FIRST 5
MERCED COUNTY
www.first5mercedcounty.org

STRATEGIC PLANNING NEEDS ASSESSMENT

Prepared for the Commission's 2021-2026 Strategic Plan

Produced by

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"Strategic funders typically see themselves as accountable for successful outcomes."
—Forbes Leadership Strategy

INTRODUCTION

The Children and Families Act of 1998 requires First 5 Commissions to have a strategic plan to guide their work. Community input and data-driven or evidence-based strategic planning helps funders define their direction and decision-making process. This needs assessment provides the framework that will allow the Commission to more strategically plan and guide its future community investments to achieve desired results. The Commission engaged Barbara Aved Associates in December 2019 to research and prepare this report. The report is organized into 5 sections: an assessment of external data (Parts I and II); an assessment of operational and program information (Part III); an overview of systems-level and sustainability considerations and evidence-based interventions; and a brief summary of findings from other local needs assessments not otherwise included in the other sections of the report.

DATA SOURCES AND PROCESS

To launch the strategic planning process, we identified the issues of highest relevance to First 5's mission, and collected applicable data to inform the Commission of current needs, gaps, barriers and community perspectives. The information from this research came from the sources below.

Statistical Data (Secondary Data)

Data Dashboard. The most recently available and relevant statistical data from secondary data sources that aligned with each of the Commission's goal areas, such as the percent of children who visited a dentist in the past year, were identified, extracted and organized into a reader-friendly "dashboard" format. The Dashboard includes 56 indicators and allows the Commission and its partners and stakeholder groups to track these key data points and monitor progress toward the early childhood outcomes sought by First 5.

Community Input (Primary Data)

Parent Survey. A *Parent Survey* was designed to learn more about the needs and experiences of Merced County's 0-5 children and families (Attachment 2). The 16-question survey in English and Spanish was widely distributed between January and March to parents and other caregivers of children 0-5 at grantee and other community sites. A total of 1,338 parents responded to topics that included access barriers and utilization of services; nutrition and other preventive practices; early learning experiences; highest needs and concerns; and awareness and use of community resources.

Interviews and Provider Surveys. To gain an understanding of the perspectives of community leaders and individuals who work directly with families, we invited input to the strategic planning process through key informant interviews and surveys with provider/professionals. We posed many of the same questions to these groups to look for universal themes and common perspectives, tailoring some interview questions to individuals' specific areas of expertise.

- Twenty-one Key Informants representing a cross-section of Merced County health and human service and other professionals with a broad and informed perspective about the county's population and needs participated in a one-hour telephone interview with the consultant between January and February. (See Attachment 1 for a list of these individuals.)
- During late March and early April, 12 individuals representing First 5 Merced County providers and other community professionals responded to an emailed survey* that asked them to identify highest needs and top priorities, insights and recommendations for 0-5 children and families.
- Commissioners and staff also participated in individual interviews to structured questions; this opportunity afforded historical perspectives as well as input concerning planning, programming, evaluation and other operational issues (Attachment 1).

Key Evaluation Findings

Any available evaluation-related documents were sought and reviewed for findings that could inform strategic planning. We were particularly looking for conclusions about approaches that have increased parenting knowledge, skills, and practices; strategies that facilitated access to services; interventions that promoted children's developmental progress; and evaluation capacity-building offered to grantees that might have occurred among grantees.

Others' Approaches

We conducted a brief literature search and spoke with other funders to learn what best-practice interventions, sustainability and systems-level approaches, including revenue maximization strategies, have been used successfully elsewhere that could have applicability to Merced County.

