe can you say a word
22 about the road map process that the Governor's budget
23 envisions? It's really getting at the rates and the
24 access fees.
25 MS. PATTILLO BROWNSON: And also just to sum up

1 Becca's description. If the four pillars are facilities,
2 workforce, access, and rates, the Governor has already
3 proposed investments in two. We're supporting those,
4 helping to shape it and make it most useful in
5 implementation so that the money flows properly and
6 actually reaches children and child outcomes.
7 There is a proposal, which is 125 million, which
8 does get two slots. And so, again, we are basically
9 helping to shape the thinking on slots and to be
10 inclusive, not just for fours, but zero to threes as well.
11 In terms of the road map, there is a proposal for
12 $10 million between the State Board of Ed, the Department
13 of Social Services, and the Department of Finance to
14 further detail out what targeted universalism looks like
15 for four-year olds, and then to also develop a road map
16 for broader subsidized child care so income-eligible
17 recipients of the child care for the zero to three space.
18 I think the Governor has signaled that he's very
19 interested in growing high-quality programs. Also
20 signaled interest in dual language learners and making
21 sure that it is a thoughtful rollout of what additional
22 spaces look like. I think part of the messaging from the
23 ECE coalition is that the road map is absolutely the right
24 way to head and that we need a systems approach for the
25 long haul, but that there are immediate pinpoints and that

1 there is some need for immediate relief for very poor
2 families until either that road map can be rolled out or
3 until paid family relief proposal is giving families six
4 months at home with a newborn child can be rolled out
5 because both of those are long-term proposals, and there
6 has a short-term solution.
7 COMMISSIONER ZEPEDA: Commissioner Woods.
8 COMMISSIONER WOODS: Good afternoon. Thank you
9 for this information in this report.
10 I have a couple of comments. And I think I'll
11 start with the probably the easier comment or questions to
12 the team in -- that's more around aligning all the
13 different kinds of systems that's out here. And I, too,
14 am very, very excited about Governor Newsom's proposed
15 budget and, indeed, we have a long way to go. This is
16 just the tip of it. But there's so many other systems out
17 there. What are we doing to ensure, as we are supporting
18 this really aggressive agenda, that we're also giving
19 input about how to align and not duplicate, not cross over
20 each other in our work?
21 One of the things -- Becca, you spoke about the
22 Quality Start LA. I think one of the great benefits that
23 -- I mean, charting to over the last four months -- four
24 years, a lot of work is going into areas, what have you,
25 but we've come to a place where we're kind of manage

1 aligning a system to where we're moving in a like
2 direction. That was a lot of hard work, but I -- I think,
3 ultimately, when we speak about Quality Start or QRIS for
4 Los Angeles, we have more positives that we can share
5 versus the negatives. And we ought to at least know that
6 we're all speaking the same message when we're going to
7 various levels. So what are we doing as relates to that?
8 The other part that I wanted to bring up, you
9 talked about the system approach and you mentioned some
10 agencies you're working with, particularly the Office of
11 the Advancement. I will also encourage you -- and I think
12 I've said this before, Kim, is to really get with LACOE,
13 because we are the largest education agency in California
14 and the nation. We also have a new charge by the Board of
15 Supervisors about our role with early education and our
16 own road map with that. I would love to make sure we're
17 not duplicating and that we're together speaking the same
18 messages, as we not only are reporting to the Board of
19 Supervisors, but as we have the responsibility, oversight
20 for all 80 school districts.
21 In the LCFS formula, the plan that they do every
22 year, we're doing more around their ECE pieces, TK and so
23 on and so forth. We really should be talking the same
24 thing as we're looking at that, as we're monitoring.
25 Right now, we are at LAUSD with a -- because of their

1 financial issues. And so no direction they can go in
2 without LACOE approving that direction. So I really
3 encourage us to be moving in the same page as we do that.
4 And then the last, larger issue I think for me --
5 and it's no support over one program versus another, but
6 as we talk about access, as we talk about needs on -- a
7 very huge part of our foundational funding structure right
8 now is Head Start federal dollars. We have the funding
9 analysis happening right now. We don't know the outcome
10 of that yet. However, federal dollars are becoming
11 increasingly more difficult to utilize in Los Angeles, in
12 particular California overall. How are we looking at the
13 impact of that? Are we working together to try to -- try
14 to continue to allow those dollars to come in?
15 Los Angeles received 25 percent of all of
16 California's dollars for Head Start. That's a huge cut if
17 we cannot find those children. So while we're looking at
18 universal access, we want to make sure we're able to send
19 the children to the programs, but we're streamlining how
20 we're getting them across and what have you so we don't
21 lose those federal dollars in the county.
22 COMMISSIONER ZEPEDA: Do you want to respond?
23 COMMISSIONER WOODS: Yeah, you can respond. A
24 lot of information. No absolute question. Just more of
25 thinking as we're move forward. I want to be partner with

1 you side by side as we're moving. I'm speaking for both
2 agencies, commissioner, employee, what have you, but I
3 want to make sure I'm speaking the same language as the
4 commission as First 5 as I move forward.
5 MS. PATTILLO BROWNSON: Just on the Head Start
6 alignment piece, there are a set of amendments that we're
7 going to be proposing to a couple of bill authors to be
8 more inclusive of Head Start to allow the systems to align
9 in terms of both availability of funds for the revolving
10 loan fund on the facility side and then also to enable
11 some alignment between CSPP and the ratios for Head Start,
12 as well as early transitional -- expanded transitional
13 kindergarten as well as TK. And so that's part of the
14 amendment package that we're putting forward for AB 123,
15 which is the McCarty bill, for four-year olds.
16 And then I'll turn to around the Becca for the
17 Office of Advancement.
18 MS. PATTON: Yeah. Also for the Head Start being
19 able to utilize all those federal dollars, we've had some
20 conversations with the California Head Start Association
21 because those federal dollars use federal poverty line
22 eligibility requirements and that in California is very
23 disproportion at compared to our cost of living of what
24 potential federal policy opportunities are there for us,
25 and would love partnership and input as we continue to

1 look through that.
2 The other piece around sort of aligning systems,
3 I actually think Quality Start Los Angeles provides us a
4 really good road map for how to do that, because it
5 brought the right people to the table at the right time in
6 the right way. It gave us enough time and enough
7 flexibility to build that. And I think continuing to see
8 what are opportunities to use that table as a way to align
9 those systems because you are really -- at that table, you
10 have a lot of representatives that basically cover the
11 entire system. So how are we using that table not only to
12 align QRIS, but align larger quality improvement efforts,
13 potentially align sort of enrollment and access so that
14 we're making sure that the right children are at the right
15 programs.
16 COMMISSIONER WOODS: Thank you.
17 COMMISSIONER ZEPEDA: Other questions?
18 Commissioner Howell.
19 COMMISSIONER PLEITEZ HOWELL: Thanks so much for
20 that information. Incredibly, incredibly thorough. I
21 feel like the two of you should hit the road across the
22 state for a lot of ECE folks. So thank you.
23 I am -- as you all representing, one of the
24 things that strikes me is the Governor has lifted up three
25 main pillars you all are -- we are lifting up the rates

1 pillar. There's a part to the Governor that I think is
2 inviting us for a new opportunity, and that's sort of the
3 data system throughout the state of California. And our
4 previous governor made the point about longitudinal data
5 being used a potential weapon. I think we've got to be
6 cautious. There was a cautionary warning that is right in
7 certain places. But the early care and education field
8 explores this in silos in terms of what data we agree on
9 in terms of what we need. And there are some with the
10 mentality of, you can't track or improve what you can't
11 measure. And then there are others that think about child
12 development, there's a lot you really can't measure there.
13 But our field needs to come out strong with the Governor
14 because he is going to put out a data system. And with
15 all the work we're doing here in First 5 LA and all the
16 work that First 5s are doing up and down the state, I'm
17 wondering what conversations we're having around that, and
18 then what opportunities do we have to convene the really
19 smart people that do this all the time to educate us on
20 the sort of things we need to think about to build this
21 system for ECE at the state level.
22 MS. PATTILLO BROWNSON: So I met with Janina
23 Perez yesterday from -- the new senior policy advisor, and
24 she is very interested in this. And her office mate is
25 Ben Cheeta (phonetic), who is the senior visor on Cradle

1 to Career. And his very first task is in fact to actually
2 build out the recommendations that will form a
3 longitudinal data system that does exactly that, cradle to
4 career. They have been very interested in the CDN work
5 and -- looking for Armando who is really in many ways the
6 godfather of that effort. That sounds far more ominous --
7 I mean it only in a positive way.
8 COMMISSIONER TAYLOR: You're on the hook, big
9 guy.
10 MS. BELSHE: Or else.
11 MS. PATTILLO BROWNSON: And he's also I think
12 expressed a lot of interest in looking at some of our
13 county partners in the First 5 world. Joleen Smith that
14 has done a lot of work to connect administrative data
15 within Santa Clara county across child welfare, across
16 educational systems, interestingly across the juvenile
17 justice system for parents who are incarcerated. And so
18 there I think are pockets of innovation that they are
19 looking to figure out whether these innovations can be
20 scaled. But they are -- they are clearly looking for the
21 pilots that can be grown.
22 COMMISSIONER ZEPEDA: Commissioner Taylor.
23 COMMISSIONER TAYLOR: I think this is a primary
24 opportunity for our lead around the impact framework, and
25 not everything is relevant to data. Data doesn't tell you

1 everything about the impact. And I know we're starting to
2 lead that to develop these concepts about impact and what
3 it means to do systems change. So this would be a primary
4 time to get along -- get with everyone that here at the
5 table and others that may be opportune collaborative
6 partners to help develop that impact framework that talks
7 about the impact of what we're trying to do and how it's
8 effecting communities, how it's affecting families and
9 children, and not just look at data. How are we teaching
10 the parents how important it is to help the child through
11 those first five years of their life? How is it that
12 we're helping communities to help these families and these
13 parents to help these children's first five years of their
14 life? How are we helping our colleagues in DCFS to help
15 those children? They must take for their safety to get
16 what they need while they're in our custody. Those kinds
17 of things need to be in this impact framework so that
18 we're taking everyone involved and collaborating with them
19 as well as the others and -- because I keep seeing data,
20 and it's freaking me out because I know we're doing impact
21 framework and not everything is related to data.
22 And so where's my friend? She's teaching me real
23 good about data collection and stuff like that, so I want
24 to make sure that we're looking at the impact framework.
25 I really appreciated Kim telling you what do we

1 -- give us what that looks like. That's the first time
2 I've heard about the four pillars. So we need to know so
3 we can support you in what you're trying to do, what does
4 that pillar look like. Someone has added another pillar
5 that says, we need to add data. But I would say data and
6 impact framework within the essence of what we're trying
7 to do so that we can guide what we're doing at the state
8 level. And it's driving me crazy, but I think, because of
9 what you said, we may have to go to the feds and talk
10 about changing them and how they talk about us.
11 So I mean, that's why I'm saying we need to -- I
12 need to have a macro and a micro perspective on this.
13 And then my other colleague said, there's a level
14 in between. What was that? Meso. So we need to be
15 thinking in these dimensions when we're talking about the
16 impact; what does that look like. Starting somewhere and
17 stay saying, does that work. And if it doesn't work, what
18 does work and getting with all these brilliant minds to
19 come up with these measures or concepts or approaches to
20 say, this is the impact of that change, and it's not
21 always relevant to a data. If we turn around and say, if
22 we educate, how many people out there know that in the
23 first five years of their lives, the children develop 90
24 percent of their brains. If you ask the general public
25 and the community, they have no knowledge of this. The

1 medical profession doesn't tell them about it. We don't
2 tell them about it. No one's telling them. And so it's
3 important that we educate the community both at family
4 level, in between, and the system's level. Right? So
5 it's important that we talk about the impact framework.
6 Just a thought.
7 COMMISSIONER ZEPEDA: Thank you, Commissioner
8 Taylor.
9 Other comments?
10 Commissioner Abdo.
11 COMMISSIONER ABDO: I have a couple of things.
12 Just as an example of the issue of the poverty
13 level nonalignment, shall we say. Last week the Santa
14 Monica Malibu School Board decided not to go for their
15 next Head Start application for that very reason, that
16 there are not enough children within the -- the district
17 to do the kind of work that we needed to do. However,
18 what they did do and what some of us had to work hard to
19 do, is they -- they got the school board to commit to five
20 years of funding for early childhood including the Head
21 Start requirements to have nursing, community liaisons
22 work with families, and expanded, of course, the -- who's
23 eligible for those programs.
24 So it's all in transition. And Keesha
25 understands exactly what's going on because she was part

1 of that discussion, but it's -- it's unbelievable to me
2 that we are still working on this nonaligned program when
3 there is all this federal money that we cannot access.
4 And I -- it -- I don't know how to work on that, but it
5 needs to be worked on. I don't think the current federal
6 world is going to fix this.
7 So -- and then the other thing I wanted to
8 highlight, I guess -- I agree with almost everything else
9 that's being said, and I won't repeat that. But in the
10 quality assessment issue, as regards retaining qualified
11 providers and qualified teachers and -- and the others who
12 work within the field, if the quality -- if we're going to
13 demand increased quality without acknowledging that there
14 are many, many people who work with children who don't
15 have BAs, who are not going to go for BAs, they've worked
16 in this field for a very long time, and sometimes are the
17 leaders within a district or within a center because they
18 know so much. It's just not -- to go with the data issue,
19 it's not a check that you can make that they have a BA or
20 an MA or. And so -- and I don't know how to do that
21 because you can't build a system around checking every
22 single teacher or every single providers on all of those
23 things. But if we're going to retain those excellent
24 staff people who are working and -- and teaching their
25 colleagues, especially their newer colleagues how do you

1 do this, we need to find a way to acknowledge their skills
2 and their understanding of early childhood and not sort of
3 put them aside as, oh, they're not okay because they don't
4 have this check mark. And I don't know how to solve that
5 problem.
6 I know that's why my school district decided not
7 to participate in some of the quality improvement stuff
8 because we had -- and still have union represented
9 protected staff people who could not be moved around or
10 moved out and they shouldn't have been, but because they
11 -- you had to check these things and prove that you are
12 quality by using those check marks, it didn't make sense
13 for us. So I -- and I don't think that my school district
14 is alone in this. So I -- I -- I don't know how to solve
15 it because it's really complicated and it would take a lot
16 of time and effort for many, many people to try to solve
17 this problem.
18 MS. PATTILLO BROWNSON: If I can -- just two
19 thoughts on that. One is that during World War II when a
20 number of women filled in for the K-to-12 system without
21 having had BAs, what they essentially did was they
22 grandfathered or grandmothered a number of highly --
23 grandparented a number of highly-qualified but not
24 credentialed teachers to have either time to achieve a BA
25 or stay in the system and keep teaching under one of these

1 sort of grandparented requirements. And some other states
2 have actually delved into this as well. Importantly,
3 Assembly Member McCarty, who is the chair of assembly
4 budget sub one on education has previously I think been
5 very hawkish on the BA requirement. And a number of folks
6 took him on a tour of New Jersey, New York, and Boston
7 universal preschool programs and some targeted universal
8 programs for threes and fours late -- I guess in
9 December. And one of his major takeaways, in fact, was --
10 was to focus lesson the BA and more on the workforce
11 competencies which I think is sort of symptomatic of
12 evolution in thinking for a lot of people.
13 And then the last thing I'll just say is that we
14 are expecting SCIU to put forward a collective bargaining
15 agreement for family child care homes. And I think they
16 will add some wind into the sails of that conversation
17 around competencies and Becca's investments in making sure
18 that people have the skills and behaviors to actually help
19 children succeed rather than the BA credential as the
20 single and only route there.
21 COMMISSIONER ZEPEDA: Other questions or comments
22 by commissioners?
23 MS. BELSHE: Keesha was --
24 COMMISSIONER WOODS: No.
25 COMMISSIONER ZEPEDA: I'd like to go back, Becca,

1 to this issue of reimbursement rates. Wasn't there
2 discussion or presentation here last year about a
3 compensation study that First 5 LA was going to undertake
4 or am I hallucinating. No?
5 MS. BELSHE: There was home visiting.
6 MS. PATTON: So we are you undertaking a
7 financial assessment that is sort of selecting ECE
8 providers throughout the county to kind of do a deep dive
9 into essentially their books and based on sort of their
10 reimbursement rate, how many children they're serving,
11 what their overhead is, how do you the numbers pencil out
12 to give us a better idea of what the true cost of care is.
13 And part of that will have some information about around
14 compensation and salaries, but it's not necessarily
15 specific compensation study.
16 COMMISSIONER ZEPEDA: I thought that came out of
17 the report you did with the advancement office on a
18 preexisting child care in LA County which found tremendous
19 attrition of family child care providers, in particular
20 with the zero to three population. So -- and I think, you
21 know, this is something I brought up a number of times.
22 It's your family child care providers -- you know, we can
23 get into a discussion of qualifications and all that.
24 That's another big discussion. But they are the ones --
25 and you talk about targeted universalism. They are the

1 ones that are dealing with most vulnerable children.
2 We're not even talking about exempt care here. But they
3 are the ones that are dealing with the most vulnerable
4 children, and there needs to be attention paid to that
5 population, regardless of whether they're going to have a
6 BA or they're not going to have a BA. That's a whole
7 other discussion. That particular sector, if you will,
8 needs strengthening. And the compensation feeds into
9 that, because they're not going to -- they're not going to
10 do that if they can't make ends meet. So that's why I
11 asked about that, because I thought there was a
12 compensation study.
13 Then I also wanted to ask about the role or --
14 you know, what is going to be the intersection between
15 some of the ideas that you have and the blue ribbon
16 commission? What is the blue ribbon -- there's -- for the
17 other commissioners, there is blue ribbon commission, and
18 I think they finished, right? No, they haven't finished?
19 MS. PATTILLO BROWNSON: They announced principles
20 in November and the full report will be in March.
21 COMMISSIONER ZEPEDA: Okay. And McCarty, he's
22 the co-chair of that commission. So I'm interested to see
23 what they're going to come out with.
24 And then the other thing -- and Karla and I have
25 talked about this and it can kind of surfaced in our

1 discussion this afternoon, you know, we're all happy to
2 see all this investment in early childhood but it's
3 occurring at the time of declining enrollment because
4 birth rate is going down, the K through 12 folk are
5 picking up all our three and four year olds, and we have
6 an immigration situation that is also depressing
7 enrollment. So that -- and the birthrate is projected to
8 go down for the next ten years.
9 So as we're rolling out all these things, it's
10 like we're shooting at a moving target in trying to figure
11 things out and where do you put your investment in what
12 communities, et cetera, et cetera. So it's just something
13 to kind of think about as we're -- as the train is going
14 down the track here.
15 COMMISSIONER WOODS: I'd just add one point to
16 what you said, and, absolutely, I agree with you.
17 Recently there's data to show the -- our immigration and
18 migration of population is pretty much equal, about the
19 same number come and go, but the ones that are the most
20 emigrating populations are middle class versus lower
21 class. So definitely just for Los Angeles that our
22 numbers are going down and our data around the need of
23 access or what have you is not consistent. So we really
24 need to get on page just one clear assessment of the
25 county needs that align with all the major players that's

1 doing that need assessment.
2 COMMISSIONER ZEPEDA: Commissioner.
3 COMMISSIONER CAGLE: One of the things I just
4 wanted to put out is what I see as a real need around
5 high-quality early education child care opportunities for
6 children in foster care. And, you know, I look at this in
7 terms of the kind of trauma that these kids have
8 experienced. We know that the brain development of
9 children who are in these traumatic environment is
10 severely impede, and that the way that you overcome that
11 is by getting them into a more stimulating environment
12 that's goal directed with the good teacher. And one of
13 the impediments to that is the rules around funding for
14 child care for kids in foster care. There is still a
15 focus in California on the income and the employment
16 status of a foster parent when considering the eligibility
17 for the child.
18 That's something that we worked through in
19 Georgia while I was there and were able to move beyond
20 because we began to see it as a focus on the needs of the
21 child as opposed to the eligibility according to the
22 resources of the foster parent, which really have nothing
23 to do whatsoever with the long-term needs of that child.
24 So if we could make some impact in being able to
25 say that those children are categorically eligible because

1 they are in foster care system without regards to the
2 employment status of the foster parent, we would be going
3 a long way towards making sure that the most needy kids in
4 our system have the best opportunities.
5 MS. BELSHE: Bobby, it's such an important point.
6 LA has provided a lot of leadership on this issue with
7 some support by First 5 LA.
8 Peter, do you want to talk about the bridge fund?
9 Come on up just so people --
10 COMMISSIONER HEGER: They can be disappointed in
11 how we don't provide care to the foster population because
12 I am disappointed by that. And I think that -- I think
13 the primary goal has to be putting children first. We've
14 talked about that. And the idea being -- and I think the
15 idea of whether you have a BA or just an incredible skill
16 set, that certainly comes into play here. We've certainly
17 seen enormous gap -- and since I represent the 5th
18 district in Antelope Valley in getting access to resources
19 for this population. We have 70 percent of the children
20 up there and we have probably ten percent of the
21 resources. We did make an attempt within the HUB
22 systemically to create an entry point which included some
23 assessment, some integration of services, stabilizing kids
24 before they went to foster care, a callback system for
25 foster parents, you know. Our recommendations to the

1 county blue ribbon commission was that we assess the
2 resources in every district and access for foster parents.
3 A lot of that was shot down because of lack of resources
4 or from the State. And the State regulations really
5 worked against us in delivering care to foster kids.
6 So I think it's an opportunity to say and make it
7 an absolute right. And Bobby and I were talking about
8 putting some therapeutic day care immediately in regions
9 around the county focusing just on foster kids and looking
10 at that. And, obviously, every kid entering foster care
11 needs to be assessed for developmental destabilization
12 because of their childhood.
13 I don't know exactly what role First 5 can play
14 in that but I think taking very strong position with the
15 State is important that we're going to fund that because I
16 think it was the State that called me on the phone and,
17 basically, said we couldn't do stabilization mechanisms
18 because it was against the State law.
19 So I think working with them would be incredibly
20 important.
21 COMMISSIONER ZEPEDA: Thank you for those
22 comments.
23 MS. BELSHE: Peter, you want to weigh in a little
24 bit on some opportunities we're seeing on the foster --
25 MR. BARTH: Yeah, absolutely. So as

1 commissioners will recall, a couple of years ago -- it was
2 actually LA county, the Child Care Alliance and Child Care
3 Resource Centers, Supervisor Kuehl, and Genie Chough who
4 helped really champion this idea of the emergency child
5 care vouchers for families in addition to training for
6 child care providers for being better able to serve foster
7 youth.
8 That really was a first step in what is now this
9 year anticipated and asked to make that permanent, that we
10 don't want to just have emergency child care that's
11 temporary but that we actually want to make sure that we
12 fulfill the promise, which technically isn't state law, if
13 you read it that way, that foster youth should be priority
14 populations for subsidized care.
15 So we're anticipating and already are working
16 with our partners on what that might look like in terms of
17 a proposal because, relatively speaking, especially with
18 this governor, the cost to do that is relatively small
19 given the need. And it also has the benefit of being able
20 to open up other subsidized care spaces for lower income
21 families who are currently on wait lists.
22 So just anticipate that First 5 LA will, in
23 partnership with our county agencies and other partners
24 and advocates, be pushing this as an opportunity this
25 year.

1 COMMISSIONER ZEPEDA: Thank you, Peter.
2 Okay. I think that concludes our commentary.
3 MS. BELSHE: Wendy had --
4 COMMISSIONER ZEPEDA: Okay. Commissioner Smith.
5 COMMISSIONER SMITH: I just want to take
6 advantage of Kim being here today before we let her go to
7 thank her. She -- I asked her in my role as a chair of
8 the Children's Commission if she could help me put
9 together a panel on poverty among children and families in
10 LA county, which she did, and she anchored that panel as
11 well. And it was an extremely informative meeting. And,
12 actually, I wish you all could have been there and heard
13 the panel discussion. It was extremely helpful. And
14 thank you so much and thank you for lending her.
15 COMMISSIONER ZEPEDA: Well, just shows the
16 quality of the staff here at First 5. Thank you, Becca.
17 Thank you, Kim for that.
18 Oh, Deanne. I'm sorry, Deanne.
19 COMMISSIONER TILTON: First of all, I really want
20 to emphasize how important what Bobby Cagle and Astrid
21 Heger are saying about the foster children zero to five.
22 They've already been through trauma. They're already
23 identified as vulnerable. I can't even imagine why we
24 wouldn't want to access the best of all kinds of care for
25 these kids very much, including preschool. And also what

1 Romalis was saying about how the brain develops and the
2 vulnerability of this age group. There are so many things
3 that go through may brain when we talk about zero to three
4 or zero to five. There are so many issues that come
5 together so -- to impact the future of these children and
6 the quality of life for all of us.
7 So when we kind of narrow this down to early
8 childhood education, I'm really upset that the 58 percent
9 of the child care workers are eligible for public
10 assistance, 30 percent are turning over. That's horrible
11 that, the younger the child, the less you're paid.
12 There's something wrong with that when you think about how
13 much more important it may be to impact the lives of these
14 children.
15 So, again, I would maybe want to ask that we
16 continue to think about the broader universe that affects
17 these children who are in preschool but also how are we
18 bringing the preschool providers into the broader
19 universe: Are they part of the community? Are they part
20 of the system of not only health and safety, but just in
21 terms of the experiences that children should understand
22 and know other than just what a preschool teacher may
23 personally be able to provide?
24 And also I think it improves the job satisfaction
25 and the attractiveness of working with young kids when you

1 aren't expected just to provide ABC, but you are a part of
2 making a difference in the lives of these kids overall and
3 the parents.
4 Certainly, again, I want to emphasize the foster
5 care issue. I mean, these kids are moving around.
6 They're not just in one place, unfortunately. Sometimes
7 they can be, but it's a huge challenge to figure out why
8 and how we can make a difference when the statistics or
9 data that aren't always everything, but they aren't
10 succeeding in life at same rate as kids who grow up with
11 their own parents and own siblings.
12 I guess I'm just thinking, how are we bringing
13 early childhood education into the broader universe of the
14 structure of our communities and how are we assuring that
15 the child protections and the health system and the mental
16 health system and the community are involved with that --
17 that -- that important task of early childhood education.
18 And we need to get more money for these child care
19 providers. I am as frustrated --
20 COMMISSIONER HEGER: Can I just comment on that?
21 One of the things that I think we've mentioned,
22 this idea of getting -- foster parents getting emergency
23 vouchers or there are services available in the community,
24 et cetera. The linkages are not being made there. We've
25 overemphasized and over-required and overburdened DCFS

1 with the role of making all the linkages. And one of the
2 things that we certainly need help with in terms of where
3 I'm coming from with the kids entering foster care since
4 we see 70 percent of them going into foster care coming
5 through our agency and through the med center, is the idea
6 of creating a database like we've recommended to the blue
7 ribbon commission that looks at all the resources and all
8 the areas, including that person that can be assigned to
9 the foster family to help them make the linkages. It's a
10 community-based organization, a mentoring service,
11 whatever's going on. Because, you know, CASA has, what
12 900 people working for it? There's 19,000 kids, right,
13 currently in foster care? So we have a large number of
14 kids that aren't getting advocacy.
15 So we would really -- I would love to have First
16 5 help or staff help since there's so many brilliant
17 people here to look at how do we identify all the
18 resources and how do we build a database that gets them to
19 early childhood education but also gets them to day care
20 and gets them music lessons and maybe gym lessons or
21 sports or -- so that they do succeed. And I think we need
22 to engage the community and the private resources not just
23 looking at the State. Maybe the State will change now. I
24 don't know. But we need to do that, and I think that's
25 one of the things we just got a grant to try to build a

1 resource center for mentoring for all foster kids.
2 COMMISSIONER ZEPEDA: Okay. Well, thank you. As
3 you can see, it stimulated quite a bit of conversation and
4 you can see all the linkages that people were trying to
5 make. So it really does go to that issue of the whole
6 child. And as you move forward in your advocacy work in
7 the early childhood, it's just more than just that
8 teaching/learning situation; it's the whole child growth
9 across the spectrum. So our work -- we have a lot of the
10 work to do. So thank you for that presentation.
11 So we are -- we have a ten-minute break coming
12 up. So I'll see you back here in about ten minutes.
13 (A brief break.)
14 COMMISSIONER ZEPEDA: Okay. Moving on to Item 5,
15 the Impact Framework and Strategic Plan Refinement Process
16 Launch. And we have Daniela Pineda, Christina -- oh,
17 she's here. I thought you weren't going to be here.
18 Christina Altmayer, Steven LaFrance. So the three you.
19 Thank you.
20 MS. ALTMAYER: Great. Good afternoon. Thank
21 you.
22 Very excited to begin the launch of our strategic
23 plan refinement process. As you may recall before the
24 holidays, we had a very robust board discussion at the
25 November board meeting where we talked about launching

1 this process in January. So here we are and very excited
2 to begin the conversation with you today.
3 We want to share where we are in terms of process
4 and some of the planning that we've done, some of the work
5 that we've done to get started and get ready for today's
6 launch, and then also engage you in a discussion that
7 Steven LaFrance from LFA -- that was part of the board
8 action in November, I should remind you all, to bring on
9 LFA Associates to support our strategic plan refinement
10 process.
11 So Steven is here and will be helping to
12 facilitate and guide the first what I would say meaty
13 discussion that we look forward to engaging you all in
14 around our investment guidelines.
15 Bringing us back to November, we want to start
16 with looking at results for children. And I want to
17 emphasize how closely and how integrated the impact
18 framework work -- the impact framework process and the
19 SPR-4 process are -- processes are. And with that, I want
20 to introduce Daniela who will talk about and remind us of
21 the four results that the board endorsed in November.
22 MS. PINEDA: Thank you. Happy new year
23 everybody.
24 Great to be back and great to talk about results.
25 So having been in the earlier conversation, I was

1 happy to see that my colleagues Kim and Becca both talked
2 about our north star and talked about the centrality of
3 these results for how we're thinking about how this
4 organization moves forward to make impact for kids in LA
5 county.
6 So what I just want to do today is briefly remind
7 us about how we got to these set of four results that you
8 all approved in November and also to talk about how
9 they're going to -- how they reflect really integrated
10 strategies across this organization that support us as we
11 step into the launch of the strategic plan refinement
12 process that my colleagues will talk to you immediately
13 after.
14 So just to take us back a little bit in the last
15 few months in our journey, we engaged as an organization
16 in comprehensive organization-wide conversation about how
17 do we contribute to our north star, what does it mean for
18 us to really be making process towards that star as an
19 organization with a set of strategies that are -- that
20 speak to -- honestly, to what we do as an organization.
21 So in that process, we engaged the board multiple
22 times as well as our staff, and we also got the
23 opportunity to unpack the concept of readiness in a way
24 that speaks to how First 5 LA understand this, right? So
25 we talk about our north star as having children entering

1 kindergarten ready to succeed in school and life. So we
2 talked about the importance of really helping children
3 being ready for school, but also the necessity of
4 understanding how we can support schools in getting ready
5 to integrate and support children, and also the central --
6 the families and communities preparing children for
7 school. We talked about children don't live in a silo and
8 they have communities and families, and it's really
9 speaking to this whole perspective that we really embrace.
10 So if you look at the results that we have here,
11 I just want to make a couple of comments on them. First,
12 is that, individually, the results are very clear. So
13 they stand alone in terms of being concrete about what is
14 progress for us mean, what do we care about as an
15 organization. Collectively, if you look at all four, they
16 really do acknowledge the whole child perspective in that
17 we acknowledge that there is much more that goes into
18 having the ability to be ready. It's not just about
19 academic preparation. There's so many things that affect
20 a child's life.
21 So what's really important to just -- just to put
22 us back in that space where the results, each one of these
23 are -- they represent a -- the work of multiple strategies
24 across departments and across the organization.
25 So if you look at first one -- I just want to

1 take a moment here. Families have the awareness,
2 resources, opportunities, relationships, and environment
3 to optimize the child's development. Merit of our work
4 there is represented the work that our work in
5 communities. We're working with community members,
6 parents to understand what do they think they need to help
7 their children and the communities. But work in home
8 visiting, multiple type of home visiting, interventions,
9 as well as ECE where we're looking at, what is the
10 importance of bringing resources to the home environment
11 or wherever the child is. We talked about children are
12 not just in one place.
13 The second result, children enter kindergarten
14 without any previously unidentified developmental delays
15 and connected to developmentally appropriate services and
16 supports. Now we just had a very robust conversation
17 about the importance of identifying developmental delays
18 earlier and thinking about how -- what policy levers, what
19 boots on the ground, what can this organization do to help
20 identify how do we think about straining those systems of
21 identification, whether it be in the context of a home
22 visiting intervention, whether it be in a formal ECE
23 environment, work in our health systems, Help Me Grow.
24 There's just so much into a lot of the work that's
25 integrated across our strategies to support these results.

1 The third result, children are safe from abuse,
2 neglect, and other trauma, really speaks to the work that
3 First 5 LA does in prevention. I want to specifically
4 call out some of the work our in trauma-informed care,
5 some of our work in partnerships with the County where
6 we're looking at some of you and your organizations start
7 looking to think about, what does it mean to implement
8 trauma-informed care in the context in which you operate,
9 because we know that that's so critical for the child's
10 ability to be ready. So we're really thinking about how
11 this is relevant for a lot of our strategies.
12 And finally, the four result, children have high
13 quality early care and education experiences prior to
14 kindergarten entry. A lot of the work across the
15 organization, the policy agenda work that you just heard
16 about, the work with the ECE department, the kindergarten
17 readiness assessment work where we're looking at bringing
18 communities and schools together to have conversations
19 about what does it actually mean to support children. A
20 lot of these strategies kind of converge, and the results
21 speak to what we want to be better for children in the LA
22 county.
23 And I'll just leave with the fact that I'm very
24 excited that this work that the organization started to
25 undertake last year is really going to help to anchor the

1 launch of the new strategic plan refinement process that
2 my colleagues will speak to.
3 So thanks.
4 MS. ALTMAYER: Thank you, Daniela.
5 So I want to kind of bring us back to where we
6 were in November and start with the action and the
7 concepts that we discussed with the board at that time. I
8 know a lot has happened since then, but if we can kind of
9 get back in that time and space. We had a good
10 conversation about why First 5 LA is approaching this as a
11 refinement and recognizing that we are keeping our focus
12 on that north star of all children being ready to succeed
13 in school and life. And we talked about the fact that we
14 are going to hold tight to some elements, such as our
15 north star, but also recognize that in the first three
16 years of current strategic plan, that there's been a lot
17 of learning, learning about how we do this work. There's
18 also been changing -- changes in the environment. Very
19 excited about the changes that we talked about on the
20 previous presentation today.
21 So we want to both hold tight to some elements,
22 the core focus that we had. And yet at the same time,
23 being a learning organization, we have to adapt to what we
24 learn and to the changes and to the environment. And that
25 was the direction that we talked about in November.

1 So as we think about this strategic plan
2 refinement process, we talked about four phases. And
3 today we're excited to launch the first of those four
4 phases, which is really the review phase. I will say this
5 is a slight modification from November because in November
6 we talked about three phases and we've added a fourth that
7 I'll get to in just a moment.
8 So the phases are really, first, to do this
9 review, review of what have we learned, what do we
10 understand, a review and an understanding of the changes
11 in the landscape for early childhood.
12 Secondly, is the reflect phase. So part of
13 learning is both to review but then also to have that
14 moment where you look at this information and say, so what
15 does it tell us, what are the implications of that, which
16 would then inform our third phase, which is the refine
17 phase, which is, how do we build upon what we learned and
18 really incorporated and have a much more focuses process.
19 Additionally as we heard from the board in
20 November when we had this discussion that this is both an
21 examination at this point in time, but also thinking about
22 how do we build this in on a future, go-forward basis;
23 that if we're looking at a ten-year planning horizon,
24 which is part of our north start, to look to 2028, we're
25 going to have to as a matter of ongoing strategic

1 reflection put in those points where we will continue to
2 do this and what's the frequency and format of that. So
3 that will be one of the decision points and discussion
4 points in this SPR-4 process.
5 And the fourth R that we have added as a
6 recognition of our focus on results and that we are
7 looking to have this plan focused on producing a plan that
8 will guide us, but also that it really affirms our
9 commitment to how we will achieve the four results that
10 Daniela just spoke to.
11 So that is our process at a very high level. And
12 today we're really excited to launch the first phase
13 officially, which is our review phase. And we have been
14 starting this important work. As you see here, there is
15 some analyses that we are beginning to compile. We have
16 spent some staff time going through last year's board
17 minutes and really reviewing them and trying to cull out
18 what are the themes that we heard the board and the PPC
19 discuss at various meetings; what were some of those
20 pullouts that we can identify that speak to not just the
21 matter that was before you, but also have implications for
22 our strategic plan. So we've done some good staff work
23 and really reflecting on what you have spoken about in the
24 past.
25 We've had some conversations with staff and are

1 beginning to compile that information so we've had some
2 staff surveys to learn and hear from staff. And then
3 we've been collecting both internal reports that have been
4 produced in the county, things like the prevention plan
5 and -- and home visiting board motion response report that
6 went to the board in July, and the needs assessment report
7 in terms of ECE. Let's compile these reports that speak
8 to what are some of the critical issues that are facing LA
9 County in the space of early childhood and what can we
10 learn from these reports.
11 So there's also been a series of reports, and
12 they're referenced in the appendix that have been written
13 about the landscape of early childhood in California. So,
14 again, our focus is, how do we cull this information.
15 We'll speak to it in just a moment, but part of the task
16 of LFA will be to look at this body of information and see
17 how do we consolidate it into key themes of what are some
18 overarching considerations for our strategic plan. That
19 report is scheduled to be completed in March and will be
20 presented back to the PPC.
21 At this point, we just want to demonstrate that,
22 while we're launching the process, we've already done some
23 good staff work to kind of jump start and get started.
24 As we think about this, we have some preliminary
25 themes. So we're learning along the way and we want to

1 capture these learnings. This is by no means
2 comprehensive. And we do know LFA has been scheduling
3 interviews with each of the board members, and that will
4 be a further input to the process. So we really
5 appreciate those that have already participated interviews
6 and those that have already made the time to put on your
7 calendar to meet with LFA. Those will be very informative
8 as we think about this.
9 We have some preliminary themes, and they are
10 very much that, preliminary ideas that we're hearing from
11 this culling of information that exists, that we're
12 introducing for your discussion at this point. The first
13 is, we're seeing a lot resonance of the importance of
14 focusing on policy and systems change. This was a pivot
15 that was made in 2014 for First 5 LA. And we have seen
16 evidence -- early evidence, again, that that is both a
17 valued role from our other partners as well as some places
18 where we've made some progress.
19 Second issue -- and this was something that was
20 particularly discussed and identified as we think about --
21 as we look through the board minutes and the board's
22 discussion, this concept of how should First 5 LA
23 incorporate equity more explicitly within its strategic
24 plan. There are elements of equity within our current
25 strategic plan and certainly within our work of our focus

1 on those children most at risk for positive outcomes, but
2 it's not explicitly identified in our current strategic
3 plan. And that's a question that has arisen in this early
4 stage.
5 The need to -- again, this was a discussion as we
6 heard -- looked at the transcripts from board meetings
7 over the past year. This idea of more explicitly
8 articulating the results, so we're excited that we've done
9 that and the board has embraced that with the action in
10 November.
11 The idea of partnership being core and central to
12 our work as we looked at some of the county reports, the
13 prevention plan, home visiting, some of the county level
14 reports, again, we're another source where this theme of
15 partnership and not just partnership at the beginning, but
16 partnership throughout our initiatives is critical to
17 achieving our results. It's also a theme as we look at
18 some of our advocacy efforts over the past year, that
19 First 5 LA is not a solo voice, but we're having positive
20 results because we're doing that work in partnership.
21 I think Commissioner Abdo will appreciate this
22 next point as someone that has raised the importance of
23 both communications being accessible and simplified in
24 terms of our language and that, if we're going to get
25 other champions, we really need to make sure that we're

1 speaking in a way that's clear and succinct. As we think
2 about the input from staff, this has been -- and, again,
3 I'm giving examples, but none of these are exclusive
4 sources that speak to these themes -- common themes from
5 our preliminary review. But the need to think about our
6 work more integratively as we work across all four
7 outcomes. There are connections from our work in
8 communities with our access to early care and education.
9 These -- these are not siloed opportunities. We really
10 need to support families, think about our work far more
11 integratively.
12 Recognizing our fiscal constraints. This was a
13 big theme within the 2014 -- between the work in 2014 and
14 resulting in the 2015 plan that, unfortunate, Prop 10 is a
15 reduced revenue source. It continues -- our tobacco tax
16 continues to decline and we need to be cognizant of the
17 fiscal environment in which we exclusively work. So how
18 can we continue to make the most impact uniquely as First
19 5 LA with the diminishing revenue source.
20 The need to prioritize our strategies. Our
21 current strategic plan has four outcome areas and ten
22 strategies and then multiple strands of work across those
23 ten strategies. Is there some prioritization? Are some
24 strategies more critical to achieving our results than
25 others; and if so, how would we prioritize it? Is it

1 based on our unique role?

2 Consistently, we've heard I think from a number
3 of different sources, including this commission, about the
4 importance of elevating the voice of parents and that
5 parents have a unique perspective and we need to create
6 those opportunities so that parents and community members
7 have an opportunity to directly influence. And we also
8 saw successes last year wherein we did more intentionally
9 capture the voice of parents, whether it's in advocacy
10 efforts at the local or the state level. It yielded
11 benefits.

12 And, finally, you know, consistent new work that
13 we have done in the strategic plan is our focus on
14 organizational learning, but also recognizing that we have
15 to think about what are the opportunities to continue to
16 improve as an organization. And a new line of strategic
17 thinking that will be encompassed in this strategic plan
18 refinement process is really thinking about this
19 organizational capacity. It wasn't explicitly spoken to
20 in the current strategic plan, so that is a new through
21 line that we look at add in this refined process.

22 At both the board and staff discussion, we've had
23 a number of conversations about, you know, a year from
24 now, when we complete this plan by November of 2019, how
25 -- and we reflect back, how will we know that we have been

1 successful in this refinement process. So we have
2 identified seven critical success factors that we're going
3 to hold ourselves accountable for to make sure that we can
4 demonstrate this success. And these critical success
5 factors were both informed by board discussions, PPC
6 discussions, as well as by staff. And many of them are
7 reflective of the key themes that you just heard me speak
8 to.
9 So the first is equity, that we need to ensure
10 that our plan more specifically articulates how First 5 LA
11 is working to ensure that all children -- that all
12 children is a critical complaint there -- are ready to
13 succeed in school and life, and recognizing that we need
14 to have a priority focus on those that are facing
15 disparities across multiple dimensions. The process will
16 be successful if we really clearly and succinctly and in a
17 way that's successful identify our intended impact and the
18 means to measure our progress. Integration -- I've spoken
19 about this -- as well as the fiscal stewardship, plain
20 speak, priorities, and capacity building of First 5 LA as
21 an organization.
22 So these are the elements that we'll hold
23 ourselves accountable to to know that this process was
24 successful. And you can all help us be judges along the
25 way to see if we're meeting good on these benchmarks that

1 we've set for ourselves.
2 I will not go through this next chart in detail,
3 but the takeaway that I hope you have and we are working
4 -- we've set a bar for ourselves to try and simplify this
5 process as well. But the key takeaway I want you to have
6 is by really looking at the color coding, is that we're
7 looking for multiple opportunities for the board to be
8 engaged in this process. And this will have high
9 interaction at both the PPC and the board level throughout
10 this process. So there are multiple steps. We're really
11 thinking through the sequencing of those steps to get us
12 from here until November.
13 So with that we want to -- I can pause for just a
14 moment if there's any questions about the process as I
15 walk through it. Then I'm going to turn it over to Steven
16 to really begin one of our first discussions that we look
17 forward to engaging you on with the investment guidelines.
18 COMMISSIONER ZEPEDA: Thank you, Christina.
19 Any questions at this point from the
20 commissioners?
21 COMMISSIONER CAGLE: Just a couple comments.
22 First of all, I have a strategic planning in me
23 right now. I hope to become First 5'd some day.
24 The other things that I see here -- this is
25 wonderful. But it just strikes me that in that whole list

1 of things that are so positive in the critical success
2 factors, that -- that physical constraints is the one
3 that's stated in the negative. And it's really about -- I
4 think you stated on through there, it's really about
5 fiscal stewardship and assuring that we make the best use
6 of the funds that we have as opposed to remaining focused
7 on the -- the negative there or sustainability either.
8 MS. ALTMAYER: Great point. Thank you.
9 COMMISSIONER TAYLOR: Can I jump in on that one?
10 Because we have done some great things around leveraging.
11 I've seen that you guys have come up with great ideas
12 about leveraging, taking what we have and leveraging it so
13 we can do more or do something different. But we need to
14 look at expanding the dimensions so that we look at other
15 resources of revenues to do creative things, such as grant
16 funding from foundations that want to do creative and
17 innovative things with us because I -- I'm -- I have to
18 say, I think we have a name out there -- maybe I'm wrong,
19 but I do -- of being innovative and doing innovative
20 things. And I think we can find a lot of grant agencies
21 that want to do something similar to what we want to do
22 that will fund those activities in partnership with us.
23 And then we have wonderful universities around us, UCLA,
24 USC, and so forth and so on, that would be great partners
25 with us to do some of these great things. So I think we

1 need to broaden that to say, not only -- I agree with you
2 totally -- not only the constraints but restraints, but
3 look at other opportunities to fund the things that we
4 come up with a plan so that we don't cut ourselves off
5 from doing great things. So I'm just saying, open that
6 bubble up a little bit more and be more broader thinking
7 in that. So be more macro thinking around this issue.
8 I like the idea about constraints because we need
9 to know that what we have, but I think we look at it from
10 a way of, how can we leverage, how can we bring in more
11 resources, how can we look at the State and see if there's
12 some things that the State can give us that they have
13 resources and revenues to do some of those things.
14 One of the things that I noticed that the -- I
15 heard -- maybe I'm wrong. You can correct me. The
16 Governor's talking about child care for all. You know,
17 education, child care for all. That's -- that's a very
18 north star kind of thinking. And so if we work with him
19 to talk about how we can tap those resources that the
20 State has to work in partnership with him, that's why I
21 was talking about how can we get up there and kind of
22 shape this. That's why I'll leave it to my leader here
23 because she has done wonderful work with the great people
24 to do that.
25 So I'm saying, think creative. You guys have got

1 the mind and the ability to do it. Think more creative on
2 about how we can do that so you don't stop the creative
3 bubble that you guys have created. It's really good
4 stuff. So, please, think more broader.
5 COMMISSIONER ZEPEDA: Other comments by
6 commissioners?
7 COMMISSIONER CAGLE: Can I just echo off that?
8 COMMISSIONER ZEPEDA: Sure.
9 COMMISSIONER CAGLE: I came from Georgia about a
10 year ago. The point that you made about the reputation of
11 this organization. I knew about First 5 LA before I ever
12 got here, way before I ever got here. In the early
13 education space, this organization has a fantastic
14 reputation. So I think sometimes you don't realize that
15 if you're in the midst of it. So I just wanted to say
16 that.
17 COMMISSIONER ZEPEDA: I have a question if none
18 of the other commissioners have comments. I'm just --
19 when I look at the critical success factors, you have --
20 in the preliminary themes you have partnership, and I know
21 partnership and systemic change is a big issue for us.
22 We've been talking about that a lot. But then when I look
23 at the critical success factors, it's not necessarily
24 singled out. And then I started looking to see, well,
25 maybe it's embedded in one of these because I think that

1 the capacity building is -- I guess a word leverage as the
2 process is kind of nebulous to me because we don't know
3 what the process is I guess or -- but I would think that
4 this issue of partnership -- I mean, that -- that's a word
5 that comes up over and over and over again, and it relates
6 to our ability to do our work as our monies go down
7 actually. So that's stood out to me when I was looking at
8 that listing. You know, I don't know when you were
9 thinking about it and you guys were brainstorming how --
10 how slide -- whatever slide it was with the green boxes
11 relates to the subsequent slide.
12 MS. ALTMAYER: That's good feedback. We'll
13 consider it. And I think it's very relevant as we get
14 into our investment guidelines as well.
15 COMMISSIONER ZEPEDA: Sure. Go ahead.
16 COMMISSIONER HEGER: I guess not to be devil's
17 advocate here, but to be devil's advocate. I think that
18 there have been times in the last 15 years that First 5's
19 reputation has been like the rich uncle that you want to
20 make sure that you're in good with because they have this
21 never-ending source of money that you can go to. And it
22 was like, well, go to First 5 and ask them, go to First 5
23 and ask them. So there's a certain reputation and power
24 associated with the cash. And I'm just being honest here.
25 I'm the newest commissioner is all. I have a license.