Other Local Needs Assessments

Other relevant local needs assessments, when used or updated by us, allowed us to avoid duplication of effort. Some of these reports included:

- 2018 Community Health Needs Assessment Report (Valley Children's Hospital)
- Merced County Office of Education (MCOE) Head Start 2018-2019 Community Assessment
- Merced County Early Learning and Care Needs Assessment, Merced County Collaborative for Children and Families (MCOE)
- Merced County Community Health Needs Assessment and Community Health Improvement Plan (Merced County Public Health)
- Merced County Oral Health Needs Assessment and Community Oral Health Improvement Plan (Merced County Public Health)
- Merced County Public Health – Maternal Child and Adolescent Health Needs Assessment

* The original plan was to use focus groups. The two meetings that were scheduled had to be cancelled because of the work-from-home mandate due to the COVID-19.

FINDINGS

Overview of Selected Merced County Child Demographics and Socioeconomic Indicators

Child Population by Age Group (2018)

- Ages 0-2 - 12,212
- Ages 3-5 - 12,706
- Ages 6-10 - 22,365

CA Department of Finance, Race/Ethnic Population Detail

Child Population by Ethnicity

- African American 2.8%
- American Indian 0.2%
- Asian American 6.5%
- Hispanic/Latino 70.5%
- White 17.7%
- Multiracial 2.1%

CA Department of Finance, Race/Ethnic Population Detail

Top non-English Languages Learners, K-6th Grade (2017-18)

- Spanish - 92% (13,694)
- Hmong - 4% (569)
- Punjabi - 2% (243)
- Other - 1.6% (251)

CA Department of Education, Demographics by Language Group

Migrant Students Ages 0-12 (2018)

- Infants and Toddlers - 172
- Preschool - 420
- School-Age - 1,375
- Total Migrant Families - 1,034

Merced County Office of Education, Migrant Education Program

Children with Special Needs (2016)

	0-2 yr	3-5 yr	6-12 yr
Intellectual disability	0	0	236
Speech or language impairment	43	263	735
Other health impairment	34	13	262
Emotional disturbance	0	0	45
Specific learning disability	0	0	1308
Autism	0	210	284

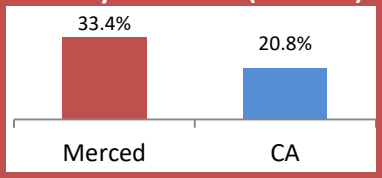
CA Department of Education, Special Ed Division (MCOE report)

Health Insurance Coverage (Ages 0-6)

- Medi-Cal (83%)
- Employment-based (17%)

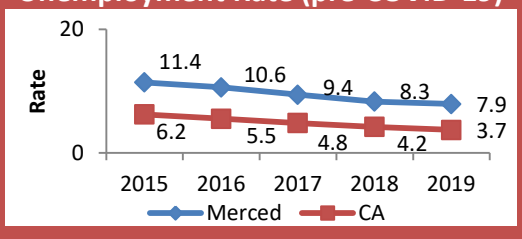
UCLA CA Health Information Survey, 2018.

Percent of Children < Age 18 Living Below Poverty Threshold (2013-17)



Public Policy Institute of CA & Stanford Center on Poverty and Inequality

Unemployment Rate (pre-COVID-19)



CA Employment Development Department, Labor Market Information

PART 1: 2020 DATA DASHBOARD (Statistical Data)

The dashboard below displays Merced County's progress toward the early childhood outcomes sought by First 5. Each strategic result area is measured by a community-level indicator; the county's status on each of the 56 indicators is compared to California state averages. Unless otherwise noted, the time period for the state data is the same as county period. It should be kept in mind that some age, race/ethnic and other differences may exist in population data. Merced County status is compared to statewide averages using the rubric below:

⇧ = Better than the state average (favorable condition)
⇩ = Poorer than the state average (unfavorable condition)
⇔ = Similar (same or relatively close to the state average)
N/R = Not rated (not applicable or neither favorable nor unfavorable)

Result Area	Indicator	Merced County	California	Compare
DESIRED OUTCOME: HEALTH AND DEVELOPMENT Children achieve optimal developmental, behavioral and social-emotional health 				
Birth Rate	The number of births per 1,000 women age 15-44.[1]	71.5 (2006-2016) (Merced/Modesto region)	60.6	N/R
Access to Prenatal Care (Adequate/ Adequate Plus Prenatal Visits)	The percent of women who begin prenatal care in the first trimester of pregnancy.[2]	67.5% (2015-2017)	83.5%	⇩
	The percent of births with mothers receiving adequate number of visits.[3]	65.2% (2015-2017)	77.9%	⇩
Low Birth Weight	The percent of babies born with low birth weight (<2500 grams).[4]	6.4% (2015-2017)	6.9%	⇧
Infant Mortality	The number of deaths of children less than one year of age per 1000 live births (rate).[5]	4.0 (2015-2017)	4.4	⇧
Breastfeeding	The percent of women who initiate any or exclusive *breastfeeding after childbirth,*[6] *and* the percent of women who continue breastfeeding for at least 3 mos.[7]	Any 92.6% Exclusive 60.4% (2018) Hospital / Any / Exclusive Memorial 90.7% 46.9% Mercy 93.5% 65.3% MIHA follow-up data (2013-15) Any, at 1 mo. 80.1% Exclusive, at 1 mo. 37.5% Any, at 3 mos. 63.8% Exclusive, at 3 mos. 22.7 %	Any 93.3% Exclusive 70.4%	⇔
Immunization	The percent of children fully immunized by entry into kindergarten and enrolled in licensed child care facilities.[8]	97.5% entering kindergarten (2018-19) 97.0% (avg) enrolled in child care centers (2018-19)	94.8% 95.9%	⇧ ⇧

Result Area	Indicator	Merced County	California	Compare
(HEALTH AND DEVELOPMENT continued)				
Oral Health: Access	The percent of all children[9] and children with Medi-Cal[10] with a dental visit in the last 12 months.	93.4%, all children ages 2-11 (2018) Children with Medi-Cal: (2017) 19.9% ages 1-2 50.9% ages 3-5 58.2% ages 6-9	81.2% Children with Medi-Cal: 27.1% ages 1-2 53.4% ages 3-5 61.7% ages 6-9	⇧ ⇩ ⇔ ⇔
	The percent of women with a dental visit during pregnancy.[11]	27.8% (2013-2015)	43.0%	⇩
Untreated Decay	The percentage of kindergarteners screened with untreated dental decay.[12]	25% (2017)	Fluctuates, but average is ~ 23%	⇔
	The percent of children that get juice or sugary beverage in their bottle or sippy cup.[13,14]	7.2% - regularly 57.4% - sometimes (2018)	36%	N/R
Nutrition and Fitness	Percent of 5th graders who are overweight or obese.[15]	46.9% (2017-18)	40.5%	⇩
	Percentage of 5th graders meeting 6 of 6 Healthy Fitness Zone fitness standards.[16]	15.8% (2018-19)	23.1%	⇩
	The proportion of women who are obese before pregnancy (that can influence the risk of obesity for the child)[17]	26.4% (2013-15)	20.3%	⇩
	The percent of children that eat 5 or more servings of fruit/vegs daily; percent that ate fast food 2 times last week.[18]	66.9% (2018) 35.1% (2016)	27.0% 18.8%	⇧ ⇩
Children's Mental Health	Number of hospital discharges for mental health issues per 1,000 children and youth ages 5-14.[19]	2.8 (2018)	2.7	⇔
Children's Emotional/ Developmental Health Status	The percent of children 0-5 screened for developmental/ social-emotional with indications requiring a more comprehensive assessment or referral for services. *(Using a standardized assessment tool.)*	922 ASQ screened 21.1% needed referral (Head Start)[20] 206 ASQ screened 25.7% needed referral (Merced Co HSA, 2019)[21] _____ Note: Merced PH was unable to provide requested CHDP screening data results.	NA	N/R
Maternal Mental Health	The percent of women with postpartum depression.[22] (*Which can affect children's emotional and behavioral outcomes.*)	17.8% (2013-15)	13.5%	⇩