1 So I personally believe that we have an enormous
2 responsibility right now to change that into being the
3 go-to place for information, advocacy, integration,
4 collaboration, and that we put children first and that's
5 our motto, And that we know what's going on. And, for
6 example, if I'm -- that we're not just funding service,
7 that we are funding advocacy and integration. And that
8 when people think of us, that money is not the first thing
9 they think of because our revenue is going to go down, but
10 they think of advocacy, innovation, collaboration, and
11 information that allows us to be the leader and take the
12 leadership role in this county. And I think the money
13 gets in the way sometimes of -- it's like marrying for
14 money, right? So I would much rather be marrying for
15 knowledge and advocacy and than it would be just marrying
16 for money. That's all I have to offer at this moment.
17 MS. BELSHE: That's a great point.
18 COMMISSIONER ZEPEDA: Thank you. Okay. If there
19 are no more questions, we'll move on to the third part.
20 So the floor is yours, Steven.
21 MR. LaFRANCE: Wonderful. Thank you, madam
22 chair.
23 And good afternoon, happy new year, commissioners.
24 It's an absolute pleasure to be launching this
25 process with you. And I want to echo Christina's thanks

1 to those of you who've already taken the time to speak
2 with me or my colleague, Alex. I think the vast majority
3 of you have scheduled to speak with us. So I'm really
4 appreciating those conversation.
5 Many of you are new to the commission, so I will
6 state and perhaps reiterate for some of you that my
7 colleague Alex and I and others in our group worked with
8 First 5 in 2014 to develop the current strategic plan.
9 And so I'm going to get us into this conversation about
10 the investment guidelines by taking a little bit of a trip
11 down memory lane to talk about where they came from and
12 why, and then engage you all in a conversation, like
13 Christina said, kind of the first substantive, meaty
14 conversation about potential refinements to those
15 investment guidelines.
16 So with that, I first want to say, when we were
17 in the planning process in 2014, it's really apropos of
18 some of the conversation that we've heard here, but I'll
19 use a couple of metaphors. I think of the planning
20 process in 2014 as having -- working with an adolescent.
21 There was a lot of incredible energy and potential and
22 accomplishments. And there was this need for landing on
23 kind of identity formation and kind of stating what is our
24 philosophy about our role in creating change, in the work
25 that we do, and the children and families that we care

1 about.

2 And so we looked to the literature of strategic

3 grant making, strategic philanthropy, and drew on our

4 practice as well to identify these six dimensions along

5 which you tend to see foundations array themselves. The

6 second reference point I'll make is to what I think is a

7 seminal study that the Center For Effective Philanthropy

8 did on foundation strategy, and they -- they provided a

9 typology that they said, generally, foundations can be

10 found within one of four buckets in terms of strategy.

11 And the first was charitable an banker, which sounds a lot

12 like the rich uncle that -- who you went to the check

13 with. The second stage or the second kind of type was

14 called perpetual planner. So those that just kept

15 planning and planning and planning and never did anything.

16 Third is a partial strategist, and the fourth is total

17 strategist.

18 And so my -- my sharing that with you is to

19 really say that investment guideline establishment in 2014

20 was significantly an effort to put a stake in the ground

21 as to what this organization was going to -- the role it

22 was going to play in creating change as a grant-making

23 organization. I think move it along the continuum towards

24 total strategist. And I think this refinement process is

25 in this same spirit. I mean, I think, you know, the far

1 end of any continuum is always a journey and you're always
2 pushing yourself to move farther along the lines.
3 So as we know, the investment guidelines have
4 been used as decision making criteria. They have -- they
5 are points of conversation as opportunities come to the
6 staff, to the board, as staff and board engage in
7 communications about the organization and serve as
8 ambassadors to this organization's work, engaging partners
9 and being clear with them, that your intent is to engage
10 with them early on to think through the approach and then
11 throughout the process. As the policy agenda gets
12 established, we would prioritize matter that's focus on
13 prevention, such as home visiting. Just to give you a few
14 examples of how those have been used and to ground them in
15 best practices in strategic philanthropy.
16 This gorgeous graphic provides the six investment
17 guidelines as they were articulated in 2014. But the
18 substance of today is to talk about refinements to them
19 based on learning. So, well, maybe I'll just take a quick
20 minute to speak to each of them that -- as I mentioned, as
21 an example, there is a focus on prevention, systems and
22 policy change, seeking to have a broad impact, focusing on
23 identifying and scaling of best -- evidence-based
24 practices, engaging partners at the earliest stage
25 possible, and prioritizing investments that strengthen

1 families, and where possible improve community capacity.
2 So that was the 2014 articulation of them.
3 The questions that we've been thinking about and
4 have some discussion recommendations for you all to
5 consider is, you know, what have we learned about the
6 value of the guidelines for our work? Are they
7 articulated in a way that provides clear implementation
8 guidance? And then finally, how should they be refined
9 now that we're in this process, having had three years of
10 putting them to work under our belt?
11 So I will move to --
12 MS. BELSHE: Steven, before we move on, can you
13 elaborate a bit more given particularly -- we have a
14 number of relatively new commissioners about kind of the
15 -- the tradeoff calculation or the continuing calculation
16 for each of the six investment guidelines? So the
17 construct of, more oven than not, First 5 LA will fund --
18 will approach its work through the lens of policy and
19 systems change. It wasn't an explicit, we will always do
20 policy and systems change, but it said, looking at direct
21 services at one end of the continuum, policy and systems
22 change on the other, more often than not, we're going to
23 focus on policy and systems change because we want to
24 maximize our contribution to the greatest impact possible.
25 However, we sometimes will focus on direct services, but

1 only under certain proscribed conditions. And in that
2 case, it's when we're investing in direct services to
3 inform and drive policy and systems. So say a little bit
4 more about the more often than not part of this framework.
5 MR. LAFRANCE: Absolutely. I'm glad you asked
6 because I took a fun trip in the way-back machine in
7 preparation for today and actually dug up and looked
8 through all of the points on each continuum or -- on each
9 continuum, yes, for each of the six guidelines. And as
10 Kim gave the example, one of those continuum was from
11 direct services to policy and systems change. Another was
12 with respect to the evidence-based undergirding, an effort
13 that you might support from, you know, complete brand new
14 innovation to something that had a very strong evidence
15 based. And each of them had two, three, four, sometimes
16 five points on the continuum.
17 But the point that Kim is getting is, we use two
18 ways of thinking about this because we know that being
19 strategic is also not about being so absolute in your
20 thinking that you're not open to opportunities as they
21 come along. So we talked about one being kind of the
22 80-20 rule, which is the more often than not. You know,
23 80 percent of the time-ish, where do we see ourselves
24 looking to make our investment. And by investments, by
25 the way, I always mean both dollars and staff time, social

1 capitol, political capitol, everything that falls under
2 the bucket of investment. But the other was, we talked
3 about -- and I like this quite a bit. But we said, where
4 was First 5 LA going to put its thumbprint and where might
5 it put its pinky print. You know, to say there's a
6 stronger degree of emphasis, but we want to make sure
7 we're not closing the doors on some ways of working that
8 could really serve advancement of the mission and vision.
9 So we're eager to hear how you would suggest
10 making some refinements based on some of the learnings
11 that we are offering you today. Some of this will be
12 repeat from what you just heard from Christina. But,
13 again, one of the learnings has been about equity as a
14 priority issue. As you'll see in our recommendations, we
15 think the concept is reflected in the investment guideline
16 but it could perhaps be called out more explicitly.
17 Engaging partners early, of course, is -- is critical, but
18 that statement really exists in a time capsule, if you
19 will. That was at a time when First 5 LA was more often
20 than not -- and, again, pardon me for being direct and
21 candid -- but I think was kind of seeing as going it
22 alone. And so the notion that partnership would be
23 established early on was the key signal to make there.
24 But what we've learned over the past three years
25 is that that's not enough. You can't just partner at the

1 early stages, which is great; you also have to partner all
2 the way throughout. And the investment guidelines have
3 been really critical for reflecting on internal
4 organizational policies as well as making investment
5 decisions. And so there's maybe an opportunity there to
6 -- to -- to refine the guidelines to reflect that
7 learning.
8 And then, lastly, Commissioner Cagle just made
9 this point about the importance of fiscal stewardship and
10 operating within our means and expected resources.
11 So taking those -- those learnings into account,
12 what we have here are some suggested concepts for
13 commissioner consideration. And what we've done here is
14 to line up on the left column each of the existing
15 investment guideline statements and then some suggested
16 concepts on the right-hand side.
17 Again, generally speaking, the focus on
18 prevention, we know that First 5 does support work along
19 the continuum, but endeavoring to have that thumbprint on
20 prevention seems to remain relevant. We've discussed
21 focus on systems and policy change also remaining
22 resonant. And we think there might be an opportunity here
23 to integrate the second and the third existing guidelines
24 because, when you think about what is the purpose of
25 systems and policy change work, it really is to affect the

1 broadest change, to have the broadest possible impact
2 affecting a large number of children and families.
3 So depending on your reaction and response to
4 that suggestion, that third might be removed.
5 I will add that conversation among staff has been
6 emerging about this fourth guideline regarding the
7 identification and scale up of evidence-based practices;
8 that maybe that is one where we also look at a combination
9 of promising and evidence-base, because when you look at
10 what is in that evidence-based column, it's pretty narrow.
11 It can be narrow. And in part, what this organization
12 could be helping to do is to deepen the evidence base of
13 promising and best practices, as well as helping to take
14 evidence-based practice to scale.
15 I've commented already on this -- on the fifth
16 one regarding partnership, that our observation is that we
17 could expand that to be through the life cycle of a
18 partnership. And then we have two suggestions for
19 possible additions. One is to consider an investment
20 guideline that has us focusing on children that have or
21 are at the greatest risk due to disparities in outcomes,
22 and then finally, to operate consistent with current and
23 long-term financial resources and constraints.
24 So with that, I actually think -- I'll flip to
25 the questions, but then I'll turn back to the slide that

1 has the actual suggestions for discussion. But we were
2 hoping to get some of your input, feedback, and discussion
3 on the suggested concepts and see if they align with your
4 sense and feedback of where we should be going for the
5 refinement to the current strategic plan, or if there are
6 other changes and revisions would you propose.
7 So, again, I'll turn back to the actual slide
8 with them and open it up for commissioner discussion.
9 COMMISSIONER ZEPEDA: Okay. Commissioners?
10 Commissioner Smith.
11 COMMISSIONER SMITH: Thank you. I have a couple
12 of suggestions. I do like a lot of what -- what you're
13 suggesting. In the prioritize the evidence-based
14 practices, I think in addition to promising practices, we
15 should include the concept of innovation because --
16 because I think we should. I mean, I think that we don't
17 want to close the door to people trying things that look
18 promising but aren't yet supported by evidence.
19 I -- I also thought from the previous slide that
20 there was going to be something about the internal
21 organization incorporation of some of this. And I was
22 thinking that in the one on engaging partners through the
23 development and execution that that could also be applied
24 internally; that the staff -- how the organization works
25 -- the partnerships within the organization.

1 MR. LAFRANCE: That's excellent.
2 COMMISSIONER SMITH: And then, finally, on the
3 last one about consistently operating within financial
4 resource and constraints, to incorporate some of what
5 Commissioner Taylor and Commissioner Cagle were saying
6 about including the outside or external opportunities that
7 might be of a fiscal nature also.
8 MR. LAFRANCE: Wonderful. Thank you for the
9 input and feedback. And I just had the inspiration about
10 the engaging partners one that we could expand that to
11 include consideration as to how the work leverages
12 internal integration and partnership.
13 COMMISSIONER TAYLOR: As well as external.
14 MR. LAFRANCE: As well as external. Exactly. I
15 think it was written with the external lens in mind, and I
16 appreciate the point you're making regarding how we
17 operate as well.
18 COMMISSIONER ZEPEDA: Other comments by
19 commissioners or ideas?
20 Commissioner Howell.
21 COMMISSIONER PLEITEZ HOWELL: Welcome back. I
22 like the analogy to the machine going back in time and
23 comparing us to teenagers.
24 MR. LaFRANCE: And I didn't pull that through to
25 say that this is a maturation process.

1 COMMISSIONER PLEITEZ HOWELL: I love that.
2 I'm going to try to articulate this for the focus
3 on systems change and policy. And I think First 5 LA has
4 an opportunity to think about taking advocacy to
5 implementation, and I feel like our guidelines are missing
6 in that. So let me give a concrete example. Last year,
7 some early care and education advocates advocated for $5
8 million for professionals in the dual language field. The
9 dollars were given, which is really terrific, for systems
10 and policy change. But as the dollars are being drawn
11 down, what we find at the local sort of district levels is
12 that the professionals that are needed to execute that
13 plan do not exist. And we find this in early care and
14 education and some of our health systems as well where we
15 have really -- we know some of the policy changes that are
16 needed. But there's a link to the implementation of when
17 that happens or how that happens. And when First 5 LA
18 sort of like hits walls for the implementation of the good
19 policies asks. And I think we've seen this with some of
20 the home visiting. We've seen this with some of the work
21 around early identification. And I think we have to call
22 out the implementation part of our systems change, so
23 linking that to that second guideline.
24 I don't think we need to talk about large numbers
25 of children and families. Systems automatically make us

1 think of that. So instead of adding -- I agree we could
2 take out that third point. But instead of adding the
3 total number of children, actually thinking about the
4 implementation of what is required at the local level.
5 And there might be different language for that.
6 The additional work to add on here, the equity
7 framework -- so this is suggested concepts -- absolutely,
8 has come up over and over again in discussions here with
9 the commission. It is a statewide issue. The blue ribbon
10 commission is talking about it and figuring out how we do
11 that. The one thing about the language as we put it here,
12 how do we lift up the assets. So, yes, it's children that
13 are under disparity -- are facing difficult circumstances,
14 have disparities in outcomes; it's also children that
15 overcome a lot of obstacles. So switching the language
16 from calling out at-risk youth and really elevating First
17 5 LA will focus on equity issues that elevate and
18 celebrate racial diversity, cultural language diversity,
19 and making that part of the equity framework that we look
20 at as opposed to coming in as saviors for some of those
21 issues.
22 MR. LAFRANCE: Thank you very much.
23 COMMISSIONER ZEPEDA: Thank you, Karla.
24 Other questions or comments by commissioners?
25 I think we might need some time to reflect on

1 this. I know that the equity piece was something that I
2 was very concerned about. I know that Commissioner Fierro
3 is also been bringing this up, this whole issue of how do
4 we articulate that idea to the masses, if you will, in a
5 way that reflects a common interest and a common goal. I
6 think implicitly, First 5 has always done that.
7 If you look even with the teacher strike that
8 went on, I mean, I think people in the nation were shocked
9 that 80 percent of the children in LAUSD are in poverty.
10 It was like a big surprise. I mean, we're kind of inured
11 to it, but, you know, once you kind of look -- go outside
12 the bubble, we have a lot of issues here in LA county, and
13 -- and so I think that this equity issue should be part of
14 what we're talking about. We really got to think about
15 how we articulate it. I know we've talked about that
16 universal -- targeted universalism, which I think is a
17 relatively new idea in education, as opposed to in
18 philanthropy. I may be wrong. I know in higher education
19 they've been talking about it. But that I think needs to
20 be in there.
21 And then I think the issue that Karla brings up
22 with the implementation piece, the relationship of, you
23 know, do we just stop at the policy, you know. We've
24 gotten the policy through, and that's it, we've done our
25 work. Is that where we stop? You know, what is our

1 responsibility beyond that? That's a big, big question.
2 But I think that merits some reflection as well.
3 Commissioner Taylor.
4 COMMISSIONER TAYLOR: I think we need to also
5 look at -- when we talk about focusing on prevention and
6 the other issues where we work on change, that we work on
7 the things that focus on our targeted strategic plan.
8 I want to talk about models that implement the
9 strategies that we're talking about so we can evolve. So
10 it shouldn't be just prevention as a general statement; it
11 should be targeted prevention that goes to the point of
12 what we're trying to achieve with regards to targeted
13 goals so -- and that we're not just doing prevention.
14 We're doing prevention that is targeted to make change,
15 right, as we see it and it affects children zero to five
16 and families so that we get to this point when we're
17 talking about measuring the impact, the impact framework
18 or data, we're saying, we implemented this to see if there
19 would be a change in the dynamics within the communities,
20 within families, and in general. So we can say it's a
21 targeted practice. Right?
22 And so -- and as part of that, we evolved by
23 trying to say, okay, how can we bring this to scale, which
24 you guys have done with our partners very successfully.
25 And we've advocated for money to expand that at the

1 highest level of the State. So we have to talk about
2 targeted prevention. We have to talk about seeking these
3 impacts that are broader based on our targeted goal.
4 The other issue, I want to get back to what
5 you're saying. I don't want us to lose the fact that we
6 care about all children and all families. I don't care if
7 you're rich or poor. But I know we want to do that.
8 So I'm with you about, how do we say that. So we should
9 start off as saying, all children, especially those that
10 are facing high risk or something like that. So it's not
11 where we're monolingual; we're looking at just one
12 targeted population, we're looking at all kids in broad
13 perspective. Why am I saying that? Because the Governor
14 said that. He wants all children to have it. He didn't
15 say rich or poor. And I think what you'll have is the
16 public getting behind us when we go forward and then
17 nobody seeing themselves as not being included. And so I
18 think we need to think about that, how are we going to be
19 perceived outside of here. Right?
20 So I'm with you on that. I don't know that
21 that's the absolute way, but that's a thought. And so
22 maybe you great people can come up with a better, more
23 clever way of saying it. But the idea is to get to that
24 function so we're not being visualized as one focus.
25 COMMISSIONER ZEPEDA: Other comments, questions?

1 Commissioner Woods.

2 COMMISSIONER WOODS: I'm going to be very quick.

3 Thank you for this. I did have an opportunity to meet

4 with your colleague today. So kind of got some processing

5 happening and this adds to that. This is very good.

6 I just wanted to add -- just kind of piggy back

7 on Commissioner Howell when she was talking about

8 implementation of systems once we get to the policy

9 change. And I want to really think policy comes before

10 the systems change, but if we talk about sustainable

11 systems, that will put us in the -- put us in a mind set

12 that it's a continuous quality improvement around

13 sustainable systems as well.

14 COMMISSIONER ZEPEDA: Thank you.

15 MR. LAFRANCE: Thank you very.

16 COMMISSIONER ZEPEDA: Commissioner Tilton, did

17 you want to make a comment? No.

18 Commissioner Heger.

19 COMMISSIONER HEGER: I can't sit here without

20 saying, I love the idea, Wendy, what you said about

21 innovation. I think that's critically important that we

22 support innovation as we move forward. I think that the

23 other thing that we haven't touched on at First 5 is the

24 idea that isolation of these children at whatever -- in

25 whatever socioeconomic bracket that they are in is really

1 one of the critical factors to their being at risk
2 wherever they are. And when one of my clients contacts
3 whatever in the community in east LA says that to me being
4 poor is lonely, I think that that's true. And I think the
5 idea that we're going to stamp out poverty is not going to
6 happen from First 5, but we can certainly look at
7 isolation as a factor that contributes to child failure
8 and the idea and that certainly goes to home visitation,
9 to education, to access to mentors and -- and other kinds
10 of success issues. So I think that that's critically
11 important as we invest in these -- and I, again, use
12 marriage as an analogy. I'm not very good at it. But the
13 idea of long-term commitments rather than a short-term
14 investment is critically important for First 5 LA right
15 now as we begin to been seen differently have a different
16 image is that we're here for the long run and not just a
17 fund a project for a year, but we're here for a long-term
18 commitment. I think that's critical that's a part of our
19 goal statement.
20 COMMISSIONER ZEPEDA: Yup. Okay. If there are
21 no other questions or comments, I think we'll still be --
22 you'll present this again to the full board.
23 MR. LAFRANCE: Yes. I can speak to next steps
24 very briefly.
25 COMMISSIONER ZEPEDA: Okay. Why don't you -- oh,

1 Commissioner Smith.

2 COMMISSIONER SMITH: I just -- what you were just
3 talking about made me wander if we want to consider the
4 idea of increasing social connectiveness as a part of
5 something.

6 MS. ALTMAYER: Thank you. So yes, Commissioner
7 Zepeda, we will be bringing this back and introducing and
8 furthering to think about this input and how this input
9 can be incorporated both in the investment guidelines, but
10 also this feedback that we can keep to us as we continue
11 down the road in this process. There's multiple places
12 where in capturing this input, it can be incorporated
13 within the plan.

14 So we anticipate having a discussion at the
15 February 14th commission meeting, both about the critical
16 success factors, the investment guidelines, and this
17 overall road map. And the input from the PPC members is
18 so helpful as we think about what we're missing, what we
19 haven't thought of. So it's really helpful.

20 Again, Steven and his team is continuing to do
21 the interviews. So thank you again for making the time to
22 meet with him and his team. Very, very helpful. And then
23 we will be continuing the data review process. As I
24 mentioned, the first major deliverable that LFA will be
25 producing by the end of March is on consolidating the

1 major learnings from the review phase.

2 COMMISSIONER ZEPEDA: That's helpful.

3 So, Steven, did you want to add anything to that?

4 MR. LAFRANCE: I don't think so. There's just a

5 visual on the next slide that kind of summarizes what

6 Christina just described and just wanted you all to know

7 that, by end of March, we will be producing our first

8 major report to kind of round out the review phase. And

9 if I recall correctly, we'll be doing about 50 interviews,

10 reviewing about 20 studies, and just synthesizing all we

11 can to inform the reflect phase and then refine.

12 COMMISSIONER ZEPEDA: Thank you.

13 MS. BELSHE: To advance results.

14 MR. LAFRANCE: Exactly. Why else would we be

15 doing this?

16 MS. BELSHE: The why of our work. The how of

17 this project and undertaking is a big, ding dang deal. We

18 are excited to be launching it today. So thank you for

19 the very thoughtful engagement and feedback. Just really,

20 really very constructive.

21 Part of -- an important part of how is the team

22 that is supporting this. This is an organization-wide

23 effort. Christina is our executive sponsor and we have a

24 fabulous project manager that I want to make sure

25 Christina introduces because she is known to many

1 commissioners but not to all. So let's give a shout out.
2 MS. ALTMAYER: Kaia Tith. Many of you may have
3 worked with her. We are incredibly, no one more than I,
4 thrilled that she has joined First 5 LA again. So she
5 joined over the Christmas holidays and will be serving as
6 the project manager. Worked on the 2014-2015 strategic
7 plan, and has a history of working with First 5 LA. So
8 very excited that we were able to entice her to come back
9 and be the project manager. So Kaia.
10 MS. BELSHE: Yay, Kaia.
11 MR. LAFRANCE: We are second most excited.
12 COMMISSIONER ZEPEDA: Well, welcome back, Kaia.
13 And we'll see your smiling face around here.
14 MS. BELSHE: We have a written only item, so if
15 you want to invite any feedback from any commissioners on
16 Item 6.
17 COMMISSIONER ZEPEDA: Okay. We have a,
18 commissioners, Item 6, Family Outcome Project Development
19 on the Project DULCE. Does anybody have any questions
20 about this?
21 Barbara's here so she can answer questions.
22 MS. BELSHE: This will be coming back to the
23 board on consent. This is basically seeking board
24 approval to receive money from the Center For Study of
25 Social Policy, board action and support. Barbara and

1 Christina are having important conversation. Is there
2 anything you want to say, Barbara.
3 MS. ALTMAYER: I was just saying that, Barb,
4 we've got almost a success, a little mini celebration, but
5 I may be getting ahead of us.
6 MS. ANDRADE DUBRANSKY: We've had an opportunity
7 to commune -- to engage with multiple health plans across
8 the county on many of our investments, not only this
9 investment. And this has captured the attention of some
10 of them and it appears as thought there may be an interest
11 in replicating DULCE, not -- again, not as the rich uncle,
12 but just as someone who's interested in learning from what
13 we've done. We'll continue to keep you.
14 MS. BELSHE: They represent the really rich
15 uncle.
16 MS. ANDRADE DUBRANSKY: Exactly. They're the
17 much richer uncle. So we'll keep you up to date as we
18 learn more about this potential opportunity.
19 And also want to thank Lindsey Angela (phonetic).
20 She's not in the room who to continues to lead our work
21 engaging health plans on multiple strategies across our
22 strategic plan.
23 COMMISSIONER ZEPEDA: And when will this come up
24 again for -- to the full board?
25 MS. ANDRADE DUBRANSKY: Next month it will be on

1 consent. And this is to receive additional resources to
2 continue the pilot from the Center For the Study of Social
3 Policy.
4 MS. BELSHE: So this is an example, Romalis,
5 where we're bringing money in.
6 COMMISSIONER TAYLOR: And that's good.
7 MS. BELSHE: It's modest but important.
8 COMMISSIONER TAYLOR: This is what I'm saying
9 that you do -- you guys do. This one model that's being
10 seen as an opportunity to model the concept we would hope
11 that people would want to do. And now people are hearing
12 about it and saying, oh, let's do it. Even what this
13 tells me is, the person that's funding is saying, damn,
14 this is good, let's do some more. And then -- so bringing
15 it up to the next level. That tells me that the
16 opportunity sits there to model this for others. And
17 that's what I want for prevention, and that -- so we may
18 not be doing home visitation, but there may be another
19 opportunity for another model under prevention that we
20 want to do based on where we're going and how we're
21 evolving with regard to the strategic plan. So this
22 exactly what I was talking about.
23 Also, I want to say, please, put in there the --
24 like you're bringing in other people to help with the
25 strategic plan. But as we evolve, we may need to evolve

1 with regards to the resources you may need to implement
2 the new strategy. So that should be a part of the
3 strategic plan, you know. So you brought some wonderful
4 people here to do what we're doing now, but if we go in a
5 different direction, you might have to add others.
6 MS. BELSHE: We're refining.
7 COMMISSIONER TAYLOR: You might have to add other
8 refined strategies -- knowledge people to implement those
9 strategies. So I'm just saying we're doing a remodeling
10 of the facility. That has to be put in that too.
11 Because, if we're going to do something different or more,
12 does that require a different part of that model being
13 done in a different way? Or do we have to plan to do a
14 change down the road a year or now? Do we need to put
15 some funding for that evolution as well? So don't forget
16 that was as well. That's all I'm saying.
17 COMMISSIONER ZEPEDA: Thank you. So this will be
18 -- this will come before the full board for consent.
19 If there's no other questions, let's move on to
20 Item 7. Is there a request for public comment?
21 SPEAKER: No public comment.
22 COMMISSIONER ZEPEDA: If there's no public
23 comment, then I think we stand adjourned. Thank you,
24 everybody.
25 (At 4:13 PM, the meeting was adjourned.)

C E R T I F I C A T E

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

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

The meeting was taken down in shorthand and transcribed into English under my supervision and authority;

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

Attested to on this 6th day of February, 2019.

DocuSigned by:
Heatherlynn Gonzalez
AE10E8980664405...
____

CERTIFIED SHORTHAND REPORTER

FOR THE STATE OF CALIFORNIA

Policy & Strategy Update: Early Childhood Priorities, Processes and Partnerships from Governor Newsom’s Administration
Kim Pattillo Brownson, VP of Policy & Strategy
Kris Perry, Deputy Secretary of the California Health and Human Services Agency for Early Childhood Development and Senior Advisor to the Governor on Implementation of Early Childhood Development Initiatives, Office of the
February 28, 2019
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first 5 la
Giving kids the best start
FIRST 5
20
YEARS
OUR KIDS
OUR FUTURE
CALIFORNIA REPUBLIC

What’s Driving our Work

Results for Children and Families

Policy Agenda

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

Problem Statements

Impact Framework

Governor's Jan. 10 Budget Proposal: A Comprehensive Package

Family Strengthening

- $78.9 million to home visiting to expand and make permanent the CalWORKs Home Visiting Initiative (HVI)
- $23 million to double the federally-funded Maternal Infant Early Childhood Home Visiting (MIECHV) program within California Department of Public Health
- $347.6 million increase to California Work Opportunity and Responsibility to Kids (CalWORKs) cash grants to bring families up to 50% of federal poverty line
- Announced goal of expanding Paid Family Leave from 6 weeks to 6 months, with task force to design options
- $50 million for Child Savings Account in partnerships with F5s

Health

- $45 million in state and federal funding to ensure all families on Medi-Cal receive Adverse Childhood Experiences (ACEs) screens
- $60 million in state and federal funding to increase developmental screenings for young children, aligned with First 5 LA's sponsorship of AB 11
- $7.5 million for Black Infant Health programs to address disparities in infant and maternal mortality for African American women

Governor's Jan. 10 Budget Proposal: A Comprehensive Package

Early Care and Education

- $750 million in one-time funding for full school-day, full school-year kindergarten facilities
- $500 million in one-time funding to improve child care infrastructure, including support for professional development and facilities.
- $247 million for the Cal State system in one-time funding to child care facilities
- $125 million to enable all income eligible four year olds can access State Preschool Program, adding 200,000 spaces by 2022
- $10 million for State Board of Education, Department of Finance, and Department of Social Services to create a roadmap toward universal preschool and quality, affordable subsidized child care.

What's Ahead

- Now until April: Legislature considers Governor's Budget through Committee hearings
- April 30: First 5 Advocacy Day
- May 15: May Revision to the Governor's Budget
- June 15: Legislative deadline to pass Budget
- June 30: Deadline for Governor to sign Budget
- Sept 13: End of Legislative session
- Oct 13: Last day for Governor to sign bills

Remarks
Kris Perry
Deputy Secretary of the California Health and Human Services Agency for Early Childhood Development and Senior Advisor to the Governor on Implementation of Early Childhood Development Initiatives, Office of the Governor of California
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FIRST 5
20
YEARS
OUR KIDS
OUR FUTURE
1ST
LA
first 5 la
Giving kids the best start

Questions?
1ST LA
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Giving kids the best start
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FIRST 5 LA

SUBJECT: Establish a Strategic Partnership for a period of up to four years with L.A. Care Health Plan in an amount not to exceed $1,209,460 to implement and evaluate a pilot aimed at 1) engaging health providers and practices in integrating early identification and intervention protocols into practice workflow and 2) increasing community and family awareness and education on the importance of early identification and intervention.

RECOMMENDATION (PROVIDED AS INFORMATION):

This memo is provided as information for the discussion at the February 28, 2019 Special Program and Planning Commission Meeting. During the next scheduled Board of Commissioners meeting on March 14, 2019, First 5 LA staff recommends the Board approve the establishment of a Strategic Partnership with L.A. Care Health Plan for an amount not to exceed $1,209,460 for up to four years and authorize staff to execute an initial agreement. Funds to support this initiative will be included in the appropriate fiscal year budget which will be brought to the Board of Commissioners for approval in June of the corresponding fiscal year. At the time of budget approval, requested resources will shift from the Assigned resource category of the fund balance, dedicated for broad Strategic Plan purposes, to the Committed category, which are amounts dedicated for a more specified purpose via resolution.

BACKGROUND:

First 5 LA and L.A. Care Health Plan ("L.A. Care") have a long history of working together to support programming and services for young children. In addition to co-launching the Help Me Grow–Los Angeles (HMG-LA) planning efforts and co-chairing a HMG-LA planning workgroup, L.A. Care has committed to partnering with First 5 LA to pilot early identification and intervention strengthening efforts in the health care sector. As staff presented to the Board in October 2018, L.A. Care initiated and financed research with local clinic staff to build evidence-informed recommendations for an early identification and intervention pilot.

L.A. Care's research highlighted that primary care clinics are busy and have large and diverse patient populations. Their patients have a broad range of needs including physical health, behavioral health and supports for social determinants of health. Providers and staff are often challenged to meet those needs and complete screening and referral in the current resource-constrained environment. The research recommends changes to the clinic, technology, staffing, and workflows to optimize the ability of providers to have productive developmental conversations and connect families to services.

L.A. Care's research findings are in line with what First 5 LA has learned in the First Connections investment as well. Through First Connections, six grantees (federally qualified health centers, community based organizations, and a family resource center co-located at a Regional Center) designed innovative approaches to embed developmental screening and strengthen referral processes within their practice. This includes using technology to support providers in integrating screening and referrals into workflow. There may be an opportunity for L.A. Care to glean learnings from First Connections to further shape the pilot.

In addition, L.A. Care's findings elevate what the Los Angeles Department of Public Health (LACDPH) found in their environmental scan of county programs and practices related to early identification and intervention (presented to the board in October 2018). Preliminary findings from LACDPH's environmental scan indicate that many county health providers are not using a validated developmental or behavioral screening tool and cite "limited time" and "limited staff" as the greatest barriers to

screening while perceived parent hesitation and "unsure who provides services" were selected as the greatest barriers to making a referral.

Partnership with L.A. Care represents an important element of HMG-LA's Child Health Provider Outreach core component strategy, which seeks to raise early identification and intervention standards across all health service sectors. L.A. Care provides health care coverage to over half of the birth to five population in Los Angeles County ("L.A. County") through all their lines of business, including plan partners. L.A. Care's scope and reach make them a valuable partner to influence system change and increase the countywide impact of HMG-LA. Although we are working with L.A. Care directly, many of the activities in the pilot will impact families/members, providers and clinics across all health plan partners.

Pilot Overview and Objectives:

Over the course of up to four years, L.A. Care will implement and evaluate a pilot aimed at engaging multiple levels of the health care sector including: 1) communities/families; 2) health providers; 3) clinics/practices; and, 4) managed care plan. The proposed pilot leverages existing L.A. Care knowledge and relationships to create sustainable systemic change that supports the ability of providers to work closely with families to promote child development, use validated developmental screening tools, and improve access to local resources for children. The proposed pilot will use First 5 LA resources to support sustainable practice transformation at the clinic level.

The pilot design utilizes three prevention effort strategies (education/awareness, early identification and intervention) across each level of the health care sector. The following outlines the proposed pilot objectives and activities across each of the health care sector levels.

Communities/Families:
The pilot seeks to increase knowledge among communities/families of developmental health, including accessing available community and health system resources and how to navigate the complex system of care. To reach communities/families, L.A. Care will use public health messaging in health and community settings and leverage the multiple L.A. Care-operated Family Resource Centers across the county. Through programming at L.A. Care Family Resource Centers, L.A. Care plans to host 60 classes/events, reaching approximately 1,000 community members/parents over the course of the pilot. L.A. Care has recently made investments to expand the network of Family Resource Centers for members and this will be an important platform to test and develop strategies for engaging families in their children's care.

Health Providers:
The pilot seeks to increase provider knowledge of child development and validated screening tools through various communication and training strategies. L.A. Care will utilize their Continuing Medical Education (CME) events to train 300 providers and advance their knowledge about child development, validated screening tools, appropriate referrals, and available community resources for developmental concerns. Potential reach of L.A. Care's larger communication and messaging to providers through mail/website etc. will target at least 1,000 providers.

Clinics/Practices:
The pilot seeks to adjust practice workflow to imbed developmental conversations and screening into well-child and other visits. L.A. Care will utilize their extensive experience supporting practices through change and will leverage their established relationships with high-pediatric volume practices. L.A. Care will contribute internal practice change expertise to these high-pediatric volume clinics through their Health Information Technology (HIT) Department. The HIT Department oversees practice transformation programs and interacts directly with county facilities, safety-net clinics and private practices.

When barriers to implement developmental screening into workflow or needs of the clinic are identified throughout the pilot, mini-grants will be awarded to practices/clinics by L.A. Care. These funds will be

used to implement specific, sustainable technological and/or infrastructure improvements. Any efforts taken on by pilot clinics will be tailored by the pilot's staff to ensure that they are fully embraced and sustained by the practice beyond the duration of the project (see section below "Staffing and Evaluation for Pilot Activities"). L.A. Care plans to work with 10 high-volume pediatric clinics through this strategy.

Managed Care Plan:
The pilot seeks to increase the number of children who access primary care appropriately, are screened for developmental and behavioral delays using validated tools, and strengthen referrals for appropriate supports. L.A. Care will explore many different strategies at the health plan level to reach these objectives. Some proposed strategies include, but are not limited to:

1. Engaging with practices and community based organizations for more efficient coordination between health care settings and referral agencies in screening and follow-up for identified delays.
2. For key partnerships (like with Family Resource Centers) requiring commitment to share resources and data on intervention and educational programming implementation.
3. Monitoring screening rates and utilization trends for positively screened patients to build the evidence base for the most effective care/referral flow.

Staffing and Evaluation for Pilot Activities

L.A. Care will leverage current staff and First 5 LA funding to provide adequate staffing for the project. These staff are skilled with quality improvement, workflow redesign, and practice facilitation/coaching to oversee the rollout strategy and implementation activities of the pilot. Pilot staff will engage with community resources, internal L.A. Care departments, and external public health partners to plan and implement education/awareness efforts. Staff will work directly with practices and their care teams to support the identified tiered interventions and the transformation needed to consistently implement developmental screening and monitoring in a meaningful, measurable and sustainable way.

L.A. Care will monitor the pilot's reach (population and clinics) and implementation. L.A. Care will also develop a program evaluation plan and measurement plan to track improvements in pilot-related health care outcomes at pilot practices.

Pursuant to the Procurement Policy, Strategic Partners of $75,000 or more in a fiscal year must be presented to the Board for approval. Staff is requesting an establishment of a Strategic Partnership for an amount not to exceed $1,209,460 to comply with this policy.

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

The objective of this pilot is to create sustainable systemic change that supports the ability of providers and practices to have conversations about child development, use validated screening tools, and improve access to local resources for children. Many of the activities rely upon in-kind contributions by L.A. Care and may be sustained after First 5 LA funding ends. Additionally, clinic practice transformation and practice staff capacity improvements will be designed to ensure that the activities are fully embraced and sustained by the practices beyond the duration of this project. And finally, the member engagement and community materials created and paid for by the pilot can be used through L.A. Care's Family Resource Center networks and other community based organizations into the future.

Investing in this pilot will allow First 5 LA to leverage channels already in place at L.A. Care to reach providers and members for early identification and intervention promotion. First, L.A. Care plans to provide many partial FTE personnel in-kind to contribute to the project, including:

1) Department Coordinator and Program Manager to arrange provider training through Continuing Medical Education (CME)
2) Regional Family Resource Center Manager
3) L.A. Care Senior Director, Strategic Planning
4) L.A. Care Chief Medical Officer

5) CME Speaker (consultant)
6) Health Information Technology Department Executive Director

First 5 LA will be able to leverage existing L.A. Care touchpoints with providers and members including Continuing Medical Education (CME) provider training events and L.A. Care-operated Family Resource Centers. The pilot will also leverage L.A. Care's existing relationships with clinics to target high-pediatric volume practices for practice transformation efforts. Additionally, the pilot will leverage L.A. Care's data sources to target roll-out to areas of highest need.

Finally, L.A. Care will leverage internal practice change expertise through its Health Information Technology (HIT) Department which oversees practice transformation programs and interacts directly with county facilities, safety-net clinics and private practices. Several of the HIT Department's initiatives focus on supporting different types of providers in the adoption and meaningful use of electronic health records (EHRs), including technical assistance to support workflow redesign, data-driven quality improvement and team-based care. To date, the HIT Department has supported nearly 10,000 clinicians through transformation programs including Transforming Clinical Practice Initiative (TCPI) which provided tailored technical assistance to practice care teams, delivered through a practice coaching model, to achieve program goals of improved care for patients with diabetes and/or depression, decreased utilization, and overall cost-savings.

JUSTIFICATION:

This Strategic Partnership meets the criteria below:

☒ The Strategic Partnership can provide specific resources needed by First 5 LA to implement an approved program or initiative in a manner or on a scale that makes the Strategic Partnership more cost effective than resources provided through a competitive solicitation; or

☒ The Strategic Partnership can implement an approved program or initiative more expeditiously than resources provided through a competitive solicitation; or

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

☐ The Strategic Partnership provides an opportunity to leverage First 5 LA funds to produce additional funding for the program or initiative or service.

AND

☒ The proposed Strategic Partnership is aligned with the adopted Strategic Plan.

The Strategic Partnership with L.A. Care can provide specific resources needed by First 5 LA to implement this pilot in a manner and scale that makes the Strategic Partnership more cost effective and implement this pilot more expeditiously than resources provided through a competitive solicitation. L.A. Care's resources are:

- L.A. Care funded and completed research on developmental monitoring and screening practices across L.A. County clinics. This research put forth recommendations that will be used by the pilot to optimize the ability of providers to have productive conversations about developmental health with families, screen children for developmental and behavioral delays and assist families in accessing services.

- L.A. Care's Health Information Technology Department's collective experience with practice change is one of the resources that supports this pilot being implemented in a more cost-effective and expeditious manner than resources provided through a competitive solicitation since it is an already built capacity.

- L.A. Care, through its multiple lines of business and plan partners provides insurance coverage to approximately 65% of the birth to five year old population in L.A. County. The partnership provides wide accesses to our target population through L.A. Care's existing members, relationships with clinics and their Family Resource Centers throughout L.A. County.

The Strategic Partnership with L.A. Care is directly aligned with First 5 LA's adopted Strategic Plan, through the Health Related Systems Outcome – Early Identification and Intervention to increase the effectiveness and responsiveness of screening and early intervention programs across health, mental health and substance abuse service systems.

Special Commission/Program and Planning Committee Meeting

February 28, 2019

EARLY IDENTIFICATION AND INTERVENTION: PILOT WITH L.A. CARE HEALTH PLAN

Cristina J. Peña, Senior Program Officer, Health Systems
Alexandra Parma, Program Officer, Health Systems

Objectives

1. Provide overview of the current early identification and intervention experience in L.A. County
2. Provide overview of Help Me Grow-LA's health sector engagement strategy
3. Review proposed L.A. Care Health Plan pilot
4. Request to establish a Strategic Partnership with L.A Care Health Plan

Connection to Results for Children and Families

North Star Aspiration

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

Results for Children and Families

- Families have the awareness, resources, opportunities, relationships and environment to optimize their child's development
- **Children enter kindergarten without any previously unidentified developmental delays and connected to developmentally appropriate services/supports**
- Children are safe from abuse, neglect, and other trauma
- Children have high-quality ECE experiences prior to kindergarten entry

first 5 la
Giving kids the best start

A Family's Journey Through Early Identification and Intervention

Afraid

Concern at 10 months, family members said "don't worry he's a boy"

Doubtful

Mom still worried and waiting, Mom trusted expertise of pediatrician.

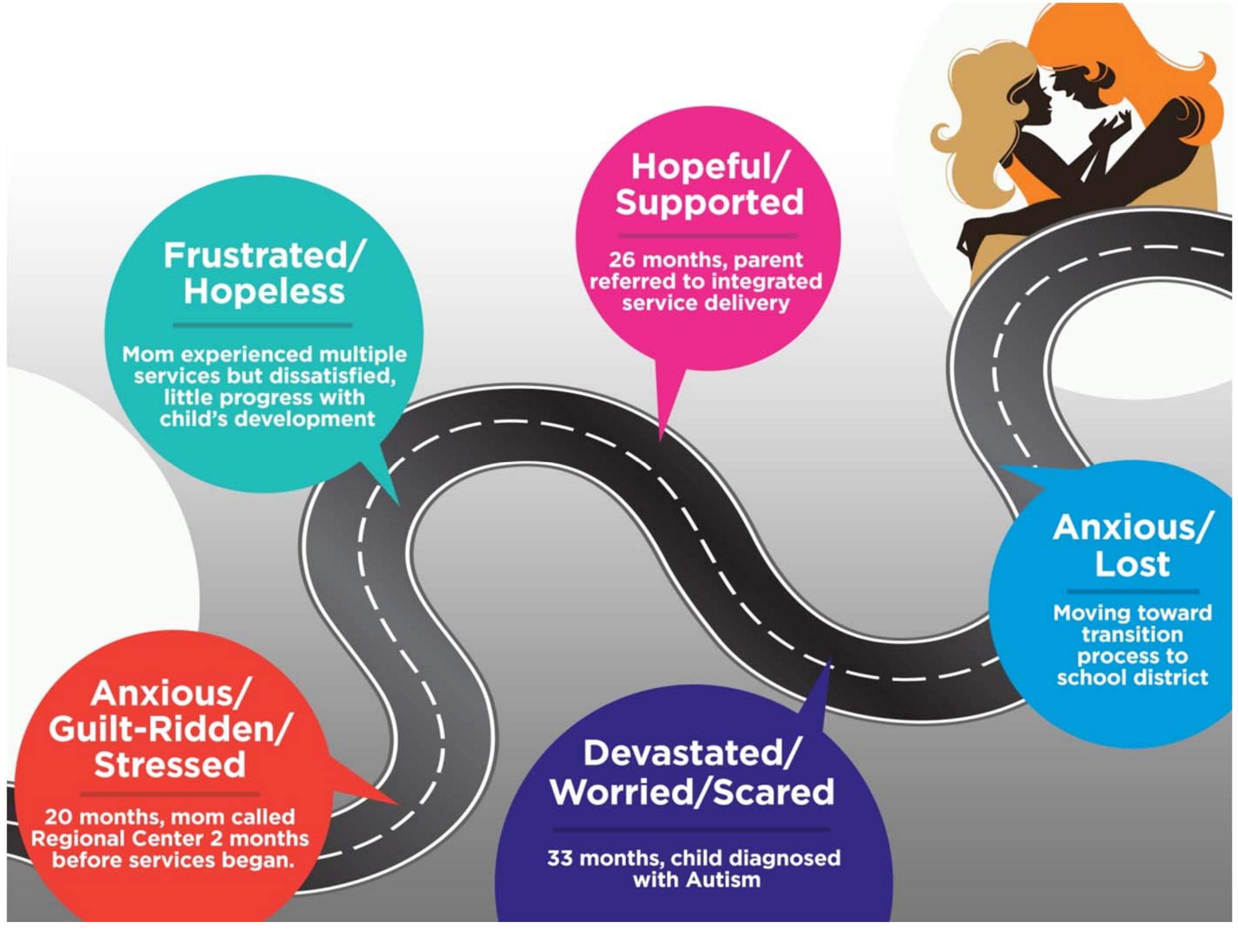
Confused/Lost

12 month well baby visit, mom expressed concern to pediatrician, no screening done. MD said, "don't worry, let's wait"

Scared/Hopeful/Validated/Guilty

18 month well baby appointment, mom shared concern again, no screening but MD referred to Regional Center

A Family's Journey Through Early Identification and Intervention



Current Early Identification and Intervention Experience in L.A. County

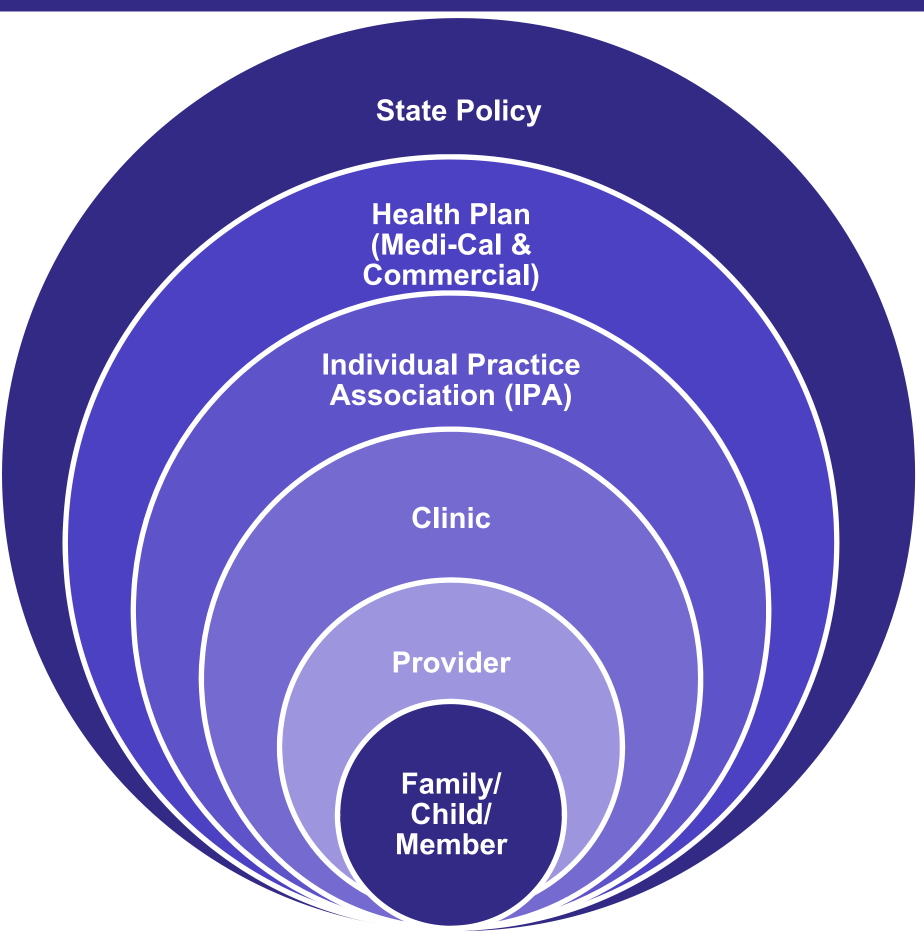
Where did we look for learnings?