Result Area	Indicator	Merced County	California	Compare
DESIRED OUTCOME: STRONG FAMILIES Families Raise Their Children in Safe, Stable and Nurturing Homes				
Family Structure	Number and percent of families living with own children ages 0-5 only.[23] (*"Families" defined as a householder and one or more other people related to the householder by birth, marriage, or adoption.*)	5,067 (6.4%) (2017)	6.3%	⇔
	Percent of children ages 0–17 living with two married parents present.[24]	55%	63.7%	⇩
	Percent of children ages 0-17 living with grandparents who provide primary care for one or more grandchildren in the household.[25]	3.3% (2013-17)	3.2%	⇔
Child Abuse and Neglect: **Suspected and Reported**	Rate of children with *reported* (allegations) cases of abuse and neglect, per 1,000 children.[26]	(2019) By child age < age 1: 79.4 ages 1-2: 57.7 ages 3-5: 60.3	By child age < age 1: 67.0 ages 1-2: 45.7 ages 3-5: 49.9	⇩
Substantiated	Rate of children with *substantiated* cases of abuse and neglect, per 1,000 children.[27]	(2019) Substantiated cases by child age < age 1: 23.1 ages 1-2: 8.2 ages 3-5: 8.0	Substantiated cases by child age < age 1: 22.6 ages 1-2: 9.2 ages 3-5: 7.8	⇔
Foster Care	Rate of first entries into foster care per 1,000 children age <18.[28]	< age 1: 13.0 ages 1-2: 4.3 ages 3-5: 3.1	< age 1: 12.2 ages 1-2: 3.6 ages 3-5: 2.6	⇔
	Percentage of children age <18 who have been in foster care less than 12 months, by number of placements during their stay in care.[29]	62.2%, 2 or fewer placements (2017) 37.8%, 3 or more placements	67.8%, 2 or fewer placements 32.2%, 3 or more placements	⇩ ⇩
Domestic Violence	The number of domestic violence calls for assistance.[30]	1,541 (2017)	NA	N/R
	Percent of women who experienced physical or psychological intimate partner violence during pregnancy.[31]	10.1% (2013-14)	7.0%	⇩
Unintentional Injury Hospitalizations	The rate of hospitalizations due to non-fatal unintentional injuries per 100,000 children age 0-20.[32]	135.7, ages 1-4 (2014) 79.4, ages 5-12	212.2 118.1	⇧ ⇧

Result Area	Indicator	Merced County	California	Compare
DESIRED OUTCOME: HIGH-QUALITY LEARNING Children Have Access to High-Quality Early Learning Opportunities 				
Unmet Need and Availability of Child Care	The estimated unmet child care need, i.e., children not participating.[33] (*Note: Calculations are estimates due to missing counts, duplicative enrollment and other challenges.*)	2016 / For Children in Low-Income Families: Infant/Toddler / Preschool Programs Meeting Title V Stds: 96% / 58% All Programs: 84% / 40% 2016 / For Children in Working Families: Infant/Toddler / Preschool Programs Meeting Title V Stds: 98% / 39% All Programs: 87% / 17%		N/R
	The estimated percent of children with parents in the labor force for whom licensed child care is available.[34]	19%, in 2017 (Based on the 5,976 licensed child care center and family home center slots in Merced County; doesn't include license-exempt programs)	23%	⇩
	Average annual cost of licensed child care.[35]	Child care center: Infant $11,838; Preschool $7,893 Family child care home: Infant $7,389; Preschool $7,079	Child care center: Infant $16,451; Preschool $11,202 Family child care home: Infant $10,609; Preschool $9,984	⇧
Preschool Enrollment	The estimated percentage of children ages 3-5 enrolled in preschool or transitional kindergarten.[36]	44% 2018	49%	⇩
Early Literacy	The percent of children ages 0-5 whose parents read books with them every day.[37]	26.4% (2018)	63.2%	⇩
Reading and Math Proficiency	The percent of 3rd grade children at grade-level proficiency in reading and math.[38]	41% English (2018-19) 26% Math	48.5% English 50.2% Math	⇩
Language	The percent of the population age 5+ who speak a language other than English at home.[39]	52.3% (2013-17 average)	44.0%	N/R
	The percent of children ages 0-17 living in households in which no person age 14 or older speaks English "very well."[40]	15.7% (2012-16 average)	10.8%	⇩
English Learners	The percent of English Learner (EL) students at Risk of Becoming Long-Term English Learners (EL students for 4 or 5 Years), grades 3-12.[41]	39.2% (2018-19) (varies by school district)	36.3%	⇔

OTHER COMMUNITY DETERMINANTS Related Indicators of Well-Being				
Connection to Community Resources	The number of 2-1-1 calls requesting a community referral.[42]	1,300 calls to 2-1-1 last year 98-120/mo. avg). *(Affordable housing/rentals/shelters was the main need, followed by assistance for utilities and funeral costs.)*	NA	N/R
Poverty	The percent of children in deep poverty.[43]	15.8% (2017)	7.2%	⇩
Food Security	Percent of adults unable to afford enough food (food insecure). [44] The percentage of children ages 0-17 living in households with limited or uncertain access to adequate food.[45]	36.7% (2018) 24.4% (2017)	37.4% 18.1%	⇔ ⇩
Educational Attainment	Percent of population age 25 and older with less than and with only a HS/GED diploma.[46]	31.1% (2017) 25.1%	17.5% 20.6%	⇩
	The percent of mothers (women who gave birth in a given year) with no HS/GED diploma.[47]	23.4% (2013-14)	16.3%	⇩
Homelessness	The percent of public school students recorded as being homeless at any point during a school year.[48] (*Disrupts family relationships, puts child health and safety at risk and hampers development.)*	2.8% (2016)	4.4%	⇧
Births to Adolescents	The number of births per 1,000 females ages 15-19.[49]	26.0 (2015-2017)	15.7	⇩
	Percentage of repeat births (all births to mothers aged 15-19 with one or more previous live births).[50] *(Associated with greater hardship for infants as they're more likely born prematurely.)*	18.4 (2015-2017)	16.1	⇩
Exposure to Second-hand Smoke: Adult Smoking **Maternal Tobacco Use**	Percent of individuals age 18+ reporting current cigarette smoking.[51]	19.3% (2018)	11.2%	⇩
	Prevalence of maternal smoking 3 months prior to pregnancy.[52]	12.8% (2013-2015)	10.8%	⇩
Exposure to Lead	The percent of children ages 0–5 screened with elevated blood levels (lead greater than or equal to 4.5% µg/dL.[53]	1.85% (2018)	1.48%	⇩
Adverse Childhood Experiences (ACES)	Prevalence of people with ACES in the county.*[54] *Combined with Madera and San Benito counties	0 38.2% 1 24.6% 2 or 3 24.9% 4 or > 12.3%	0 38.3% 1 21.7% 2 or 3 23.3% 4 or > 16.7%	⇔

DASHBOARD SUMMARY
(56 Indicators)

DESIRED OUTCOME (n = number of indicators assessed)	MERCED COUNTY COMPARED TO CA	
Health and Development (n = 23)	⇧	6
	⇩	9
	⇔	5
	N/R	3
Strong Families (n = 12)	⇧	2
	⇩	5
	⇔	4
	N/R	1
High-Quality Learning (n = 9)	⇧	1
	⇩	5
	⇔	1
	N/R	2
Other Community Determinants (n = 12)	⇧	1
	⇩	9
	⇔	2
	N/R	0

Key:

⇧ = Better than the state average (favorable condition)

⇩ = Poorer than the state average (unfavorable condition)

⇔ = Similar (same or relatively close to the state average)

N/R = Not rated (not applicable or neither favorable nor unfavorable)

PART II: COMMISSION & COMMUNITY INPUT

"These families are in survival mode every day of their lives." – Key Informant Interview

Community input—the primary data—is key in identifying needs and offering informed perspectives about ways to address them. This section of the assessment report highlights findings from Interviews, and Provider and Parent Surveys. The perspectives of these groups generally aligned with the dashboard data presented above.