- *L.A. Care Pre-Discovery Research*
- *First Connections*
- *L.A. County Department of Public Health Help Me Grow-LA Environmental Scan*

What did we learn?

1. Many county health providers are not using a validated screening tool.
2. Screening and referral are challenging in resource-constrained clinics.
3. Clinics need assistance designing and implementing practice transformation.
4. Technology can enhance sustainable practice transformation efforts.

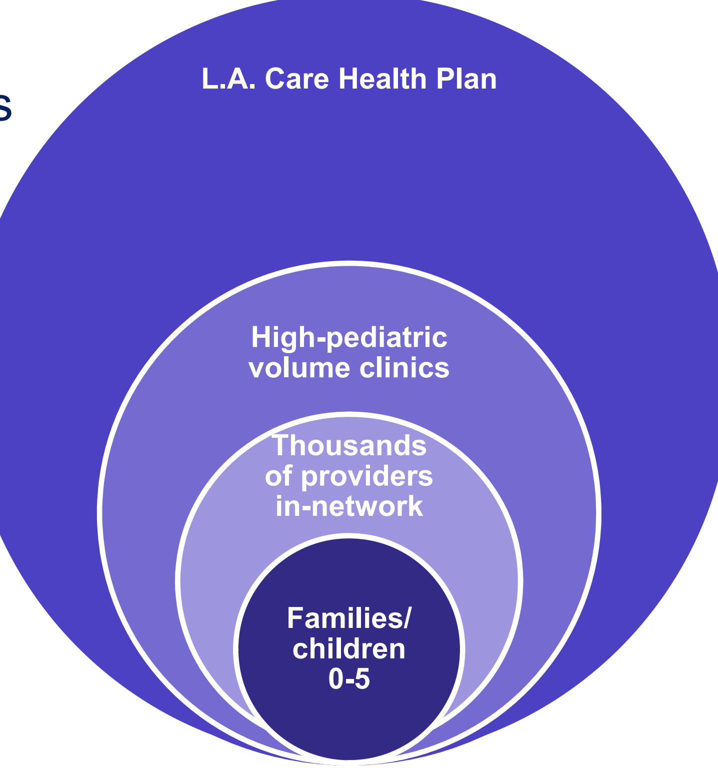
Health Care Sector: Levels of Engagement



Health Care Sector: Engagement through L.A. Care Pilot

L.A. Care Opportunity:

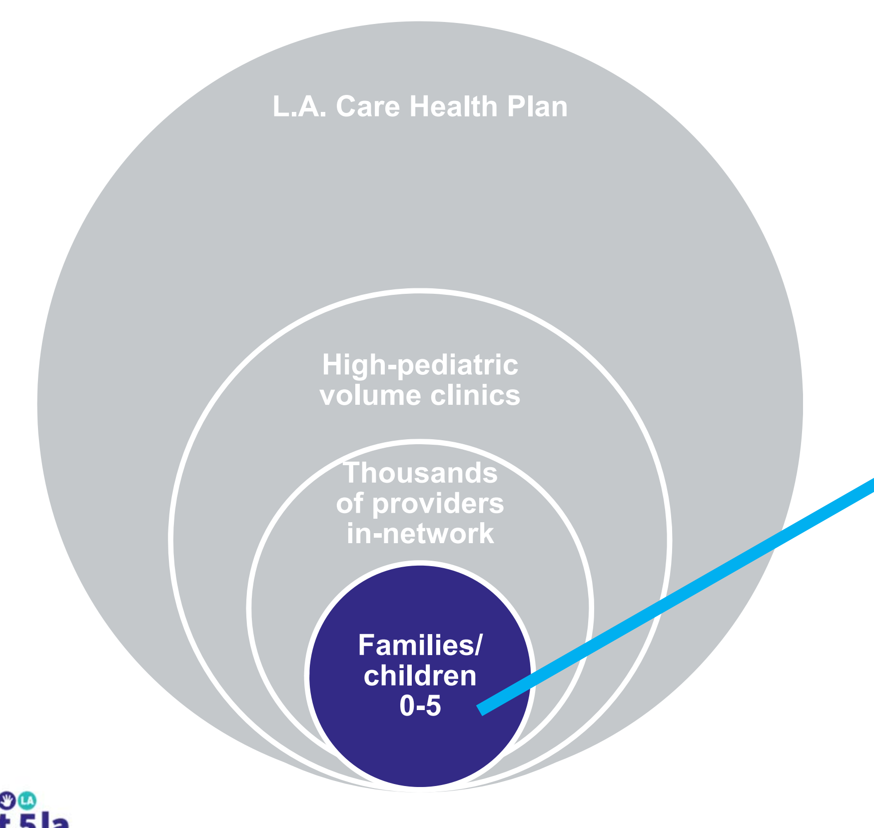
- Provides health coverage to approximately 65% children 0-5 years old through all lines of business & plan partners
- Engagement at multiple health care sector levels
- System change approaches



Pilot Objectives:

1) Integrate early identification and intervention protocols into practice workflow
2) Increase awareness and education on the importance of developmental screening and monitoring across levels (e.g.: health providers, clinics, community)

Pilot Objective and Activities: Communities/Families



Objectives:

- Increase knowledge among communities and families
- Utilize public messaging
- Leverage L.A. Care-operated Family Resource Centers

Anticipated Reach:

- Broad impact of public health messaging
- 60 classes/events at L.A. Care-operated Family Resource Centers reaching approximately **1,000 families/children**

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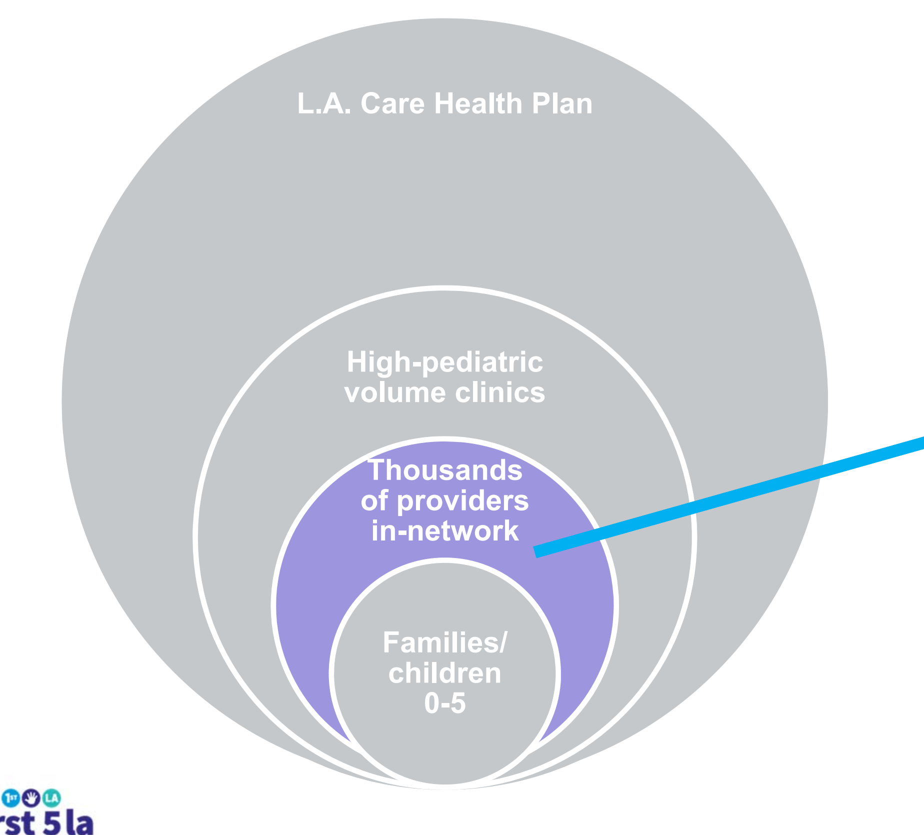
Pilot Objective and Activities: Health Providers



Objectives:

- Increase provider knowledge about child development, screening and referrals
- Leverage existing training and educational platforms

Anticipated Reach:

- Reach at least **1,000 providers** through communication and messaging
- Reach at least **300 providers** through Continuing Medical Education events

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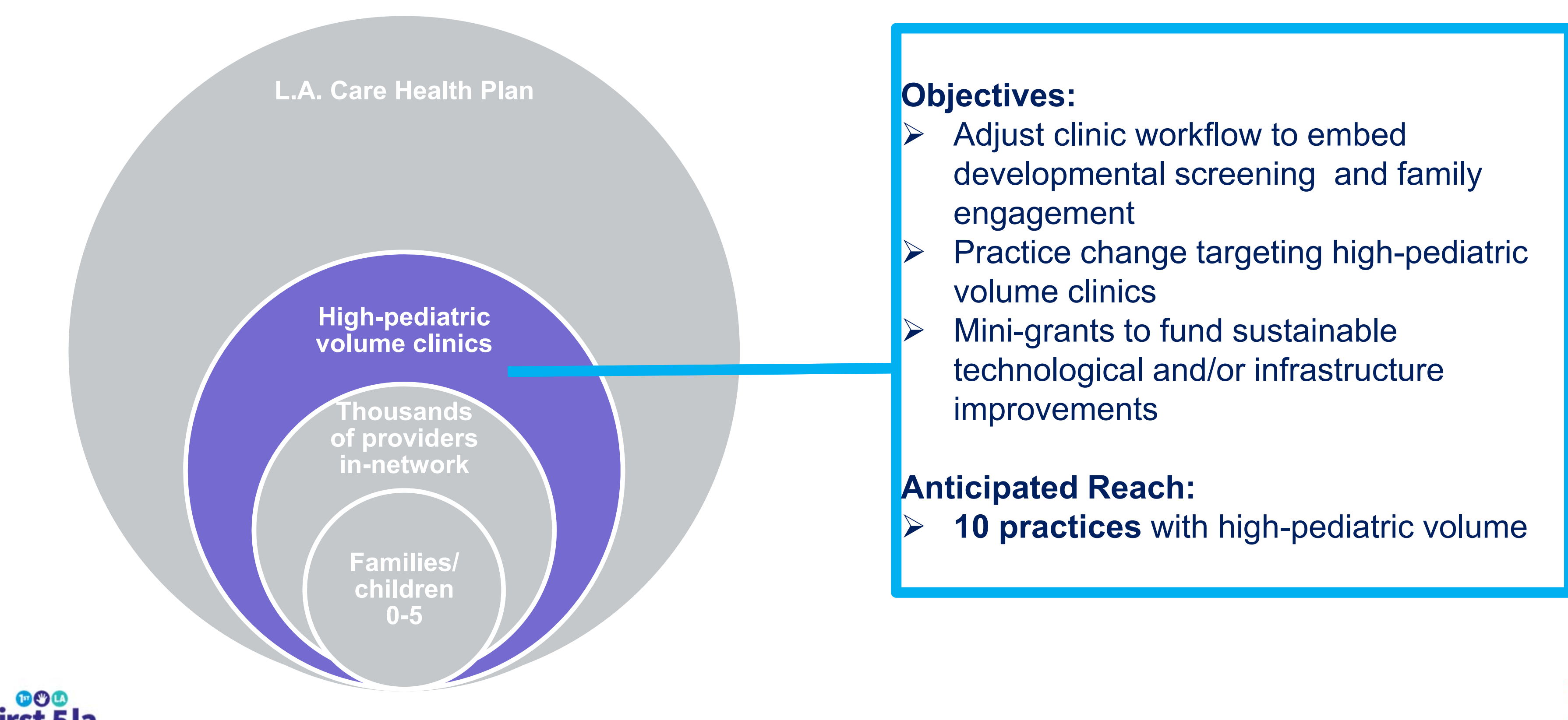
Pilot Objective and Activities: Clinics



Objectives:

- Adjust clinic workflow to embed developmental screening and family engagement
- Practice change targeting high-pediatric volume clinics
- Mini-grants to fund sustainable technological and/or infrastructure improvements

Anticipated Reach:

- **10 practices** with high-pediatric volume

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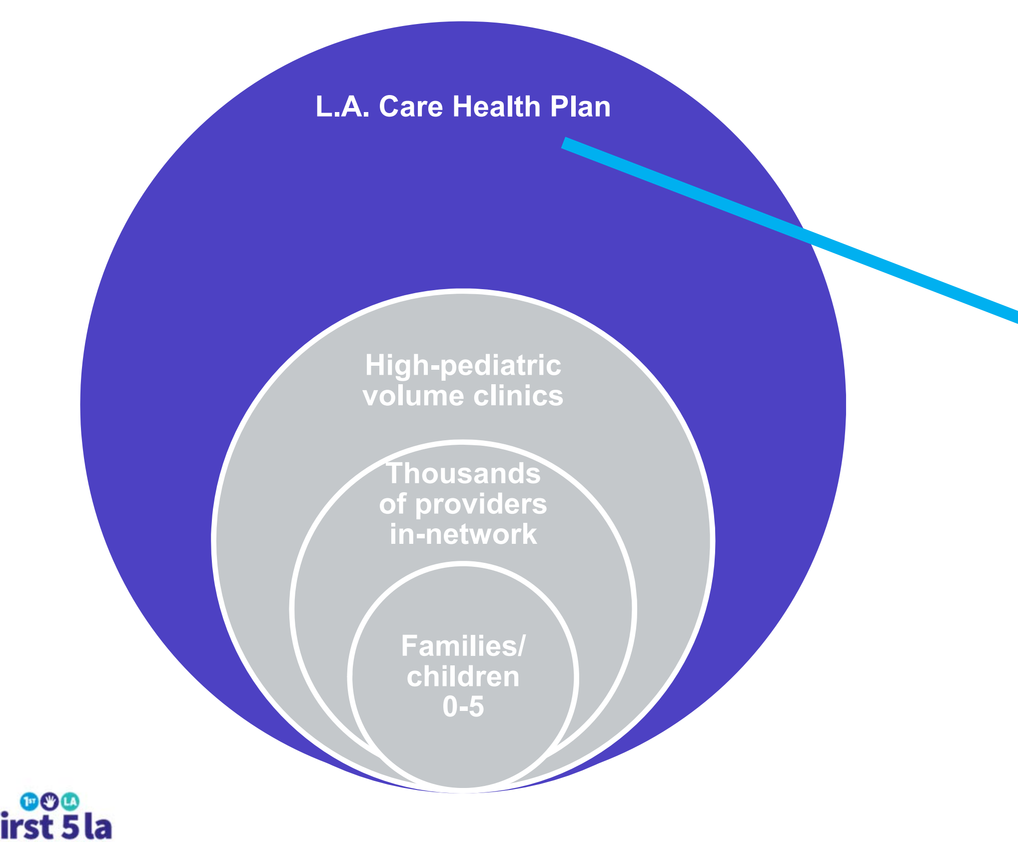
Pilot Objective and Activities: Managed Care Plan



Objectives:

- Leverage health plan infrastructure, expertise and network
- Leverage health plan policies and procedures
- Data collection and sharing for system improvement

Anticipated Reach:

- Wide reach across all members and providers

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Sustainability & Leveraging L.A. Care Resources

- Sustainability embedded within strategy
- Leverage L.A Care's expertise, infrastructure, and network
  - L.A. Care personnel in-kind
  - Access to providers and members
  - L.A. Care-operated Family Resource Centers
  - Use of Continuing Medical Education (CME) platform
  - Health Information Technology Department expertise in practice transformation

Next Steps

- March 2019 board meeting (action)
  1. Approve Strategic Partnership with L.A. Care Health Plan in the Amount of $1,209,460 for up to four years
  2. Authorize First 5 LA Staff to Execute an Agreement for year one

- Spring (March/April) 2019- HMG-LA implementation updates

Questions
FIRST 5
20
YEARS
OUR KIDS
OUR FUTURE
1ST
LA
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Agenda Item: 06
Date: February 28, 2019

FIRST 5 LA

SUBJECT:
Request to:

1. **Establish a Strategic Partnership with KPCC Southern California Public Radio (SCPR) in the Amount of $100,000 to support KPCC's Community-Engaged Early Childhood Coverage for the period of two years and**
2. **Authorize First 5 LA Staff to Execute an Agreement for an amount not to exceed $100,000 from March 15, 2019 to March 15, 2021. (Fund Balance Category: Committed for FY18-19 and Assigned for FY 19-20).**

RECOMMENDATION (PROVIDED AS INFORMATION):
This memo is provided as information for the Board's consideration at the February 28, 2019 Special Meeting of the Board of Commissioners/Program & Planning Committee Meeting. First 5 LA staff recommends that at the March 14, 2019 Board of Commissioners meeting, the Board approve the establishment of a Strategic Partnership with KPCC Southern California Public Radio (SCPR) and authorize staff to execute a contract from March 15, 2019 to March 15, 2021 for an amount not to exceed $100,000. Funds for FY 2018-2019 are included within the current First 5 LA Programmatic Budget under Communications and Marketing, which was approved by the Board of Commissioners on June 14, 2018. Funds for FY 2019-2020 will be included in the FY 2019-2020 First 5 LA Programmatic Budget which will be brought to the Board of Commissioners for approval in June 2019. At the time of budget approval, requested resources will shift from the Assigned resource category of the fund balance, dedicated for broad Strategic Plan purposes, to the Committed category, amounts dedicated for a more specified purpose via resolution.

BACKGROUND:
First 5 LA is dedicated to serving children from prenatal to age 5 and their families, with the understanding that when we dedicate attention and resources to children at the earliest stages of their lives, we are laying the foundation for the social and economic future of the child, the family, and our community. Elevating the importance of early childhood development through credible, trusted news outlets enables First 5 LA and its partners to more effectively engage and urge leaders and lawmakers to prioritize young children in policy and budget decisions. As we have learned from previous investments, news media outlets are frequently not well-equipped or well-practiced to report knowledgeably on early childhood development policy, programs, and practice.

As a continuation of the overarching communication investment strategy to engage decision makers on issues affecting young children, First 5 LA Commissioners have approved investments in several strategic partnerships. These investments to organizations and news outlets have served to build their capacity to cover early childhood development issues, helping First 5 LA elevate awareness and create urgency. By elevating these issues through thoughtful reporting, in outlets trusted and respected by decision makers, we can create opportunities for leaders and lawmakers to better understand and prioritize the needs of young children.

Previous Board-approved Strategic Partnership investments include:

- Creation of an Early Childhood Journalism Fellowship at Pacific Oaks College & Children's School
- The Center for Health Reporting at the USC Schaeffer Center for Health Policy and Economics
- The USC Annenberg Center for Health Journalism's Children's Health Matters Blog, and the National Health Journalism Fellowship

Continuing this work, First 5 LA will contribute funding to Southern California Public Radio's community-engaged early childhood reporting.

KPCC Southern California Public Radio (SCPR) is an innovative public service newsroom dedicated to providing Southern California communities with high-quality news and information. In 2012, the L.A. Partnership for Early Childhood Investment, along with five of its members, embarked upon a unique philanthropic partnership with SCPR to fund a dedicated Early Childhood Development (ECD) beat reporter and establish an innovative communications model, marking a historical shift at SCPR with the first-of-its-kind "issue-focused" coverage at the station. Since 2012, SCPR has integrated "issue-focused" coverage across its newsroom with dedicated beat reporters.

Over the past six years, the goals of the SCPR investment have largely centered on public awareness of ECD. Prior to this investment, Southern California lacked consistent, quality coverage in which the importance of early childhood development was amplified to the general public. Over this same time period, the media environment in which news operates has shifted dramatically. Audiences increasingly consume news online and journalists must contend with "fake news" in their efforts to help Angelenos sift through facts in a dynamic 24-hour news cycle.

As the news environment shifts, SCPR recognizes the need to adapt to serve a changing audience, and to become more intentional about engaging new audiences, in particular low-income parents and families, who have not been the traditional target demographic for SCPR. This investment would build upon First 5 LA's prior investment strategy of creating awareness and urgency among parents and policy makers alike about the importance of ECD. Additionally, elevating the voices and experiences of families also serves to better inform policy makers about the unique needs of families with young children throughout L.A. County.

Project Summary

SCPR is proposing a new, community-engaged model for its Early Childhood coverage, an effort that builds upon its strengths as a local public radio station, leverages the reputation it has gained as a credible voice in early childhood over the past six years, and responds to the environment of evolving media consumption.

SCPR now seeks to build even deeper relationships with community members who could benefit from its reporting yet are underserved by traditional media: low- and middle-income parents and caretakers of young children in Los Angeles County***.*** SCPR plans to seek out the parents and caregivers of young children in low- and middle-income families in L.A. County and build trust using an approach called community-engaged journalism. This entails asking these community members what they want from news coverage, and how they consume media to ultimately create an information service that fits their identified needs. This approach means outreach to relatively new and growing audiences for SCPR, as the parents of young children living in poverty are often young, single, and/or immigrants. The coverage would also serve as an important model that could be replicated to other beats, such as coverage of transportation, or park and healthy food access, which are not exclusively ECD issues.

With this enhanced approach, SCPR's goal is to build a news service dedicated to informing, connecting, and empowering a community of low- and middle-income L.A. County parents and caregivers of children ages 0–5, while continuing to inform and educate its existing broadcast audio and digital audiences on early childhood development topics. This approach would mark a shift in the way SCPR journalists serve the community by having coverage and content be driven by the parents most in need of high-quality early childhood programs and services. This approach will add to, and not replace, SCPR's existing ECD coverage.

SCPR's adaptation process will include two phases: an initial phase of research and design (roughly 6 months), and an implementation phase of 2.5 years. The initial phase will be focused on research, data synthesizing, prototyping, and shared learning, beginning in July of 2018. The team will work directly with the Senior Early Childhood Education and Development Reporter as well as community partners to conduct this research with specific populations in Los Angeles. After data collection, SCPR staff will synthesize the data to find patterns and themes, commonly identified issues, and pose important questions about why these issues are important to people and whether SCPR is positioned to help fill

the gap. SCPR recently released a report that details the methodology and strategy uncovered during the research phase that will inform how they intend to redesign their news coverage of early childhood education and development issues (see Item 6 - Attachment A).

With the knowledge from the research phase, SCPR staff will identify potential news product prototypes and develop at least one community-engaged product to test with their audience. SCPR will observe how the audience is using the work, incorporating feedback into the design. This allows SCPR to test new ideas before they become finalized, resource-intensive projects, and ultimately design at least one additional community-engaged news product as part of an expanded version of their existing early-childhood beat. These efforts will happen in addition to the continued early childhood coverage via SCPR's broadcast audio and digital platforms, and ultimately will require additional SCPR staff to conduct.

The implementation phase will integrate the new community-engaged news product(s) into SCPR's early childhood coverage, serving a community of parents and caregivers of young children with the specific information they need in a way they can access it. At the same time, SCPR will continue to provide key policymakers, community members, and stakeholders in the early childcare community with coverage on a wide range of topic areas such as infants and new parents, home visiting, mental health and nutrition, science around the development of young children, and legislation and statewide financial support of early childhood programs.

Major desired outcomes of the project are as follows: 1) Design at least one additional community-engaged news product as part of an expanded version of the Early Childhood Development beat that responds to the direct feedback of low-income parents of children, zero to five; 2) Engage and retain a more economically and geographically diverse audience that is more representative of Los Angeles as a whole; and 3) Support parents in becoming more informed consumers of early childhood programs and services. These outcomes are in direct alignment with First 5 LA's goal of exposing policy makers to the priorities expressed directly from families of young children.

Pursuant to the Procurement Policy, Strategic Partners of $75,000 or more in a fiscal year must be presented to the Board for approval. Staff is requesting an establishment of a Strategic Partnership for an amount not to exceed $100,000 to comply with this policy. Section IV.5 of the Procurement Policy also states that contracts of $75,000 or more requires Board approval prior to execution. Staff is seeking approval to execute a contract for the period of March 1, 2019 to March 1, 2021 for $100,000.

GOVERNANCE GUIDELINES #5 AND #6 (SUSTAINABILITY AND LEVERAGING):
The following outlines how First 5 LA along with KPCC will address the implementation of the sustainability and leveraging components of the First 5 LA Governance Guidelines approved by the Board in March 2014.

Sustainability – SCPR has a three-year timeline for this project. First 5 LA's investment comes at the end of the research phase and will cover most of the implementation phase. Continuation of this specific project would depend on additional funding; however larger outcomes will be sustained after the end of funding. SCPR's ability to reach and inform both community members and policy decision makers through this work is expected to be sustained beyond the funding period as a result of awarded grant funds. Examples of this include: sharing the outcomes and successes of the project with journalism, philanthropic, and early childhood communities and decision makers, presenting findings at conferences that draw relevant crowds, demonstrating reach and level of interaction of the journalism with the communities it is informed by and intended for, etc. SCPR will provide six-month reports that will serve as clear markers to show progress on achieving the goals of the project.

Leveraged Resources – This expanded early childhood desk has a total budget of $1.68 million over a three-year period. SCPR is able to provide $390,000 of the budget from operating funds. A group of aligned funders currently includes the L.A. Partnership for Early Childhood Investment, The Atlas Family Foundation, The Carl and Roberta Deutsch Foundation, and the Tikun Olam Foundation. This accounts

for roughly $1.2 million of the budget, with the possibility of more funders joining this group going forward.

JUSTIFICATION:
This Strategic Partnership meets the criteria below:

☐ The Strategic Partnership can provide specific resources needed by First 5 LA to implement an approved program or initiative in a manner or on a scale that makes the Strategic Partnership more cost effective than resources provided through a competitive solicitation; or

☒ The Strategic Partnership can implement an approved program or initiative more expeditiously than resources provided though a competitive solicitation; or

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

☒ The Strategic Partnership provides an opportunity to leverage First 5 LA funds to produce additional funding for the program or initiative or service.

AND

☒ The proposed Strategic Partnership is aligned with the adopted Strategic Plan.

The Strategic Partnership provides an opportunity to leverage First 5 LA funds to produce additional funding for the program or initiative or service. The Strategic Partnership allows First 5 LA to leverage funds from the L.A. Partnership for Early Childhood Investment to produce additional support that will strengthen the implementation of this program. The Partnership shares First 5 LA's vision of a system of early childhood development with journalism as a fundamental component. First 5 LA would join a group of aligned funders who have dedicated resources to this work. Current funders include:

- Atlas Family Foundation: $262,500
- The Carl and Roberta Deutsch Foundation: $195,000
- L.A. Partnership (Baby Futures Fund): $75,000
- Tikun Olam Foundation: $337,500

This is in addition to the $390,000 of its own resources that SCPR is dedicating to this project. In September, SCPR worked closely with the LA Partnership to cohost a funder briefing at the KPCC studio in Pasadena to introduce the project to potential new funders. First 5 LA's contribution can help unlock more support for this work.

The Strategic Partnership can implement an approved program or initiative more expeditiously than resources provided though a competitive solicitation, as KPCC is already nearly eight months into this work and, and there is no other opportunity of similar scope and scale for First 5 LA to explore.

The goals of the Communications Department include engaging decision makers and elevating awareness to create urgency around the 2015-2020 Strategic Plan outcome areas. This strategic partnership will allow First 5 LA and SCPR to engage decision makers by elevating the quality and quantity of coverage on early child development issues.

First 5 LA's past investments with the LA Partnership for Early Childhood, the USC Annenberg Center for Health Journalism, and Center for Health Reporting have proven successful at elevating the quality and quantity of coverage of early care and education issues. First 5 LA has learned from its past experience that when issues are reported in the news, from trusted outlets, people--including decision makers--pay attention. First 5 LA's funding contribution will help create and sustain a project that will

increase the amount of high-quality early childhood relevant content across broadcast, digital, social media and live event platforms from trusted outlets, while increasing the distribution of stories and connecting news coverage to the broader early child development movement throughout California.

Specifically, these investments in communications will help First 5 LA elevate awareness and engage decision and policy makers in multiple ways:

- Building media outlets' capacity to cover early childhood development issues, and engage their audiences
- Elevating these issues through thoughtful reporting, in outlets trusted and respected by decision makers, helping to raise the awareness of leaders and lawmakers on these issues
- Awareness leads to conversations on First 5 LA priority issues with other decision makers and constituents/people served
- These conversations help create opportunities for policy and systems change to address the issues elevated, in part, by First 5 LA investments

The proposed Strategic Partnership is aligned with the adopted 2015-2020 Strategic Plan.
This strategic partnership will advance 2015-2020 Strategic Plan Outcome area goals across the Communications strategy as it relates to educating the public and key stakeholders about the importance of investing in our children and families. This strategic partnership will complement similar investments made by the Communications Department and will allow First 5 LA to engage decision makers by elevating the quality and quantity of coverage on early child development issues. Communications' overarching goal is to engage decision makers by elevating the quality and quantity of the media's coverage of issues within First 5 LA's 2015-2020 Strategic Plan outcome areas. Previous experience has shown that investments to build the capacity of newsrooms to cover the issues First 5 LA cares about are an effective way to engage decision makers.

FEBRUARY 2019

GOING TO THE EXPERTS

How KPCC turned to parents when redesigning its early childhood education and development coverage.

Prepared by:
Ashley Alvarado
Kristen Muller

Elena, parent

INTRODUCTION

How KPCC is adapting to serve new audiences

KPCC (Southern California Public Radio) is an innovative public service newsroom dedicated to providing Southern California communities with high-quality news and information. Every day, our journalists help audiences catch up on the latest headlines, explore the complexities of life in Southern California, and connect curious communities with one another.

Yet as we report on key issues like early childhood education and development (ECED), the media environment in which we operate is shifting dramatically. We know that we must try new approaches in order to engage and better serve Southern Californians. It's imperative we reach diverse audiences: Roughly half the population in Los Angeles County is nonwhite; about 6 percent is 5 years old or younger.

To fulfill KPCC's mission, we must continue to innovate by designing our coverage in new ways so that we can reach audiences in their daily lives—where they live and how they consume information—and provide a public service unavailable anywhere else.

In 2012, KPCC hired a reporter to focus on the first five years of life. The goal: to examine how access to education in the early years affects outcomes later in life, including but not limited to incarceration rates, income, and career opportunities. KPCC was progressive in this approach. Most education reporting focuses on K–12, despite the evidence that 85 percent of brain development occurs in the first three years.

Priska Neely, KPCC's senior early childhood reporter

We built expertise in the emerging science of brain development and examined the availability and affordability of childcare as well as how current public policy syncs up (or fails) to meet the needs of caregivers. We delivered this information through broadcast, digital stories, and in-person events. By all measures, our work has been successful. In the beat's first six years, KPCC's effectively reached key policy makers and stakeholders in the early childcare community with more than 830 stories and won more than a dozen awards along the way. There was demonstrated impact at the individual, network, and institutional levels.

We also saw a major shift in the public dialogue around early childhood issues. When we began our coverage in 2012, the conversation focused on whether preschool was effective. In 2019, California Governor Gavin Newsom describes himself as a fanatic about early childhood issues and says improving care and education for infants, toddlers, and preschoolers is a top priority for the world's fifth-largest economy.

KPCC now seeks to build deeper relationships with community members who could benefit from our service yet are underserved by public media: low- and middle-income parents and caretakers of young children in Los Angeles County. While KPCC reaches roughly 1 million people each month, that does not represent the full range of Angelenos who most need this information.

In order to reach those most in need, we've launched a new strategy that will allow us to go deeper, identifying the information needs, concerns, and problems these parents and caregivers face every day. This requires changing our approach and embracing experimentation so that we might better understand and meet the information needs of these parents and caregivers. What follows is a report on what we've tried so far, early results, and learnings.

PROJECT DESCRIPTION

The project seeks to answer whether KPCC's journalism can be useful to communities outside of our traditional distribution channels. Is there reporting we could do that would meaningfully engage more caregivers of children ages 0–5 in L.A. County? How would we define success, and how do we need to modify our approach to be effective?

There is urgency in answering these questions as Governor Newsom has made early childhood education a legislative priority. KPCC is in a unique position to hold government officials accountable. There is an opportunity to connect caregivers who live and breathe our early childhood system with academics, researchers, and policy makers to reveal gaps between the two and shine a light on what's working (or not).

The research team, from top: Kristen Muller, Ashley Alvarado, Priska Neely, Tran Ha, Jane Jozefowicz, and Natalie El-Hai.

METHODOLOGY AND PROCESS

To better understand the information needs and habits of those KPCC aims to serve with its ECED coverage, we turned to design thinking.

Design thinking is a methodology for solving complex problems that forces you to identify actual problems before offering solutions. As Jennifer Brandel, the cofounder of the engaged journalism platform Hearken, has written, "At its most basic, design thinking is an agile process for solving complex problems. It's a way of understanding the needs of the people you're building a solution for, and testing that solution with them before creating it."

For this research, we employed a human-centered design approach (a form of design thinking), which emphasizes deep listening. The team consisted of chief content officer Kristen Muller, community engagement director Ashley Alvarado, early childhood reporter Priska Neely, human-centered design expert Tran Ha, and interns Jane Jozefowicz and Natalie El-Hai.

Based on our previous work with early childhood coverage, we selected a target audience of L.A. County parents and caregivers of children ages 0–5 and a goal of expanding and deepening our public service journalism,

Before launching the research, each member of the team had different ideas about what sort of outcome could be useful to parents and caregivers: an app that would help caregivers locate affordable, quality childcare, partnering with ethnic media to distribute the journalism we already produce, and distributing stories in preschools.

But we didn't know whether our ideas would be useful to the community we were trying to serve. We needed to first make sure we were identifying the right problem(s) before spending time brainstorming solutions.

We launched a five-step process:

1. **Development of stakeholder map and target characteristics**
2. **Stakeholder interviews**
3. **Synthesis**
4. **Brainstorming**
5. **Development of potential prototypes**

DEVELOPMENT OF STAKEHOLDER MAP AND TARGET CHARACTERISTICS

The most effective ideas are most likely to come from stakeholders. In the case of early childhood education and development coverage, that means people who spend a significant part of their day engrossed in early childhood development—as parents, caregivers, childcare providers, or otherwise.

We needed to better understand their wants and needs,

Based on Neely's previous reporting and expertise in the ECED field, we developed a list of stakeholders.

As we mapped these stakeholders (pictured: top right corner), we started to identify shared experiences or characteristics and we were able to see categories emerging.

Based on our goal going in, we prioritized parents, family members, and other caregivers, including professionals.

What had started as a very long list became manageable.

Working with Ha, we developed a list of target characteristics (pictured: righthand column) that would allow us—with the target audience of parents and caregivers of children 0–5 years old in Los Angeles County—to interview stakeholders with a wide range of experiences.

PARENT TARGET PROFILES

- *Has child/children 0-3 years old*
- *Has child/children 3-5 years old*
- *KPCC listener*
- *KPCC non-listener*
- *High school or no high school diploma*
- *Masters or PhD*
- *Black*
- *White*
- *Undocumented*
- *Spanish speaking*
- *Speaks non-dominant primary language*
- *Lives in incorporated city in L.A. County*
- *Lives in unincorporated area in L.A. County*
- *Lives downtown*
- *Lives in suburbs*
- *Takes public transportation as main mode of transport*
- *Drives as main mode of transport*
- *Lives close/far from freeway*

CAREGIVER TARGET PROFILES

- *In-home daycare*
- Drop-off daycare
- Relative who provides primary care for child

Ashley Alvarado interviews Janet, a Pasadena preschool teacher.

STAKEHOLDER INTERVIEWS

Traditionally, when journalists are on deadline, we ask subjects very direct questions that need a precise answer. Human-centered design, on the other hand, employs more open-ended questions like “What do you worry about when it comes to your children?” and “If you had more time in the day, how would you use it?” as well as the observation of body language. This is to draw out implicit needs, in addition to explicit ones.

Explicit needs are what we can see: our conscious decisions and behaviors that we can observe and discuss. Implicit needs lie below the surface, and include emotions, values, and beliefs. Implicit needs are harder to observe, but they often provide deeper insight and focus. By approaching our interviews in this fashion, we aimed to step back, drop our assumptions, and immerse ourselves in the environment of those we are aiming to serve.

We went in looking for insights that could help point the way toward solutions. This approach is different from traditional research, focus groups, and engagement activities. Target profiles were carefully identified through research and Neely's experiences in the field.

Interviews took place in interview subjects' homes or workplace. Observing their behavior in their natural context helped us better understand what commands their attention throughout the day...and where and when we might fit into their routines. [Continued on page 8.]

INTERVIEWS: WHAT WE HEARD

The interviews were conducted in person across L.A. County; they usually lasted 45 minutes to an hour. Once all of the interviews were completed, we spent three days focused on sense-making: looking for patterns, themes, and meaning in what we had heard and observed so that we might identify actionable insights and frameworks. Here is some of what we heard:

"I overwork a lot of times. It brought me to tears when I realized this."
—Denise, ***in-home daycare provider***

"The force of money can move you beyond borders."
—Janet, ***preschool teacher***

"If you know something or have advice, I'd really appreciate."
—Berenice, ***relative with temporary custody***

"When my baby's sick, the first person I call is my grandmother in Mexico."
—Elena, ***parent***

"[My wife] does the research, and I agree with her."
—Justus, ***parent***

From left, Kristen Muller, Priska Neely, Tran Ha, and Ashley Alvarado (not pictured) analyze the interviews, looking for patterns and opportunities.

SYNTHESIS

Once all of the stakeholder interviews had been conducted, we worked with human-centered design specialist Tran Ha over the course of three days to identify patterns and themes in the interviews and observations.

This synthesis is critical.

It allowed us to identify archetypes within our target audience as well as key insights that will drive our next phase of early childhood education and development reporting and engagement, including the development and testing of prototypes.

SYNTHESIS: THE ARCHETYPES

During the synthesis process, we identified and developed four archetypes.

Conspicuous Consumer

Likely part of KPCC's existing reach, the Conspicuous Consumer needs information to feed curiosity, improve quality of life, and reinforce world views.

Conscientious Caregiver

Less likely to be a regular KPCC listener, the Conscientious Caregiver needs information to inform their mission-driven work in the early childhood sector or to navigate the services designed for parents and caregivers.

Busy Bootstrapper

Completely outside of KPCC's existing reach, the Busy Bootstrapper needs information to survive and connect to resources.

Passive Follower

Unlikely to be a regular KPCC listener, the Passive Follower has experienced financial insecurity but not so much as to search out information in the way the Busy Bootstrapper does. She is more likely to be English dominant and to have spent the majority—if not all—of her life in the United States.

Justus and his wife, Liz, along with their 4-month-old daughter.

SYNTHESIS: KEY INSIGHTS

During the synthesis process, we identified new principles that will guide our work moving forward.

Formal and informal networks play an important role in collecting and disseminating information.

These networks include churches, public libraries, teacher associations, playgrounds, Facebook groups, families, and friends.

Many parents are worried about their kids' long-term futures instead of 0–5.

Parents of children 0–3 discussed anxiety about their children's long-term future while parents of children 3–5 focused on more immediate needs like performance in school.

Some face an additional learning curve and burden to navigate the early childhood education and development system to qualify for or take advantage of resources.

Many parents—especially those with limited English—detailed the challenges they faced in trying to access early childhood services for their children: from confirming eligibility for certain programs to the transportation required to participate.

SYNTHESIS: WHAT WE LEARNED

We cannot rely solely on radio, social media, or English-language media.

KPCC recognizes the greatest opportunity to expand its reach and deepen its impact in a meaningful way is with the Busy Bootstrapper and Conscientious Caregiver archetypes.

To really tap into the networks and informal distribution models we know exist, we must do much of this work in person. We cannot rely on our radio and digital platforms. At the same time, we cannot—and will not—stop doing the journalism that serves the Conspicuous Consumer. This is not a technology solution. Instead, it is low tech and high touch.

KPCC is particularly well positioned to carry out this work because of our longtime commitment to reporting on early childhood education and development and to engaged journalism practices (including but not limited to in-person events, community listening, and sourcing). We have established connections throughout the early childhood space and are skilled at in-person facilitation, producing live events, and engaging people where they are.

In January, KPCC hired its first-ever engagement producer dedicated to early childhood education and development. Over the next two years, we will conduct a series of experiments with the aforementioned prototypes and share learnings as we go.

Stefanie Ritoper
Engagement Producer

Before joining KPCC, Ritoper spent more than 10 years supporting civic engagement through media in mission-driven organizations, including Evo Health and Wellness, the UCLA Labor Center, and Asian Americans/Pacific Islanders in Philanthropy. Ritoper was also the founding producer and host of "Re:Work," a storytelling show about work. She holds a master's degree in city planning from the Massachusetts Institute of Technology.

Ritoper is a native Angeleno and spends most of her free time relearning everything she thought she knew about life from her toddler.

KPCC staff members joined the core research team to reflect on key insights and opportunities, brainstorming potential news sources based on these findings.

BRAINSTORMING

Drawing on the archetypes and key insights developed during the synthesis phase, KPCC journalists and non-journalist staffers gathered to brainstorm potential news services and distribution models that could reach the target ECED audience.

Staffers were asked to answer questions like "How might we think about ECED stories and information in formats beyond radio and web?" and "How might we engage with and build awareness among informal gatekeepers not familiar with KPCC? Of the potential news services identified during the brainstorm session, we have selected three ideas to prototype and develop as community-engaged news products (CNPs).

Prototypes at a glance:

- **Printed fliers in libraries and parks**
- **Early childhood community ambassador program**
- **Children's book club at public libraries**

DEVELOPMENT OF POTENTIAL PROTOTYPES: 3 COMMUNITY-ENGAGED NEWS PRODUCTS

The fifth step of this process was to develop the prototypes, or community-engaged news products, that we would test out.

1. PRINTED FLIERS IN LIBRARIES AND PARKS

Throughout the interview process, parents and caregivers cited fliers and postcards as sources of critical information—whether they were spotted at a local public library, park, or mailbox.

We have already begun to prototype this by distributing informational postcards (pictured above) that shared information about KPCC's reporting series on black infant mortality and promoted a January KPCC In Person event called "Racism and Reproduction: What Black Women Need to Know." For more information, see page 16.

Based on the key insights that "Formal and informal networks play an important role in collecting an disseminating information" and "Some face an additional learning curve and burden to navigate the early childhood education and development system to qualify for or take advantage of resources," KPCC has begun prototyping paper materials through informal partnerships and direct mail. We are also experimenting with in-language materials.

This prototype is specifically designed to reach those we would identify as belonging to the Conscientious Caregiver and Busy Bootstrapper archetypes.

2. EARLY CHILDHOOD COMMUNITY AMBASSADOR PROGRAM

This type of framework is meant to encourage a sense of shared ownership in the newsgathering and distribution processes.

Building on the engagement and journalism KPCC has already done, the early childhood community ambassador program will regularly convene stakeholders in the communities where they live, not only distributing information but more importantly surfacing the needs and issues they're facing.

The convenings will be designed to foster small-group conversations and build trust between communities and KPCC journalists. Within the facilitation design, the emphasis will be on deeper listening and participation among all attendees.

They will also serve as an opportunity to identify other nontraditional distribution models.

Based on the key insights "Formal and informal networks play an important role in collecting and disseminating information" and "Many parents are worried about their kids' long-term futures instead of 0–5," KPCC will regularly convene stakeholders to surface specific needs and stories we may be missing, as well as leverage points to activate interest in coverage.

This prototype is designed to facilitate connection with and better understand the needs of all four archetypes. While each has a different degree of familiarity with KPCC, this prototype allows KPCC journalists to better understand and meet the information needs of each through deep engagement.

3. CHILDREN'S BOOK CLUB AT PUBLIC LIBRARIES

The children's book club prototype leverages KPCC's existing relationships with the local library system as well as listeners across Southern California.

We will turn to KPCC's existing audience members across radio, website, social media, and in-person platforms to crowdsource children's books that can be read at a series of facilitated community story times.

Working alongside the library system, KPCC will not only produce the events but also table at them in order to distribute key informational and branded materials.

We believe that KPCC's expertise in producing live events uniquely positions us to offer compelling book club story times that will engage parents and children, increasing parents' familiarity with us and building trust.

This has the potential to build on and to support the Early Childhood Community Ambassador Program prototype.

Based on the key insight that "Formal and informal networks play an important role in collecting and disseminating information," KPCC has begun looking at ways in which we could leverage our existing relationships and those of parents and caregivers with public libraries to meet people where they are.

This prototype is specifically designed to reach those we would identify as belonging to the Conspicuous Consumer, Conscientious Caregiver, and Busy Bootstrapper archetypes.

AN EARLY WIN

A January 2019 event served as case study for initial prototype testing

Based on the results of our human-centered design research, KPCC saw an immediate opportunity to implement one of the prototypes: the use of paper materials as a distribution method. This predated the hire of Stefanie Ritoper as engagement producer.

With Priska Neely's January 24 event focused on the black infant mortality, we identified a target audience of African American women in their early childbearing years (this is a segment of the population deeply affected by the mortality crisis and one largely outside of KPCC's traditional radio audience; African Americans represent roughly 8 percent of our listenership). We set the goal of having an audience of at least 100 people that was majority African American.

Nearly 6,000 informational postcards were distributed via direct mail to residents in neighborhoods with high rates of infant mortality and shared by health organizations. Printed fliers (pictured, opposite page) were displayed at an L.A. County Library branch near the venue, and digital fliers were shared by various organizations.

The results demonstrate a clear early win: more than 400 people registered for the event. Despite a trend toward higher attrition rates, roughly 200 people attended the program. More than 90 percent presented as black women, including high school students, grandmothers, medical professionals, and others.

An early review of the website analytics indicates that about 330 unique visitors came to the black infant mortality landing page from the unique URL. Roughly 51 percent of people who RSVP'd said they had heard about the event in a way other than our traditional outreach model.

The conversation was informative, with the host and panelists sharing a mix of advice and personal experiences.

Audience feedback (in-person and online) was extremely positive.

On Twitter, Isabeth Mendoza wrote, "So much community & love at 'Racism & Reproduction: what black women need to know.'" Twitter user @HeyImIvanna described the evening as "an eye-opening event."

As part of the post-event survey, one attendee wrote, "The speakers were great and diverse in their professions and experiences. The questions raised were very enlightening and the audience was able to engage the speakers."

WHAT BLACK WOMEN NEED TO KNOW

Black babies in the United States are far less likely than white babies to reach life's simplest milestones: to form words, to learn to crawl, to take their first steps.

That's because black babies born in the United States are two times more likely to die before their first birthday than white babies. The numbers are even worse in Los Angeles, where black babies are three times more likely than white babies to die in their first year of life. A growing body of research suggests the root cause is a social one, and the suspected assailant is chronic stress brought on by being a black woman in this country.

Join KPCC In Person and KPCC-LAist reporter Priska Neely and a panel of guests on January 24 as they share personal stories and information women can use to empower themselves — in and outside of the doctor's office — to improve outcomes for their babies and themselves.

JANUARY 24 · 7 P.M.
LA84, 2141 W. ADAMS BLVD., LOS ANGELES
RSVP: KP.CC/BLACKBABIES

Opposite page: So many people attended the January event that an overflow space was opened. This page, from top: The informational flier that was distributed, a young audience member asks a question.