COMMISSION AND STAFF INTERVIEWS

Five of the 8 Commissioners who chose to participate in a one-on-one telephone interview and the 3 staff provided input about community needs, issues and suggested approaches, and their input is combined as "the Commission" in the summary below. (Note: Commission input concerning internal/operational issues is included in Part III of this report.) It should be noted that the interviews were conducted pre-COVID-19.

Most Important Concerns and Needs

Parent engagement and "ineffective parenting" were among the most commonly mentioned concerns relative to Merced County families with young children (Figure 1). Screen time and other forms of technology were said to be interfering with parent/child bonding as well as having a negative impact on early literacy. Disparities among race/ethnic groups in parent knowledge about child development are apparent and also a concern.

Children's access and utilization of oral health services was specifically identified as a top concern, especially those with Medi-Cal, given the importance of regular visits, caries risk assessment, and the need for parent education. There was mentioned again in questioning whether Medi-Cal Managed Care is doing enough outreach, especially in regard to follow-up appointments, as well as ensuring children are receiving primary care services, and not only referred for but make regular dental visits.

Figure 1. Top Concerns and Needs Relative to the 0-5 Population

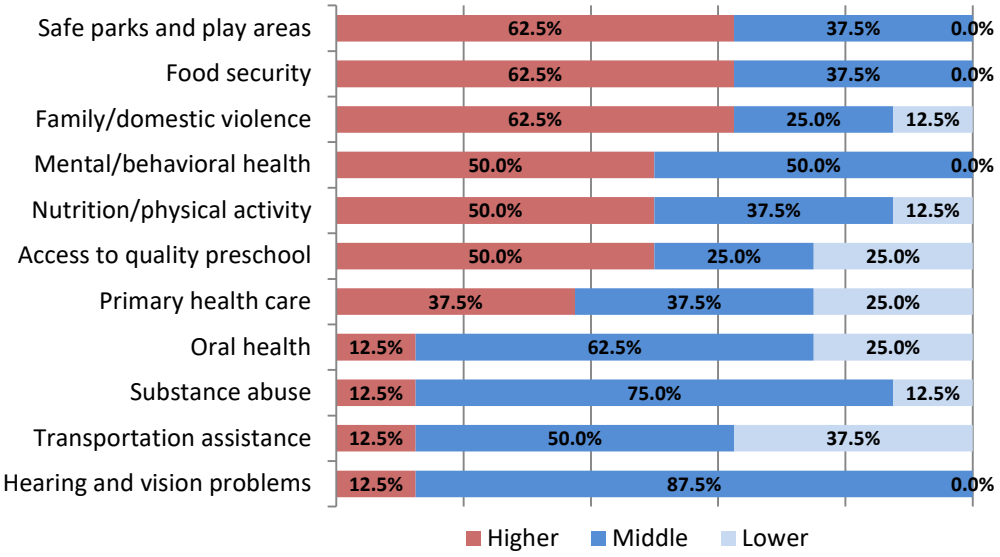
- Safe, affordable housing
- Poor parent-child bonding/engagement
- Children's oral health
- Fulfillment of Medi-Cal Managed Care contract responsibilities
- Access to good quality food
- Access to reliable, affordable transportation

Recommended Priorities

Given the knowledge of the extent of community need, *and some understanding about where other monies are currently or expected to be available,* the Commission was asked to rank 12 priority problem areas (Figure 2), with no presumption about the strategies for addressing them. The purpose was to assess the extent of accord among the interviewees. This was a challenging exercise because all of the concerns clearly are important, all are interconnected, and all have a direct or indirect impact on each another.