RESEARCH & DESIGN PHASE EVALUATION

Measuring the success of KPCC's research and implementation of the identified prototypes.

RESEARCH AND DESIGN OBJECTIVES

As we entered into the research and design phases of our ECED reporting project, KPCC identified three main objectives:

1. Learn the identified community's needs, focusing on:

- Understanding the topics and issues of most interest as well as the preferred or convenient delivery formats and engagement methods.
- Understanding what is already being done by other organizations in the field to meet these needs.
- Identifying what KPCC as a local news organization can uniquely provide.

2. Design an editorial strategy to test, including:

- Identifying potential news product(s) specifically designed for low- and middle-income parents, families, and caregivers of young children.
- Identifying a distribution pipeline(s) and engagement tool(s) that allow us to serve a community traditionally underserved by media.

3. Develop a report on information learned during the research phase for distribution to journalism organizations, service organizations, and the philanthropic community.

FINAL RESEARCH OUTCOMES

The following pages include the research, analysis, prototyping, and sharing activities that KPCC proposed as we headed into the research and design phase as well as the actual outcomes and measures.

Research Activities

Proposed Activities

- ☑ Hire human-centered design specialist
- ☑ Identify 3 in-community informal partner organizations to facilitate introductions to community members
  - Outcome: We worked with multiple in-community informal partner organizations (including First 5 LA, Long Beach Forward, and Children Today) to facilitate introductions to stakeholders
- ☐ Either through partner organizations or services like Exact Data, purchase cell phone numbers for community members
  - Outcome: We chose not to do this.
- ☑ Implement direct mail strategies in specific communities
  - Outcome: Implemented direct mail strategies in specific communities like Inglewood
- ☐ Hold in-community Feeding the Conversations engagement-sourcing gatherings utilizing facilitation techniques and methodologies to surface needs
  - Outcome: We chose not to do this.

Proposed Outputs

- ☑ Create 3–5 types of survey materials (postcard, text message, digital)
  - Outcome: During research we focused on in-person interviews. When prototyping printed materials, we created two types of digital surveys (at time of RSVP and post event) and tracked URLs as another way to survey behavior of target audience
- ☑ Develop 3–5 archetypes representing potential community members served
  - Outcome: Developed 4 archetypes
- ☑ Develop a list of no more than 5 issues and topics of interest
  - Outcome: Developed 3 key insights (takes the place of key topics or issues as identified in research proposal)
- ☑ Develop a list of no more than 3 potential delivery formats
  - Outcome: Developed multiple delivery formats, including but not limited to direct mail, fliers in public libraries and parks, and in-person events.

Expected Outcomes

- ☑ Specific archetypes have been identified for KPCC to build content around
- ☑ A wide range of needs and opportunities specific to the community members are identified
- ☑ Several options for news products to pilot are identified, including the potential formats, delivery mechanisms, issues and topics
- ☑ The community has been intentionally involved in productive conversation to imagine the most effective coverage

Printed fliers were identified as the first prototype that would be produced as a community-news engaged product. Ahead of a January 2019 event, fliers were distributed to a local library branch. Thousands of postcards (pictured) were also distributed via direct mail.

Data Analysis

Proposed Activities

- ☑ Synthesize data through multiday work sessions
- ☑ Compare the range of needs with what journalism is equipped to help solve

  Outcome: Compared the range of needs with what KPCC newsroom was equipped to help solve; identified the need for a full-time engagement producer position to support ECED reporting

Proposed Outputs

- ☑ Create list of patterns and themes
- ☑ Break down those issues and opportunities where KPCC journalists could help fill the gap
- ☑ Identify those issues that could be addressed with a community and/or journalism partner

Expected Outcomes

- ☑ Specific potential information and delivery problems we are trying to solve are identified

  Outcome: While KPCC entered the research phase with the assumption that there would be a high-tech solution, it became clear we needed low-tech, high-touch solutions that reached people where they are (often outside of KPCC's traditional reach)
- ☑ Several specific community-engaged news products are identified

  Outcome: Three prototypes identified as community-engaged news products (CNPs)
- ☑ Move into design and prototyping phase with clear focus on issues, delivery types to pilot

Pretotyping and Prototyping

"Pretotyping" is a precursor to prototyping; it's a way to test an idea quickly and inexpensively to see whether the premise that "If we build it, they will use it" is correct.

Proposed Activities

- ☑ Pretotyping potential CNPs to test the initial appeal and actual usage to learn if people will be interested in it
  - Outcome: Pretotyped then prototyped printed fliers in libraries and parks idea with January event on black infant mortality (see page 16)
- ☑ Prototyping potential CNPs to test our actual ability to make the product, and adjusting as needed

Proposed Outputs

- ☑ No more than 3 pretotypes are developed, tested, qualified or disqualified
- ☑ 1–2 prototype(s) are developed and tested
  - Outcome: Tested fliers at libraries as well as postcards that were distributed via direct mail to neighborhoods experiencing higher rates of black infant mortality
- ☑ Ongoing surveys are conducted, asking questions of community members about the CNPs
  - Outcome: Surveying people who RSVP'd and attended event at time of registration and following event

Expected Outcomes

- ☑ The first CNP we will produce and test is determined
  - Outcome: Postcards and fliers identified as first CNP
- ☑ Scorecard for early success of the CNP is developed, with 3–5 key metrics determined
- ☑ Production of CNP commences

Sharing

Proposed Activities

- ☑ Write, present, and share a public report

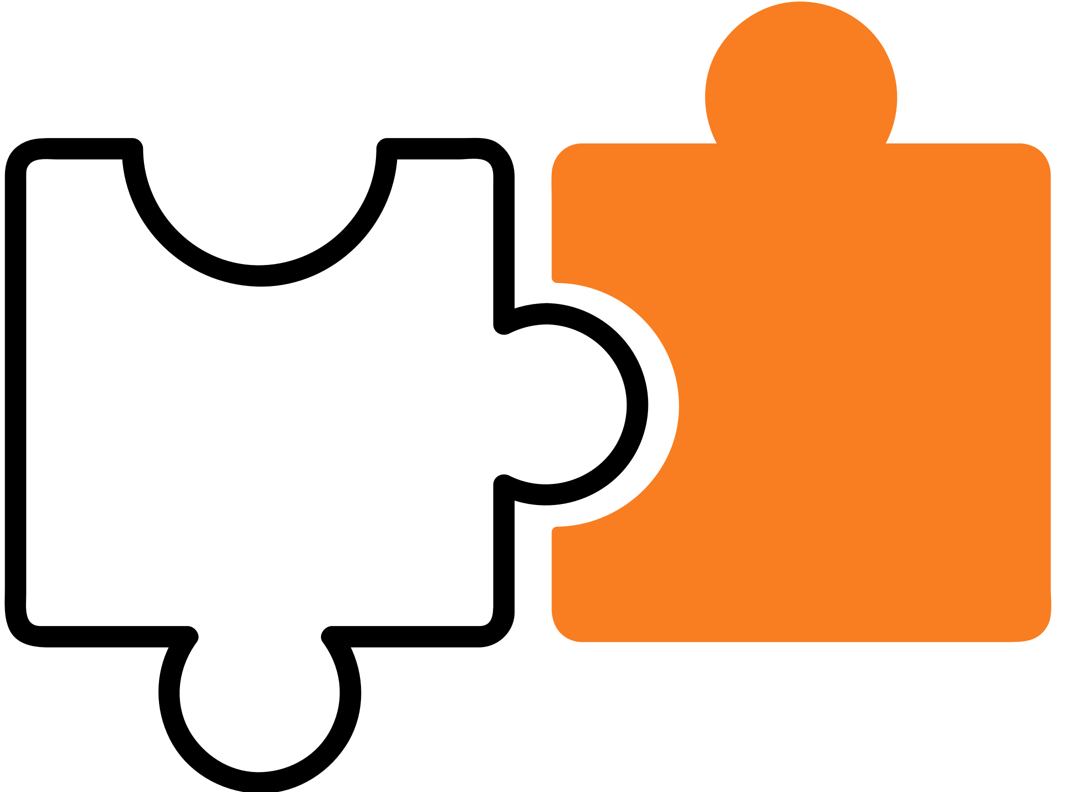
Proposed Outputs

- ☑ Produce public report on findings to date and next steps
- ☑ Attend conferences, panel discussions, summits, or other events, where appropriate, to share our learnings
  - Outcome: KPCC has already begun presenting on this human-centered design research at schools and with other journalists

Expected Outcomes

- ☑ Information on the specific community's needs are available to various stakeholders
- ☑ Information about our editorial strategy and planning process model is available to other journalism organizations

IMPLEMENTATION PHASE EVALUATION FRAMEWORK



Implementation Strategy

1. Through iteration and continually monitoring performance, test the editorial strategy of the community-engaged news product designed to meet the identified community's information needs by:
    a. Developing the specific news product(s) designed for parents, families, and caregivers (examples below).
    b. Distributing the news product(s) through identified pipelines.
    c. Evaluating impact by measuring the output, level of community engagement, and outcomes.
2. Focus on meeting the identified community's needs by remaining aware, regularly adapting, and changing tactics, if necessary:
    a. Only produce news products that the community is using, and not produce those that it is not.
    b. Only distribute on platforms where we see evidence of useful consumption.
    c. Engage in ways that attract participation and build the community.
3. Through transparency, seek out evidence of outcomes for the project, as well as potential impacts currently unknowable, and welcome opportunities for us and our partners to learn and improve.

Community-Engaged News Product(s) Scorecards

We will measure important qualitative and quantitative data including reach, geographic location, demographics, consumption, attention, referral sources, and devices/platforms. Below are metrics by which we will measure the success of news products we have identified to prototype.

Printed Fliers in Libraries and Parks

Planned Activities

- [ ] Fliers and postcards as ads for events
- [ ] Fliers as distribution for stories and information
- [ ] Fliers as asks for input on stories

Planned Outputs

- [ ] 35 percent of attendees RSVP through fliers
- [ ] At least 50 percent of fliers are consumed by target audiences (as reported by distribution partners)
- [ ] Generate at least 3 actionable leads for reporting

Planned Outcomes and Measures

- [ ] Attendees sign up for newsletter, follow Priska Neely on social media, RSVP for another event, provide a tip for our reporting
- [ ] Readers signal interest in learning more (digital and SMS signup options listed on printed materials)
- [ ] Stories have higher reach and engagement time

Early Childhood Community Ambassador Program

Planned Activities

- [ ] 8-12 in-person Feeding the Conversation-style convenings with stakeholders in their communities

Planned Outputs

- [ ] 2–3 story leads generated per convening

Planned Outcomes and Measures

- [ ] Stories distributed with ambassador program have higher-than-average share rate

Children's Book Club at Public Libraries

Planned Activities

- [ ] Crowdsource book suggestions with current audience to stage reading time event

Planned Outputs

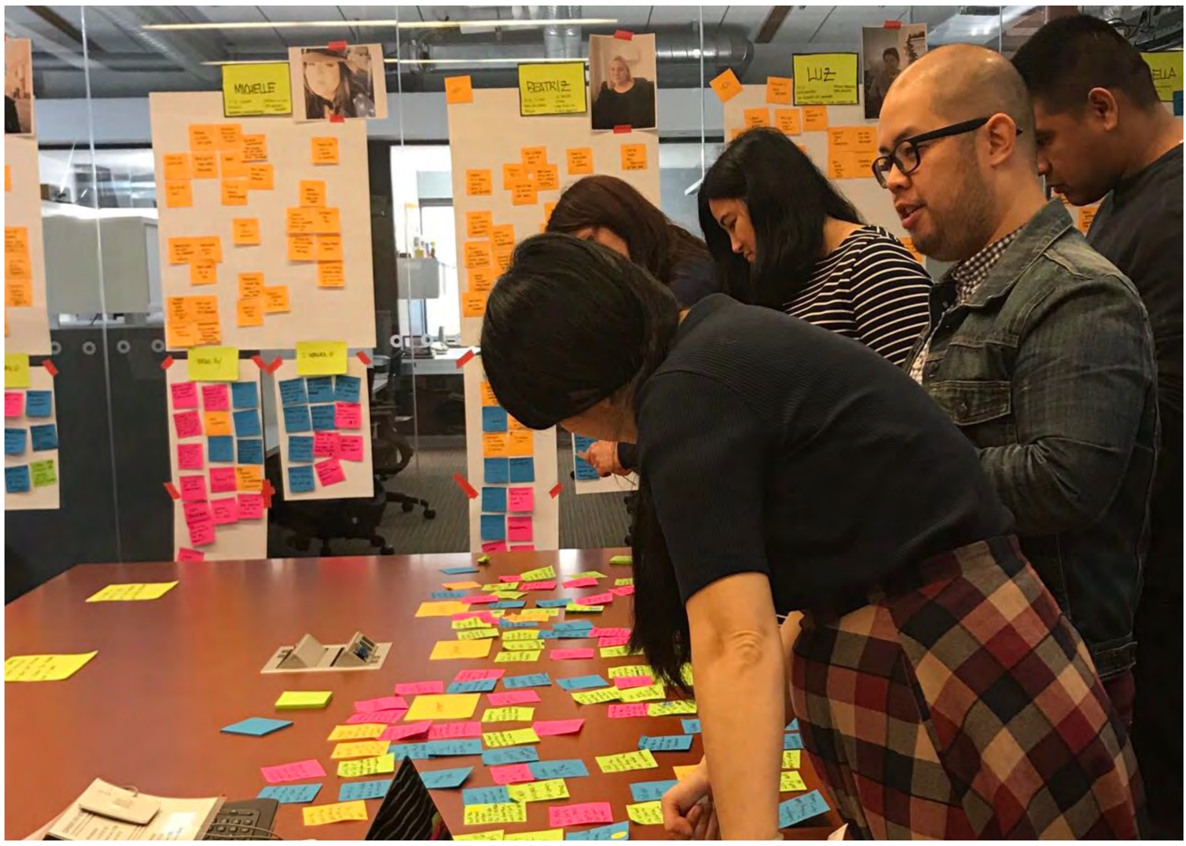
- [ ] Set up story time at popular L.A. County library in neighborhood with lots of young children

Planned Outcomes and Measures

- [ ] Attract a crowd of at least 15 caregivers and kids. Ask for questions that they may have regarding caregiving/education

CONCLUSION

Next steps for KPCC's early childhood reporting—and beyond.



KPCC is already applying what we've learned through the human-centered design approach to other coverage areas, including our Census 2020 plans.

As the policy debates over early childhood education continue to intensify in California, it is critical that our reporting reflects the concerns of the people who are affected the most: parents and caregivers who are steeped in early childhood work. We are eager to start informing, connecting, and convening these stakeholders, especially those who are not already familiar with KPCC or NPR.

The approach we have outlined is experimental but well worth the time and effort. We are applying what we have learned to other coverage areas in our newsroom, including our Census 2020 plans. We are also excited to document our work and distribute it throughout the journalism community.

It is our hope that our successes (and, possibly, failures) will accelerate the field of learning so that public media can play a more active role in engaging new audiences.

This project was made possible with support from the Atlas Family Foundation, the LA Partnership for Early Childhood Investment,The Carl & Roberta Deutsch Foundation, and the Tikun Olam Foundation.

Strategic Partnership: KPCC Community Engaged Journalism

Jennifer Pippard
Director of Strategic Partnerships
Marlene Fitzsimmons
Communications Manager

February 28, 2019

Communications Strategy

- Goals
  - Build our brand
  - Engage decision makers
  - Elevate awareness and create urgency
  - Support internal communications

- Investments in communications will help First 5 LA elevate awareness and engage decision makers by:
  - Building media outlets' capacity to cover early childhood development issues, and engage their audiences
  - Elevating these issues through thoughtful reporting, in outlets trusted and respected by decision makers, helps raise the awareness of leaders and lawmakers on these issues
  - Awareness leads to conversations on our issues with other decision makers and constituents/people served
  - These conversations help create opportunities for policy and system change to address the issues elevated, in part, by our investments

Past & Current Investments

- LA Partnership for Early Childhood – KPCC, Early Childhood Reporter, Priska Neely
- USC Annenberg Center for Health Journalism's Children's Health Matters Blog
- USC Annenberg Center for Health Reporting
- Pacific Oaks Early Childhood Reporting Fellow, Early Childhood Development Reporter, Deepa Fernandes

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A new approach in early childhood coverage

- Southern California Public Radio (SCPR) is engaging in a new, community-engaged model for its Early Childhood coverage, an effort that builds upon its strengths as a local public radio station

- Community members who could benefit most from SCPR's reporting are underserved by traditional media: **low- and middle-income parents and caretakers of young children in Los Angeles County**

- SCPR plans to seek out the parents and caregivers of young children in low- and middle-income families in L.A. County and build trust using an approach called **community-engaged journalism**.

Project Goals

1. Design at least one additional community-engaged news product as part of an expanded version of the Early Childhood Development beat that responds to the direct feedback of low-income parents of children, pre-natal to five
2. Engage and retain a more economically and geographically diverse audience that is more representative of Los Angeles as a whole
3. Support parents in becoming more informed consumers of early childhood programs and services.

These outcomes are in direct alignment with First 5 LA's goal of exposing policy makers to the priorities expressed directly from families of young children.

Funding Partners

- The Strategic Partnership allows First 5 LA to leverage funds from the L.A. Partnership for Early Childhood Investment, and First 5 LA would join a group of aligned funders who have dedicated resources to this work. Current funders include:

  - Atlas Family Foundation
  - The Carl and Roberta Deutsch Foundation
  - L.A. Partnership (Baby Futures Fund)
  - Tikun Olam Foundation
  - This is in addition to SCPR resources that are dedicated to this project

Questions

“Good habits formed at youth make all the difference.”

- *Aristotle*

Agenda Item: 07
Date: February 28, 2019

FIRST 5 LA

SUBJECT:
Strategic Plan Refinement Process (SPR4) Update

DISCUSSION:

Strategic Plan Investment Guidelines

The Strategic Plan Refinement (SPR4) process is grounded in the learnings from the first three years of implementation and the recognition that the fundamental elements of the FY 2015-2020 Strategic Plan continue to drive and prioritize our work. For example, we will "hold tight" to our North Star and policy and systems change orientation to maximize impact for young children and families. There are also elements of the Strategic Plan that we will "hold loose" to and refine as part of this process, such as our current strategies.

Background

The SPR4 process officially launched in January with a discussion at the PPC and then the February Board meeting on First 5 LA's Investment Guidelines. Created as part of the 2014 strategic planning process, the Investment Guidelines serve as criteria for decision-making for all major components of the strategic plan and as ongoing policy guidance for Board and staff during implementation. Together, the Investment Guidelines represent a "six-part identity statement" for First 5 LA.

In 2014, the Board adopted the following investment guidelines that state, more often than not, First 5 LA will:

- Focus on **prevention**
- Focus on **systems and policy change**
- **Seek to have a broad impact**, affecting larger numbers of people
- Prioritize investments that **strengthen families** and, whenever possible, **improve community capacity**
- Prioritize the **identification and scaling up of evidence-based practices**
- **Engage partners at the earliest possible stage** of activity and/or investment

Since the launch of the SPR4 process in January 2019, Board and staff have engaged in discussions and provided input on the use of the current Strategic Plan Investment Guidelines and how these should be refine based on learnings and experience.

Next Steps

During this February PPC meeting, staff will present recommended revisions of the Investment Guidelines and proposed Operating Principles, grounded in current learning of our work and how they can be further refined to provide clear implementation guidance. The proposed Operating Principles are designed to complement the Investment Guidelines and provide further guidance for Board and staff decision-making.

STRATEGIC PLAN REFINEMENT (SPR4) UPDATE

Christina Altmayer

Vice President, Programs

Steven LaFrance

Founder and CEO, Learning for Action

first 5 la
Giving kids the best start

Objectives

- Review “Pathway for Systems Change”
- Recap Board input on Investment Guidelines
- Discuss Recommended Investment Guidelines and Operating Principles
- Next Steps

Strategic Plan Refinement Process Summary

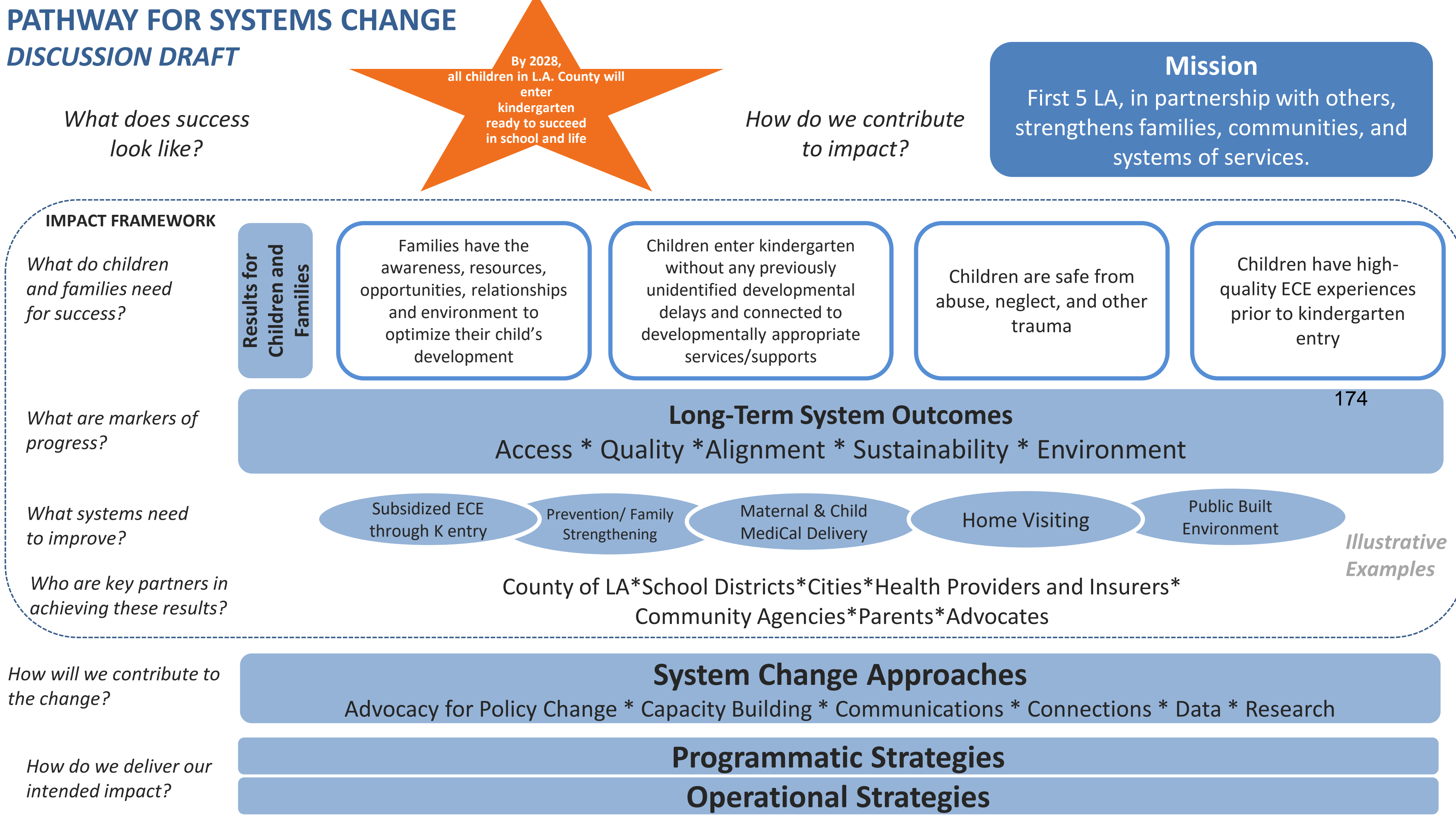
Proposed planning process will focus on ***reviewing, reflecting, and refining*** the current Strategic Plan with a focus on ***results***

Review
- How have our strategies been implemented?
- What progress has been made?

Reflect
- What has changed in the environment?
- What have we learned about policy and systems change?

Refine
- How should we refine our work based on what we've learned and strategic opportunities?

Results
- Document our strategic direction and targeted results


PATHWAY FOR SYSTEMS CHANGE
DISCUSSION DRAFT
What does success look like?
By 2028, all children in L.A. County will enter kindergarten ready to succeed in school and life
How do we contribute to impact?
Mission
First 5 LA, in partnership with others, strengthens families, communities, and systems of services.
IMPACT FRAMEWORK
What do children and families need for success?
Results for Children and Families
Families have the awareness, resources, opportunities, relationships and environment to optimize their child's development
Children enter kindergarten without any previously unidentified developmental delays and connected to developmentally appropriate services/supports
Children are safe from abuse, neglect, and other trauma
Children have high-quality ECE experiences prior to kindergarten entry
What are markers of progress?
Long-Term System Outcomes
Access * Quality *Alignment * Sustainability * Environment
What systems need to improve?
Subsidized ECE through K entry
Prevention/ Family Strengthening
Maternal & Child MediCal Delivery
Home Visiting
Public Built Environment
Illustrative Examples
Who are key partners in achieving these results?
County of LA*School Districts*Cities*Health Providers and Insurers*
Community Agencies*Parents*Advocates
How will we contribute to the change?
System Change Approaches
Advocacy for Policy Change * Capacity Building * Communications * Connections * Data * Research
How do we deliver our intended impact?
Programmatic Strategies
Operational Strategies

Investment Guidelines
Steven LaFrance, Learning for Action
5
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Investment Guidelines Refinement Process

- January:
  - All-Staff feedback on current Investment Guidelines and suggested concepts
  - PPC discussion on Investment Guidelines and suggested concepts
- February:
  - Board discussion on Investment Guidelines, what we've heard and preliminary concepts
  - Synthesis of Board and staff input to inform recommended revisions and operating principles
- March:
  - Board endorsement of refined Investment Guidelines

Investment Guidelines: Learnings

- Investment Guidelines effectively provide parameters for Board and staff decision-making
- Engaging partners early has shifted First 5 LA's approach to working with partners throughout systems change work
- Investment Guidelines could further drive internal organizational policies and procedures to support implementation
- Increasingly need to reflect First 5 LA’s fiscal stewardship to operate within expected resources
- Equity has been identified as a priority issue by our Board and staff

Current and Recommended Investment Guidelines

First 5 LA will make policy and implementation decisions based on the following Investment Guidelines to optimize achievement of our targeted results for children and families.

Current Investment Guidelines	What We've Heard	Recommended Revision
No prior Investment Guideline – new guideline EQUITY	• Define what equity means for First5 LA • Utilize asset-based language	**Prioritize children, families, and communities in our target population who would benefit the most in achieving our targeted results**
No prior Investment Guideline – new guideline FISCAL STEWARDSHIP	• Sustainability	**Co-invest with partners and embed sustainability strategies within all of our work**
Focus on prevention	• Consider targeted prevention efforts	**Focus on prevention**
Focus on systems and policy change	• Sustainable systems change • Value of equity • Policy implementation	**Focus on system/policy change and implementation to impact the most children and families**
Prioritize the identification and scaling up of evidence-based practices	• Consider "promising practices" • Include space for innovation • Equity	**Prioritize scaling up evidence-based practices, balanced with investments in innovative and promising approaches to address community needs**
Engage partners at the earliest possible stage of activity and/or investment	• Leverage internal and external partners	**Engage partners throughout planning, development, and execution of our work**
~~Seek to have a broad impact, affecting larger numbers of people~~		Remove; consolidated above
~~Prioritize investments that strengthen families, and, whenever possible, improve community capacity~~		Remove; consolidated above

Investment Guidelines and Operating Principles

First 5 LA will make policy and programmatic to optimize achievement of our targeted results based on the following:

Current Investment Guidelines	Recommended Investment Guidelines	Preliminary Operating Concepts
No prior Investment Guideline – new guideline EQUITY	**Prioritize children, families, and communities in our target population who would benefit the most in achieving our targeted results**	• Identify and prioritize children, families and communities that our work has the greatest potential to impact • Strengthen existing public systems to be family-focused and child-centered • Incorporate the voice of families and communities in policy and system change
No prior Investment Guideline – new guideline FISCAL STEWARDSHIP	**Co-invest with partners and embed sustainability strategies within all of our work**	• Plan and operate within the LTFP projections, while creating new revenue and fund leveraging strategies • Embed sustainability strategies in all investments.
Focus on prevention	**Focus on prevention**	• Invest in prevention and early intervention as the primary focus of our work; any downstream investment must be linked to prevention
Focus on systems and policy change	**Focus on system/policy change and implementation to impact the most children and families**	• Focus on strengthening existing systems rather than creating new systems • Consider direct services only when there is significant potential to demonstrate models for scalability and sustainability
Prioritize the identification and scaling up of evidence-based practices	**Prioritize scaling up evidence-based practices, balanced with investments in innovative and promising approaches to address community needs**	• Explore innovative and promising approaches, as necessary, to respond to community needs and achieve scale
Engage partners at the earliest possible stage of activity and/or investment	**Engage partners throughout planning, development, and execution of our work**	• Demonstrate committed partnerships as fundamental to achieving sustainable results

Next Steps

Next Steps for Strategic Plan Refinement Process

REVIEW | REFLECT

January

- Official launch of process
- January PPC: Present roadmap, Critical Success Factors, and Investment Guidelines
- Begin scheduling and conducting key informant interviews
- Begin data review of current SP implementation progress and learning

February

- February BOC: Present roadmap, Critical Success Factors, and Investment Guidelines
- February PPC: Update on Review phase
- Complete key informant interviews
- Complete data review

March

- March BOC: Directional endorsement of recommended Investment Guidelines
- Develop summary report of Review processes
- Begin Reflect processes
- March PPC: Update on Review phase and Impact Framework

Questions?
1ST LA
first 5 la
Giving kids the best start

Agenda Item:
Date: February 28, 2019

First 5 LA

SUBJECT:
Welcome Baby Implementation and Outcomes Study Evaluation Report.

RECOMMENDATION:
To receive and file the Welcome Baby Implementation and Outcomes Study Evaluation Report

BACKGROUND:
Since 2009, First 5 LA has supported the launch and expansion of home visiting services throughout Los Angeles County through two initiatives - Welcome Baby and Select Home Visitation. Welcome Baby plays a unique role in the constellation of home visiting resources in Los Angeles County, as it is a universal platform for participating hospitals and plays a critical role in ensuring families are assessed for strengths and needs and offered home visiting services that are the best-fit for the family. Further, a "light touch" model has been found to be the best fit for most families and Welcome Baby is currently the primary resource in the county for brief home visiting services. Therefore, it is critical to understand the impact of the model.

A series of evaluations of the Welcome Baby program have accompanied the programmatic efforts with the goal of better understanding the benefits of Welcome Baby to children and families as well as to aid in programmatic improvement efforts. The findings from prior evaluations, such as the pilot evaluation and the psychometric study, have been presented to the Board as the results were available. Staff has also updated the Board on how the lessons learned from the evaluations inform programmatic efforts.

DISCUSSION:
In April 2015, First 5 LA awarded a contract to The RAND Corporation to conduct the Welcome Baby Implementation and Outcomes Study Evaluation. As presented in the attached report, this evaluation examined the fidelity of Welcome Baby delivery and the outcomes achieved during the program across twelve different sites. The following seven evaluation questions were examined:

1. To what extent do participants achieve short- and intermediate-term outcomes?
2. What are the relationships between program fidelity outcomes and participant outcomes?
3. What are participant perceptions of and experiences with the program and Welcome Baby service providers?
4. What factors contribute to participants leaving the program early?
5. How are sites maintaining community resource and referral networks? What if any gaps exist in these networks?
6. To what extent are sites implementing Welcome Baby to fidelity?
7. Is there variability in sites' ability to reach fidelity to Welcome Baby? If so, what factors account for this variability?

Multiple methods were used to analyze data from across the twelve sites, including interviews with program staff, focus groups with program participants and staff, participant surveys, program administrative data, and document review. Data was collected during a period spanning January 2016 to December 2017. Overall, the study identified that the Welcome Baby program sites were meeting many of the program's implementation and outcome goals and that participants had favorable views of the program. For example, participants overwhelmingly reported that the

Welcome Baby program met their needs and helped them connect with services. Where regional or national benchmarks were available, Welcome Baby participants exhibited better outcomes in more than half of the outcome areas measured. The evaluation findings highlighted potential areas for improvements which will be explored and addressed by staff and Welcome Baby sites to continue strengthening the program and its outcomes.

For an electronic version of the report and appendices, visit:
https://www.rand.org/pubs/research_reports/RR2440.html

Research Report

The Welcome Baby Program

An Implementation and Outcomes Evaluation

Sarah B. Hunter, M. Rebecca Kilburn, Teryn Mattox, Jill S. Cannon,

Terry Marsh, Melissa Felician, Maya Buenaventura, Lauren Davis,

Matthew Cefalu

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Preface

Welcome Baby is a universal home visitation program offered to families at birth in participating hospitals across Los Angeles County. First 5 LA (F5LA) supported the development of the program and its implementation across 14 traditionally underserved "Best Start" communities. In 2015, F5LA selected the RAND Corporation to conduct an implementation and outcomes evaluation to address seven research questions related to the fidelity of Welcome Baby delivery and the outcomes achieved during the program across the different sites. The contract also specified a need for the evaluation efforts to inform ongoing monitoring of the Welcome Baby program.

This report provides the results from the seven evaluation questions posed by F5LA. We also provide recommendations regarding ongoing monitoring of the Welcome Baby program based on the evaluation findings. This report will be of interest to entities providing home visitation programming, including states, counties, and health care organizations. The research was conducted in the Social and Behavioral Policy Program within RAND Social and Economic Well-Being. The program focuses on such topics as risk factors and prevention programs, social safety net programs and other social supports, poverty, aging, disability, child and youth health and well-being, and quality of life, as well as other policy concerns that are influenced by social and behavioral actions and systems that affect well-being. For more information, email sbp@rand.org.

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Summary

First 5 LA (F5LA) is a public entity that supports collaborative work across Los Angeles County to strengthen families, communities, and systems of services and supports so that all children in the county are born healthy, maintain a healthy weight, are safe from abuse and neglect, and enter kindergarten ready to succeed in school and life (F5LA, 2014a). Over the last decade, F5LA has developed a unique approach to supporting families through a tiered home visiting approach. Among women living in 14 designated communities in Los Angeles County, births at participating hospitals are screened for risk; the highest-risk families are offered one of two intensive evidence-based home visiting programs. Lower-risk families are offered Welcome Baby, which provides a visit in the hospital after birth and up to five post-partum visits through the child's ninth month of life. The combination of the program's "light touch" and its targeting of low- or moderate-risk families sets Welcome Baby apart from many home visiting programs, which tend to be more intensive and target high-risk families (Michaloupolos et al., 2015). With the recent addition of Family Connects (a home visiting program providing only one to three visits) to the federal evidence-based home visiting list (Sama-Miller et al., 2017), there is considerable interest in the potential of less-intensive programs to improve family outcomes at less expense than other federally listed programs.

This report presents the findings from our evaluation of the Welcome Baby program. F5LA has undertaken a series of evaluations of Welcome Baby over the program's lifecycle, and this evaluation examines the realization of implementation and outcome goals. The evaluation focused on answering the following questions about the implementation and outcomes of Welcome Baby:

1. To what extent are sites implementing Welcome Baby to fidelity?
2. Is there variability in sites' ability to reach fidelity to Welcome Baby? If so, what factors account for this variability?
3. How are sites maintaining community resource and referral networks? What if any gaps exist in these networks?
4. What are participant perceptions of and experiences with the program and Welcome Baby service providers?
5. What factors contribute to participants leaving the program early?
6. To what extent do participants achieve short- and intermediate-term outcomes?
7. What are the relationships between program fidelity outcomes and participant outcomes?

To address these questions, we examined the fidelity domains in the Welcome Baby fidelity framework and assessed outcomes drawn from the stated goals and objectives in F5LA's Welcome Baby logic model (F5LA, 2014b). We used multiple methods to analyze data from the

first 12 sites that implemented the program,[1] including interviews with program staff, focus groups with program participants, staff and participant surveys, program administrative data, and document review. These data were collected during a period spanning January 2016 to December 2017.

This evaluation was designed to help F5LA decide how to best allocate resources for training, program monitoring, and other program management activities. The evaluation findings are also likely to be valuable to other home visiting programs, as the fidelity components identified in Welcome Baby are similar to those of other family services. Finally, the information in this report will contribute to the ongoing discussion in the home visiting field regarding the use of universal, and lower-intensity, home visiting services.

The Welcome Baby Program

During pregnancy or soon after delivery, a Welcome Baby staff member conducts a risk assessment with families interested in receiving home visitation services. The triage process involves using a screening tool to assess a family's risk level and determining whether the family resides in one of F5LA's focal communities. Families in the focal communities who are at high risk are recommended to area home visiting programs that provide more intensive home visiting services than Welcome Baby. Families in the focal communities who score under high risk on the screening tool are offered Welcome Baby. (The focal communities are among the highest-risk communities in the county, so even lower-risk families may face many child rearing challenges.)

Families enrolled in Welcome Baby may receive three prenatal home visits, a visit in the hospital after birth, and up to five postpartum home visits. This evaluation focuses on the postpartum visits (see Figure S.1). Each Welcome Baby home visit includes risk and developmental assessments, and these are used to guide the topics covered during the visit, as well as any referrals made to other services. The Welcome Baby curriculum delivered at each engagement point is designed to be flexible to meet families' differing needs. Welcome Baby emphasizes that a service relationship characterized by connectedness, empathy, and empowerment helps promote positive behavior changes (Edelman, 2004). During the home visits, parents receive support and information on such topics as postpartum depression, breastfeeding, immunizations and well-baby doctor visits, and home safety. During each home visit, home visitors model reflective communication and empathy to teach parents interaction skills that help them better connect with their child.

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[1] Although 13 hospitals participated, two hospitals (Torrance and Little Company of Mary) shared staff, so the data for these two sites were combined for the purpose of our analyses. Another site (Martin Luther King, Jr., Community Hospital) started implementing the Welcome Baby program after the study launched and therefore was not included.

Figure S.1. Timeline of Welcome Baby Visits

SOURCE: LA Best Babies Network, "Welcome Baby Timeline of Program Visits," fact sheet, undated.

F5LA developed a Welcome Baby Fidelity Framework (see Table S.1; Appendix A) to guide the implementation of the program, and the framework specifies central components of the program in terms of staff training and expertise, number and timing of family encounters, and approach to interactions with families. Examining whether Welcome Baby sites meet these fidelity standards and whether the standards are related to client outcomes were central components of this evaluation. Each of the Welcome Baby positions has different qualification requirements, such as degrees, certifications (e.g., lactation consultant certification), as well as preferred experience and language capabilities (see Appendix A). Each position also has training requirements, which consist primarily of training provided by Welcome Baby.

Table S.1. The Welcome Baby Fidelity Domains

Fidelity Domain	Description
1. Staff Qualifications	Staff meet minimum requirements
2. Staff Training	Staff meet training requirements
3. Supervisory Requirements	Supervisors oversee no more than 4 coaches
4. Reflective Supervision	Staff participate in the required amount of reflective supervision sessions
5. Home Visitor Workloads	Staff meet suggested workload amounts
6. Prenatal Recruitment and Enrollment	Eligible prenatal families offered and enrolled in program
7. Hospital Enrollment	Eligible mothers approached and enrolled in the hospital
8. Service Dosage	Participating families receive appropriate service dosage
9. Timing of Service Delivery	Home visits are completed within the recommended time period
10. Referrals to Community Services	Clients receive appropriate referrals, and referrals are verified by staff as completed
11. Participant Perception of the Relationship	Staff build positive relationships with their clients
12. Family Centered Approach	Home visitors use a family-centered approach
13. Content of Home Visits	Home visits include the recommended content
14. Responsiveness of Provider	Home visitors address unplanned situations

Data Sources

To address these evaluation questions, we used multiple data sources (e.g., interviews, focus groups, client surveys, staff surveys) and analytic methods (e.g., quantitative analysis of both primary and secondary data, qualitative analysis of interview data). Table S.2 provides an overview of the data sources and relationship to each evaluation question. Of note, we intended to include observational assessments of the home visits performed by home visitor supervisor staff in our analyses, but because of a delayed start in the use of the observational assessment tool during our study period, too few observation assessments were completed to include in our analyses.

Table S.2. Data Sources Used for Each Research Question

Evaluation Question	Site Interviews	Client Focus Groups	Staff Survey	Referral Documents	Client Survey	Stronger Families Database[a]
1. To what extent are sites implementing Welcome Baby to fidelity?			X		X	X
2. Is there variability in sites' ability to reach fidelity to Welcome Baby? If so, what factors account for this variability?	X		X		X	X
3. How are sites maintaining community resource and referral networks? What, if any, gaps exist in these networks?	X		X	X		
4. What are participant perceptions of and experiences with the program and Welcome Baby service providers?		X			X	
5. What factors contribute to participants leaving the program early?	X		X		X	X
6. To what extent do participants achieve short- and intermediate-term outcomes?					X	X
7. What are the relationships between program fidelity outcomes and participant outcomes?			X		X	X

[a] The Stronger Families Database is the administrative database maintained by Welcome Baby.

Findings

We tailored the methods for addressing each evaluation question using the multiple data sources and qualitative and quantitative methods as appropriate. For the fidelity analysis, we identified a threshold that we could use to assess whether or not a site had achieved the fidelity standard. We briefly summarize the main findings for each evaluation question.

1. To What Extent Are Sites Implementing Welcome Baby to Fidelity?

There was great variability in the degree to which the sites achieved fidelity to the Welcome Baby model. For each site, we assessed fidelity for the 11 of the 14 fidelity domains for which we had data. No site achieved fidelity in all 11 domains, but every site achieved fidelity in

supervisory requirements and participant perceptions of the relationship. Individual sites achieved fidelity in 18 to 80 percent of measured domains, with an average of 48 percent.

2. Is There Variability in Sites' Ability to Reach Fidelity to Welcome Baby? If So, What Factors Account for This Variability?

For each of the 11 fidelity domains, there were large differences in the proportion of sites that met the fidelity threshold. For two domains (supervisory requirements and participant perceptions of the relationship), all assessed sites achieved fidelity thresholds; for another three domains (staff qualifications, reflective supervision, and hospital enrollment), only one site achieved fidelity thresholds. For the other domains, between five and eight sites achieved fidelity thresholds. Across all of the domains, an average of 5.5 sites achieved domain fidelity. In several domains, sites also varied in achieving thresholds by specific elements of the domain criteria (e.g., by staff position, visit type). Findings from site interviews with Welcome Baby staff provided information that helps explain the challenges in meeting the fidelity thresholds.

3. How Are Sites Maintaining Community Resource and Referral Networks? What, If Any, Gaps Exist in These Networks?

The completeness of referral directories varied widely across sites. Very few sites had developed the organizational infrastructure to facilitate successful referrals (e.g., memoranda of understanding with service providers and referral forms). The Welcome Baby program provides sites with protocols that outline procedures for five referral types, including domestic violence, early intervention for child developmental delay, postpartum care, maternal depression, and suicide prevention. These five Welcome Baby protocols require monitoring referral completion; four require that Welcome Baby staff help clients gain access to the services, and two emphasize client confidentiality. Staff across all sites reported referring to a wide range of referral resources, regardless of the infrastructure developed to facilitate successful referrals.

4. What Are Participant Perceptions of and Experiences with the Program and Welcome Baby Service Providers?

Both qualitative and quantitative data indicated that Welcome Baby participants generally had a positive perception of the program. In focus groups, participants overwhelmingly reported that the Welcome Baby program met their needs and helped them connect with services. Program participants indicated that they would participate in the program again if seeking parenting help in the future and rated their relationships with the Parent Coaches extremely positively. Clients noted that the program enrollment process was easy, and they appreciated most the assistance with breastfeeding. Overall, Welcome Baby staff were perceived as responsive to their needs, easy to communicate with, accessible, and flexible. Clients identified a few areas for improvement, such as offering more visits and providing program materials in non-paper formats. Survey results corroborated the information from the focus groups: Across sites and time (i.e., from the two-to-four-week visit to the nine-month visit), program participants

generally had positive perceptions of the Welcome Baby program and their relationship with their Parent Coaches.

5. What Factors Contribute to Participants Leaving the Program Early?

We assessed whether participant characteristics and fidelity during a previous Welcome Baby program visit predicted families getting a successive visit. Family characteristics associated with being at risk of poor outcomes (e.g., a high risk score, being young) were often associated with a greater likelihood of transitioning from the hospital to a registered nurse (RN) visit, but a lower likelihood of staying in the program for later visits. For the two-to-four-week visit and later visits, adherence to Welcome Baby fidelity standards, such as covering the curriculum, was related to lower rates of participants leaving the program.

6. To What Extent Do Participants Achieve Short- and Intermediate-Term Outcomes?

We examined Welcome Baby participants' outcomes across all sites and visits for 12 outcome measures. Where regional or national benchmarks were available, Welcome Baby participants exhibited better outcomes in more than half of the outcome areas measured, including more positive parenting practices, higher levels of breastfeeding, and safer sleep environments (i.e., back sleeping and no co-sleeping) than benchmarks. Welcome Baby participants exhibited lower levels of family planning and exclusive breastfeeding compared to the benchmarks.

7. What Are the Relationships Between Program Fidelity Outcomes and Participant Outcomes?

We estimated the relationship between the 12 outcomes and eight fidelity measures. We found little evidence of relationships between program fidelity and participant outcomes. Across the eight fidelity components included in this analysis, the ones most likely to be associated with improved outcomes were staff qualifications, staff training, reflective supervision, home visitor workload, and curriculum content coverage.

The findings from this evaluation provide Welcome Baby stakeholders with data-based information on the implementation and outcomes of the program. Additionally, the findings inform the home visiting field as a whole, providing rigorous analysis of such issues as factors contributing to home visiting program attrition and assessing referral networks.

Conclusions and Recommendations

Overall, we found that the Welcome Baby program sites were meeting many of the program's implementation and outcome goals and that participants had favorable views of the program. The evaluation findings highlighted some areas where F5LA could explore improvements or clarity in policies and procedures. Next, we provide suggestions for these areas.

Staff Qualifications and Training

Sites typically did not perform well in the staff qualifications *and* training fidelity domains, although some sites performed well in one or the other. A review of staff qualifications and training requirements for each position might be helpful to see how relevant these are in the future recruitment and training of Welcome Baby program staff. These two fidelity domains are particularly critical because they appear to be related to program attrition; sites that met the fidelity thresholds appear to have had less participant attrition than those that did not.

Supervision

While sites generally achieved fidelity in terms of supervision caseload levels, the frequency and quality of reflective supervision may benefit from further examination. Some staff positions reported not receiving reflective supervision very frequently, and staff across positions and sites questioned reflective supervision's quality and value. This is particularly important because reflective supervision was related to several positive participant outcomes, such as well-child visits, immunizations, home safety, and safe sleeping practices. Reflective supervision also appears to negatively relate to attrition between the hospital and RN visit. F5LA may want to further examine the quality of the reflective supervision, especially for hospital liaisons and RNs.

Hospital Enrollment

This fidelity domain consisted of two components: (1) approaching 90 percent of eligible families in the hospital and (2) enrolling 40 percent of those approached. Most sites missed the 90-percent approach target. Since sites reported challenges meeting the target for approaching eligible families in the hospital, F5LA may want to address staff coverage issues (e.g., not having staff available 24/7, including nights and weekends). While most sites met the target for enrolling families, there was wide variation, suggesting that staff across sites could learn from one another on effective enrollment practices. F5LA may also want to consider whether site-specific targets may be more appropriate, given the number of births and Welcome Baby staffing levels at the different participating hospitals. Now that more data have been collected on Welcome Baby, the threshold enrollment rate can be adjusted based on observed site enrollment rates to set more realistic targets.

Service Dosage

Sites exhibited wide variation in the percentage of participants who received four or more postpartum Welcome Baby visits. Although program staff thought that the large gaps between the three-to-four month and nine-month visits contributed to attrition, the analysis found that most attrition occurred between the hospital and RN visit. F5LA may want to undertake continuous quality improvement approaches to increase program retention between the hospital enrollment visit and the first in-home visit. Staff at higher-performing sites may have lessons learned that could improve performance at other sites.

Home Visit Content

Overall, across sites and across visits, coverage of the Welcome Baby curriculum was good. Since coverage was lower at the hospital visit, F5LA may want to examine whether crucial content is being missed in the hospital.

Community Referral Process

Performance on this fidelity domain was extremely varied across sites, representing another potential opportunity to learn from best practices at some sites. Due to the limitations of the Stronger Families Database (SFDB), the administrative database maintained on the Welcome Baby program, we were able to evaluate this domain for only a short time period and did not include it in our analyses of factors related to program attrition and outcomes. Based on review of each site's documentation on the referral process, F5LA should consider the development of detailed protocols for all high-priority referral types, including public benefits, alcohol, smoking, and drug treatment (all protocols should include the provision of client confidentiality). F5LA should also support sites in developing and maintaining a standardized referral directory and establish memoranda of understanding with service providers to improve service access.

Outcomes

Sites' abilities to achieve outcomes, such as family planning, exclusive breastfeeding, and co-sleeping, varied widely and, therefore, could be areas to target for staff retrainings and booster sessions. Sites that performed better may be able to share experiences and lessons learned with sites that did not perform as well. Rates of postpartum depressive symptoms were extremely low in comparison to other benchmarks, suggesting that administration of the postpartum depression screener may be improved.

Acknowledgments

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We are grateful to the many Welcome Baby staff who participated in interviews, took the online staff survey, gathered the relevant referrals documents, trained in the data collection activities, collaborated with site-specific Institutional Review Board activities, and gathered and maintained signed consent documentation. We greatly appreciate their time, attention to detail, and willingness to provide input based on their expertise and experience. Their contributions have enriched our understanding of the Welcome Baby program.

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Abbreviations

ASQ	Ages & Stages Questionnaire
BSC	Best Start Community
CLE	Clinical Lactation Educator
CSQ	Client Satisfaction Questionnaire
EPDS	Edinburgh Postpartum Depression Scale
F5LA	First 5 LA
HV	home visit
HOME	Home Observation for Measurement of the Environment inventory
IRB	Internal Review Board
KIDI	Knowledge of Infant Development Inventory
LAC	Los Angeles County
LABBN	LA Best Babies Network
LAMB	Los Angeles Mommy and Baby Project
LSP	Life Skills Progression Tool
MCH	Maternal Child Health
MCHA	Maternal Child Health Access
MOA	memorandum of agreement
MOU	memorandum of understanding
NICU	neonatal intensive care unit
NSFG	National Survey of Family Growth
NLSY79	National Longitudinal Survey of Youth 1979
PAC/LAC	Perinatal Advisory Council: Leadership, Advocacy, and Consultation
PHQ	Patient Health Questionnaire
PRAMS	Pregnancy Risk Assessment Monitoring System
RN	registered nurse

SFDB	Stronger Families Database
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
WAI-BOND	Working Alliance Inventory – Bonding subscale
WB	Welcome Baby
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children

1. Introduction

More than 120,000 children are born in Los Angeles County each year, the highest annual number of births of any county in the United States and a number higher than all but eight individual states (Kidsdata.org, 2018a; Centers for Disease Control, 2018). Along with the notable size of the birth population, Los Angeles County births are also remarkably diverse. More than half of all births in the county are of Hispanic origin, another third are either white or Asian/Pacific Islander, and about 7 percent are African American (Kidsdata.org, 2018). Births in Los Angeles County are also more likely to be to foreign-born mothers (60 percent) than anywhere else in the United States (Myers and Pitkin, 2013). Families in Los Angeles County live in neighborhoods where many languages are spoken and cultural practices related to child rearing are varied (Allen and Turner, 2013; Benatar et al., 2013).

Given the quantity of births and diversity of families, it is not surprising that child and family outcomes are highly variable. There have been gains in some areas over the last decade—for instance, the rate of third-grade students scoring at or above proficiency in reading rose 19 percentage points between 2003 and 2012 (California Department of Education Assessment and Accountability Division, 2012). However, downward trends for some outcomes and racial and ethnic disparities for others persist. For example, the rate of substantiated prenatal-to-age-five maltreatment and the disparity in low birth weight for African-American and Asian babies compared to white babies both continue to grow (Needell, 2013). Because children experiencing challenges such as child maltreatment and low birth weight are at risk for developmental delays and long-term physical and emotional challenges (Center on the Developing Child at Harvard University, 2007), trends and disparities such as these indicate that families need support in raising strong, healthy children.

Created in 1998, First 5 LA (F5LA) is a public entity that supports collaborative work across Los Angeles County to strengthen families, communities, and systems of services and supports so all children in the county are born healthy, maintain a healthy weight, are safe from abuse and neglect, and enter kindergarten ready to succeed in school and life (F5LA, 2014a). Since 1998, F5LA has invested more than $1 billion to support programs, initiatives, research, partnerships, and public education (F5LA, 2014b). In 2014, F5LA produced a strategic plan that highlighted communities as physical and social supports for families and as the context in which policies and programs operate to support families. F5LA puts this emphasis into practice through its focused, place-based support of the Best Start Communities, a set of 14 traditionally underserved communities. These communities were selected for support based on lessons learned in F5LA's first decade and research that demonstrates the influential role of a young child's neighborhood.

F5LA's strategic approach recognizes that strong and supportive communities lead to better outcomes for children. F5LA characterizes strong families as having protective factors, such as resilience, parent knowledge, and positive relationships, which support children's social and

emotional competence. F5LA defines supportive communities as those with opportunities for positive social networks and access to concrete supports in times of need (F5LA, 2014a). F5LA hopes to increase family and community and other protective factors through investments in direct service programs that serve families.

Welcome Baby is an F5LA-supported, locally designed, free, and voluntary home visiting program for pregnant and postpartum women. The primary goal of Welcome Baby is to use a family-centered, strength-based approach to accomplish the following objectives: ensuring parents can provide enriching structured and nurturing environments, strengthening parental resilience and self-efficacy, ensuring that children and mothers are healthy, and addressing families' essential needs.

Despite common features, home visiting programs and systems differ in execution in some ways. Some in the home visiting field advocate targeting services to families who demonstrate the highest need, which is often measured using socioeconomic measures, such as mother's education, marital status, or income (Olds et al., 2003; Pew Center on the States, 2011). An emerging alternative view emphasizes a public health systems approach that provides a spectrum of home visiting services depending on family need (Schuyler Center for Analysis and Advocacy, 2007). Proponents of this view see tiered intervention as providing families with the required level of services at the lowest cost. This approach to home visiting is supported by research by Every Child Succeeds in Cincinnati that suggests that postpartum depression may be a more useful indicator than socioeconomic measures in predicting families' likelihood of benefitting from home visits (Ammerman et al., 2010). Additional empirical support for the tiered approach comes from recent evaluations of the Durham Connects program (now known as Family Connects), which provided universal home visiting to families of all newborns as a way to improve short-term outcomes and identify families who could benefit from additional services (Dodge et al., 2014; Schuyler Center for Analysis and Advocacy, 2007).

Welcome Baby's Research-Informed Program Development

In developing Welcome Baby, F5LA created a logic model (see Figure 1.1) that includes inputs, strategies, engagement points, and outcomes for Welcome Baby children and families in the areas of learning, behavior change, and condition/status change. This logic model drew from the existing evidence base on child development and family support. F5LA rolled out Welcome Baby using a strategic planning and evaluation program that follows the processes outlined in the evidence-based Getting To Outcomes® implementation framework (Mattox et al., 2013) and the Coalition for Evidence-Based Policy (2013) recommendations. These research-based frameworks recommend engaging in an evidence-informed planning stage for implementation, then engaging in a pilot evaluation to assess whether initial implementation produces desired outcomes. If the pilot program succeeds, subsequent expansion should be subject to implementation evaluation to monitor the success of scaling up with fidelity and replicability. When the program achieves maturity and systems have been established to ensure fidelity, a randomized controlled trial or other rigorous impact evaluation should be conducted.

Figure 1.1. Welcome Baby Logic Model: Family & Child Level

First 5 LA Welcome Baby Logic Model: Family & Child Level

The primary objective of Welcome Baby is to use a family-centered, strength-based approach to enhance parent-child relationships, improve the health and safety of the mothers and their children, and increase access to support services for families.

INPUTS

- Staff
- Families
- Financial resources
- Community resources
- Hospital Infrastructure
- Community-based Organization Infrastructure
- Protocols
- Tools (Universal Screening & Risk Assessments)
- Stronger Families LA Database
- Training

STRATEGIES

Risk and Developmental Screenings
- Bridges universal screening tool: risk screening
- Life Skills Progression Tool: risk screening
- PHQ: Depression
- ASQ: Child Development

Staff Assessments
- RN assessment of post-partum and newborn health
- Breastfeeding observation
- Home Environment
- Parental Capacity
- Parent-Child Relationship
- Health & Psychosocial

Education on MCH, child development and safety
- Modeling
- Coaching
- Printed materials
- Didactic

Link to social supports and concrete services
- Referrals

ENGAGEMENT POINTS

Outreach & Enrollment
- Clinic visits (i.e. waiting rooms)
- Community Events (i.e. baby showers, prenatal classes)
- Hospital Tours
- Marketing Campaigns
- Best Start Community Partnership Meetings
- Referrals (i.e. provider, community partners, self)

Service Delivery
- Intake (prenatal phone intake or hospital Intake)
- PC Prenatal visits (up to 27 weeks HV, 20-32 week phone call, and HV 28-38 weeks)
- Hospital visit (liaison)
- Nurse HV (up to two visits)
- PC Post-partum visits (2-4 weeks HV, 2 month phone call, 3-4 month HV, and 9 months HV)
- Additional PC Visit (as needed)

OUTCOMES

LEARNING

Parents are knowledgeable of, motivated to, and/or skilled in general and participant specific :
- Effective parenting strategies & child development
- Prenatal Care
- Maternal health (i.e. depression, family planning, post-partum care)
- Child health (i.e. breastfeeding/infant feeding, well-baby visits, immunizations, developmental milestones)
- Child safety issues (i.e. safety seats, baby proofing, safe sleep)
- Available services for specific needs

BEHAVIORS

Parents exhibit:
- Positive parenting behaviors and practices
- Healthy behaviors during pregnancy and interconception
- Breastfeeding (initiation, duration, & exclusivity)

Families access:
- Concrete services (i.e. WIC, food stamps, etc./ see WB protocols)
- Medical/dental/ psychosocial services (pre-natal care, immunizations, well baby visits, develop-mental services)

CONDITION/STATUS CHANGE
- Parents provide enriching, structured, and nurturing environments
- Parents have self-efficacy and resiliency
- Children and mothers are healthy
- Families essential needs are addressed (i.e. health, safety, and food)

Short-term — Intermediate — Long-term

SOURCE: F5LA, "First 5 LA Welcome Baby Logic Model: Family & Child Level," fact sheet, undated.
NOTE: PHQ = Patient Health Questionnaire; ASQ = Ages and Stages Questionnaire; RN = Registered Nurse; MCH = maternal and child health; PC = Parent Coach; HV = home visit; WIC = Special Supplemental Nutrition Program for Women, Infants, and Children; WB = Welcome Baby.

In keeping with their commitment to using data and evaluation to inform its work, F5LA conducted an initial implementation evaluation and outcomes evaluation at the Welcome Baby pilot site. This report represents the next phase in the Welcome Baby evaluation program—an implementation and outcomes evaluation of Best Start communities charged with scaling up Welcome Baby. F5LA plans a rigorous impact evaluation as the next phase of the Welcome Baby program evaluation.

In 2010, the Welcome Baby pilot evaluation commenced with a series of studies related to the implementation and outcomes of the Welcome Baby program in the pilot site, known as "Metropolitan Los Angeles." The evaluation included case studies of efforts to build program capacity and focus groups with stakeholders that found that participants were satisfied with the program and found value in the services provided (Adams, Hill, and Benatar, 2012). A Child and Family Survey was also administered at 12, 24, and 36 months using a quasi-experimental design comparing women older than 18 years old who participated in the pilot Welcome Baby program with other women who resided in the Metropolitan Los Angeles area but did not participate in the program (Benatar et al., 2014). The Child and Family Survey measured seven outcome domains: quality of home environment, parenting and parent-child relationship, child development, child nutrition, health care coverage, maternal mental health, and family well-being. Across all outcome domains, Welcome Baby mothers fared better relative to the comparison group, with many positive gains—particularly in the domains of child development and home environment—sustained through 12 and 24 months. Welcome Baby families did not show significant improvement in areas such as children being overweight, the use of physical punishment, and parental distress (Benatar et al., 2014). The final component of the pilot evaluation was a cost-effectiveness study using the findings from the outcomes evaluation. This study found that Welcome Baby cost less to implement than other home visiting programs, which was related to the fact that it was less intensive than those programs. Additionally, the evaluation yielded cost estimates for the amount of investment required to get certain outcomes for policymakers and other stakeholders to consider (Benatar et al., 2014).

A qualitative study of the early implementation of the Welcome Baby expansion in the remaining Best Start sites was conducted in March 2014. Through semistructured interviews with a variety of key stakeholders, researchers found that stakeholders were enthusiastic about implementing the program and that the program worked well in a variety of settings. Research results also demonstrated that having certain elements (e.g., fidelity framework, data collection tools and protocols, applied professional development and training) in place initially promoted smoother implementation of the program when scaling up (Hill, Wilkinson, and Benatar, 2014).

A 2017 study examined the relationship between Welcome Baby participation and maternal and child enrollment in Medi-Cal (Howell et al., 2017). This study found that by age two, children whose families had participated in Welcome Baby were more likely to have both well-child visits and, perhaps counterintuitively, more emergency room visits than children whose families had not participated in Welcome Baby. Mothers who participated in Welcome Baby had longer Medi-Cal enrollment, were more likely to have postpartum doctor visits within

recommended time frames, and were less likely to have a Medi-Cal covered birth within two years of the previous birth relative to comparison mothers.

Implementation and Outcomes Evaluation

In 2015, F5LA selected the RAND Corporation to perform an implementation and outcomes evaluation of the Welcome Baby program. The primary objectives of the implementation and outcomes evaluation were to answer the following questions:

1. To what extent are sites implementing Welcome Baby to fidelity?
2. Is there variability in sites' ability to reach fidelity to Welcome Baby? If so, what factors account for this variability?
3. How are sites maintaining community resource and referral networks? What, if any, gaps exist in these networks?
4. What are participant perceptions of and experiences with the program and Welcome Baby service providers?
5. What factors contribute to participants leaving the program early?
6. To what extent do participants achieve short- and intermediate-term outcomes?
7. What are the relationships between program fidelity outcomes and participant outcomes?

We used the Welcome Baby logic model to identify outcomes to assess with this evaluation. We analyzed data from 12 Welcome Baby sites collected from January 2016 to December 2017. This information will help F5LA decide how to best allocate resources for training, program monitoring, and other program management activities. The findings of this report are also likely to be valuable to other home visiting programs, as the fidelity components identified in Welcome Baby are similar to those for other family services.

Outline of the Report

The remainder of the report describes the program under study, our approach to examining implementation and outcomes, results from the evaluation, implications, and conclusions. Chapter 2 provides an overview of the Welcome Baby program. Chapter 3 describes the data sources used for each of the evaluation questions. Chapter 4 presents evaluation question–specific analyses and findings. Chapter 5 summarizes the findings across the evaluation questions and provides recommendations for ongoing monitoring for Welcome Baby program stakeholders and other family service providers. Appendix A provides information about the Welcome Baby Fidelity Framework and staffing qualifications. Appendix B presents more detailed information on the data collection approaches, including procedures on how the data were collected and sample sizes. Appendix C describes the fidelity domain measures in detail, and Appendix D describes the outcome measures. Finally, Appendixes E, F, and G provide detailed results from the analyses of Evaluation Questions 5, 6, and 7.

2. Overview of the Welcome Baby Program

Welcome Baby is offered to women residing in Best Start communities who give birth or are planning to give birth at participating hospitals serving Best Start communities. Families may receive three prenatal home visits, a visit in the hospital after birth, and up to five postpartum home visits (see Figure 2.1).[1] A Welcome Baby staff member, known as a Hospital Liaison, conducts the assessment in the hospital and enrolls families following the baby's birth. RNs conduct the first postpartum visit, and a Parent Coach conducts each of the remaining four home visits. Visits are between 45 and 90 minutes long, depending on the engagement point and the complexity of client needs. This evaluation focuses on Welcome Baby's postpartum home visits.

The Welcome Baby curriculum, as delivered at each engagement point, is designed to be flexible to meet the differing needs of families. The primary motivation for this flexibility is Welcome Baby's family-centered approach that stresses that parents are able to fulfill their potential for growth and that they are the experts on their family's strengths (McCroskey and Meezan, 1998). Another pillar of home visiting is that positive behavior change is promoted when services are provided in a relationship characterized by connectedness, empathy, and empowerment (Edelman, 2004). Each Welcome Baby home visit includes risk and developmental assessments, and these are used to guide the topics covered during the visit as well as any referrals made to other services. During the home visits, parents receive support and information on such topics as postpartum depression, breastfeeding, immunizations and well-baby doctor visits, and home safety. Home visitors undertake the activities while modeling reflective communication and empathy to teach parents interaction skills that help them better connect with their child.

Soon after delivery, a Hospital Liaison conducts a risk assessment with women interested in receiving home visitation services. The level of risk identified through the Modified Bridges for Newborns Screening tool (Stucky et al., 2017) is one component of eligibility for Welcome Baby. This risk assessment occurs at the hospital visit for all Welcome Baby participants, even those that receive services prenatally.

- Women who live in a Best Start community and score **low to moderate risk** on the Modified Bridges for Newborns Screening tool are offered Welcome Baby.
- Women who do not live in a Best Start community and score **low to moderate risk** on the Bridges assessment are not offered any home visiting services from F5LA.
- Women residing in Best Start communities who score **high risk** on the Bridges Assessment are recommended to home visiting programs in their area that provide more intensive services than Welcome Baby. The home visiting models offered during our study period were Healthy Families America and Parents as Teachers.

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[1] This number does not include an extra post-Neonatal Intensive Care Unit [NICU]–discharge visit, for those who qualify. Mothers with children in the NICU also receive a home visit after the child has returned home.

- Women who do not reside in Best Start communities but score as **high risk** are eligible for Welcome Baby "Lite," a less-intensive version of Welcome Baby that includes a hospital visit and up to three postpartum visits. These participants are not included in our evaluation.

Figure 2.1. Timeline of Welcome Baby Visits

SOURCE: LA Best Babies Network (LABBN), "Welcome Baby Timeline of Program Visits," fact sheet, undated.

Welcome Baby is currently being implemented at 14 sites in Los Angeles County, and our study includes the first 12 sites that implemented the program.[2]

Table 2.1 provides an overview of participant demographic characteristics during our study period (January 1, 2016 to December 31, 2017).

[2] Although 13 hospitals participated, two hospitals (Torrance and Little Company of Mary) shared staff; for evaluation purposes, we combined data for these two sites. One site (Martin Luther King, Jr., Community Hospital) launched the Welcome Baby program after the study started and therefore was not included in our analyses.

Table 2.1. Demographic Characteristics of Welcome Baby Clients

Mother's demographics	
Average age at program entry	27.60
Percentage of moms under 18 at program entry	2.02
Percentage with a high school diploma (includes General Education Development)	70.98
Percentage whose primary language is not English	44.46
Race/ethnicity	
Hispanic ethnicity	82.78
African American	8.32
White	4.61
Asian	1.92
Mother's risk factors	
Average Bridges Score (standard deviation)	43.27* (16.33)
Percentage first time mothers	36.60
Child's risk factors	
Percentage gestational age < 37 weeks at birth	7.26
Percentage low birth weight	5.69

SOURCE: Stronger Families Database (SFDB). Includes clients with visits completed between January 1, 2016 and December 31, 2017.
* Bridges scores of 50 or greater are defined as high risk.

Oversight

F5LA contracts with the Family Strengthening Oversight Entity (Oversight Entity) to manage the adoption and integration of the Welcome Baby program into hospitals and community-based organizations. LABBN serves as part of the Oversight Entity. LABBN provides training and technical assistance to all Welcome Baby sites, as discussed in more detail later, and organizational-level technical assistance to hospitals and community partners through workshops that focus on promoting and supporting integration of Welcome Baby practices and protocols in the hospital systems of care.

Staff

Key program staff at each site include

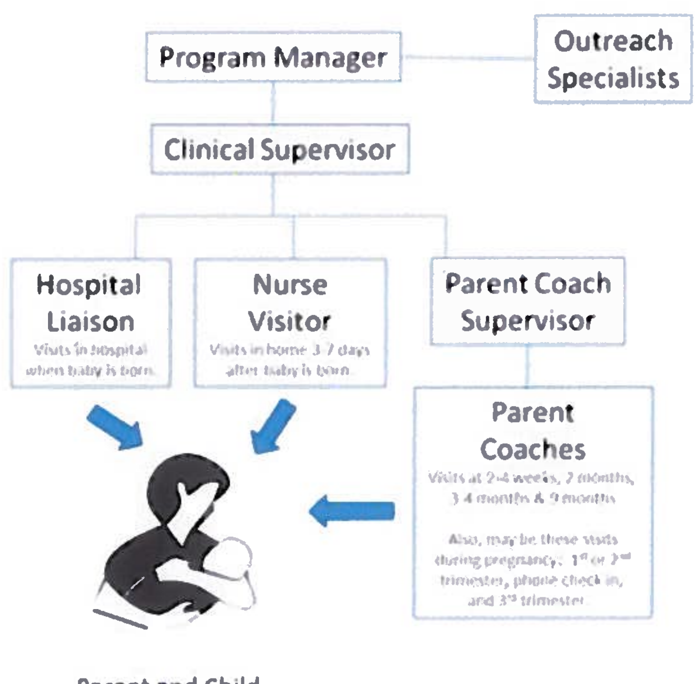
- the **Program Manager/Director**, who has overall responsibility for implementation of Welcome Baby, including overseeing and monitoring adherence to procedures, policies and protocols, and maintaining and improving the quality of the program
- the **Clinical Supervisor**, who is responsible for day-to-day oversight of program staff, including supervision of Parent Coaches and RNs, and for ensuring that staff are trained and participate in reflective supervision (a clinical approach that incorporates active, empathic, and nonjudgemental listening; collaborative relationships between supervisor

and supervisee that support shared responsibility and decisionmaking; and regular interactions)

- the **Data and Evaluation Manager**, who provides the Program Manager with assistance in implementation and program evaluation activities and implements systems for program management and outcomes assessment
- the **Parent Coach Supervisors**, who conduct prenatal and postnatal home visits, oversee other Parent Coaches, and provide weekly reflective supervision
- the **Parent Coaches**, who conduct prenatal and postnatal home visits
- the **RNs**, who conduct the first home visit within three to 14 days after the mother is discharged from the hospital
- the **Hospital Liaisons**, who invite mothers to participate (or encourage mothers to continue to participate) by discussing the program and related services during hospital visits, complete the Bridges for Newborn Screening Tool, and assess the family for social support needs, infant feeding, and maternal depression during hospital visits soon after delivery
- the **Outreach Specialists**, who conduct community outreach at social service sites, social service offices, and health care providers' offices to recruit and enroll eligible clients; Outreach Specialists develop and maintain key community contacts, conduct client intakes, and follow up with potential clients.

Figure 2.2 depicts an organizational chart for a typical site.

Figure 2.2. Typical Welcome Baby Site Organizational Chart for Postpartum Services



Training

Welcome Baby staff attend 184 hours of training, which covers up to 27 topics related to program objectives and goals with specific sessions required for each position (see Table 2.2). New staff must also be certified in lactation education within six months of hire. LABBN develops and coordinates continuing education for staff, including quarterly training sessions (delivered in workshop and webinar formats) on topics aligned with program goals and needs, such as best practices from evidence-based models, and monthly conference calls to review performance measures and provide an opportunity for shared learning between sites.

Table 2.2. New Staff Training Topics

- Welcome Baby Framework and Orientation
- Home Visitor Safety and Self Defense
- Parent-Child Empathetic Communication
- Brain Development and Early Infant Development
- Bonding and Attachment
- Child Abuse and Mandatory Reporting
- Cultural Competency
- Preventive Care: Prenatal, Postpartum, and Newborn Care
- Universal Risk Screen/Bridges for Newborns
- Healthy Homes
- Home Safety for Infants and Toddlers
- Reflective Practice
- Welcome Baby Nurse Visit
- Perinatal Depression and Patient Health Questionnaire-9 Screening
- Using ASQ-3 to Communicate about Children's Development
- Milestones and Development: Expectations for Birth to 12 Months
- Family Planning
- Motivational Interviewing and Follow-Up
- Health Coverage
- Family Violence
- Childbirth Education
- Consent and Confidentiality
- Health Insurance Portability and Accountability Act
- Parent Coach Visit
- Stronger Families Database: Data Collection, Tracking, and Reporting
- Outreach and Communications
- Life Skills Progression

Fidelity

To guide implementation quality, F5LA developed a Welcome Baby fidelity framework (see Table 2.3), which specifies the central components of the program in the domains such as staff training and expertise, number and timing of family encounters, and approach to interactions

with families (see Appendix A). The fidelity framework specifies the criteria that Welcome Baby sites must meet in order to demonstrate that they are providing high-quality services and that the Welcome Baby model is being delivered as intended. In addition to drawing on the existing evidence base related to child development, positive parenting, and family supports, the fidelity framework and performance matrix also drew on the Welcome Baby Family and Child Level Logic Model and the Welcome Baby Program Level Logic Model, as well as qualitative data collection from families, the Welcome Baby pilot study, and extensive meetings with other stakeholders (LABBN, 2008).

Table 2.3. The Welcome Baby Fidelity Domains

Fidelity Domain	Description
1. Staff Qualifications	Staff meet minimum requirements
2. Staff Training	Staff meet training requirements
3. Supervisory Requirements	Supervisors oversee no more than 4 coaches
4. Reflective Supervision	Staff participate in the required amount of reflective supervision sessions
5. Home Visitor Workloads	Staff meet suggested workload amounts
6. Prenatal Recruitment and Enrollment	Eligible prenatal families offered and enrolled in program
7. Hospital Enrollment	Eligible mothers approached and enrolled in the hospital
8. Service Dosage	Participating families receive appropriate service dosage
9. Timing of Service Delivery	Home visits are completed within the recommended time period
10. Referrals to Community Services	Clients receive appropriate referrals, and referrals are verified by staff as completed
11. Participant Perception of the Relationship	Staff build positive relationships with their clients
12. Family-Centered Approach	Home visitors use a family-centered approach
13. Content of Home Visits	Home visits include the recommended content
14. Responsiveness of Provider	Home visitors address unplanned situations

3. Data Sources

As stated earlier, the project was designed to address the following questions:

1. To what extent are sites implementing Welcome Baby to fidelity?
2. Is there variability in sites' ability to reach fidelity to Welcome Baby? If so, what factors account for this variability?
3. How are sites maintaining community resource and referral networks? What, if any, gaps exist in these networks?
4. What are participant perceptions of and experiences with the program and Welcome Baby service providers?
5. What factors contribute to participants leaving the program early?
6. To what extent do participants achieve short- and intermediate-term outcomes?
7. What are the relationships between program fidelity outcomes and participant outcomes?

This chapter describes the data sources used to address these questions. Before describing each data source, we summarize the guiding principles underlying our approach to selecting the specific data sources. To the extent possible, in drafting and deploying the different data collection instruments, we aimed to

- build on existing Welcome Baby data collection methods, preserving aspects that have worked well for stakeholders and modifying aspects that stakeholders reported as needing improvement
- select measures from the literature that have been successfully used for home visiting or related services and have demonstrated desirable psychometric properties, such as inter-rater reliability and validity
- gather information from a spectrum of Welcome Baby stakeholders to ensure that multiple perspectives are included
- pilot test all instruments before deploying
- design data collection, analysis, and reporting procedures to facilitate sustainability by Welcome Baby stakeholders for purposes of ongoing monitoring after this project ends.

With these underlying principles, we designed the evaluation with multiple data sources, including interviews, focus groups, observational assessments of home visits, client surveys, and staff surveys. Across these data sources, final versions of all data collection instruments and consent materials were approved by RAND's Internal Review Board (IRB) and local Welcome Baby site IRBs.

Table 3.1 provides an overview of these data sources and how they relate to each evaluation question. Appendix B has more details for each data source, including dates of administration, sample, data collection protocols, and instruments.

Table 3.1. Data Sources Used for Each Research Question

Evaluation Question	Site Interviews	Client Focus Groups	Staff Survey	Referral Documents	Client Survey	SFDB
1. To what extent are sites implementing Welcome Baby to fidelity?			X		X	X
2. Is there variability in sites' ability to reach fidelity to Welcome Baby? If so, what factors account for this variability?	X		X		X	X
3. How are sites maintaining community resource and referral networks? What, if any, gaps exist in these networks?	X		X	X		
4. What are participant perceptions of and experiences with the program and Welcome Baby service providers?		X			X	
5. What factors contribute to participants leaving the program early?	X		X		X	X
6. To what extent do participants achieve short- and intermediate-term outcomes?					X	X
7. What are the relationships between program fidelity outcomes and participant outcomes?			X		X	X

As mentioned earlier, F5LA has specified 14 fidelity domains that characterize the Welcome Baby program, and we gathered information on the fidelity domains from different quantitative data sources (Table 3.2). Of note, although we planned to use data from home observations to address the family-centered approach fidelity domain, small sample sizes precluded us from using that data source in our analyses. The small sample size was primarily the result of the delay in the implementation of the home observation assessment tool because of staff training concerns from F5LA, LABBN, and the participating sites. The national evaluation of the fidelity of evidence-based home visiting programs also reported challenges in collecting data to assess the quality of the home visitor–participant relationship (Boller et al., 2014). We also used data from the qualitative efforts to enrich the quantitative data sources. More specifically, information from staff interviews helped to explain variation on the staffing- and service delivery–related domains, and client focus groups helped to explain variation in the participant-related domains (e.g., participant perception of the relationship).

Table 3.2. Quantitative Data Sources That Capture Each Fidelity Domain

Fidelity Domain	Data Source
D1. Staff Qualifications	Staff survey
D2. Staff Training	Staff survey
D3. Supervisory Requirements	Staff survey
D4. Reflective Supervision	Staff survey
D5. Home Visitor Workloads	Staff survey
D6. Prenatal Recruitment and Enrollment	No data available
D7. Hospital Enrollment	LABBN site reports[a]
D8. Service Dosage	SFDB
D9. Timing of Service Delivery	SFDB
D10. Referrals to Community Services	SFDB
D11. Participant Perception of the Relationship	Client survey
D12. Family Centered Approach	Observational assessments[b]
D13. Content of Home Visits	SFDB, observational assessments[b]
D14. Responsiveness of Provider	Observational assessments[b]

[a] These data were not available in the SFDB but collected and monitored by LABBN, which provided us with site-level reports to use for our analyses.
[b] Sample size was too small to use this dataset.

The outcomes we analyzed reflect the outcomes drawn from the Welcome Baby logic model and assessed using data reported in the SFDB and measures collected in the Client Survey (Table 3.3).

Table 3.3. Quantitative Data Sources That Capture Each Outcome

Outcome Category	Outcome Measure	Data Source
Parenting	Parenting practices	Client Survey (subset of HOME inventory)
	Parenting knowledge	Client Survey (subset of KIDI)
Maternal health	Family planning	SFDB
	Maternal depression	SFDB (PHQ-9)
Maternal social support	Maternal social support from all sources	SFDB
Child health	Breastfeeding—exclusive	SFDB
	Breastfeeding—any	SFDB
	Child health insurance	SFDB
	Child immunizations up to date	SFDB
	Child attended well-child visits at recommended intervals	SFDB
Child safety	Home safety—no issues identified	SFDB
	Safe sleep practices (child sleeps on back, no co-sleeping)	SFDB
Child development	Communication	SFDB (ASQ)
	Gross motor	SFDB (ASQ)
	Fine motor	SFDB (ASQ)
	Problem solving	SFDB (ASQ)
	Personal/social	SFDB (ASQ)
	Child development—overall	SFDB (ASQ)

NOTE: HOME = Home Observation Measurement of the Environment; KIDI = Knowledge of Infant Development Inventory; LSP = Life Skills Progression Tool.

Next, we briefly describe each qualitative and quantitative data source. More complete details are located in Appendix B.

Qualitative Data Collection

Site Interviews

We conducted semistructured phone interviews (and some in-person interviews) about Welcome Baby program delivery with individuals representing each of the different staffing roles at each of the participating sites. This information allowed us to collect qualitatively rich information about staff perceptions of support for Welcome Baby program implementation, including factors that staff perceived as influencing program delivery. Key domains in the interview protocol included training and technical assistance experience, leadership support, staff support, facilitators and barriers to program delivery, and enrollment and engagement experiences. In Table 3.4, we summarize the research questions and topic areas addressed by the site interviews (see Appendix B for a copy of the site interview protocol).

Table 3.4. Data Source: Site Interviews

Evaluation questions	2. Is there variability in sites' ability to reach fidelity to Welcome Baby? If so, what factors account for this variability? 3. How are sites maintaining community resource and referral networks? What, if any, gaps exist in these networks?
Topic areas (components of fidelity framework)	• staff training • supervisory requirements • reflective supervision • service dosage • referrals to community services

Client Focus Groups

We conducted one or two focus groups with Welcome Baby clients at each site. Welcome Baby staff at each site assisted us in this effort by recruiting individuals who had experience with different Welcome Baby engagement points. The client focus groups allowed us to gain insight into client experience with the program, including aspects of the enrollment process, what clients liked and disliked about program content, relationships with home visiting staff, and ideas for ongoing quality improvement. In Table 3.5, we summarize the evaluation questions and topic areas that the focus groups addressed. We conducted focus groups in English and Spanish (see Appendix B for more information).

Table 3.5. Data Source: Client Focus Groups

Evaluation questions	4. What are client perceptions of and experiences with the program and Welcome Baby service providers?
Topic areas (components of fidelity framework)	• client perception of the relationship • family-centered approach • responsiveness of the provider

Quantitative Data Collection

Staff Survey

We conducted an online survey of key Welcome Baby staff at each site, including Parent Coaches, Parent Coach Supervisors, RNs, Outreach Specialists, and Hospital Liaisons. The primary goals of the survey were to capture the qualifications, training, and supervision of Welcome Baby staff so that we could compare those to the relevant Welcome Baby fidelity components. In Table 3.6, we summarize the evaluation questions and topic areas that this survey addresses (see Appendix B for more details, including a copy of the staff survey instrument).

Table 3.6. Data Source: Staff Survey

Evaluation questions	1. To what extent are sites implementing Welcome Baby to fidelity? 2. Is there variability in sites' ability to reach fidelity to Welcome Baby? If so, what factors account for this variability?
Topic areas (components of fidelity framework)	• staff qualifications • staff training • supervisory requirements • reflective supervision

Referral Documentation

We collected documentation from site Program Managers related to each site's referral system to address the evaluation question concerning site maintenance of community resource and referral networks and gaps in existing networks (see Table 3.7; see Appendix B for the document review protocol).

Table 3.7. Data Source: Referral Documentation

Evaluation questions	3. How are sites maintaining community resource and referral networks? What, if any, gaps exist in these networks?
Topic areas (components of fidelity framework)	• referral sources to community services

Client Survey

Client surveys were conducted to obtain information about several fidelity domains and outcomes. In relation to fidelity, the surveys included questions that addressed program components from the perspective of the client (i.e., the use of the family-centered approach, the client–home visitor relationships, the client experience). The survey incorporated existing measures from the literature that were adapted to the Welcome Baby context and built on the existing Welcome Baby client satisfaction survey (see Chapter 4 and Appendix B for more information on specific items). For this effort, we trained Parent Coaches at each site to introduce the opportunity for Welcome Baby clients to complete the anonymous survey using a tablet that the Parent Coach brought to any home visit during the data collection period. Clients also had the option of completing a paper version of the survey, but this option was rarely taken. Home visitors did not record the number of clients who were offered the survey or refused to complete the survey during the data collection period.

In Table 3.8, we summarize the research questions and topic areas that this survey addressed. Note that our access to Client Survey data was from September 2016 through September 2017; however, the survey administration start date varied by site because of IRB schedules and other constraints. We had access to less than four months of data for five sites, resulting in a low number of observations at those sites, precluding site-level comparisons with these data.

Table 3.8. Data Source: Client Survey

Evaluation questions	1. To what extent are sites implementing Welcome Baby to fidelity? 2. Is there variability in sites' ability to reach fidelity to Welcome Baby? If so, what factors account for this variability? 4. What are participant perceptions of and experiences with the program and Welcome Baby service providers? 6. To what extent do participants achieve short- and intermediate-term outcomes? 7. What are the relationships between program fidelity outcomes and participant outcomes?
Topic areas (components of fidelity framework)	• parent perceptions of the relationship with the Welcome Baby providers (part of fidelity framework) • whether the providers use a family-centered approach (part of fidelity framework) • the responsiveness of the provider (part of fidelity framework) • parent knowledge of child development (part of outcome measurement) • parenting behaviors and practices (part of outcome measurement)

Stronger Families Database

We accessed data from the SFDB for several aspects of the fidelity framework, client outcome measurement, and client demographic information. The SFDB houses data recorded by Hospital Liaisons, RNs, Parent Coaches, and Parent Coach Supervisors over the course of a client's engagement with the Welcome Baby program. Examples of information recorded in the SFDB are the types of content covered during home visits, measures of maternal and child health and safety, maternal and child health insurance coverage status, maternal mental health status, breastfeeding status, and measures of child development. In Table 3.9, we summarize the research questions and topic areas that the SFDB addressed (see Appendix B for more details).

Table 3.9. Data Source: Stronger Families Database

Evaluation questions	1. To what extent are sites implementing Welcome Baby to fidelity? 2. Is there variability in sites' ability to reach fidelity to Welcome Baby? If so, what factors account for this variability? 5. What factors contribute to participants leaving the program early? 6. To what extent do participants achieve short- and intermediate-term outcomes? 7. What are the relationships between program fidelity outcomes and client outcomes?
Topic areas (components of fidelity framework)	• service dosage (part of fidelity framework) • timing of service delivery (part of fidelity framework) • content of home visits (part of fidelity framework) • maternal health (part of outcome measurement) • child health inputs (part of outcome measurement) • child safety (part of outcome measurement) • child development (part of outcome measurement)

4. Methods and Findings by Evaluation Question

This section organizes the findings by each of the seven evaluation questions. We first present each evaluation question and provide a brief summary of the findings. Appendices B–G contain additional details about the data collection methods and analyses referenced next.

Evaluation Question 1: To What Extent Are Sites Implementing Welcome Baby to Fidelity?

At the site level, there was a large amount of variability in the degree to which individual sites achieved fidelity to the Welcome Baby model. No site achieved fidelity in all of the assessed fidelity domains, but every site achieved fidelity in at least two domains (supervisory requirements and participant perception of the relationship). Individual sites achieved fidelity in 18 to 80 percent of measured domains, with an average of 48 percent.

Methods

Our approach to measuring fidelity was based on the criteria specified for 14 domains in the Welcome Baby Fidelity Framework, June 2016 version (see Table 2.2 and Appendix A). Our analyses involved establishing minimum requirement thresholds against which sites were measured. To the extent possible, we tried to measure domain fidelity as specified in the Framework, but in several cases, we established domain fidelity indicators based on the best data available (similar to the process used in Daro et al., 2012). Each of these fidelity domain thresholds were discussed with F5LA staff and staff from the LABBN to ensure relevance and accuracy. For three domains (Domain 6 [prenatal enrollment and recruitment], Domain 12 [family-centered approach], and Domain 14 [provider responsiveness]), we lacked available data to conduct site-level analysis, so our site-level results include assessments of only 11 of the 14 domains in the Welcome Baby Fidelity Framework.

Table 4.1 summarizes data sources, dates covered by the data, a brief description of the threshold standard established for meeting fidelity at the site level, and the average relevant percentage meeting minimum requirements across all of the sites. Appendix C provides details for the data sources and standards we applied for each fidelity domain. For each site and domain, we calculated whether the site met the minimum fidelity requirements and thus designated that the site met or did not meet the threshold standard outlined in Table 4.1.

Table 4.1. Fidelity Domain Data Sources, Site Threshold Standards, and Average Performance Across All Sites

Fidelity Domain	Data Source (Sample Size)	Dates Covered	Threshold Standard Established	Average Across Sites
D1. Staff Qualifications[a]	Staff Survey (116)	May–August 2017	All staff in 5 positions met minimum education, certification, and previous experience requirements	64% of staff
D2. Staff Training[a]	Staff Survey (117)	May–August 2017	All staff in 5 positions met minimum new staff training requirements for their role and had lactation education certification, as applicable	86% of staff
D3. Supervisory Requirements[a, b]	Staff Survey (15)	May–August 2017	All Parent Coach Supervisors oversaw no more than 4 Parent Coaches each at time of survey	100% of PCSs
D4. Reflective Supervision[a]	Staff Survey (107)	May–August 2017	All staff in 5 positions met minimum requirements for individual and group reflective supervision in 3 months prior to survey	61% of staff
D5. Home Visitor Workloads[a]	Staff Survey (72)	May–August 2017	All Parent Coaches, Parent Coach Supervisors, and RNs met minimum client engagement requirements, based on number of visits in last week worked prior to survey	78% of staff
D7. Hospital Enrollment	Site reports (12 months per site)	January–December 2017	Site staff approached 90% of available families and enrolled 40% of those approached	75% of available families approached; 58% of approached families were enrolled
D8. Service Dosage[c]	SFDB (4,928)	January 2016–December 2017	46% or more of Best Start clients completed at least 4 of 6 postpartum engagements	46% of clients
D9. Timing of Service Delivery[c]	SFDB (26,028)	January 2016–December 2017	84% or more of completed prenatal and postnatal client visits occurred within specified time period	84% of visits
D10. Referrals to Community Services[c]	SFDB (4,387)	April–December 2017	25% of created referrals from April through October 2017 were verified by staff as completed or under way by December 31, 2017.	25% of referrals
D11. Participant Perception of the Relationship[d]	Client Survey (1,976)	September 2016–September 2017	85% or more of clients responded "often" or "very often" for all four items in the Working Alliance Inventory, Bond subscale	89% of clients
D13. Content of Home Visits[c]	SFDB (32,597)	January 2016–December 2017	87% or more of recommended content was covered in completed postpartum client visits	87% of visit content

[a] Four sites had a staff survey response rate of less than 54 percent, so results from those sites should be interpreted with caution for this domain. The overall response rate for the survey across sites was 73% (121 of 166 staff).
[b] Four sites did not have a Parent Coach Supervisor complete the survey, so the sites were not assessed for fidelity on this domain.
[c] This domain did not have a specified threshold to use from the Welcome Baby Fidelity Framework. One hundred percent is not a realistic threshold, as these domains are not entirely under the control of the Welcome Baby program and require client involvement; however, one aim of the Welcome Baby program is to be responsive to the client. Therefore, we established the threshold as the average across all sites in our sample that met the particular domain criteria. Achieving a threshold in those domains indicates the site was at or above the Welcome Baby program site-wide average.
[d] This domain did not have a clear minimum requirement; therefore, the fidelity threshold was set at 85 percent of clients meeting the standard.

Findings

Sites varied in their ability to meet fidelity threshold requirements (Table 4.2). Each cell indicates whether a given site met the fidelity threshold for a specific domain. Green shading and "Yes" indicate the threshold was met, and red shading and "No" indicate it was not met. Gray shading and "N/A" indicates we did not have data for that site and domain. Additionally, we exclude from the summary the three domains for which we did not have available data for site-level analysis (domains 6, 12, and 14). Eight of the 12 sites were measured on 11 domains, and the other four sites were measured on 10 domains.

The two sites with the highest fidelity threshold achievement—sites 2 and 7—met the minimum requirements for seven to eight of ten domains (70 percent and 80 percent, respectively). Sites with the lowest fidelity threshold achievement met minimum requirements for only two to three of 11 domains (from 18 percent to 27 percent). On average, sites achieved fidelity thresholds for just under half (48 percent) of the measured domains.

Comparing these findings to the home visiting fidelity study by Boller et al. (2014), we observe that dosage was one of the most difficult fidelity measures for sites to attain in both studies. The sites in the Boller et al. study also struggled with maintaining caseloads, which was not one of the bigger challenges for Welcome Baby sites. The Welcome Baby sites also have low rates of completed referrals (25 percent across sites), but we did not find comparisons we could use to assess the relative value of this rate of referral.

Table 4.2. Summary of Fidelity Domain Achievement, by Site

Site	D1. Staff Qualifi-cations	D2. Staff Training	D3. Parent Coach Supervisor Supervisory Requirements	D4. Staff Reflective Supervision	D5. Home Visitor Workload	D7. Hospital Enrollment	D8. Service Dosage[b]	D9. Service Timing[b]	D10. Referrals Completed[b]	D11. Perception of Relationship	D13. Visit Content[b]	Domains Achieved
1	No	No	Yes	No	No	No	No	No	No	Yes	No	18%
2	No[a]	Yes[a]	N/A	Yes[a]	Yes[a]	Yes	Yes	No	Yes	Yes	No	70%
3	No	No	Yes	No	No	No	Yes	Yes	Yes	Yes	Yes	55%
4	No[a]	No[a]	Yes[a]	No[a]	Yes[a]	No	Yes	No	No	Yes	Yes	45%
5	No	No	Yes	No	No	No	No	No	Yes	Yes	No	27%
6	No	No	Yes	No	No	No	No	Yes	No	Yes	No	27%
7	Yes	Yes	N/A	No	Yes	No	Yes	Yes	Yes	Yes	Yes	80%
8	No	No	Yes	No	No	No	No	No	No	Yes	Yes	27%
9	No[a]	No[a]	N/A	No[a]	Yes[a]	No	Yes	Yes	Yes	Yes	Yes	60%
10	No[a]	Yes[a]	Yes[a]	No[a]	Yes[a]	No	No	Yes	Yes	Yes	Yes	64%
11	No	Yes	Yes	No	No	No	Yes	No	Yes	Yes	Yes	55%
12	No	Yes	N/A	No	Yes	No	Yes	No	No	Yes	Yes	50%
Sites meeting threshold (Total Yes)	1	5	8	1	6	1	7	5	7	12	8	48%

NOTES: For sample size information, see Table 4.1.
[a] Site had a staff survey response rate of less than 54%.
[b] The threshold was set at the Welcome Baby program average across all sites, so by definition, some sites will fail to achieve the threshold.

Evaluation Question 2: Is There Variability in Sites' Ability to Reach Fidelity to Welcome Baby?

At the domain level, a large amount of variability existed in the proportion of sites that met the fidelity threshold. For two domains (supervisory requirements and participant perceptions of the relationship), all assessed sites achieved fidelity thresholds with the Welcome Baby model; three sites achieved one domain each (one site met staff qualifications, one met reflective supervision, and one met hospital enrollment. The remainder of the domains had five to eight sites achieve fidelity thresholds. On average across all of the assessed domains, 5.5 sites achieved domain fidelity. Within several domains, there was also variability in achieving thresholds for specific elements of the domain criteria (e.g., by staff position or visit type). Findings from the interviews with Welcome Baby staff at the sites lend some information to help explain challenges faced in meeting the fidelity thresholds.

As noted in the previous section, we used data from a variety of sources to examine fidelity to the Welcome Baby model. For this evaluation question, we describe how we assessed whether sites met the specific domain fidelity thresholds and the results from that assessment. Following the presentation of each of the domain-specific findings, we present findings from the qualitative data collected from interviews with site staff that we used to explore and understand the implementation context that might explain the sites' ability or inability to meet fidelity requirements. In many cases, there were no observable differences between sites that met the fidelity requirements of a particular domain and those that did not, so we report overall the themes.

Methods

For the quantitative analysis, we used the same methods as described for Evaluation Question 1 to establish minimum requirements and site-level domain fidelity thresholds. In Evaluation Question 1, we looked *across* sites at the number of domains for which fidelity thresholds were achieved; now, we look *within* each domain to assess how many sites achieved fidelity thresholds. We provide additional descriptions of methods particular to specific domains, as appropriate.

In addition to analyzing data sources, we conducted interviews with site staff representing eight positions across each of the sites to qualitatively describe factors affecting the achievement of domain fidelity thresholds. Data collection details are included in Appendix B. Field notes taken during the interviews were reviewed against a digital recording of the interview for accuracy and then uploaded into the qualitative software program (MaxQDA) for qualitative data analysis. We used field notes rather than transcripts, following a long tradition in anthropology (Bernard, 2006; Sanjek, 1990) because it better met the purposes of our study— documenting themes based on interview questions—and is less time consuming and expensive than transcription analyses. All notes were stripped of identifying information (except for Site Code and Position Code) before data analysis. Data were coded independently by research staff using a

constant comparative process. Initial coding was done on notes from 25 of the earliest interviews conducted, using a conventional content analysis approach and allowing the content of the text to drive thematic development before imposing categories defined according to the areas covered (i.e., section headers) in the respective interview protocols. To create a theme for coding purposes, research staff were instructed to identify at least three excerpts from different respondents that illustrated the theme. For example, looking at the data on staff experience with the cohort training, we initially developed themes using words from the text, such as "the training was long and intense," "more of the training should be web-based," and "it is difficult traveling to LA every day for training." Later, these were all coded under the theme "logistical challenges," which is one theme in the category "perceptions of staff training." Some segments were *double-coded*, meaning that they could be categorized into more than one theme. For example, the suggestion that "more of the training should be web-based" was coded under the theme "suggestions to improve training" as well as "logistical challenges."

Following an initial round of coding, consensus meetings were conducted (including one of the principal investigators as well as the research staff that were involved in the interviews and focus group data collection and analyses) to develop a codebook. The codebook consisted of a detailed description of each code (theme), inclusion and exclusion criteria for sorting coded segments, and some typical exemplars. Codebook development activities included removing and collapsing redundant codes and repositioning others as necessary.

In the next phase, we used the codebook to review and systematically code all the interview notes independently, including those that had been previously coded during codebook development. We did not measure intercoder consistency; instead, one of the project leaders randomly selected a subset of coded segments that had been coded by more than one member of the research staff and reviewed to ensure that there was consistency during the initial round of coding. The few inconsistencies found were discussed, and a final determination was made by consensus. All the excerpts presented in the results section have been reviewed for consistency with the theme by more than one member of the research team.

Findings

Only one site achieved fidelity in each of the 11 measured domains, and the average across all of the domains that were assessed was 5.5 sites achieving domain fidelity (Table 4.2). However, that average masks the wide range of fidelity achievement across domains—from one to 12 sites met the fidelity threshold within each domain. For three of the 11 measured domains (domains for staff qualifications, reflective supervision, and hospital enrollment), only one site met fidelity thresholds. For one domain (participant perception of the relationship), all 12 sites met fidelity thresholds; for another domain (supervisory requirements), all sites that could be assessed (eight out of 12 sites) met thresholds. This wide range of variability in fidelity achievement across sites is consistent with the findings of the national evaluation of evidence-based home visiting programs (Boller et al., 2014). Their study of the fidelity of 17 home visiting sites across five program models found more variability in fidelity within models than across

models. Next, we discuss each domain separately to provide further information on the variability observed on the separate fidelity domains (Table 4.2).

Domain 1: Staff Qualifications

This domain comprises the sum of staff qualifications for five Welcome Baby staff positions: Hospital Liaison, Outreach Specialist, Parent Coach, Parent Coach Supervisor, and Registered Nurse. For a site to achieve the fidelity threshold, all staff must have met the minimum requirements for their positions, which may help explain why only one site achieved fidelity. The average across all staff was 64 percent (Table 4.3). Also, it should be noted that this is based on those staff responding to the survey, so it is not fully representative of all staff at the time of fidelity assessment.

Table 4.3 shows the rates of fidelity threshold achievement for each staff position across all Welcome Baby sites. Over three-quarters of Outreach Specialists and Hospital Liaisons met requirements, whereas the rates were as low as 50 percent among the other three staff positions. The pooled threshold achievement rates are reported because of the large amount of variation in staffing levels within sites and varying nonresponse rates, which would make site by site comparisons limited. For example, some sites were missing all survey responses for a specific position.

Table 4.3. Staff Qualifications (Domain 1) Fidelity Threshold Achievement, by Staff Position

Staff Position	Number Meeting Requirements	Number of Respondents	Percentage Achieving Fidelity
Hospital Liaison	19	24	79
Outreach Specialist	14	17	82
Parent Coach	20	40	50
Parent Coach Supervisor	8	14	57
RN	13	21	62
Total	74	116	64

SOURCE: Staff Survey data (n = 116; May–August 2017).

Domain 1: Qualitative Findings

Most sites reported challenges finding staff with the required qualifications, particularly the RN position. We provide illustrative examples here from the interview notes of the concerns expressed:

- *The role that is difficult to hire for is the Welcome Baby [RN]. There aren't enough RNs with that specific experience of home visiting. I think they're required to have a public health certification and six months of home visiting experience. That's hard to find, especially the home visiting experience. It would be easier to get [RNs] if they could shadow for training and get that home visiting experience that way.*

- *There are some pretty rigid criteria for each job position and it would be nice to see a little bit of room and flexibility to hire staff because it takes a significant amount of time to fill out a position because we are looking for specific set of qualifications.*

Domain 2: Staff Training

For staff training, the average percentage meeting minimum training requirements across all staff was 86 percent. Five sites achieved the fidelity threshold—markedly higher than for staff qualifications. Four of the five positions had high rates of fidelity threshold achievement, including 100 percent for Parent Coach Supervisors, whereas the percentage of Outreach Specialists was significantly lower at 56 percent (Table 4.4).

Table 4.4. Staff Training (Domain 2) Fidelity Threshold Achievement, by Staff Position

Staff Position	Number of Staff Meeting Requirements	Number of Respondents	Percentage of Staff Achieving Fidelity
Hospital Liaison	21	24	88
Outreach Specialist	9	16	56
Parent Coach	37	42	88
Parent Coach Supervisor	15	15	100
Registered Nurse	19	20	95
Total	101	117	86

SOURCE: Staff Survey data (n = 117; May–August 2017).

If we limit the sample to staff with at least one year's tenure at Welcome Baby, the rate of staff training threshold achievement was above 94 percent for all positions. We examined the rates for a smaller sample of staff (n = 93) who had been employed at least one year to see if a potential explanation for the lower Outreach Specialist percentages is that a significant number were newer hires at the time of the survey. New staff must complete cohort training within the first year of hire (see Chapter 2), but very new staff may not yet have completed that.

Domain 2: Qualitative Findings

With respect to staff training, staff representatives from many sites reported both positive and negative aspects of training, and several proposed suggestions for improving the required cohort training. In general, interviewees felt that the training was comprehensive and in-depth and provided a great introduction to Welcome Baby. However, there was an almost universal sentiment across staff roles and sites that the training was too intense and too protracted to ensure retention of all the information provided.

Suggestions for improvements fell mainly into two broad categories, "logistics" and "aligning training with specific roles," as illustrated here. A few sample coded segments from the interviews are provided to illustrate the points raised in these categories.

- Logistics
  - *I'd also say that as the trainings would go on it's been challenging because on training days that are back to back it really cuts into seeing clients. We have to see 32–40 [clients] and if I miss two to three days in a month for training, I can only see 32 at the most. It cuts into my numbers when we have so many trainings.*
  - *The main challenges for the basic required training . . . would be that it's required and spread out [over time], so getting someone up and running can take some time.*
- Aligning training with specific roles
  - *BRIDGES training was like [a] half day and it did not give a feel for how much they would go through—need to include some mock visits.*
  - *We need a more comprehensive training for outreach; I struggled with some areas of [outreach]. They should have a one-week-long outreach specialist training, A lot of what they cover doesn't capture what we do.*
  - *It would be good for Hospital Liaisons to shadow Hospital Liaisons at other sites to get a better understanding of what to do. From the training, it wasn't clear what it was like to be on the floor . . . and it made it harder when we were in our position to know what to do.*
  - *The core training is a lot about moms and kids but less on the role of Outreach Specialist and Hospital Liaisons—there needs to be more of a marketing strategy and tools on how to speak with parents to get them to enroll in Welcome Baby.*
  - *There was no specific training to be a Parent Coach Supervisor.*
    I was not trained by Welcome Baby to hire staff.

We also explored the possibility that staff turnover might be an important factor impacting the ability of sites to meet Domains 1 (staff qualifications) and 2 (staff training). Interviewees were asked whether they "thought there was high staff turnover" at their site, and if so, what they thought contributed to the high staff turnover rate. Analysis of the data from the interviews gives a sense of the potential reasons for the observed turnover rates. Two key reasons cited by interview participants include

- maternity leave (many staff are of childbearing age, and some do not return to the program or to the workforce after having a child or return only on a part-time basis)
- staff turnover among RNs (one participant noted that Welcome Baby requires a high level of experience, and RNs at that level can get a better-paying job with a lower caseload; staff burnout was also mentioned).

Domain 3: Supervisory Requirements

This domain is limited to information collected from Parent Coach Supervisors, and all 15 in our study met the fidelity threshold requirement that they supervise four or fewer Parent Coaches (Table 4.1). These staff were located in eight of the 12 sites, and two sites had one respondent for this domain, five sites had two respondents, and one site had three respondents. There were no indications from the qualitative data that sites were experiencing challenges on this supervisory requirement.

Domain 4: Reflective Supervision

Across the five staff positions, an average of 61 percent of all staff met minimum individual and group reflective supervision requirements in the past three months (Table 4.5). Only one site achieved the domain fidelity threshold by staff in all five positions reporting meeting the supervision requirements. Parent Coaches had the highest rates of fidelity threshold achievement at 78 percent, whereas the other staff positions ranged from 47 to 61 percent. For this domain fidelity threshold calculation, we allowed for one or two fewer reflective supervision meetings over three months, depending on the number required for each position, than the Framework technically required, providing some leeway for the potential that staff may have had vacation or sick leave during the specific time frame asked about in the survey that could have resulted in a lower number of meetings.

Table 4.5. Reflective Supervision (Domain 4) Fidelity Threshold Achievement, by Staff Position

Staff Position	Number Meeting Requirements	Number of Respondents	Percentage Achieving Fidelity
Hospital Liaison	11	22	50
Outreach Specialist	8	14	57
Parent Coach	28	36	78
Parent Coach Supervisor	7	15	47
RN	11	20	55
Total	65	107	61

SOURCE: Staff Survey data (*n* = 107; May–August 2017).

Domain 4: Qualitative Findings

In terms of challenges around the provision of reflective supervision that might affect the ability of sites to achieve fidelity on this domain, staff cited the lack of consistent scheduling, failure to prioritize the reflective supervision sessions, lack of supervisory support for staff, and the lack of supervisory support for the meetings. Examples from the notes are given here:

- *We're supposed to have reflective weekly but lately it's been off and on, we haven't had a good schedule.*
- *We are meant to have weekly one-on-one supervision and we've never had it done effectively or following the fidelity model. It was a total failure when done.*
- *I don't get anything out of it. We feel disconnected. We don't get anything from the one-on-ones. Sometimes we have to wait, start late, and are rushed. She seems to be busy and preoccupied.*
- *We don't feel supported. She is preoccupied. We are not a priority. We don't get anything from our meetings. I can do without it.*

Domain 5: Home Visitor Workloads

Across all Parent Coaches, Parent Coach Supervisors, and Registered Nurses, the average was 78 percent meeting the workload requirements for number of engagements (i.e., 20 per

month for Parent Coach Supervisors and 32 per month for Parent Coaches and Nurses) (Table 4.6). At six sites, all site staff met workload requirements, thus achieving the domain fidelity threshold.

Fidelity threshold achievement was high for all positions, ranging from 70 to 93 percent meeting workload requirements (Table 4.6). We note that threshold achievement rates were calculated based on survey responses for the number of client visits conducted in the last week worked, which we multiplied by four to determine number of monthly engagements. We took into account the number of hours a staff member worked per week in making calculations.

Table 4.6. Home Visitor Workloads (Domain 5) Fidelity Threshold Achievement, by Staff Position

Staff Position	Number Meeting Requirements	Number of Respondents	Percentage Achieving Fidelity
Parent Coach	26	37	70
Parent Coach Supervisor	14	15	93
Registered Nurse	16	20	80
Total	56	72	78

SOURCE: Staff Survey data (*n* = 72; May–August 2017).

Domain 5: Qualitative Findings

Staff also identified challenges that might affect the ability of home visiting staff to meet their workload requirements (in particular, factors that could affect completion of the required number of visits per week). The main facilitators of success were quick and flexible scheduling of home visits and support from supervisors for dealing with high-risk cases:

- We try *to assign cases within 24 hours so the family has the best opportunity to get the nurse in within the three days.*
- *The turnaround time goes by very fast. For example, if the Hospital Navigator enrolls a client on Monday, by Tuesday the client is already in our system, and if the clinical supervisor accepts the referral by Wednesday, then the RNs can call the client by Wednesday too. All of this happens while the mom is still at the hospital.*
- *If [home visiting staff] have concerns or high-risk cases, they can have a supervisor go out with them.*
- *The Parent Coaches are very flexible with scheduling. For instance, they offer to see moms on the weekends.*

In considering barriers to meeting the home visiting workload requirements, staff identified a number of potential risk factors for missed engagement points, such as staffing issues, staff turnover, heavy administrative burden, the dual role of Parent Coach Supervisors who are carrying a caseload, and time to complete individual visits due to the complex needs of clients.

- *In my capacity [as a Parent Coach Supervisor], it's juggling the different aspects of my role. Because I am in the field and carry a caseload . . . it's challenging to also monitor staff.*
- *With high-risk clients, sometimes difficulties come up like postpartum depression, and [Parent Coaches] can't rush these visits. I suggest that for high-risk [patients], instead of seeing eight to ten clients a week, they should see seven a week because high-risk clients take longer.*
- *[Parent Coaches] sometimes get really intensive cases, so we have to spend more time on those. Very rarely do we get a visit that lasts less than an hour.*
- *Recently, they've [Parent Coaches] been scheduling three to four clients a day and stretching themselves.*

Domain 6: Prenatal Enrollment

Although we were unable to assess whether sites met the fidelity threshold on this domain using quantitative data, staff were asked in the interviews whether there was "anything about your site or organization that has helped you to recruit women prenatally." Responses indicated that relationships with clinics and doctors, keeping track of the number of pregnant moms approached (separately from the SFDB) even if they do not sign up initially, and following up with them later were key to prenatal enrollment. Staff also noted some conflation between marketing and outreach. As a result, staff recommended more-focused training on outreach and a reduced emphasis on fliers and brochures. Some examples are noted here:

- *Strong collaborations with hospital, WIC, [obstetrician] providers, medical groups.*
- *If [obstetricians] are on board and willing to let you set up in their clinics and approach clients, this makes things easier.*
- *If the outreach staff talk to ten women, they write that down and where it happened at. We keep it in binders and add it up at the end of the month. We have a log of referrals and how many calls they are getting, if they enroll. We have a monthly directors meeting for Welcome Baby that I attend and review it as a team. We talk about challenges, trends we are seeing.*
- *There is someone in charge of outreach at LABBN, but the focus is on marketing and not necessarily outreach. There is too much emphasis on fliers and brochures.*

Domain 7: Hospital Enrollment

Fidelity threshold achievement for this domain comprised of two components: (1) 90 percent or more of available families were approached in the hospital to enroll in the Welcome Baby program, and (2) 40 percent or more of the families approached in the hospital were enrolled in the program. Only one site achieved the domain fidelity threshold by meeting both components. However, all sites met the second component. The average rate for sites for the first component was 75 percent of available families approached, with a wide range from 49 to 92 percent; the average rate for the second component was 58 percent enrolled, again with a wide range from 46 to 83 percent (Table 4.7). We note that these data were provided to us by LABBN as numbers of families eligible, approached, and enrolled reported monthly by sites. We calculated an annual rate for the two components for each site.

Table 4.7. Hospital Enrollment (Domain 7) Percentage Approached and Enrolled, by Site

Site	Percentage of Available Families Approached	Percentage of Approached Families Enrolled
1	57	56
2	92	50
3	77	47
4	74	48
5	80	46
6	85	61
7	89	65
8	78	47
9	58	83
10	83	70
11	49	79
12	72	47
Total average	75	58

SOURCE: Site data provided by LABBN from January through December 2017.

Domain 7: Qualitative Findings

Consistent with the quantitative findings, staff reported more challenges in missing some clients at the hospital (the "approach" requirement of this domain) than in enrolling families once approached. Many of the challenges cited were factors beyond the control of the Hospital Liaison, such as staff shortages, length of time in the hospital, and whether the baby is in the NICU:

- *Our Hospital Liaisons can't work at full capacity when we don't have full staff. Now that we're increasing our numbers at bedside, we lost a Hospital Liaison. We're definitely losing moms. I keep telling the Hospital Liaisons to work individually, focus on their goals. Unfortunately, they're going to miss moms and that's OK.*
- *The NICU moms are more difficult—because they cannot access the NICU to talk to the moms and [the moms] tend to spend a lot of time in there.*
- *We keep our vaginal deliveries for 48 hours and our C-sections for 72 hours, so that really helps us get to the moms. At other hospitals, the Hospital Liaisons have one shot. If I go in and the mom is busy with visitors, I can come back the next day. That's helpful.*

Domain 8: Service Dosage

For this domain, the fidelity threshold was based on rates at or above the Welcome Baby-wide average, which was 46 percent of clients achieving minimum dosage (four out of six postpartum visits). The majority of sites (seven of 12) achieved the minimum dosage for less than half of their clients, with the range across all sites 35 to 71 percent (Table 4.8).

Table 4.8. Service Dosage (Domain 8) Fidelity Threshold Achievement Percentage, by Site

Site	Percentage of Clients Completing 4 or More Postpartum Visits
1	35
2	69
3	48
4	51
5	42
6	44
7	71
8	40
9	57
10	41
11	61
12	46
Total Average	46

SOURCE: SFDB data (*n* = 4,928, January 2016–December 2017).

Domain 8: Qualitative Findings

From the perspective of Parent Coaches and Parent Coach Supervisors, the key contributing factors for program attrition were cancellations or no-shows by clients and the gap between the three-to-four-month and nine-month visit:

- *The no-show issue is just inherent in the program. For a lot of people, it's not a priority. They didn't pay for the program and don't have anything invested in the program.*
- *The gap between the three-to-four-month and nine-month visit is also a challenge because it's hard to reconnect with the client after many months. Something that has worked well for me is doing another visit in between, around the sixth month, or inviting the clients to come to Welcome Baby to an event, so that when you call them at the ninth month they still remember who you are. I wish we had a six-month visit and keep it that way. I agree there is a huge gap between the three-to-four-month and ninth-month visits and because of that you may end up losing a client.*

Although the largest drop-off in program participation occurs between the hospital and home visits, we did not find consistent themes addressing this time point.

Domain 9: Timing of Service Delivery

The fidelity threshold was based on rates at or above the Welcome Baby–wide average, which was 84 percent of visits completed on time as reported in SFDB data. Five of 12 sites achieved the domain fidelity threshold for the percentage of all prenatal and postpartum client visits that were completed within a specified time frame based on expected date of birth or hospital discharge (i.e., "completed on time"). All sites had high percentages, ranging from 78 to 90 percent (Table 4.9). We include only completed visits in our fidelity threshold assessments

(i.e., not visits that were recorded as incomplete in SFDB). We exclude three types of visits in our calculations: hospital visits, because they could all be considered on time by the nature of the visit; post-NICU nurse visits, because of limitations with the data to calculate time period correctly; or "other" visit types, because they do not include a specified time period.

Table 4.9. Timing of Service Delivery (Domain 9) Fidelity Threshold Achievement Percentage, by Site

Site	Percentage of Visits Completed on Time
1	83
2	81
3	87
4	82
5	78
6	90
7	85
8	78
9	90
10	86
11	80
12	83
Total average	84

SOURCE: SFDB data (n = 26,028, January 2016–December 2017).

Somewhat more variation existed in on-time rates by visit type, which was assessed for the full sample rather than by site (Table 4.10). The lowest on-time rates were for the postpartum nurse visit (56 percent) and the postpartum two-to-four week visit (78 percent), both of which had the narrowest calculated time periods in which to occur (within seven days or two to four weeks of hospital discharge, respectively, to achieve fidelity threshold). Conversely, the postpartum three-to-four-month visit has the widest calculated time period to be considered on time, from about three to 4.5 months after discharge, and virtually all visits (99 percent) achieved this threshold.

Table 4.10. Timing of Service Delivery (Domain 9) Fidelity Threshold Achievement Percentage, by Visit Type

Visit Type	Percentage of Visits Completed on Time
Prenatal up to 27 weeks	90
Prenatal by 32 weeks	93
Prenatal by 38 weeks	91
Postpartum Nurse	56
Postpartum, 2–4 weeks	78
Postpartum, 2 months	95
Postpartum, 3–4 months	99
Postpartum, 9 months	96
Total	84

SOURCE: SFDB data (n = 26,028, January 2016–December 2017).

Domain 9: Qualitative Findings

Staff indicated that staff shortages and difficulties faced with filling staff positions quickly may have contributed to some challenges in meeting the service delivery timing (see findings under Domains 1, 2, and 5 that offer examples about these points).

Domain 10: Referrals to Community Services

The fidelity threshold was based on rates at or above the Welcome Baby–wide average, which was 25 percent of referrals as reported in SFDB data. We included referrals made at any visit prior to the nine-month visit and considered referrals where active engagement was under way (e.g., an appointment scheduled) as "completed." Seven sites achieved the domain fidelity threshold for the percentage of Welcome Baby staff referrals made for clients that were either completed or under way. We found a wide range of referral completion rates among sites, and all sites had less than 60 percent completed. Only one of the 12 sites had more than half (58 percent) of its client referrals completed, whereas two sites had merely 6 to 7 percent completed (Table 4.11). This analysis was based on a specific window of time, and some referrals (i.e., occurring in October 2017) were observed for only two months to assess completion. Those and other referrals may have been completed after our time period.

Table 4.11. Domain 10 Fidelity Threshold Achievement Percentage, by Site

Site	Percentage of Referrals Completed
1	6
2	46
3	58
4	20
5	26
6	18
7	45
8	12
9	40
10	29
11	32
12	7
Total	25

SOURCE: SFDB data (*n* = 4,387, April–December 2017).

Domain 10: Qualitative Findings

We present findings related to staff reports of the community referral process as part of Evaluation Question 3.

Domain 11: Participant Perception of the Relationship

All sites achieved the domain fidelity threshold, indicating clients' perceptions of the relationship with their Parent Coaches or other home visitor are overwhelmingly positive. We established the fidelity threshold at 85 percent of clients reporting "very often" or "always" for all four measured items of the Working Alliance Inventory's Bond subscale (i.e., reporting a positive relationship) in the Client Survey. The average rate of reported positive relationships was 89 percent across sites, narrowly ranging from 86 to 100 percent. We note that the site achieving 100 percent of the fidelity threshold had a very small survey response rate. We also found little variation in reported positive relationships by visit type, ranging from 87 to 92 percent across the two-to-four-week, two-month, three-to-four-month, or nine-month visits.

Domains 11–14: Qualitative Findings

No specific interview questions related to these fidelity domains were given, and, therefore, there are no relevant findings to report. Of note, the qualitative data from clients regarding the responsiveness of the provider are presented elsewhere (see Evaluation Question 4).

Domain 13: Content of Home Visits

To calculate this measure, we evaluated Parent Coach–reported content covered during the home visits. These self-report data are not subject to external validation. Additional information on how this measure was specified can be found in Appendix C. Most recommended content items from the Welcome Baby Fidelity Framework were captured in the SFDB data, but in a few cases we excluded an item from calculations if we did not have an SFDB data element match. The fidelity threshold was based on rates at or above the Welcome Baby–wide average, which was 87 percent of content covered across all completed visits from 2016 through 2017. Eight of 12 sites achieved the domain fidelity threshold for the percentage of recommended postpartum visit content being covered as reported in SFDB data. All sites had fairly high rates, ranging from 74 to 94 percent. The fidelity threshold was based on the percent of recommended content items covered within postpartum visits, from hospital visit through nine months.

We also found little variation in the achievement of the fidelity threshold by visit type, with the exception of the hospital visit. Whereas 71 percent of recommended content was covered in completed hospital visits, that rate ranged from 91 to 96 percent for all other postpartum visits.

Evaluation Question 3: How Are Sites Maintaining Community Resource and Referral Networks? What, If Any, Gaps Exist in These Networks?

Sites vary widely in the completeness of their referral directories (Figure 4.1). Very few sites have developed their own infrastructure to facilitate successful referrals (e.g., MOUs with service providers, referral forms). The Welcome Baby program provides sites with protocols for five referral types, including domestic violence, early intervention for child developmental delay, postpartum care, maternal depression, and suicide prevention. All five Welcome Baby protocols require monitoring referral completion, four require that Welcome Baby staff help clients gain access to the services, and two emphasize client confidentiality (Table 4.15). Staff across all sites reported referring to a wide range of referral resources, regardless of the infrastructure developed to facilitate successful referrals.

To address this question we conducted a systematic investigation of the referral documentation available for Welcome Baby as a whole as well as at each site, providing insight into the infrastructure supporting effective referrals at the sites. We also examined responses we received from staff during the site interviews to understand the community resources and referral networks staff were using.

Methods

Our approach to assessing Welcome Baby sites' referral systems involved a systematic review of programmatic referral documentation, which was based upon the University of North Carolina's 2013 Referral Systems Assessment and Monitoring Toolkit (Measure Evaluation Center, 2013). By scanning and abstracting relevant program referral-related documents, we

identified gaps in referral networks or procedures that may be preventing the proper implementation or successful completion of referrals.

Using this approach, we requested the following documents from each site's Program Manager:

- a copy of any centrally maintained referral directories providing contact information for community service providers
- copies of any MOUs or MOAs with community service providers
- copies of any referral protocols used by staff at each site
- copies of blank referral forms used to formally connect clients with service providers.

We collected documents related to 28 different referral types, and we categorized referral types as either primary or secondary referral types (Table 4.12). RAND researchers developed a list of referrals by type, where the primary referral types included those categories of need that are given specific emphasis in the Welcome Baby Orientation and Protocol Manual (the Manual) as categories of need that are particularly relevant or important to the program and the Welcome Baby population. Secondary referral types included referrals for services that clients commonly need and/or those that are listed as common referrals in the Manual. After the initial list was developed, it was reviewed and approved by F5LA and LABBN.

Table 4.12. Primary and Secondary Referral Types

Primary Referral Types	Secondary Referral Types
Intimate partner violence	Charitable services (e.g., furniture, clothing, baby supplies)
Early intervention for child developmental delay	Housing
Environmental health	Transportation
Postpartum health care	Child care referral services
Maternal mental health–depression	Child care subsidies
Maternal mental health–other	Dental care (mother)
Suicide prevention	Health insurance (child)
Alcohol use disorder treatment	Health insurance (mother)
Substance use disorder treatment	Primary care provider/medical home (child)
Smoking cessation services	Food bank
Public benefits–general	Lactation support
Public benefits–CalWORKs (TANF, Cash Aid)	
Public benefits–SSDI/Disability	
Public benefits–Supplemental Security Income	
Public benefits–unemployment	
Public Benefits–CalFresh (food stamps)	
Public Benefits–WIC	

NOTE: TANF = Temporary Assistance for Needy Families; SSDI = Social Security Disability Insurance.

We categorized referral types in this way to conduct a more in-depth review of referral systems for "primary" referral categories. We reviewed documents for certain characteristics using a "checklist" tool that allowed us to pinpoint systematic gaps in the referral networks both within and across sites and to identify areas of strength (see Appendix B; Table B.1). Table 4.13 outlines the categories of information gathered from each of these documents, for primary and secondary referral types.

Table 4.13. Categories of Information Gathered for Primary and Secondary Referral Types

Document Type	Primary Referral Types	Secondary Referral Types
Referral directory	Contact information present in a centrally maintained directory for each referral type	Contact information present in a centrally maintained directory for each referral type
	Contact information valid	Contact information valid
	Contact information available in both English and Spanish	Contact information available in both English and Spanish
Referral protocols	Protocol present for each referral type	N/A—did not gather referral protocols for secondary referral types
	Instructions given on the role of home visitor in monitoring referrals (no policy/home visitor expected to monitor/home visitor not expected to monitor)	
	Instructions given on the role of home visitor in making referral (no policy/provide information to the family/help family gain access)	
	Protocols include emphasis on maintaining client confidentiality	
Referral forms	Referral form present for each referral type	N/A—did not gather referral forms for secondary referral types
Formal agreements between site and service providers (MOU/MOA)	MOU present with service provider for each referral type	N/A—did not gather formal agreements for secondary referral types

We summed the different elements of referral support structures for primary referral types only, as described in Table 4.13. We did not gather information on referral support structures for secondary referral types, which were lower-priority referral types as described earlier. The referral support structures score ranged from 0 to 4 and varied by referral category. Table 4.14 outlines the scorecard for the referral support structure score assigned to each site.

Table 4.14. Scorecard for the Referral Support Structure Score

Item	Score
Contact information for given referral type	0 = No, 1 = Yes
Referral protocol for given referral type	0 = No, 1 = Yes
Referral form for given referral type	0 = No, 1 = Yes
Formal agreement with service provider (MOU) for given referral type	0 = No, 1 = Yes

Findings

Referral Contact Information

We examined each site's centralized referral directory for contact information related to identified referral categories (Figure 4.1). Notably, all sites with English contact information also had valid Spanish contact information for that referral type, so we do not examine English and Spanish information separately. Among referral types, maternal mental health and housing were

the referral types most likely to have contact information in referral directories. Less than half of sites had specific smoking cessation resources. Three of 12 sites had referral directories with valid contact information related to all identified referral categories (Figure 4.2). One site did not have a referral directory, while two additional sites had referral directories with less than 50 percent of categories covered. Across the primary referral types, with respect to smoking cessation and SSDI/Supplemental Security Income (SSI) benefits, 50 percent or fewer sites had valid contact information.

Figure 4.1. Percentage of Sites with Valid English and Spanish Contact Information, by Primary/Secondary Referral Type

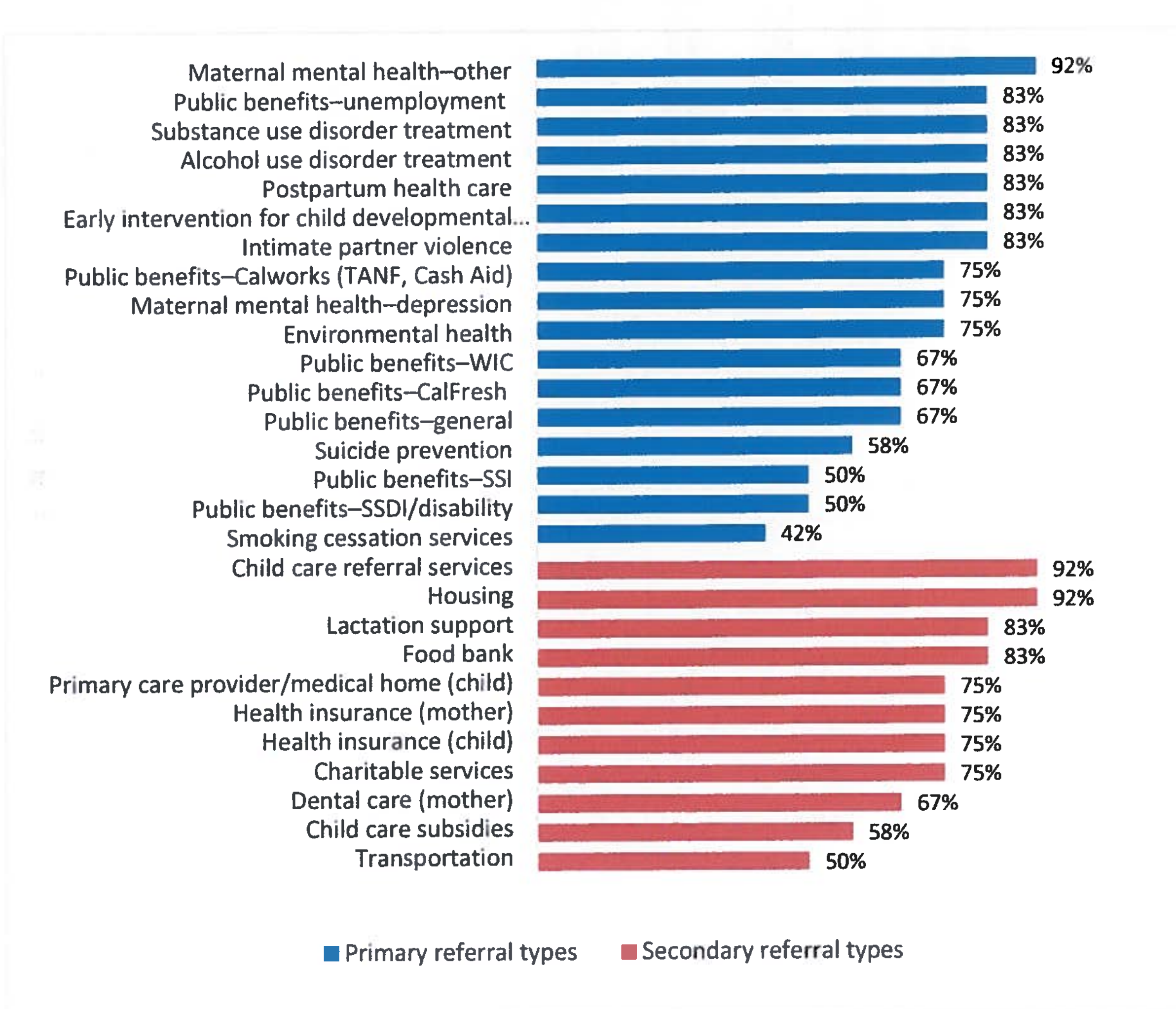


Figure 4.2. Percentage of Primary and Secondary Referral Types for Which Each Site Has Valid Contact Information

Referral Protocols

We reviewed referral protocols, where present, from both the Welcome Baby manual and any referral protocols developed by sites. We defined a referral protocol as a written instruction describing, at a minimum, under which circumstances a referral to a service provider should be made and specifying to which service provider the referral should be made (World Health Organization [WHO], 2018).

We found that the Welcome Baby manual had formal referral protocols for five of the 17 primary referral categories, and no sites had developed additional referral protocols for other referral categories. Thus, 12 of the primary referral categories did not have any formal referral protocols. The five categories that had associated protocols include

- domestic violence
- early intervention for child developmental delay
- postpartum care
- maternal depression
- suicide prevention.

We examined the five protocols for the following:

- **Client confidentiality**: Protocols including assurances that no information will be provided about a client to any person (e.g., family, police, medical personnel) without the client's prior verbal and informed consent, with the exception of when careful

consideration indicates the presence of a clear and present danger to an individual or to others (Alliance of Information and Referral Systems, 2017).

- **Role of home visitor in making referral**: Does the protocol require staff to assist the client in contacting the service provider?
- **Role of home visitor in following through on referral**: Does the protocol require home visitors to monitor referral completion?

As illustrated in Table 4.15, all Welcome Baby Manual protocols required the home visitors to monitor referral completion, but only two emphasized confidentiality (Table 4.15).

Table 4.15. Features of Welcome Baby Referral Protocols

Referral Type	Does the Protocol Require Home Visitors to Monitor Referral Completion?	Does the Protocol Require Staff to Assist Client in Contacting Service Provider (i.e., "Warm Hand-Off")	Does the Protocol Emphasize Client Confidentiality?
Intimate partner violence	X		
Early intervention for child developmental delay	X	X	X
Postpartum care	X	X	
Maternal depression	X	X	
Suicide prevention	X	X	X

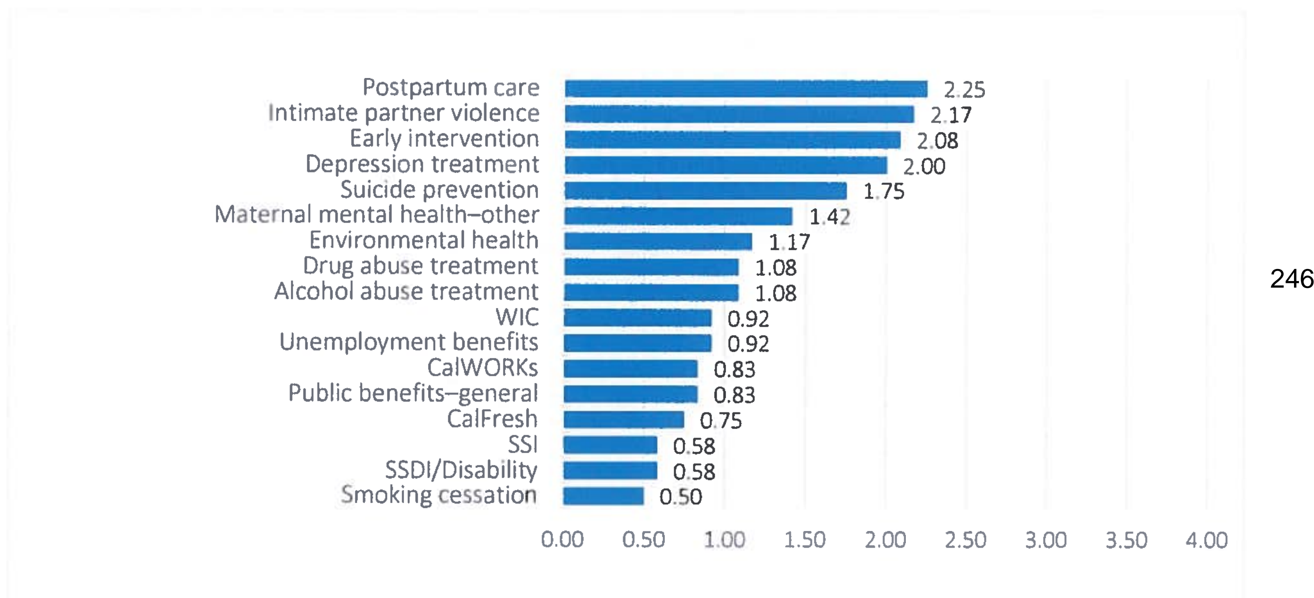
Referral Forms and Memoranda of Understanding

Five of 12 sites had developed referral forms for connecting clients to services in one or more referral areas, most commonly to health services providers. One site had implemented the use of referral forms for every referral area. Four of the twelve sites had established formal agreements (MOUs or MOAs) with service providers in one or more referral areas. Note that in the federal "MIHOPE" study of Maternal, Infant, and Early Childhood Home Visiting–funded home visiting programs, about two-thirds of sites had formal referral agreements with organizations in their communities (Michalopoulos et al., 2015).

Referral Support Structures Score

The average "referral support structures" score across sites for each referral type is illustrated in Figure 4.3. Postpartum care, intimate partner violence, and early intervention were the most well-supported referral types.

Figure 4.3. Average Score Across Sites, by Referral Type



Referral Needs

Staff identified client referral needs and described the community referral process during site interviews. Overall, staff from all sites mentioned referring clients for basic needs other than food (such as cribs, strollers, clothing); mental health care, including help with postpartum depression; public benefit resources such as WIC, CalFresh, CalWorks or other employment opportunities; Medi-Cal/health insurance; and primary care resources (Table 4.16). Other common referrals were to 211, housing resources, childcare, after-school care, dental services, domestic violence resources, and legal resources (including help with immigration issues). Staff reported fewer referrals for education and substance use (alcohol and drug) treatment resources.

Staff also noted when referrals were not made because there were no resources in the community to refer families. The most common responses were the lack of mental health care resources, especially for clients with Medi-Cal or with no insurance, and limited housing service supports. Staff from several sites also mentioned that their community lacked affordable childcare resources, help with immigration issues, and breastfeeding support groups. Staff at many sites also mentioned that a lack of transportation limited their clients' ability to access resources.

Table 4.16. Commonly Reported Community Resources, by Site Staff

Site #	Charitable Services	Mental Health	Public Benefits	Medi-Cal, Health Insurance	Primary Care	211	Housing	Childcare	Dental	Domestic Violence	Legal	Education or Parenting Classes	Alcohol or Substance Use
1	1	1	1	1	1	1	1	1	1	1	1	1	0
2	1	1	1	1	1	1	1	0	0	1	0	1	1
3	1	1	1	1	1	1	1	1	1	1	1	0	0
4	1	1	1	1	1	1	1	0	0	0	1	0	0
5	1	1	1	1	1	1	1	1	1	1	1	1	0
6	1	1	1	1	1	1	1	1	1	0	0	0	0
7	1	1	1	1	1	0	0	0	1	1	1	1	0
8	1	1	1	1	1	1	1	1	1	1	1	1	1
9	1	1	1	1	1	1	1	1	1	1	1	1	1
10	1	1	1	1	1	1	1	1	1	1	1	1	1
11	1	1	1	1	1	1	1	1	0	1	1	1	0
12	1	1	.1	1	1	1	1	1	1	0	0	0	0
Total	12	12	12	12	12	11	11	9	9	9	9	8	4

Evaluation Question 4: What Are Participant Perceptions of and Experiences with the Program and Welcome Baby Service Providers?

There was general agreement among program participants that the Welcome Baby program met their needs and helped them connect with services. Program participants indicated that they would participate in the program again if seeking parenting help in the future, and they rated their relationships with the Parent Coaches extremely positively. Clients noted that the program enrollment process was easy, and they appreciated most the assistance with breastfeeding. Overall, Welcome Baby staff were perceived as responsive to their needs, easy to communicate with, accessible, and flexible. Clients identified a few areas for improvement, such as offering more visits and providing program materials in nonpaper formats.

To address this evaluation question, we used both quantitative and qualitative data collected from program participants.

Methods

As described in more detail elsewhere (see Data Sources section and Appendix B), Parent Coaches invited their clients to complete a Client Survey at the home visits using a tablet. We computed descriptive statistics on responses to individual items and scales.

To obtain qualitative feedback, we conducted 20 focus groups (in Spanish and English) that included 140 participants across the 12 sites. Similar to the site interviews, field notes taken during the focus groups were reviewed against the digital recording for accuracy and then uploaded for qualitative data analysis. All notes were stripped of identifying information, except for Site Code and language spoken in the group, before data analysis. All notes were read into the qualitative software program (MaxQDA) for data management and coding. The notes were then organized by the topic areas covered in the focus group protocol, including responses to the questions about the enrollment process, most and least helpful program aspects, favorite visit, communication, challenges and difficulties, and areas for improvement. Data were then reviewed independently by research staff using a constant comparative process (Glaser and Strauss, 1967). The notes were further coded by theme by identifying at least three excerpts that illustrated the theme and creating a code that applied to each of the areas of the topic. For example, participants at multiple sites described the enrollment process as "easy," so one of the themes regarding enrollment was "ease." Some segments were double-coded, meaning they could be categorized into more than one theme.

Following an initial round of coding, consensus meetings were conducted (including one of the principal investigators and research staff that were involved in the interviews and focus group data collection and analyses) to develop a codebook that described each theme identified in the notes. Codebook development activities included defining each theme, inclusion and exclusion criteria for sorting coded segments into theme(s), and some typical examples, along with removing and collapsing redundant codes and repositioning others as necessary. We used the codebook to review and systematically code all the focus group notes, including those that had

been previously coded during codebook development. We did not measure intercoder consistency; instead, one of the project leaders randomly selected a subset of coded segments that had been coded by more than one member of the research staff and reviewed to ensure that there was consistency in coding during the initial round of coding. The few inconsistencies found were discussed and final determination made by consensus. All the excerpts presented in the results section have been reviewed for consistency with the theme by more than one member of the research team.

Client Survey Findings

From the client survey, program participants generally had positive perceptions of the Welcome Baby program and their relationship with their Parent Coach (see Table 4.17). Perceptions were also consistent across sites and time (i.e., from the two-to-four-week visit to the nine-month visit). The size of the sample across some of the sites precluded us from running statistical tests, but the observed average values and standard deviations showed consistently positive scores with low variability across the sites. We do not have data on refusal rates.

Table 4.17. Participant Perceptions as Assessed in the Client Survey

Scale	Question	Response Options	Mean	Std Dev
CSQ-3	How much has Welcome Baby met your needs? (scale 1–4)	4 = almost all of my needs have been met 3 = most of my needs have been met 2 = only a few of my needs have been met 1 = none of my needs have been met	3.73	0.48
F5LA-derived	Has Welcome Baby helped you to connect with services that you needed, or helped you to meet any needs that you or your baby had? (scale 1–5)	5 = yes, multiple times 4 = yes, two or three times 3 = yes, once 2 = no, they never did 1 = I have not needed any	4.63	0.94
CSQ-3	Generally, how satisfied are you with the service you have received? (scale 1–4)	4 = very satisfied 3 = mostly satisfied 2 = indifferent or mildly dissatisfied 1 = quite dissatisfied	3.95	0.25
CSQ-3	If you were to seek parenting help again, would you participate in Welcome Baby? (scale 1–4)	4 = yes, definitely 3 = yes, generally 2 = no, not really 1 = no, definitely not	3.89	0.34
WAI-BOND	I believe my Parent Coach likes me. (scale 1–5)	5 = always 4 = very often 3 = fairly often 2 = sometimes 1 = seldom	4.84	0.49

Scale	Question	Response Options	Mean	Std Dev
WAI-BOND	My Parent Coach and I respect each other. (scale 1–5)	5 = always 4 = very often 3 = fairly often 2 = sometimes 1 = seldom	4.95	0.27
WAI-BOND	I feel that my Parent Coach appreciates me. (scale 1–5)	5 = always 4 = very often 3 = fairly often 2 = sometimes 1 = seldom	4.87	0.44
WAI-BOND	I feel that my Parent Coach cares about me even if I do things that he/she does not approve of. (scale 1–5)	5 = always 4 = very often 3 = fairly often 2 = sometimes 1 = seldom	4.70	0.74

SOURCE: Client Survey (*n* = 1,780).
NOTES: CSQ = Client Satisfaction Questionnaire; WAI-BOND = Working Alliance Inventory–Bonding subscale; Std Dev = standard deviation.

Client Focus Group Findings

In the focus groups participants also shared an almost exclusively positive perception of the program and home visiting staff with no differences between responses in groups conducted in English, Spanish, or bilingual settings. Below, we highlight some of the perspectives of program participants on different aspects of the Welcome Baby program.

Welcome Baby Enrollment

Overall, participants found that the enrollment process was easy and did not require much effort or time. Examples from the focus group notes include:

- *Very brief. Sometimes we want to register for a program and it requires a lot of information. Here with Welcome Baby it was fast and did not take much time.*
- *It was pretty fun, she explained a lot of cool things about the program.*
- *It was a good experience, the lady who enrolled me was really nice, and she was just giving me a bunch of tips and stuff.*
- *I like the fact that she came to me, I didn't have to find out about it, she literally came into my room, after my son was born, the next day, and sat down and explained the whole program for me. That's what I liked.*
- *The staff member from Welcome Baby was very kind. She filled out the forms and called me back afterwards.*

In addition, clients did not report any challenges with the Welcome Baby program consent and data authorization process.

Welcome Baby Visits

Participants shared perspectives on the visit topics, frequency of visits, and favorite visits. In terms of the most useful aspects or topics covered in the Welcome Baby program, participants most often mentioned the assistance and information with respect to breastfeeding/lactation, postpartum depression, and nutrition. Examples from the focus group notes include:

- *The information on lactation was helpful because I was feeling stressed out by not producing enough milk. She [nurse/Parent Coach] helped me identify healthy food I could eat. I was able to breastfeed for nine months thanks to Welcome Baby.*
- *Welcome Baby staff explained breastfeeding step by step and provided various pamphlets, a Boppy (pillow), and a book.*
- *For me it was postpartum depression. At first, I was sad, then my mom helped me, then my husband started getting depressed too, so I got ideas on what to do [from the Parent Coach].*
- *I was not doing well the day in which the nurse visited me at home. I was crying because I had postpartum depression and the nurse helped me and gave me advice. She mentioned I should go out more often and get involved in more activities [besides being with the baby all the time]. It helped me a lot.*
- *Nutrition, because my baby, he's been growing fast the whole pregnancy, so the things to eat were helping.*

In general, participants thought that the content of the home visits was very good. However, some program participants expressed that improvements could be made in how the content was delivered. For example, reading the Welcome Baby Book presented challenges. One respondent thought that the Parent Coach may want to provide more guidance during the visit on how to use it, suggesting "bringing up the book more" at visits because "it's hard [for moms] to find time to read." Others thought that the Welcome Baby content could be delivered in a different format:

- *I know they bring a lot of information on paper, so I was wondering if we could just see the information online. Because I get confused with so many papers, and I prefer a site where I can just look at and type a question—it would be much easier.*
- *I would like to get the information in a way that has more visuals. The book that we get has too much information [that is difficult to digest].*

Another commonly expressed program improvement recommendation was to add more visits. There was some variation in responses to when those visits should occur; some suggested early in the postpartum period, whereas others wanted the program to last longer (up to one or two years). Some clients thought the visit itself was too short.

- *There should be another visit somewhere in between the first and second one because that would ease our nerves.*
- *Adding a six-month visit would be good. Teething is the hardest part to handle with a baby. There are many developmental changes between the fourth and ninth months, and we would like some guidance.*
- *They should expand the program a little bit longer. It is too short.*
- *Yes, I believe the time in the program together is too short. We want to chat with them longer, but they have to go with another person. I would like the program to be longer.*

Finally, some participants mentioned the need to incorporate opportunities to interact with other mothers as a way to improve the program.

There were differences of opinion expressed about which visit was the favorite. In some cases, participants thought all of the visits were good and did not have a preference:

- *The first visit was my favorite—nurse visit—because the baby got a similar check-up to what she usually gets at the pediatrician.*
- *I think the initial visits were the most important to me because I am also a first-time parent and it was great to get reassurance from her.*
- *I think the one that helped me the most was the last [visit]. My son wasn't developing movement and I took the walker away from him so that he could learn on his own thanks to the home visitor.*
- *Every single one was special because every time it was different.*

Provider Responsiveness

Across sites, program participants acknowledged the family-centered focus and responsiveness of the Parent Coaches and RNs during home visits. The flexibility and accessibility of Welcome Baby staff (Parent Coaches, in particular) and the information parents received was perceived as helpful:

- *They are very flexible . . . people working in the program are perfect for it because they show a lot of concern and they really like the program.*
- *If I need something, I call my Parent Coach and she provides advice and when I need her she's always there. . . . I always receive information I need.*
- *She was very accessible. I think that one of the things I really struggled with was to adapt myself because the pregnancy was different and she explained it to me. . . . I liked the fact that she was always there, when I called her or sent her a text she was always there, supporting me and guiding me with information.*

Program participants also felt that Parent Coaches gave them the confidence they needed, often assured them that they were doing a good job, and cared not only about the baby but also about them (as moms) and about their other children:

- *I even think of them like they are my family. I don't want them to leave. I would like to have more time with them . . . and they have that availability for 24 hours. She gave me a lot of encouragement. When she was there, I felt alive again.*
- *It feels like a friendship. Every single one was special because every time it was different. And it was focused on your needs whatever it was going on, and [they] want to hear how you are doing. That's what I enjoyed—the focus that they gave us as individuals.*
- *I was feeling I was going crazy with my two young girls; the Parent Coach gave me advice on how to treat the middle child in order to make her feel included.*
- *She [the Parent Coach] gave me confidence to raise my child. She listens to everything good, bad. . . . [W]e have a lot of discussion about child development. She told me to stop being nervous about my first baby.*
- *The Parent Coach worries about the kids, but also about me. Sometimes we need to chat with someone and they are there to listen to us. It is very difficult for us because we have a second baby, and other times it is our first baby, Parent Coaches are there just in the*

right moment to tell us that we are doing a good job. She confirms I am not doing a bad job.

Program Challenges and Difficulties

There were few program challenges or difficulties noted by program participants during the focus groups. Some participants noted that they were transferred from one Parent Coach to another during the program and although they thought it would be hard, they felt that their newly assigned coach was fine. Participants also understood that the program was not available to everyone and thought that expanding the program to remove geographical barriers to program participation would be helpful so that others could benefit from the program.

Evaluation Question 5: What Factors Contribute to Participants Leaving the Program Early?

Family characteristics associated with being at risk of poor outcomes were often associated with a greater likelihood of transitioning from the hospital to RN visit, but a lower likelihood of staying in the program for later visits. For the two-to-four-week visit and later visits, adherence to Welcome Baby client-level fidelity standards was related to lower rates of participants leaving the program.

We used data from the SFDB, Client Survey, and Staff Survey to identify factors that predicted whether a client who got a visit left the program without continuing to the next visit. Specifically, given that a client had a visit, we estimated a logit model that examined which client or visit characteristics were associated with continuing to the next visit.

Methods

The dependent variable in the model was the visit. The visits considered were

- the RN visit
- the two-to-four-week visit
- the two-month visit
- the three-to-four-month visit
- the nine-month visit.

For the independent variables, we selected variables that might predict continuing in the program or dropping out based on characteristics associated with attrition in the home visiting literature (Alonso-Marsden et al., 2013; Daro, Boller, and Hart, 2014; Daro et al., 2012; Daro et al., 2003; Holland et al., 2014; Ingoldsby et al., 2013; Lanier, Maguire-Jack, and Welch, 2015; McCurdy and Daro, 2001; McFarlane et al., 2010; McGuigan, Katzev, and Pratt, 2003) and research on access and retention in ongoing health treatment services (Andersen and Newman, 1973; Andersen, 1995; Gelberg, Andersen, and Leake, 2000; Ober et al., 2018). The variables fell into three categories:

- time-invariant predisposing variables, which were primarily demographic variables

- time-varying variables related to the client, and these variables were generally observed at the last completed visit (whether the mother worked, for example)
- time-varying variables that depict whether the previous visit met Welcome Baby fidelity criteria, such as whether the Parent Coach had completed training.

The complete set of variables is listed in Tables 4.18 and 4.19. Some variables were not measured at each visit (such as mother's work status) but were included for the visits in which they were measured. More specifically, we included the following client-level fidelity variables for each visit: staff qualifications, staff training, reflective supervision, home visitor workloads, participant perception of the relationship, and percentage of content covered.

Our estimates take into account the fact that the families are clustered within Parent Coach and site, and that the families served by the same home visitor or the same site cannot be counted as independent observations (Laird and Ware, 1982; Moulton, 1990). This type of clustering implies that the effective sample size for this analysis is smaller than the number of families in the data (Guo and Zhao, 2000). We implement clustering by site and home visitor using the melogit command in STATA (StataCorp, 2017).

Some of the family characteristics are correlated, and given that we are interested in helping Welcome Baby pinpoint the characteristics associated with leaving the program, we estimated separate logit models for each family characteristic one at a time, including time-invariant and time-varying family characteristics. For the fidelity component variables, we estimated a model for each fidelity variable separately, and we included family characteristics in order to account for the fact that sites serve very different types of families. The fidelity variable was measured at the previous visit—for example, staff qualifications at the hospital visit for the "hospital to RN" transition analysis. Not accounting for these differences may bias the estimates of the relationship between measures of fidelity and attrition.

We estimated the factors that are associated with retention for five different visits, and we considered many variables, resulting in more than 100 estimates. As is typical in the evaluation literature, we designated a p-value of 0.05 to designate statistically significant estimates. However, when a large number of statistical estimates are generated, it is possible that some p-values will have values less than 0.05 by chance, even though none of the estimates is different from zero (McDonald, 2014). In order to control for the possibility of false positives, we use the Benjamini-Hochberg procedure to adjust the p-value to reduce the chance of false positives due to the large number of estimates using a false discovery rate of 0.10, which is considered appropriate for the type of nonexperimental analysis undertaken in this evaluation (McDonald, 2014). This adjustment reduces the number of statistically significant estimates by only one in this analysis.

Results

We present findings for the relationship between family characteristics and program retention in Table 4.18 and for the relationship between fidelity measure variables measured at the previous visit and program retention in Table 4.19. In both tables, the first column lists the

variables, and the subsequent columns indicate the visit transition for which the model was estimated. Each cell represents an estimate from one model. Entries in bold and shaded cells are significant after making the adjustment as just discussed. Cells with green shading show which variables raise the likelihood that families get the next visit, and cells with red shading show which variables lower the likelihood that families get that visit. Cells with no shading indicate that no statistically significant relationship between the characteristic and the likelihood of the next visit was found. The values can be interpreted as the change in the log odds that the client makes the transition to the visit given a one-unit change in the characteristic noted in the first column. For example, in Table 4.18, being low-income is associated with a 0.24 decrease in the log odds of getting the two-to-four-week visit (coefficient estimate is significant and –0.24). In this model, negative values indicate that the characteristic is associated with a lower probability of getting the visit, while positive values indicate that the characteristic is associated with a higher probability of getting the visit. Larger values indicate stronger associations, and smaller values indicate weaker associations.

Relationship Between Family Characteristics and Program Retention

We examined demographic/family, birth, and visit characteristics to better understand program retention. Across all visits, receiving prenatal services was the only characteristic associated with the client receiving all subsequent visit types.

Some of the demographic or family characteristics indicating that the family may be at risk of poor outcomes (i.e., race, mother's age, risk score) were also associated with successfully transitioning from the hospital to RN visit (Table 4.18). However, among those who stayed for the RN visit, several of these same characteristics were also associated with leaving the program before later visits (i.e., mother's age, risk score). Both of these raised the likelihood of getting the RN visit but reduced the likelihood for receiving the later visits.

Certain characteristics related to the birth, such low birth weight, birth complications, and first births, that may indicate a greater need for information made it more likely that the family had the RN visit. Yet these same characteristics were generally unrelated to staying in the program for later visits.

Among the visit characteristics, families that used public benefits were more likely to continue in later visits, perhaps as a result of being more likely to participate in public programs or because Welcome Baby connected them to services for which they were eligible. The number of referrals made was also associated with staying in the program for three of the visit time points, which could reflect that higher-need families derive more value from Welcome Baby or that families that experience a greater level of Parent Coach proficiency are more likely to stay in the program.

Table 4.18. Summary of Findings on Which Family and Previous Visit Characteristics Are Associated with Client Retention, by Visit Transition

	Visit Transition				
Variable	Hospital to RN Visit	RN to Two-to-Four-Week Visit	Two-to-Four-Week to Two-Month Visit	Two-Month to Three-to-Four-Month Visit	Three-to-Four Month- to Nine-Month Visit
Family Characteristic					
Low income	**–0.04**	**–0.24**	**–0.32**	**–0.18**	0.76
Some English	–0.37	0.67	0.63	0.66	0.28
No English	–0.30	**0.40**	**0.53**	**0.48**	0.17
Mother black (Hispanic omit)	**0.38**	0.12	–0.15	**–0.46**	**–0.30**
Mother white	**–0.29**	–0.15	0.02	–0.13	–0.02
Mother other race/ethnicity	**0.40**	–0.03	0.27	0.16	0.00
High school education	0.01	–0.14	–0.07	0.00	0.05
More than high school	–0.16	0.08	0.40	0.11	**–0.26**
BRIDGES score 33–42 (less than 33 omitted)	0.04	–0.07	0.03	0.11	0.01
BRIDGES score 43–51	**0.18**	0.01	0.02	–0.13	–0.07
BRIDGES score over 51	**0.34**	–0.34	–0.01	–0.30	–0.20
Received prenatal services Welcome Baby	1.69	0.80	0.90	**0.30**	**0.21**
Mother age <19	**0.37**	–0.52	–0.40	–1.73	–0.05
Age 19–24 (age 25–34 omitted)	**0.12**	–0.40	–0.31	**–0.17**	**–0.17**
Age >34	–0.02	0.00	**0.26**	0.13	0.19
First birth	**0.11**	–0.10	–0.01	–0.09	–0.08
Low-birthweight child	**0.28**	0.26	–0.22	–0.21	–0.26
Birth complications	**0.26**	0.15	**0.19**	–0.19	–0.19
Previous Visit Variables					
Worked full time	0.08	N/A	N/A	–0.17	N/A
Worked part time	–0.11	N/A	N/A	–0.07	N/A
Used public benefits the previous visit	0.06	N/A	3.34	2.23	1.96

Variable	Hospital to RN Visit	RN to Two-to-Four-Week Visit	Two-to-Four-Week to Two-Month Visit	Two-Month to Three-to-Four-Month Visit	Three-to-Four Month- to Nine-Month Visit
	Visit Transition				
Previous visit addressed crisis needs	**0.18**	–0.32	**–0.42**	0.59	–0.23
Number of referrals made at previous visit	N/A	**3.42**	**3.33**	**1.50**	–0.03

NOTE: Entries are coefficient estimates in a logistic regression. Entries in bold and shaded cells are significant at the 0.05 level. The green shading indicates positive values, and the red shading indicates negative values. Darker shading indicates larger values. Further details of these estimates are in Appendix E, Table E.1.

Relationship Between Client-Level Fidelity Components and Program Retention

We also examined the relationship between client-level fidelity variables for each visit (i.e., staff qualifications, staff training, reflective supervision, home visitor workloads, participant perception of the relationship, and percentage of content covered) and program retention. Overall, adhering to Welcome Baby client-level fidelity components raised the likelihood that families stayed in the program at visits for at least one visit, starting at the two-month visit or later (Table 4.19). For example, the home visit provider (either RN or Parent Coach) meeting the minimum training standard and the Parent Coach meeting the caseload standards were both related to families staying in for one of the later three visits. Further, the provider meeting minimum qualifications was related to families staying in for two of the later three visits. The analysis also showed a small positive relationship between covering more of the Welcome Baby content in a visit and the chance of the family staying in the program for two of the later three visits. However, meeting the reflective supervision requirements was associated with lower rates of continuation from the hospital to RN visit, and the RN to the two-week visit, but higher rates of continuation to the three-to-four-month and nine-month visits. This pattern may be consistent with reports in the staff interviews that reflective supervision was viewed as being most helpful for the Parent Coach position. Complete results from the analysis of fidelity components and visit transitions are presented in Appendix E.

Table 4.19. Summary of Findings on Which Welcome Baby Fidelity Components Are Associated with Client Retention, by Visit Transition

	Visit Transition				
Fidelity Component	Hospital to RN Visit	RN to Two-to-Four-Week Visit	Two-to-Four-Week to Two-Month Visit	Two-Month to Three-to-Four-Month Visit	Three-to-Four-Month to Nine-Month Visit
D1. Provider met minimum qualifications	0.42	–1.85	**0.42**	**0.39**	–0.10
D2. Provider met minimum training standard	–0.51	**2.54**	0.01	**0.55**	**0.61**
D4.Staff met reflective supervision requirement	**–0.55**	**–0.32**	0.17	**0.56**	**0.50**
D5. Parent Coach does not exceed caseload standard	N/A	0.00	0.18	**0.54**	–0.01
D13. Percentage of content covered in previous visit	–0.02	0.10	**0.26**	0.11	**0.12**

NOTE: Entries in bold and shaded cells are significant at the 0.05 level. The green shading indicates positive values, and the red shading indicates negative values. Darker shading indicates larger values. Each cell represents results from a transition model that controls for the family characteristics listed in Table 4.18 in addition to the fidelity component listed in the first column. Appendix E, Table E.1 reports additional details for these estimates.

Evaluation Question 6: To What Extent Do Participants Achieve Short- and Intermediate-Term Outcomes?

Where regional or national benchmarks are available, Welcome Baby participants exhibited better outcomes in more than half of the areas measured, including more positive parenting practices, higher levels of any breastfeeding, and safer sleep environments than benchmarks. Welcome Baby participants exhibited lower levels of family planning use and exclusive breastfeeding compared to benchmarks.

Methods

To address this evaluation question, we identified outcomes of interest based upon outcomes identified in the Welcome Baby logic model (see Figure 1.1) and used cross-sectional data from the Client Survey and the SFDB to measure outcomes for participants and their children. Categories of outcomes identified in the Welcome Baby logic model included

- parent knowledge
- positive parenting practices
- maternal health (depression, family planning)
- child health inputs (breastfeeding, child health insurance status, well-baby visits, timely immunizations
- child development
- child safety.

Table 4.20 shows the specific outcome measures we examined and their associated data source under each of these categories. (Appendix D provides further detail on how the analytical file was created and how each specific outcomes measure was specified.) We examined the client-level outcomes in five categories: parenting outcomes, maternal health, child health inputs, child safety, and child development. We present outcome measures by category, summarizing outcomes by visit and, in cases where we have a sufficient number of observations, by site. Where possible, we have provided local, regional, or national findings from data on a similar measure to provide the reader with insight into how Welcome Baby clients fare relative to these external benchmarks. While we do not have the data to assess the degree to which the samples in these other data sets are comparable to the Welcome Baby sample, they use similar age groups and measures, providing some context for the Welcome Baby outcomes.

Table 4.20. Outcome Measures and Data Source

Outcome Category	Outcome	Outcome Measure	Data Source
Parenting	Positive parenting practices	Percentage of clients who passed all five or four of five HOME items at a given visit	Client Survey
	Parent knowledge of infant development	Percentage of correct responses on parent knowledge questions	Client Survey
Maternal health	Depression	Percentage of clients with a PHQ-9 score of five or greater* at a given visit	SFDB
	Family planning	Percentage of clients at a given visit using some form of contraception	SFDB
Child health inputs	Breastfeeding	Percentage of clients at a given visit breastfeeding; percentage of clients exclusively breastfeeding at a given visit	SFDB
	Child health insurance status	Percentage of clients who report that their children are enrolled in health insurance at a given visit	SFDB
	Well-baby visits	Percentage of clients up to date on well-baby visits at a given visit	SFDB
	Timely immunizations	Percentage of clients up to date on immunizations at a given visit	SFDB
Child development	Child development	Percentage of children who passed all five ASQ-3 domains at a given visit	SFDB
Child safety	Home environment	Percentage of clients for whom no home safety issues were identified in a given visit	SFDB
	Infant sleep environment—back to sleep	Percentage of clients who report putting their infant on their back to sleep at a given visit	SFDB
	Infant sleep environment—bed sharing	Percentage of clients who report never bed-sharing with their infant at a given visit	SFDB

Parenting Outcomes

We evaluated parenting outcomes (i.e., parenting practices, parenting knowledge) using results from the Client Survey (see Chapter 3 and Appendix B for more details).

Parenting practices were measured using five of the client-reported items drawn from the HOME inventory (Caldwell and Bradley, 1984); note that the full HOME inventory is a combination of observer ratings and mother-reported items. The five client-reported HOME items included in the Client Survey are shown in Table 4.21.

When looking at parenting practices for Welcome Baby overall, the percentage of clients passing four or five of the HOME items increased over time (Figure 4.4); fewer than one-fifth of clients passed all five items at the two-to-four-week visit, but nearly one-half passed all five items at the nine-month visit.

Table 4.21. HOME Items in the Client Survey

HOME Item	Response Options	"Pass" on This Item
About how often does your child have a chance to get out of the house?	5 = every day 4 = 4 or more times a week 3 = a few times a week 2 = about once a week 1 = a few times a month or less	Child gets out of the house at least 4 times per week
About how many children's books does your child have?	4 = 10 or more books 3 = 3 to 9 books 2 = 1 or 2 books 1 = none	Child has three or more children's books
How often do you get a chance to read stories to your child?	1 = never 2 = several times a year 3 = several times a month 4 = once a week 5 = about 3 times a week 6 = every day	Parent reads stories to child at least three times a week
Some parents spend time teaching their children new skills while other parents believe children learn best on their own. Which of the following most closely describes your attitude?	1 = parents should always spend time teaching their children 2 = parents should usually spend time teaching their children 3 = parents should usually allow their children to learn on their own 4 = parents should always allow their children to learn on their own	Parents should always or usually spend time teaching their children
Children seem to demand attention when their parents are busy around the house. How often do you talk to your child while you are working?	1 = always (talk to your child when working) 2 = often (talk to your child when working) 3 = sometimes (talk to your child when working) 4 = rarely (talk to your child when working) 5 = never (talk to your child when working)	Parents always or often talk to their child while working

Figure 4.4. HOME Pass Rates, by Visit Type

100%
80%
60%
40%
20%
0%

52%
19%
66%
30%
71%
37%
78%
46%

2-to-4-week visit
2-month visit
3-to-4-month visit
9-month visit

Passed 4 of 5 items
Passed 5 of 5 items

SOURCE: Client Survey; *n* = 1,780, September 2016–September 2017.

These findings are consistent with national findings on the HOME from the National Longitudinal Survey of Youth 1979 (NLSY79), a nationally representative sample of individuals who were between the ages of 14 and 22 years old in 1979 (Bureau of Labor Statistics, 2017). The 19th administration of the NLSY79 included the same HOME items for individuals in the NLSY79 with a child under the age of two (we were unable to provide a closer age approximation with the public data files). In this national sample, 44 percent of parents passed all five HOME items, and 74 percent passed four of five HOME items (Figure 4.5). The nine-month Welcome Baby pass rates for the HOME measure exceeded these benchmarks.

Figure 4.5. Welcome Baby HOME Pass Rates Compared to NLSY79

SOURCES: Client Survey for Welcome Baby (*n* = 399, September 2016–September 2017); Bureau of Labor Statistics for NLSY79 data (*n* = 325).

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Parenting knowledge of child development was measured using a modified version of the KIDI (MacPhee, 1981). Several items on the KIDI were modified, and many items were removed entirely from the survey at the request of F5LA, such that the full KIDI scale was not kept intact. The full list of the 15 items analyzed for this outcome domain, and whether/how they were modified from the original KIDI items, is included in Table 4.22.

Table 4.22. Parent Knowledge Items in the Client Survey

Survey Item	Modified from Original KIDI Item?
A baby needs to be seen by a doctor every few months in the first year of life.	No
Babies understand only words they can say.	Yes ("infants" changed to "babies")
The baby should not be held when he (she) is fed because this will make the baby want to be held all of the time.	No
You must stay in the bathroom when your baby is in the tub.	No
Talking to the baby about things he (she) is doing helps the baby's development and later competence.	No
A baby should get its first shots (immunizations) before three months of age.	Yes (modified from "Shots [immunizations] can wait until one year old because babies have natural protection from illness for the first year")
A baby with colic can cry for 20 or 30 minutes at a time, no matter how much you try to comfort him (her).	No
Fathers are naturally clumsy when it comes to taking care of babies.	No
Taking care of a baby can leave the parent feeling tired, frustrated or overwhelmed.	No
Babies should not be put in a crib with a soft pillow.	Yes (modified from "Putting a soft pillow in the crib is a good, safe way to help the baby sleep better")
New foods should be given to the infant one at a time, with 4–5 days between each one.	No
The more you comfort your crying baby by holding and talking to him (her), the more you spoil him (her).	No
Baby girls are fragile and sick more often, so they need to be treated more carefully than boys.	No
Babies do not need to be punished.	Modified from "A good way to teach your child not to hit is to hit back."
Babies do some things just to make trouble for the parent (like crying a long time or dirtying their diaper).	No

For parenting knowledge, on average Welcome Baby clients responded correctly to about 80 percent of the knowledge question across the different visit types (Figure 4.6). Because the KIDI items were modified and/or scales were not kept intact, there are not national benchmarks for this measure of parenting knowledge.

Figure 4.6. Average Percentage Correct on Parenting Knowledge of Child Development Questions

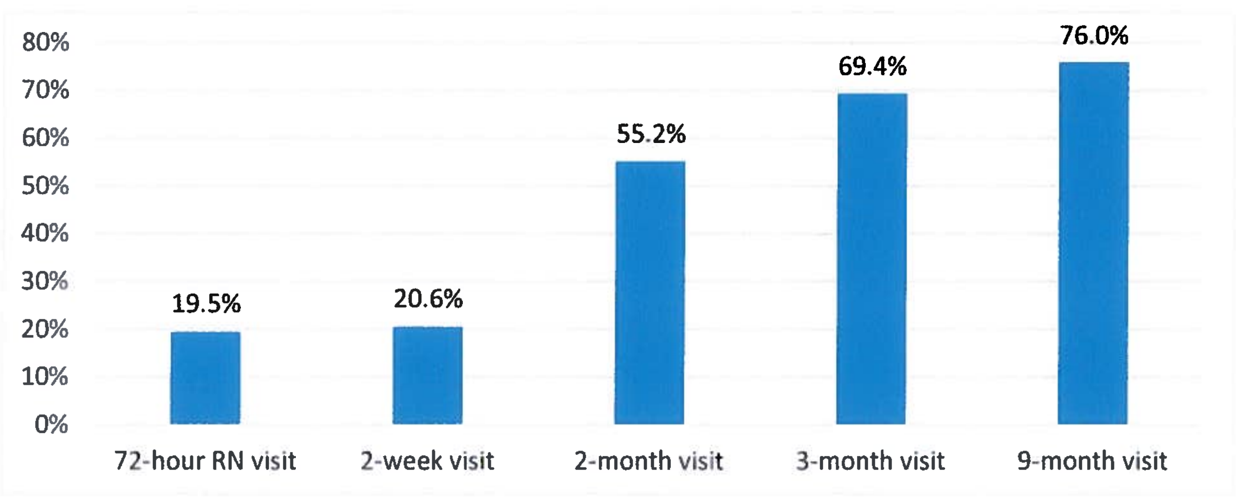
SOURCE: Client Survey (*n* = 1,780, September 2016–September 2017).

Maternal Health

We assessed maternal health outcomes, including family planning and maternal depression, using data from the SFDB, the Welcome Baby administrative database described in Chapter 3.

Family planning was measured using the home visitor's report of whether the client used any form of family planning or contraception. The percentage of clients using any form of family planning or contraception increased substantially between the 72-hour and nine-month home visits (Figure 4.7). By the nine-month visit, more than three-quarters of the clients with whom family planning was discussed were using some form of family planning method.

Figure 4.7. Percentage of Clients Using Any Form of Family Planning, by Visit

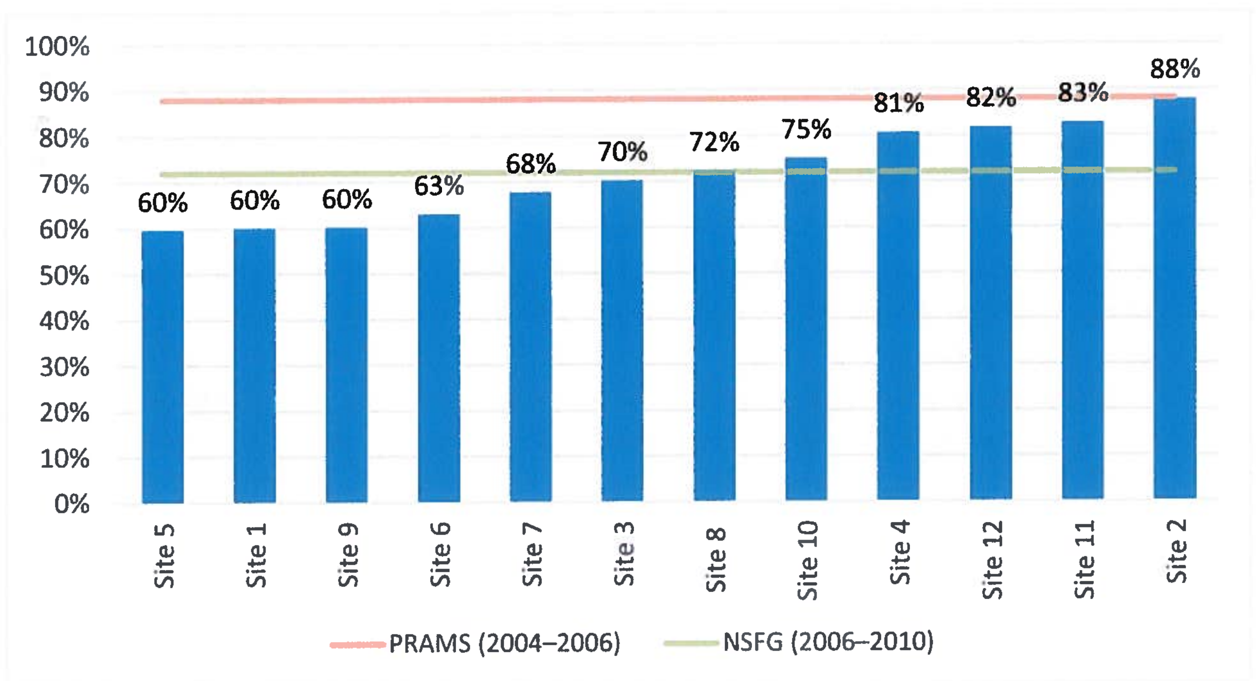


SOURCE: SFDB (*n* = 21,266, January 2016–December 2017).

Two national benchmarks related to family planning provide comparisons with the Welcome Baby results. White et al. (2015) used the 2006–2010 National Survey of Family Growth (NSFG), a national probability survey conducted by the National Center for Health Statistics, to examine women's use of contraception in the postpartum period. According to data in the NSFG, at three months postpartum, 72 percent of mothers used some form of contraception. Similarly, an analysis by Whiteman et al. (2009) of the 2004–2006 Pregnancy Risk Assessment Monitoring System (PRAMS) contraception data from 12 states and New York City evaluated mothers' use of contraception using a self-administered survey mailed to a random sample of mothers between two and four months after delivery (median = 3.7 months) and found that 88 percent of mothers used some form of contraception.

Across the sites, 60 to 88 percent of Welcome Baby mothers reported at the three-month Welcome Baby home visit that they were using some form of family planning methods (Figure 4.8). We examined the three-month visit because it is the best comparator to the national benchmarks. Overall, half of the sites met or exceeded the benchmark from the NSFG, while only one site met the 88-percent benchmark from the PRAMS.

Figure 4.8. Percentage of Clients Using Any Form of Family Planning at the 3-month Visit, by Site with National Benchmarks



SOURCES: SFDB for Welcome Baby (*n* = 3,960, January 2016–December 2017); White et al., 2015, for NSFG (*n* = 3,005); Whiteman et al., 2009, for PRAMS (*n* = 43,887).

Postpartum depression was assessed by the home visitor or nurse, who administered the PHQ-2 (Kroenke, Spitzer, and Williams, 2003) at every visit, which is intended to be a quick screening tool for depression. Following a positive screen on the PHQ-2, the home visitor or

nurse should administer the PHQ-9 (Kroenke, Spitzer, and Williams, 2001), which is a more detailed evaluation for assessing mild, moderate, or severe depressive symptoms. A score of ten or higher on the PHQ-9 indicates moderate to severe levels of depressive symptoms (Olson et al., 2006).

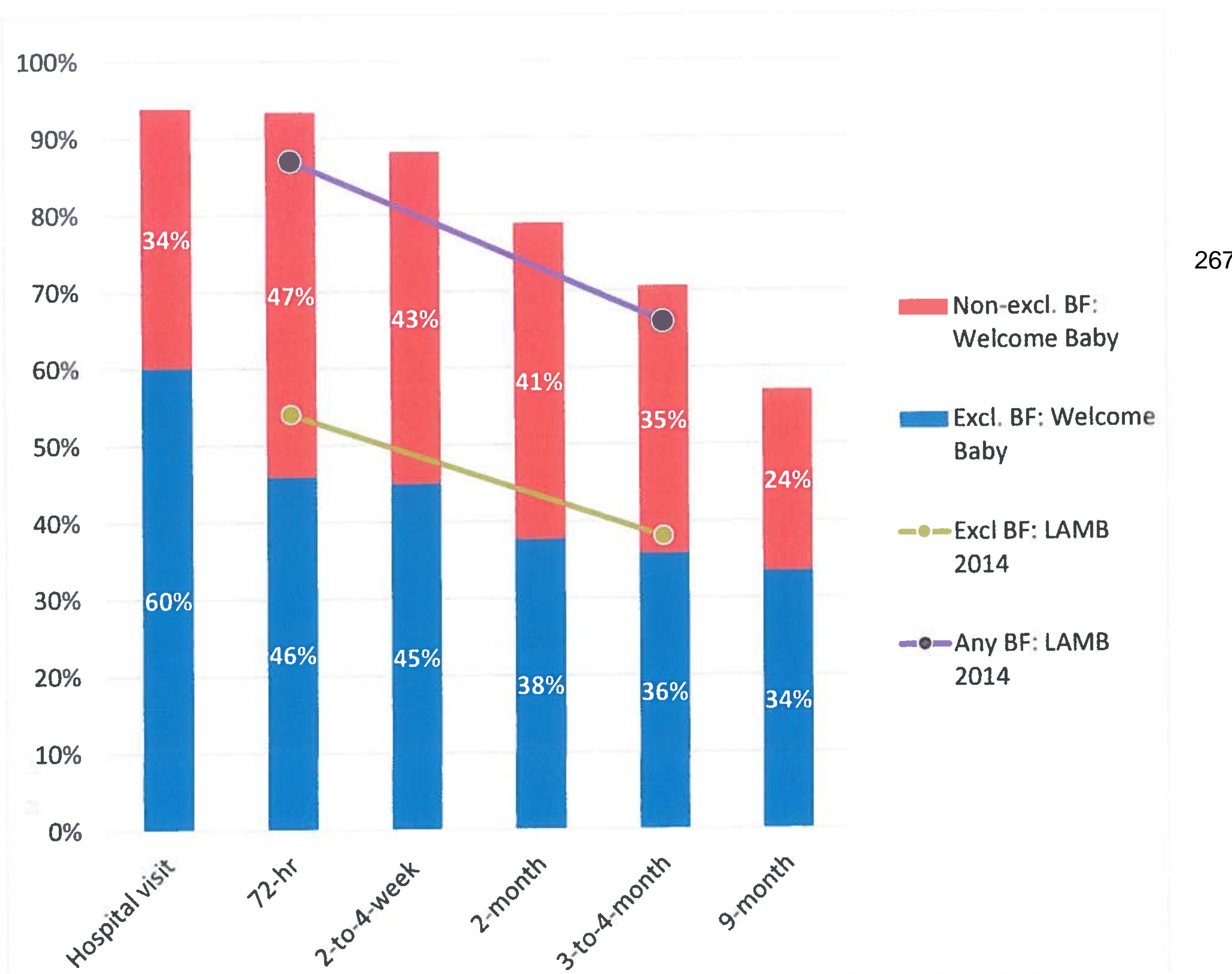
We examined the prevalence of depressive symptoms and found exceedingly low rates compared to every national and regional benchmark found in the literature. Overall, less than 6 percent of clients screened positive on the PHQ-2 at a given visit, and less than 1 percent of Welcome Baby clients were found to have moderate depressive symptoms as measured by the PHQ-9 at a given visit. For comparison, in the general population of adults in the United States, the prevalence of moderate depressive symptoms using the PHQ is estimated to be 8.1 percent (Brody, Pratt, and Hughes, 2018). We would expect the prevalence of depressive symptoms to be higher in the postpartum population, and indeed, the 2012–2013 PRAMS data show that 11.7 percent of mothers self-reported postpartum depression in a sample of 35,946 individuals in 29 states (Centers for Disease Control and Prevention, undated). The Los Angeles Mommy and Baby Project (LAMB), a Los Angeles County effort modeled on the nationwide PRAMS project, found in 2014 that 12.2 percent of mothers in Los Angeles County reported that they were moderately or very depressed following the birth of their child (n = 6,035; Los Angeles County Department of Public Health, 2014).

Child Health Inputs

We examined whether children in the Welcome Baby program were benefiting from five different important child health inputs, including exclusive and nonexclusive breastfeeding, child health insurance, child immunization status, and well-child visit status, using data from the SFDB.

Breastfeeding status is assessed by the home visitor or nurse at each visit. If the client is not breastfeeding, the Parent Coach, where feasible, provided lactation support to the client. Over 60 percent of mothers exclusively breastfed at the hospital visit, while 94 percent of mothers were breastfeeding in any capacity at the hospital visit (Figure 4.9). As expected, the portion of clients exclusively breastfeeding and doing any breastfeeding decreased over time. As a benchmark, the 2014 LAMB survey assessed the rates of exclusive and nonexclusive breastfeeding at one week and three months after birth for a probability-based sample of mothers who had recently given birth in Los Angeles County (Los Angeles County Department of Public Health, 2014). Welcome Baby clients were slightly less likely to exclusively breastfeed at both the 72-hour (46 percent in Welcome Baby versus 54 percent in the LAMB) and three-month visits (36 percent in Welcome Baby versus 38 percent in the LAMB), and slightly more likely to be incorporating breastfeeding in some capacity into their infant feeding routine than the average for Los Angeles County at both the 72-hour (93 percent in Welcome Baby versus 87 percent in the LAMB) and three-month (71 percent in Welcome Baby versus 66 percent in the LAMB) time points.

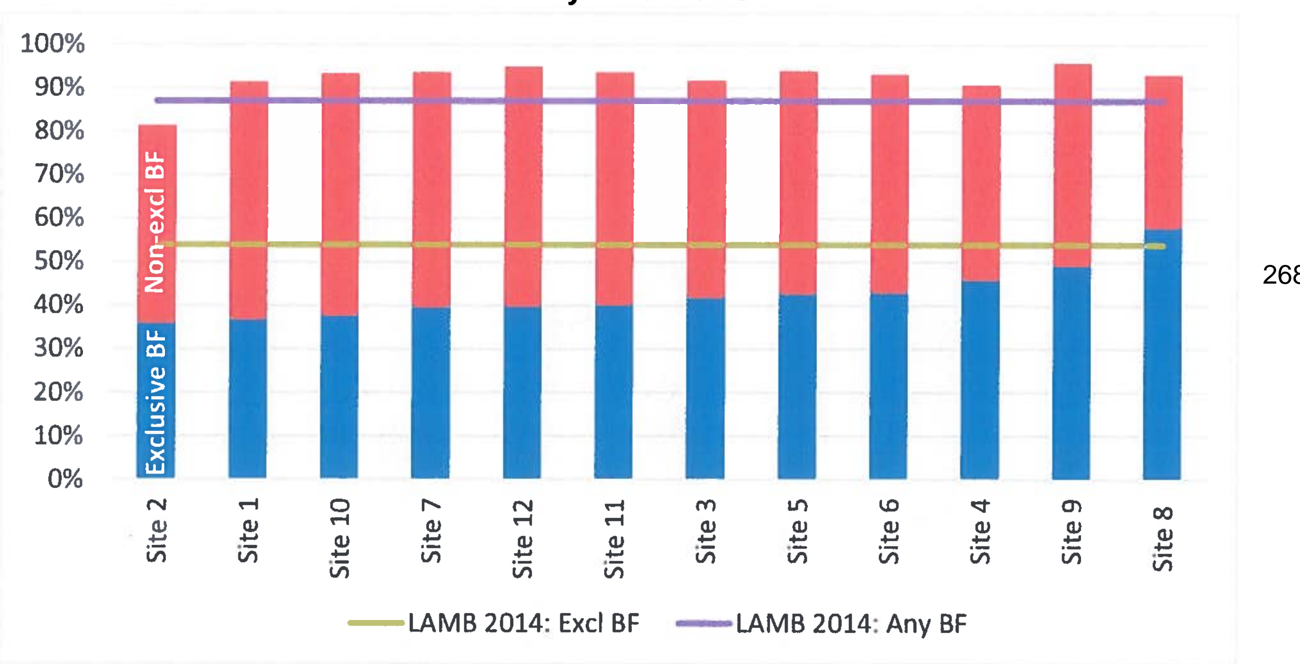
Figure 4.9. Exclusive and Nonexclusive Breastfeeding, by Visit Type, with County Benchmarks



SOURCES: SFDB for Welcome Baby (*n* = 31,486, January 2016–December 2017); Los Angeles County Department of Public Health, 2014 for LAMB (*n* = 6,035).

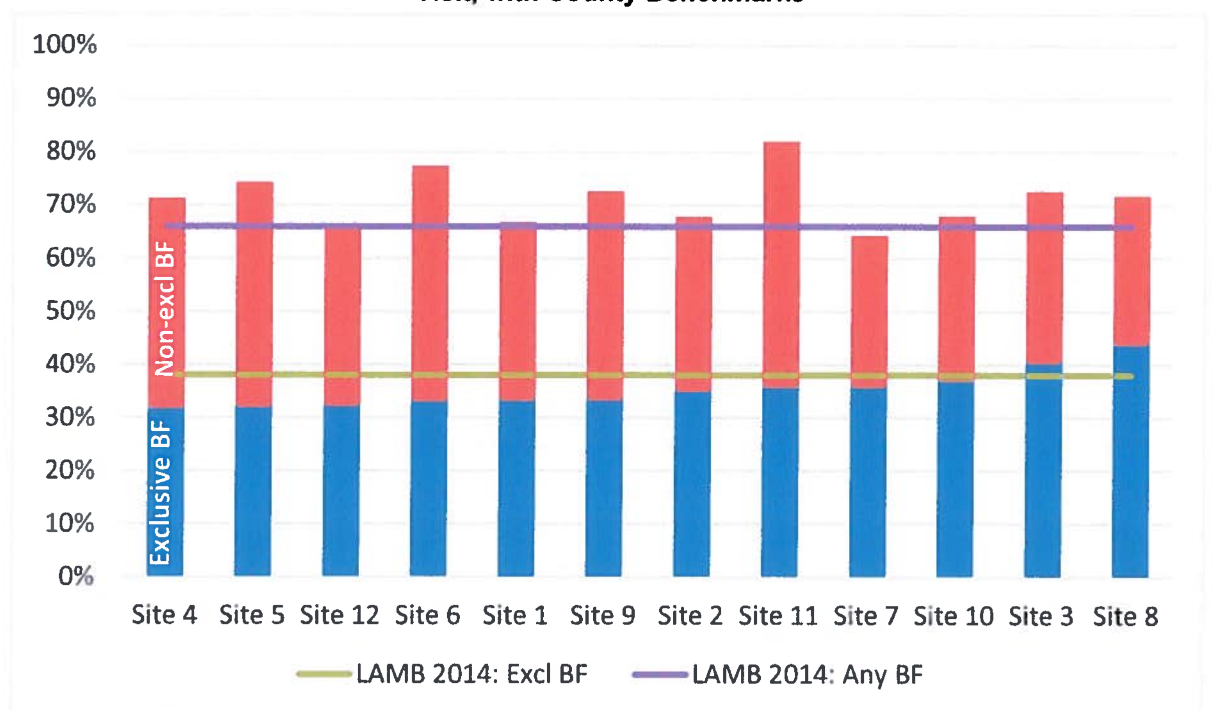
Looking at clients' breastfeeding status at 72 hours by site alongside the LAMB one-week findings, one site outperformed county benchmarks for both exclusive and any breastfeeding at this time point, while 11 of 12 sites outperformed county benchmarks for any breastfeeding (Figure 4.10). Similarly, two sites outperformed county benchmarks for both exclusive and any breastfeeding at the three-to-four-month home visit, and again, 11 of 12 sites met or exceeded county benchmarks for any breastfeeding (Figure 4.11).

Figure 4.10. Exclusive and Nonexclusive Breastfeeding by Site at the 72-Hour Home Visit, with County Benchmarks



SOURCES: SFDB for Welcome Baby (n = 5,224, January 2016–December 2017); Los Angeles County Department of Public Health for LAMB, 2014 (n = 6,035).

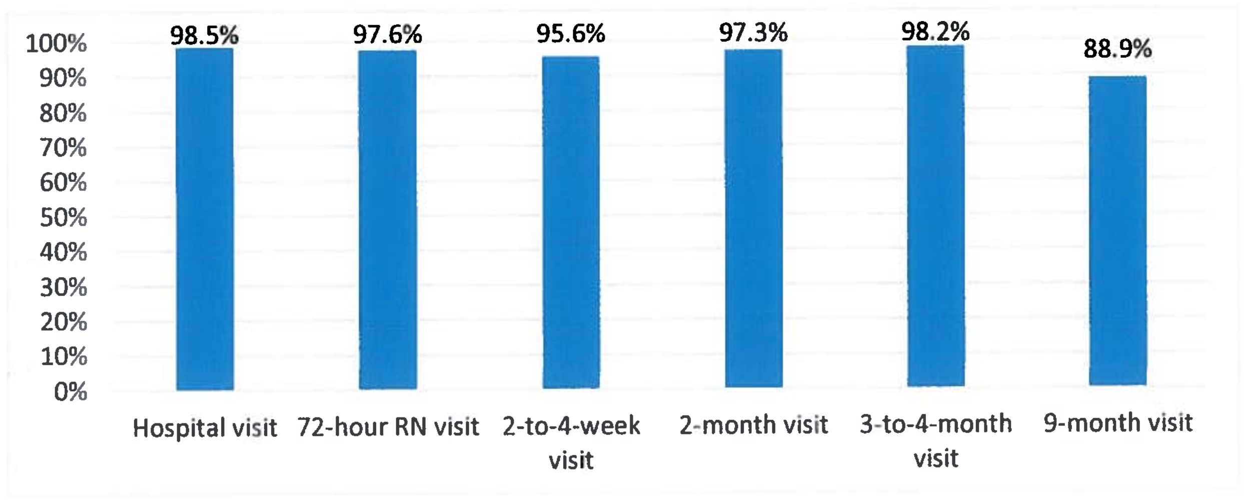
Figure 4.11. Exclusive and Nonexclusive Breastfeeding by Site at the Three-to-Four-Month Home Visit, with County Benchmarks



SOURCES: SFDB for Welcome Baby (n = 3,885, January 2016–December 2017); Los Angeles County Department of Public Health for LAMB, 2014 (n = 6,035).

The child's health insurance status is assessed by the home visitor or nurse at each visit, starting at the hospital visit. According to the SFDB, more than 98 percent of infants in the Welcome Baby program had some form of insurance when leaving the hospital, with those numbers decreasing over time to 89-percent coverage at the nine-month visit (Figure 4.12). From the hospital visit through the three-month visit, more than 95 percent of infants were covered by some form of health insurance, while this number dropped to 89 percent at the nine-month visit. There was no recent benchmark for children's insurance coverage at hospital exit, or at a specific time in the first year.

Figure 4.12. Percentage of Clients Whose Infant Is Covered by Health Insurance, by Visit, with Los Angeles County Benchmark



SOURCE: SFDB (*n* = 32,435, January 2016–December 2017).

Status of infant immunizations and whether the mother has kept up with all relevant well-child visits were assessed by Parent Coaches during routine visits. These two measures covaried as expected because well-child visits are typically where physicians recommend any required immunizations (Figure 4.13). The percentage of mothers up to date on immunizations and well-child visits was above 90 percent at the two-to-four-week, two-month, and three-to-four-month visits. At the nine-month visit, these percentages dropped about ten percentage points, consistent with the roughly ten–percentage point drop in health insurance coverage shown in Figure 4.12.

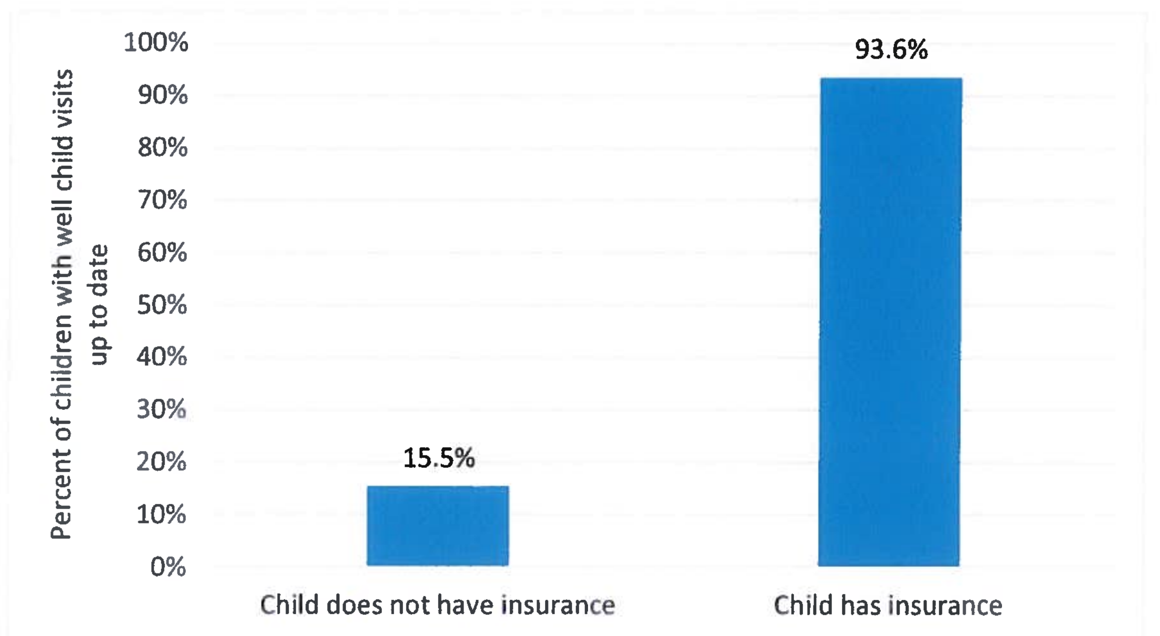
Figure 4.13. Infant Immunizations and Well-Child Visit Status, by Visit

100%
80%
60%
40%
20%
0%
92% 91%
90% 91%
94% 93%
83% 85%
2-to-4-week visit
2-month visit
3-to-4-month visit
9-month visit
Well-child-visits up-to-date
Immunizations up-to-date

SOURCE: SFDB (*n* = 16,848 for well-child visits, 17,015 for immunizations, January 2016–December 2017).

Insurance status and well-child visit status also covaried: Clients who reported a lack of health insurance for the child also reported not keeping up with well-child visits (Figure 4.14). More specifically, for a given visit where the child is reported not to have insurance, only 16 percent of mothers reported at that visit that their well-child visits were up to date.

Figure 4.14. Well-Child Visit Status for Children With and Without Insurance at a Given Visit



SOURCE: SFDB (*n* = 16,848, January 2016–December 2017).

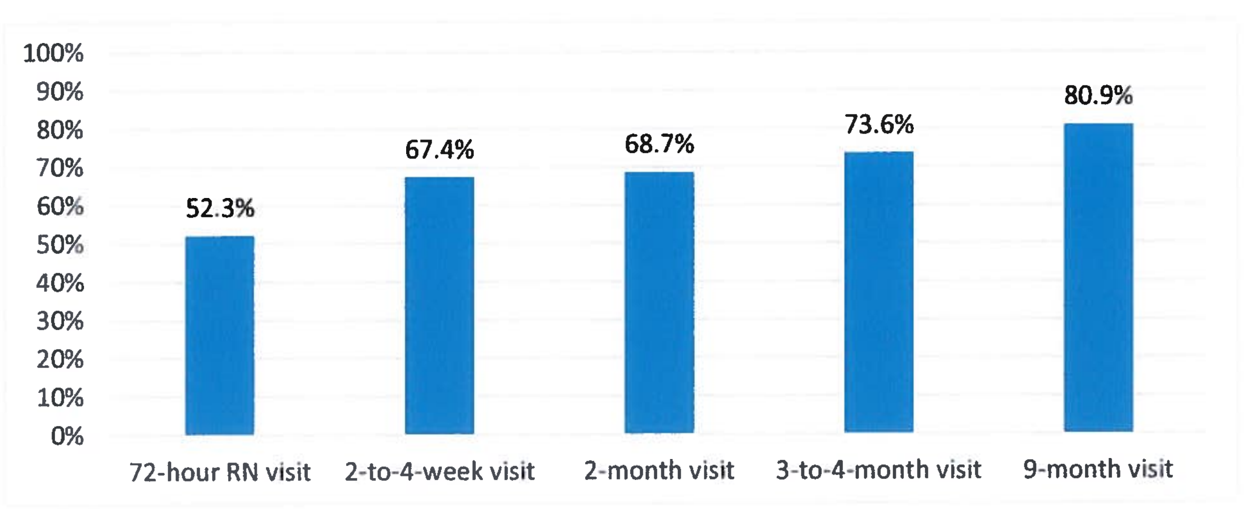
Child Safety

We used the SFDB to examine several child safety measures, including the child's environmental safety, as observed by the Parent Coach, and the mother's safe sleep practices, as reported by the mother to the Parent Coach and/or observed by the Parent Coach in the case that the infant was asleep at the time of the visit.

Home safety hazards were assessed by observation of the Parent Coach at each in-home visit. Potential hazards include a lack of childproofing, secondhand tobacco smoke in the home, visible bugs such as bedbugs or cockroaches, weapons in the home, and other similar items. Home visitors recorded whether there were any home safety issues identified, or whether the home safety inspection was completed with no issues identified. Home visitors then provide tailored home safety education to the client according to needs identified.

The vast majority of home safety issues identified fall in the category of inadequate childproofing; in 75 percent of visits where a home safety issue was identified, childproofing was one of the issues. The percentage of Welcome Baby clients for whom no home safety issues were identified at a given visit increased over time, indicating that the safety of the home environment improved as a client progressed through the program (Figure 4.15; see Appendix D, Table D.8 for information on site-level change over time). There were no national or local benchmarks using the same home safety checklist used by the Welcome Baby program.

Figure 4.15. Percentage of Clients for Whom No Home Safety Hazards Were Identified, by Visit



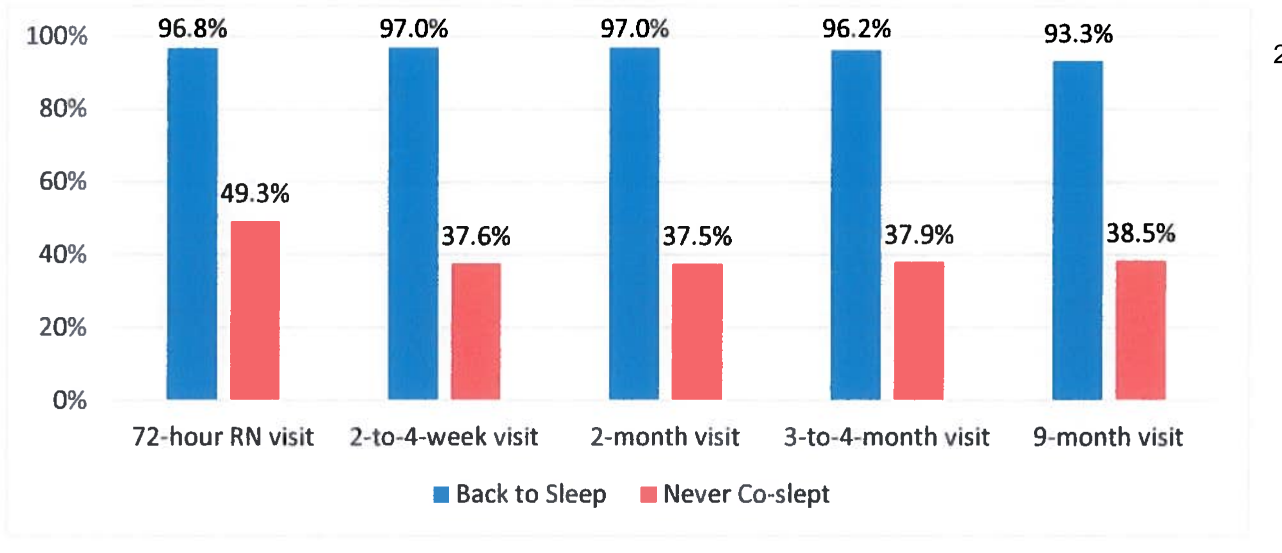
SOURCE: SFDB (*n* = 22,335, January 2016–December 2017).

Safe sleep practices were assessed by parent report or observation of the Parent Coach at every visit in the home, including whether a child was put on their back to sleep, and an assessment of whether a child ever shared the bed with another person.

A recent systematic review of studies found that the infant's sleep environment, including sleep position and bed sharing, is the most critical element of risk reduction for sudden infant

death (Carlin and Moon, 2017). Nearly all Welcome Baby clients reported putting their child down to sleep on their back, while less than half of clients reported never having shared their bed with their child (Figure 4.16). This is true even at the 72-hour RN visit, indicating that for most clients, bed sharing happened in the first days after returning from the hospital.

Figure 4.16. Safe Sleep Practices, by Visit



SOURCE: SFDB ("Back to Sleep," *n* = 21,426; "Co-Sleeping," *n* = 21,373, January 2016–December 2017).

In looking at county benchmarks, all sites are well above the 2014 LAMB survey average of 83 percent for putting infants on their back to sleep; across sites, between 95 and 98 percent of clients at the two-to-four-week visit report putting their infants on their back to sleep. For co-sleeping, all but two Welcome Baby sites outperform the county benchmark of 28 percent reporting never co-sleeping, with a lot of variation across the sites (Figure 4.17).

Figure 4.17. Percentage of Mothers Who Report That Their Children Have Never Co-Slept at the Two-to-Four-Week Visit, by Site, with Regional Benchmarks

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

4% 17% 34% 38% 39% 39% 40% 41% 41% 50% 55% 57%

Site 10 Site 6 Site 8 Site 12 Site 3 Site 1 Site 9 Site 4 Site 2 Site 7 Site 5 Site 11

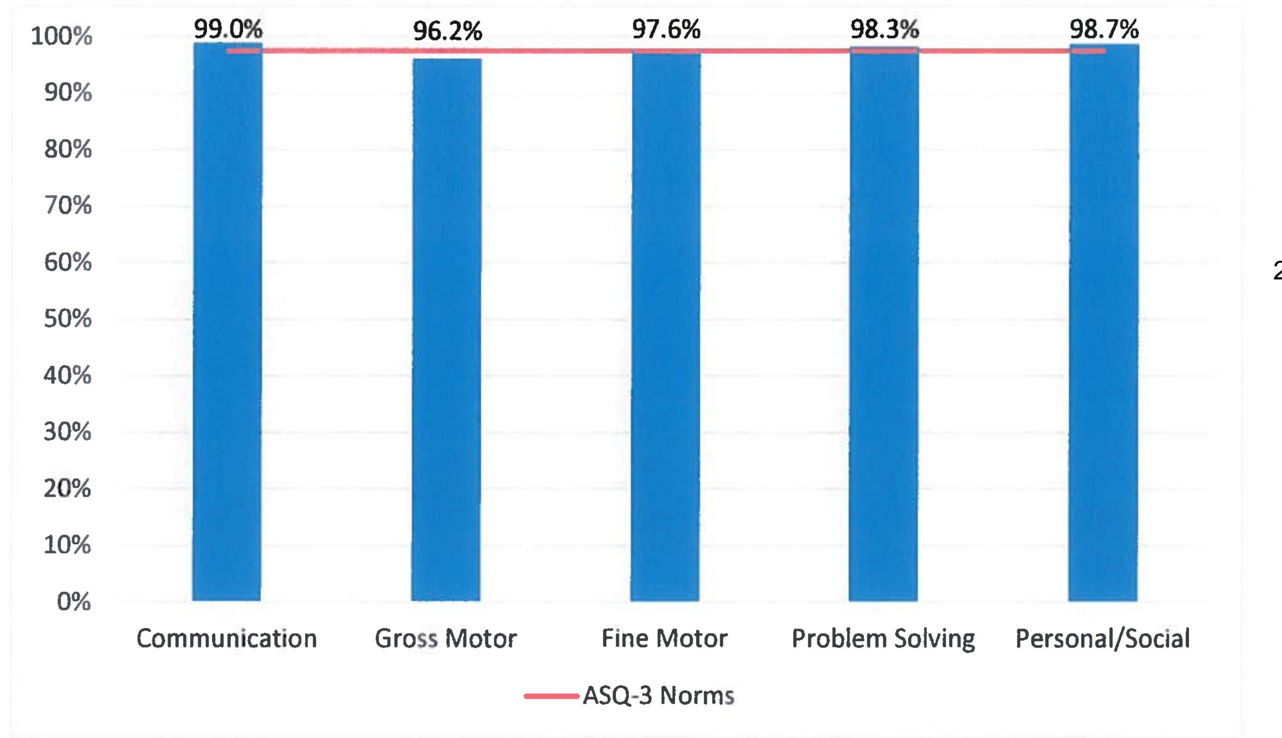
LAMB (2014)

SOURCES: SFDB for Welcome Baby (*n* = 4,958, January 2016–December 2017); Los Angeles County Department of Public Health for LAMB, 2014 (*n* = 6,035).

Child Development

As part of the Welcome Baby curriculum, Parent Coaches administer the ASQ-3 (Squire et al., 2009) at the three- and nine-month home visits, selecting the version of the questionnaire that most closely maps to the age of the child. The ASQ-3 is a developmental screening tool used with infants and young children and covering five domains: Communication, Gross Motor, Fine Motor, Problem Solving, and Personal Social. ASQ cut-points indicating a potential developmental need are set at the 2.5th percentile for each scale. Indeed, in each of the five domains, between 96 and 99 percent of children were above the cut-off for the test that they were administered (Figure 4.18).

Figure 4.18. Percentage of Infants with Passing Scores on Each of the ASQ-3 Domains



274

SOURCES: SFDB for Welcome Baby (*n* = 6,669, January 2016–December 2017); Squire et al., 2009, for ASQ-3 norms (*n* = 6,035).

Evaluation Question 7: What Are the Relationships Between Program Fidelity Outcomes and Participant Outcomes?

Overall, the number of significant relationships between program fidelity and participant outcomes was relatively low, indicating a lack of evidence for a link between fidelity and participant outcomes. Across the eight fidelity components included in this analysis, the ones most likely to be associated with improved outcomes were staff qualifications, staff training, reflective supervision, home visitor workload, and curriculum content coverage.

To address this evaluation question, we examined the relationship between the eight program fidelity components with data that could be matched to the client, visit, and participant outcomes. Next, we summarize the findings by outcome, visit type, and fidelity component.

Methods

To identify which fidelity components are associated with participant outcomes, we examined whether the fidelity components analyzed in Evaluation Question 1 and Evaluation Question 2 were related to the outcomes analyzed in Evaluation Question 6. The variables we used to examine this evaluation question are described in detail in the previous sections. The eight fidelity domains we examined in this analysis are staff qualifications, staff training,

reflective supervision, home visitor workload, service dosage, timing of service delivery, participant perception of the relationship, and percentage of content covered. For the five postpartum visits beginning with the RN visit, we estimated a set of models for 12 outcomes with these fidelity components. The outcomes were positive parenting practices, parent knowledge of infant development, use of family planning, exclusive breastfeeding, any breastfeeding, child has health insurance, child has well-baby visits, timely immunizations, child development, no safety issues in the home, putting the child on his or her back to sleep, and no co-sleeping (all measures expressed so that one is a better outcome than zero). While we aimed to estimate relationships between all 12 outcomes and all eight fidelity domains at each visit (for a total of 96 estimates for each of the five visits), not all measures were available for each visit; we report the number of estimates at each visit subsequently.

The estimates measured the association between each participant outcome at a visit and each fidelity component measured at the previous visit. The idea behind this approach is that an outcome measured at one visit would have been generated by the actions and knowledge of parents prior to that time, and that the previous Welcome Baby visit would have aimed to influence these actions and knowledge in a way that would promote child development and family wellness. While it is possible that the fidelity components of all of the previous Welcome Baby visits would influence later outcomes, we expected that the most recent Welcome Baby visit has the most influence on outcomes, and so we focused on the fidelity components of the most recent visit. Not all fidelity components or outcomes were measured at each visit, so in each model, we included all of those variables that are available in the data for that visit. For example, the service dosage variable counted the number of visits the family received out of a possible of six total, so this variable was included in only the nine-month outcome estimates. We also included family characteristics in these models to control for differences in the types of families served by different sites and home visitors. If we did not control for these differences, the estimates of the relationship between measures of fidelity and outcomes could be biased. The correlation for the fidelity components measured at the same visit was never more than 0.4, with the exception of fidelity components measured for the Hospital Liaison visit where staff meeting the minimum qualifications received less reflective supervision and staff meeting the minimum training requirements were more likely to cover all the content in the visit.

As we did in the estimates for Evaluation Question 5, we estimated these models accounting for the clustering of families within home visitors and sites. Most of the models have binary outcomes, and we used the melogit command in STATA (StataCorp, 2017) to account for clustering. For the few continuous outcomes in our analysis, we used the mixed command in STATA. Also as described in the methods for Evaluation Question 5, we used the Benjamini-Hochberg procedure with a false discovery rate of 0.10 to adjust the p-value to reduce the chance of false positives due to the large number of estimates.

Results

The findings can be summarized from several perspectives; we summarize the findings by visit type, outcomes, and fidelity component. More detailed results from this analysis are presented in Appendix G.

Findings by Visit Type

We first present these results through the lens of the visit type. Given that different staff provide services at different visit types and that different outcomes might be more relevant to different child development periods, the findings can inform Welcome Baby where to emphasize fidelity efforts to have the most impact on family outcomes. We identified several significant relationships between fidelity components and outcomes by visit.

- For the RN visit, a quarter of the relationships between fidelity components and outcomes were found to be significant (i.e., seven out of 28), with a mix of positive and negative associations.
- For the two-to-four-week visit, very few relationships were significant (i.e., six out of 77), with a mix of positive and negative relationships.
- For the two-month visit, about one-sixth of the relationships were significant, with ten positive and four negative (i.e., 14 out of 88).
- For the three-month visit, almost one-sixth of the relationships were significant, with 11 positive and five negative (i.e., 16 out of 96).
- For the nine-month visit, about one in ten of the relationships was significant, with six positive and five negative (i.e., 11 out of 96).

Since the significant results generally include both positive and negative relationships, these findings do not lend support to an overall conclusion of a clear positive association between the fidelity components and outcomes measured in this research.

Findings by Outcome

We examined the relationship between the fidelity components and five client-level outcome categories: parenting, maternal health, child health inputs, child safety, and child development.

Parenting

For positive parenting practices (as measured by five items from the HOME) and parent knowledge of infant development (as measured by items from the KIDI), most of the fidelity components did not exhibit a relationship with these outcomes. This may be related to the low amount of variance displayed among Welcome Baby participants on these two measures. Most parents scored the maximum possible on both the HOME and the KIDI, making it difficult to detect effects for these two outcomes.

Maternal Health

The findings for the family planning outcome were counterintuitive, as meeting staff training and workload standards were associated with lower rates of family planning. Further, meeting the home visitor workload fidelity threshold was associated with lower use of family planning for the last four visits, one of the most consistent patterns in these findings. We explored the possibility that these findings were related to the fact that sites may have different policies on this topic because of religious considerations; for example, different versions of the Welcome Baby manual had been created with and without the family planning component to meet the needs of religious-affiliated sites. However, we did not find that sites with religious affiliations had lower rates of family planning than other sites.

Child Health Inputs

None of the fidelity components was related to the "any breastfeeding" measure, and only one fidelity component was related to the "exclusive breastfeeding" measure. This may be related to the relatively high rates of breastfeeding among Welcome Baby participants, which makes it difficult to effect large changes on this outcome. There were some positive relationships between meeting fidelity components and having child insurance, having immunizations up to date, and having well-child visits at recommended intervals, but the positive relationships were not always consistent across visits and fidelity components.

Child Safety

There was some evidence that meeting the staff qualifications fidelity threshold was related to parents avoiding co-sleeping. However, there was also some evidence that meeting the reflective supervision component was associated with parents reporting more co-sleeping. Perhaps there is some variability in staff attitudes toward co-sleeping, with some viewing co-sleeping as a cultural norm that should be respected, and others viewing co-sleeping from a public health perspective that emphasizes the potential dangers. We also observed a mixed relationship between the fidelity components and the home safety outcome.

Child Development

Child development, as measured by the ASQ at the three-month and nine-month visits, did not show any clear patterns in the estimated relationships with fidelity components.

Findings by Fidelity Components

In looking at whether some fidelity components exhibited relationships with outcomes more often than others, five fidelity components (staff qualifications, staff training, reflective supervision, home visitor workload, and content covered) were positively related to some outcomes and negatively related to others. However, omitting the family planning and safety issues outcomes, which may reflect both Welcome Baby procedures and participant actions, there were few negative relationships. The other three fidelity components—program dosage,

timing, and the participant perception of the relationship—had two or fewer positive relationships across all the outcomes for the five visits.

Overall we find little evidence to support a relationship between the fidelity components and client outcomes. This finding could be because of a true null effect or to the analyses being underpowered—that is, the sample size is not large enough to enable the identification of the effects. We conducted some illustrative calculations to assess whether the sample size was large enough to support identification. Known as "power calculations," these calculations yield the sample size needed to estimate the true effect rather than simple chance, using a selected confidence interval and likelihood of correctly estimating nonzero effects (for more information on power calculations, see Noordzij et al., 2010). Using the smallest sample in the estimates in this section (for the nine-month outcomes), a mean number of clients per Parent Coach cluster of 11, and a typical intraclass correlation of these clusters of 0.25, we calculated that our data had an effective sample size of 400, compared to the true sample size of about 1,520 (Killip et al., 2004). Using the smallest prevalence of our outcomes of 0.19 and the smallest prevalence for our binary fidelity measures of 0.25, there is 80-percent power with Type I error of 5 percent to detect an odds ratio smaller than 0.4 or larger than 2.0. While the power of each estimated equation will be specific to the analysis due to varying sample sizes and varying prevalence rates, this illustrative example using the most conservative sample size and the lowest prevalence of the outcome and predictor shows that we are able to detect moderate relationships between fidelity and outcomes. Similarly, there is 80-percent power with Type I error of 5 percent to detect an odds ratio smaller than 0.7 or larger than 1.4 for a one standard deviation change in a continuous fidelity measure. In sum, our power calculations are consistent with the findings that there are null or weak relationships as a whole between the fidelity components and client outcomes. As mentioned, some of the outcomes with relatively high rates may exhibit no relationship with fidelity components because it would be difficult to effect large changes on those outcomes.

Overall Summary of Findings

This section has provided detailed findings on each of the seven questions that this evaluation was asked to answer. We summarize the main points for each evaluation question in Table 4.23.

Table 4.23. Main Findings, by Evaluation Question

1. To what extent are sites implementing Welcome Baby to fidelity?
Across the 11 fidelity domains for which we had data, there was considerable variability in the degree to which individual sites achieved fidelity to the Welcome Baby model. No site achieved fidelity in all of the assessed domains, but every site achieved fidelity in at least two domains (supervisory requirements and participant perception of the relationship). Within each domain, between 18 and 80 percent of sites met the fidelity threshold.
2. Is there variability in sites' ability to reach fidelity to Welcome Baby?
There were also differences in the degree to which sites met the fidelity threshold across different domains. For two domains, all sites achieved fidelity thresholds with the Welcome Baby model (supervisory requirements and participant perception of the relationship); for another three domains, only one site achieved fidelity thresholds (staff qualifications, reflective supervision, and hospital enrollment). The remainder of the domains had from 5 to 8 sites achieve fidelity thresholds. Within several domains, there was also variability in achieving thresholds for specific elements of the domain criteria (e.g., by staff position or visit type).
3. How are sites maintaining community resource and referral networks? What, if any, gaps exist in these networks?
Sites also varied widely in the completeness of their referral directories. Very few sites have developed their own infrastructure to facilitate successful referrals (e.g., MOUs with service providers, referral forms). Welcome Baby provides sites with protocols for five referral types, including domestic violence, early intervention for child developmental delays, postpartum care, maternal depression, and suicide prevention. Yet, very few sites had developed their own infrastructure to facilitate successful referrals (e.g., MOUs with service providers, referral forms). Staff across all sites reported referring to a wide range of referral resources, regardless of the infrastructure developed to facilitate successful referrals.
4. What are participant perceptions of and experiences with the program and Welcome Baby service providers?
There was general agreement among program participants that the Welcome Baby program met their needs and helped them connect with services. Families found the enrollment process easy and greatly appreciated the breastfeeding assistance. Program participants also indicated that they would participate in the program again if seeking parenting help in the future and rated their relationships with the Parent Coaches extremely positively. Overall, families said Welcome Baby staff were responsive to their needs, easy to communicate with, accessible, and flexible. In terms of areas for improvement, many participants wanted more home visits, while some noted that it would be helpful to provide program materials in nonpaper formats.
5. What factors contribute to participants leaving the program early?
Family characteristics associated with being at risk of poor outcomes are often associated with a greater likelihood of transitioning from the hospital to RN visit, but a lower likelihood of staying in the program for later visits. For the 2-to-4-week visit and later visits, adherence to Welcome Baby fidelity standards is related to lower rates of participants leaving the program.
6. To what extent do participants achieve short- and intermediate-term outcomes?
Welcome Baby participants exhibited better outcomes in more than half of the areas with available regional or national benchmarks. Welcome Baby participants exhibit more positive parenting practices, higher levels of any breastfeeding, and safer sleep environments than benchmarks. Welcome Baby participants exhibited lower levels of family planning and exclusive breastfeeding compared to benchmarks.
7. What are the relationships between program fidelity outcomes and participant outcomes?
Overall, the number of significant relationships between program fidelity and participant outcomes is relatively low, although more likely than one would expect due to chance. The fidelity components most likely to be associated with improved outcomes are staff qualifications, staff training, reflective supervision, home visitor workload, and percentage of curriculum content covered.

5. Summary, Recommendations, and Limitations

This chapter is organized into four main sections. First, we provide a summary of the strengths of the Welcome Baby Program that is based on the findings from the evaluation, that is, areas in which the Welcome Baby program sites were meeting their implementation or outcome goals. Second, we provide recommendations for improving the Welcome Baby program implementation and outcomes, including suggestions for ongoing monitoring in light of the study findings. Third, we describe the limitations we experienced with conducting this evaluation. Finally, we provide conclusions from the project.

Strengths of the Welcome Baby Program

Overall, the Welcome Baby program sites were meeting many of the implementation (i.e., fidelity) and outcome goals.

In terms of implementing the program with fidelity as measured by adhering to the fidelity domains, program strengths include

- client satisfaction, with clients generally very satisfied with the services they received (Domain 11)
- supervision levels, with all sites meeting the fidelity threshold related to the supervisory requirement levels (i.e., supervisors oversee no more than four Parent Coaches; Domain 3).
- visit content, with most sites able to achieve the home visit content fidelity domain (Domain 13)
- timeliness, with most Welcome Baby visits being conducted on time (Domain 9).

When looking at outcomes, the Welcome Baby sites scored similarly to or better than national and local benchmarks on

- parenting practices
- breastfeeding
- health insurance status
- safe sleep practices (i.e., back sleeping, no co-sleeping)
- child development.

There were other outcomes where the sites on average scored well, but we did not have any benchmarks to compare to the Welcome Baby site performance, including

- parenting knowledge
- immunization rates
- home safety.

Recommendations for Improving the Welcome Baby Program

Based on our analysis, we found several areas that may be in need of improvement and offer some suggestions for addressing them. We organize this section by first addressing the fidelity domains, next we discuss outcomes, and then we discuss the implications from the analyses where we examined the relationship between variables. More specifically, we discuss the findings from our analyses of factors related to program attrition and from our analyses of fidelity domains and program outcomes. Then, we provide some recommendations for ongoing monitoring based on these findings.

Fidelity Domains

For this section, we discuss the fidelity domains where improvements could be made. We do not address the domains where the majority of sites met the benchmark (i.e., Domain 3 [supervisory requirements], Domain 9 [timing of service delivery], Domain 11 [participant perception of the relationship]) or domains that we were not able to assess (i.e., Domain 6 [prenatal recruitment and enrollment], Domain 12 [family-centered approach], Domain 14 [responsiveness of provider). F5LA may still want to continue to monitor the domains where the majority of sites met the benchmark to ensure they are maintained, and improvements in data collection and abstraction are needed to assist with assessment of prenatal recruitment and enrollment, family-centered approach, and responsiveness of provider.

Staff Qualifications (Domain 1) and Training (Domain 2)

For the staff qualifications and training fidelity domain, there were some staff positions where the sites performed well in meeting one or the other, but typically not both. This implies that sites may be hiring staff that meet the job qualifications but may not be providing adequate training requirements (e.g., Outreach Specialists), or hiring staff that do not meet the job qualifications but are providing adequate training (e.g., Parent Coach Supervisors). To address this, it might be helpful to review the relevance of the qualifications and training requirements for each position for future recruitment and training of Welcome Baby program staff. Staff training and qualifications are particularly critical because they appear to be positively related to program retention and program outcomes, such as breastfeeding, family planning, co-sleeping, well-baby visits, and home safety.

Reflective Supervision (Domain 4)

Although sites met the mark in terms of supervision caseload levels, the frequency of reflective supervision and the quality of it is in need of further examination. Some staff positions reported not receiving reflective supervision very frequently, and staff across positions and sites questioned the quality and value of reflective supervision. Since reflective supervision appeared to negatively relate to retention between the hospital and RN visit, an examination of the quality of the reflective supervision, especially for Hospital Liaisons and RNs, is warranted. Reflective supervision is related to several program outcomes; it was found to be positively related to well-

baby visits, immunizations, home safety issues, and sleep environment (back sleeping) and negatively related to parenting practices and co-sleeping.

Home Visitor Workloads (Domain 5)

At the time of our assessment, staff at most sites were meeting the home visitor workload requirements. Given that meeting the workload requirement appears related to program retention from the two-month to three-to-four-month time point and certain outcomes (family planning, child health insurance, immunizations, home safety, and sleep environment), F5LA may want to continue to monitor this to ensure sites are maintaining appropriate workload levels.

Hospital Enrollment (Domain 7)

Meeting the fidelity threshold on this domain required approaching 90 percent of eligible families in the hospital and enrolling 40 percent of those approached. Most sites did not meet the recruitment target because of issues with staff coverage (e.g., not having staff available 24/7, including nights and weekends). While many sites met the 40-percent target for approaching families, there was wide variation, suggesting that staff from some sites may be able to learn from others on best enrollment practices. F5LA may want to consider whether these threshold levels are appropriate given the number of births and Welcome Baby staffing levels at the different participating hospitals to see if site-specific targets may be appropriate. Also, now that the program has been implemented for quite some time, the fidelity threshold for enrollment may need to be adjusted based on the observed enrollment rates to set more realistic targets.

Service Dosage (Domain 8)

There was wide variation across the sites in the percentage of participants who received four or more postpartum Welcome Baby visits, with most clients not receiving four of six targeted postpartum engagement visits. Although staff felt that the large gap between the three-to-four-month and nine-month visit contributed to program drop-out, the analysis showed that the largest attrition occurred between the hospital and RN visit. F5LA may want to undertake continuous quality improvement approaches to increase program retention between the hospital enrollment visit and first in-home visit. We were able to examine this fidelity domain only with nine-month outcomes, and it appears related to any breastfeeding. Given the wide variation across sites in percentage of clients completing four or more postpartum visits, there are potentially lessons learned from staff at the high-performing sites that could help improve performance at other sites.

Referrals to Community Services (Domain 10)

Site performance on this fidelity domain was extremely varied, suggesting again that there could be best practices in some sites that may help the lower-performing sites. Due to the limitations in the SFDB, we were able to evaluate this for only a short time period and did not include it in our analyses of factors related to program attrition and outcomes. Based on our assessment of the community referral process through each site's documentation (i.e., Evaluation

Question 3), F5LA should consider the development of detailed protocols for all high-priority referral types, including public benefits, alcohol, smoking and drug treatment, with the provision of client confidentiality. F5LA should support sites in developing and maintaining a standardized referral directory and establish MOUs with service providers to improve service access.

Home Visit Content (Domain 13)

Overall, across sites and visits, coverage of the Welcome Baby curriculum was quite good with the exception of the hospital visit. F5LA may want to explore the reasons behind this by gathering input from Hospital Liaison staff about challenges they face with delivering content and whether or not crucial content is being missed, or if modifications to the expectations of curriculum covered in the hospital are needed. Since coverage of home visit content appears to be related to program attrition as well as a number of outcomes, including family planning, child health insurance status, immunizations, and co-sleeping practices, it is important to further investigate why content is not always covered and whether there can be efforts to improve delivery of content and perhaps enhance engagement and outcomes.

Outcomes

Findings indicate that site outcomes varied quite a bit, including family planning (i.e., only about half the sites met the national benchmarks on the use of family planning, less family planning with more fidelity to Welcome Baby content) and safe sleeping practices (i.e., two sites reported high levels of co-sleeping at the two-to-four-week visit). Given these findings, family planning and safe sleep practice could be areas to target for staff retrainings and booster sessions, as well as to share lessons learned from sites showing higher rates with sites demonstrating lower rates. Additionally, while Welcome Baby participants exhibited higher levels of any breastfeeding compared to local benchmarks, they reported slightly lower rates of exclusive breastfeeding, and there may also be an opportunity to improve this outcome.

Relations Between Variables

Factors Related to Program Attrition

To better understand program attrition (i.e., Evaluation Question 5), we examined both participant characteristics and performance on the fidelity domains. The practical value of the findings from these analyses is twofold. Knowing which family characteristics are associated with participants leaving the program early can help Welcome Baby staff adjust followup, scheduling effort, or incentives toward families that are most likely to leave. Furthermore, knowing which Welcome Baby fidelity components are associated with retention can help F5LA to prioritize which fidelity component efforts to monitor.

The results on the relationship between family characteristics and staying in the program suggest that while higher-risk families—as measured by a number of characteristics—are staying for the RN visit, they are more likely to leave before the later home visits. This implies that F5LA may be able to improve Welcome Baby retention by supporting efforts to retain higher-

risk families in the later home visits. Retention efforts could include more engagement efforts, like check-in calls and opportunities for families to reach out to Welcome Baby staff.

Findings on the links between five of the fidelity components and program retention suggest that the fidelity components were associated with greater retention for the later three home visits. Finally, the findings on reflective supervision suggest that there may be value in gaining a better understanding of the quality of the supervision for the staff involved in the first couple of visits—the Hospital Liaison and the RN—as we found a negative association between reflective supervision and retention at the early time points. While we don't have quantitative data to help explain these findings, the qualitative data suggest that perhaps some Hospital Liaison and RN staff did not feel the reflective supervision was helpful.

Relationship Between Fidelity and Outcomes

The results in regard to Evaluation Question 7 (i.e., what are the relationships between program fidelity and participant outcomes?) generally demonstrate weak support for the relationship between program fidelity and participant outcomes. When focusing on outcomes that display more variation, there is evidence that the fidelity components are more likely to be related to outcomes than one would expect due to chance. However, the incidence of a relationship is relatively low, making it difficult to draw strong conclusions that there is generally a relationship between the fidelity components and outcomes measured. Clients that experienced greater levels of program fidelity also exhibited lower rates of family planning, and this pattern merits additional investigation by F5LA. The family planning rates were not associated with the religious affiliation of the hospital, suggesting that this is a training issue that could be addressed, not a site-specific policy issue. The findings do suggest some areas where F5LA could explore some improvements or clarity in Welcome Baby policies and procedures as described in more detail in next section.

Ongoing Monitoring for Quality Improvement

As described in this report, there is a wealth of data collected about Welcome Baby implementation and outcomes. Our analyses helps shed light on whether some of these data may be useful to monitor in the future to help ensure potential participants stay engaged in Welcome Baby and demonstrate good maternal and child outcomes. Specifically, we recommend the following:

- **Family risk factors:** Since characteristics of program participants may influence program participation, it may be helpful to continue to monitor these trends and be mindful that participants showing a particular risk profile may be likely to drop out so that strategies for retaining these families can be deployed.
- **Fidelity:** Given the relationships between the different fidelity domains and program retention and outcomes, F5LA should continue to monitor staff training (Domain 2) and qualifications (Domain 1), reflective supervision (Domain 4), hospital enrollment (Domain 7), service dosage (Domain 8), home visit content (Domain 13), and the community referral process (Domain 10).

- **Outcomes:**
  - We recommend deemphasizing outcomes with very high pass rates and/or very limited variability. For example, F5LA might consider removing the KIDI items from the client survey since there was not a lot of variability on these items, and there were no benchmarks.
  - Since there is room for improvement on family planning and safe sleep outcomes (particularly co-sleeping), it is worth continuing to monitor these to see if additional staff training results in improvement.
  - Although we were unable to include them in the analysis, we recommend continuing to monitor maternal depression rates. Given some concerns about the PHQ data and administration (see study limitations section), F5LA may want to consider refining the administration of the PHQ to be more consistent with guidance (i.e., self-administered), using the Edinburgh Postpartum Depression scale (EPDS; Cox, Holden, and Sagovsky, 1987) instead of the PHQ, and testing different administration methods (e.g., text-based administration between visits) for the depression measure.[4]

Study Limitations

In this section, we discuss several limitations to our evaluation, including missing data and data quality issues in regard to the fidelity and outcome domains and issues with our mixed method analytic approach due to delays in the data collection timeline.

Missing Data and Data Quality Issues

Here we discuss some of the challenges with the data since F5LA may be interested in finding ways to better capture data and assess site performance in the future. First, the evaluation was designed to gather information on the 14 elements or domains of program fidelity within the Welcome Baby Fidelity Framework. However, we lacked available data to assess site fidelity in three domains: prenatal recruitment and enrollment (Domain 6), family-centered approach (Domain 12), and provider responsiveness (Domain 14). For other domains (i.e., staff qualifications and training, supervision domains, workloads), we did not have access to full information across all sites. Data challenges also arose with the outcomes data collected to assess program outcomes in the Welcome Baby logic model. To assess parent knowledge, we proposed using the KIDI, a common scale used in the home visitation field to measure this outcome. However, during the design process, the scale was shortened and modified such that there were no benchmarks to compare findings. Moreover, as a result of the delayed rollout of the client survey component, we did not have access to enough data to examine possible site-level variation.

It is also important to note that many elements relied on self-report information that may be biased. For example, the content of home visits was based on Welcome Baby staff reports of

[4] The EPDS is tailored to assess postpartum depression and has been more commonly used among similar populations. For example, in a 2017 systematic review of assessments of screening tools for postpartum depression, three studies were identified using the PHQ and 23 using the EPDS (O'Connor et al., 2016).

what was covered in the visit. There could also have been bias introduced in the data collection methods, as we relied on Welcome Baby staff to recruit for the participant focus groups and to administer the client survey. It is possible that participants who were not satisfied with the program were less likely to be recruited for the focus groups or asked to complete the client survey.

As noted earlier, the study team determined that the extremely low prevalence rates of depressive symptoms in the SFDB meant that these data were likely not a valid representation of the true prevalence of depressive symptoms among Welcome Baby participants. There are several possible reasons for the low prevalence rates. First, clients are given the opportunity to opt out of sharing their mental health data with F5LA. While the overall opt-out rate was low, at several sites, more than 90 percent of clients opted out during some fiscal quarters. While we might expect that mothers who are not inclined to share these data are also at higher risk for mental health issues, such as depression, the low rate of depressive symptoms is consistent across all sites, including those that had high authorization rates (i.e., rates that were above 95-percent authorization). Second, the PHQ was developed to be a self-administered instrument and validated for pen-and-paper as well as electronic administration (Erbe et al., 2016). The reliability of the PHQ when administered verbally has not been well-established (Mission Health, 2018). In the Welcome Baby model, the PHQ is administered orally. The possible threats to the validity of this measure under this administration method include clients' discomfort with divulging sensitive mental health information. Indeed, in the Latino population, stigma associated with revealing potential mental health issues has been well-established (e.g., Interian et al., 2010; Interian et al., 2011; Vargas et al., 2015). We examined findings by race/ethnicity, and we did find that Latino participants were less likely to report mild or moderate depressive symptoms compared with other ethnicities. However, these rates were much lower than expected in the non-Latino population.

Delays in Data Collection

The proposed evaluation blended the collection of both qualitative data, in the form of staff interviews and focus groups with clients, with quantitative data collected via Staff and Client Surveys, home observations, and data from the SFDB. One of the goals of the evaluation was to use the qualitative data from the staff interviews and client focus groups to explain patterns found in the data collected via the quantitative means (Staff and Client Surveys, home observations, and database). However, the collection of the data from the Client and Staff Surveys and home observations was delayed and occurred after the staff interviews and participant focus groups. As a result of the discrepancy in timing of these different data collection activities, it may not be sensible to assume that the data collected at the time of the interviews and focus groups would align with the quantitative data. For example, at the time of the interviews, the staff structure may have been different from when the staff completed the Staff Survey (e.g., the Program Manager may be in place at one time and not during the other), leading to variations in program delivery and support. Therefore, the perceptions reported during

the interview phase would be different from those during the Staff and Client Survey phase. We found evidence of at least one site where this occurred and therefore are limited in our ability to use the qualitative data to help explain patterns observed in the quantitative data set.

Conclusions

Despite some limitations, we were able to provide F5LA and Welcome Baby stakeholders with data-based information on the implementation and outcomes of the Welcome Baby program. Additionally, the findings inform the home visiting field as a whole, providing rigorous analysis of the factors contributing to home visiting program retention and assessment of referral networks. Overall, the study found a large amount of variability in the degree to which individual sites achieved fidelity to the Welcome Baby model and the rate at which thresholds were met across the different fidelity domains. Similarly, sites varied widely in the completeness of their referral directories and the availability of infrastructure to facilitate successful referrals. Despite variability in the services provided across the sites, clients reported generally high levels of satisfaction with Welcome Baby services and suggested a few ways to improve the program. Further, for more than half of the outcomes measured, Welcome Baby participants exhibited better outcomes compared to regional or national benchmarks. Finally, while several factors were associated with variation in Welcome Baby program retention rates, there were few instances in which program fidelity and client outcomes were related to retention. Overall, the results of the Welcome Baby evaluation can be used by F5LA and its stakeholders to better monitor program implementation and assist in achieving program outcomes.

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Agenda Item: 09
Date: February 28, 2019

FIRST 5 LA

<u>SUBJECT</u>:
Update on the Best Start Learning Agenda

<u>BACKGROUND</u>:
In collaboration with the Communities Department, the Integration and Learning Division (I&L) has continued work on the Best Start Learning Agenda since the Board's last update in June 2018. This memo will summarize progress made on the development of the Best Start Learning Agenda and identify areas of continuing work.

As a refresher, the Best Start Learning Agenda is an organizing tool that will help frame our learning about the Best Start investment over time. The Best Start Learning Agenda will be comprised of four components: (1) learning questions accompanied by methods for collecting information to answer the questions, (2) a communication plan that details how progress will be shared and with whom over the course of the learning agenda lifecycle, (3) a meaning-making plan that outlines how we will process and reflect on the information we are collecting, and (4) a dissemination plan that addresses how we will share what we are learning and how we are using that information to improve our strategies with stakeholders and the broader place-based field. We are conceptualizing the Best Start Learning Agenda as both a process and a product, since the development of the learning agenda requires that we identify and document our learning priorities and the implementation of the learning agenda will provide us opportunities to gather and reflect on information – all in service of refining and improving our strategies on an ongoing basis.

In the last update to the Board of Commissioners in June 2018, we reported that we had accomplished the following: (1) identified our learning priority areas, (2) generated a list of potential learning questions, (3) engaged multiple stakeholder groups in prioritizing the learning questions, and (4) narrowed the list of prioritized questions to five key questions that will drive the learning agenda. Since then, we have made meaningful progress in developing a phased approach for rolling out the learning agenda, reexamining and adapting the learning questions to align with current thinking, developing and launching a formal stakeholder engagement plan, and developing an action plan for engaging Best Start parents and community members.

<u>DISCUSSION</u>:
Development of a Phased Approach
Implementing learning and evaluation mechanisms for any effort is a time-consuming and resource-intensive process, thus commissioning a learning agenda for an initiative like Best Start is a sizeable undertaking. Since the Best Start Learning Agenda is designed to focus in on complex aspects of the initiative, essentially both its implementation and outcomes, we have decided that it is necessary to use a phased approach. Phase 1 will focus primarily on understanding the implementation of the new approach to community capacity building and the strengthening of community partnerships as network leaders. Phases 2 and 3 will focus primarily on understanding local and regional networks' capacity to implement community change agendas and policy and systems changes occurring in each of the Best Start communities. In all phases of the learning agenda, we will be self-reflective and consider First 5 LA's evolution as an agent of policy and systems change on an on-going basis.

A phased approach will allow us to be more strategic with our efforts and focus in on answering certain learning questions at certain points in time. For example, since the rollout of the new regional with local customization support structure, it makes sense to first invest our resources in understanding *how* the new structure is supporting community partnerships' growth as stronger local and regional network leaders of 0-5 advocates. By obtaining a foundational understanding of how this is happening in Phase 1, we will be well positioned to deeply explore the policy and systems changes that those networks are actively working to achieve in subsequent phases. The timeframe for Phase 1 will tentatively run through June 2020, while the timeframes for Phase 2 and Phase 3 are still to be determined.

Reexamination and Adaptation of Learning Questions

Since the support structure for Best Start has been in transition and many aspects of this work is emergent, it was important that we carefully consider the learning questions and adapt them to align with emerging clarity and purpose for the investment as needed. While we were careful to avoid changing the intent of what each question was trying to answer, there have inevitably been some shifts in the scope of the questions and how the questions are framed.

The first question, for example, previously sought to understand how the new regional with local customization structure is supporting the community partnerships' ability to engage in policy and systems change. There is actually, however, a more comprehensive approach at play here – one that involves the regional with local customization structure, but also includes First 5 LA's work to 1) strategically support relationship development with cross-sector partners, 2) identify and connect opportunities for public infrastructure resources with communities, and 3) support network growth through learning and field building. In the adapted question, this is referenced to as *the new approach*, and this thinking emerged as a result of conceptual conversations had as part of the Impact Framework work. It is important that this learning question is broad enough to fully capture how the Best Start communities are being supported.

One other adaptation worth noting in nearly all of the questions is the use of the term "Best Start networks" in lieu of "community partnerships." This shift in language represents the idea that community partnerships are evolving into networks that include other stakeholders, community leaders, advocates and organizations with a vested interest in prenatal to age five issues.

Original Question (June 2018)	**Adapted Question (February 2019)**
1. How is the new structure building the capacity of community partnerships to engage in policy and systems change efforts? What is working and not working?	1. How is the new approach being implemented? What are the facilitators and barriers to implementing the new approach?
2. How are the community partnerships connecting to existing community leaders, advocates and networks to increase the impact of collective efforts? How have these connections increased the collective focus on children prenatal to age five?	2. How are the Best Start networks connecting to existing community leaders, advocates, and other networks to increase the focus on and impact of collective efforts for children prenatal to age five?
3. To what extent does the regional and local network structure position the community partnerships to drive a change agenda?	3. To what extent does the approach to building capacity position the Best Start networks to drive policy and systems change?

Original Question (June 2018)	Adapted Question (February 2019)
4. To what extent do policy and systems changes occur regionally and locally through community partnerships' community change work? What factors influence the effectiveness of policy and systems change efforts and how?	4. To what extent does policy and systems change occur through Best Start networks' efforts? What factors influence the effectiveness of their efforts and how?
5. How is First 5 LA adapting and evolving as an agent of policy and systems change as a result of its work with the communities?	Question has not been adapted.

Development and Launch of the Stakeholder Engagement Plan

In the last update to the Board of Commissioners, we identified that one of our next steps in moving the learning agenda forward involved ongoing stakeholder engagement. Since then, we have taken steps to solidify a plan for doing so. This plan will guide our efforts to strategically leverage different perspectives at different points during planning and implementation of the learning agenda. The stakeholder engagement plan identifies the groups of stakeholders we plan to engage, the mechanisms or formats we will use to engage them, and the content around which we plan to engage them. We will continue to build on this plan by incorporating a timeline for sequencing convenings of different stakeholder groups as components of the learning agenda begin to take shape.

The stakeholder engagement plan was formally launched in October 2018. We have socialized the entire Communities Department staff to the learning agenda, and we will continue to engage the leadership team and program officers as we move into developing other components. We also brought on a contractor to facilitate a four-month long engagement with Best Start parents and community members slated to begin in late February 2019.

Development of an Action Plan to Engage Parents and Community Members

Authentic engagement of parents and community members is a core principle of Best Start, and we are committed to ensuring this group is meaningfully engaged to offer their voice, ideas, and feedback as the learning agenda takes shape. In July 2018, we hired a consultant to design and execute an engagement process over a four-month period to gain input from parents and community members about the learning agenda components. This group will act in an advisory capacity to provide us with feedback on our proposed plans for data collection efforts, facilitating meaning making, and sharing and dissemination of what we are learning. We will also be asking this group to identify potential ways that parents and community residents can be involved in an ongoing capacity as we begin implementing the learning agenda. As stated above, the engagement is slated to begin in late February 2019.

NEXT STEPS:

Next steps for the Best Start Learning Agenda include (1) formally launching Phase 1 of the learning agenda, which will focus in on developing methods, planning for meaning making and developing sharing and dissemination plans for learning questions 1 and 2, (2) revising narratives for all learning agenda questions to communicate the scope and intent of each question, (3) executing our stakeholder engagement plans for all key stakeholder groups to socialize the learning agenda and begin to solicit input and feedback, and (4) planning for contracting and procurement as we move into the actual implementation of Phase 1 of the learning agenda (data collection and information gathering activities, meaning making, and sharing and dissemination).