Of highest priority for First 5 funds over the next 5 years were safe parks/play areas and food security (62.5% agreement), followed by concerns around domestic violence. The issue of children's behavioral/mental health was also believed to be a highest priority (50% agreement) followed closely by the need to address poor nutrition and inadequate physical activity and access to quality preschool. Other areas such as hearing and vision problems were not viewed as *un*important but just less of a priority for First 5 to take on. As you will see in the next section, except for concern about children's mental/behavioral health, this input lines up in many places with the rankings of the Key Informants.

Figure 2. Commissions' Relatively Ranked Priorities for First 5*



*By rank order for highest priority

Intervention Strategies

The most common response to the question of what type of program strategy should be supported to impact the identified needs was home visitation (Figure 3). While this is a service-intensive strategy—challenging the concept of shift-from-client-services-to-systems-level-funding—the Commission felt strongly that home visitation should remain a key strategy. An example of a specific investment to promote children's mental health was early identification of behavioral risk issues and referral for further evaluation and/or treatment—which could of course be facilitated through support for home visitation as well as enhanced training for childcare and preschool staff. The

recommendation for more support for community-based organizations to help address the priorities included skill building of existing CBO personnel and ensuring they have adequate staffing, as well as the idea of identifying a strong fiscal intermediary in the community that could serve certain administrative functions (e.g., maintain liability coverage, offer supportive services) for less "sophisticated" applicants. One individual observed that support had been limited to "just putting money into little pockets of areas" and not being more proactive throughout the county.

The ideas around FRC development included establishing more 1-stop-shopping service opportunities, and having an active referral database. A more comprehensive communications plan ("*establishing a First 5 Merced brand*") would help raise visibility, promote health/social messaging, and potentially encourage other funders to collaborate in endorsing First 5 priorities. In shifting to more systems-level investments, brought up by just one of the interviewees, First 5 should think about addressing policies as well as practices.

Figure 3. Commissions' Suggested Program/Grant Strategies for More Impactful Results

- Home visiting programs
- CASA, and CASA-like programs
- Approaches that promote mental health, particularly maternal mental health
- Capacity-building for community-based organizations
- Tailored outreach for underserved populations
- Education/information for the public about available resources
- Family Resource Center-type entities
- Help Me Grow
- Be OK with narrowing and then focusing on selected priorities
- Look for more applicants beyond the usual players (than MCOE, for instance)
- Establishing a comprehensive communications plan
- More systems-level investments

Potentially Under-Utilized Opportunities

Besides the opportunity afforded by incorporating more data analytics into the program, the Commission did not know of current or future opportunities First 5 might be unaware of or not taking sufficient advantage of; one interviewee, however, believed there was potential for the Commission to do more through Help Me Grow. One individual pointed out that since many of the Commissioners were agency heads, they were generally aware when there were new funds, new policies and legislation, etc.

Support for Providers/Professionals

Nearly all of the interviewees thought First 5 had not done enough to support the professional/ provider community. Some of the specific areas in which the Commission hadn't either proactively reached out or been responsive included: education (e.g., helping pediatricians understand the

effects of poverty on nutritional status); capacity building (e.g., helping prospective applicants in grant seeking to make them competitive for First 5 and other funders);
Short staffed to do it themselves – but could bring in experts from the outside (e.g., workshops in grant writing, grantseeking, evaluation capacity), arrange for

Missing Stakeholders

In general, the Commission felt comfortable with stakeholder reach except, according to a couple of individuals, questioning whether it had enough ways to hear from the Hispanic/Latino community in terms of "missing voices" and/or funding opportunities.

"Some parents come from families who haven't valued education. They think 'teaching' kids takes a major time commitment but it really doesn't; it's the small, consistent amounts of time that count."
– Key Informant Interviewee

Gaps and Needs

Thinking about the scope of the First 5 Desired Outcomes, the 21 Key Informants (see Attachment 1) were asked to identify the top gaps—in knowledge, services, policies and so forth—relative to Merced County's 0-5 population. (It should be noted that the interviews were conducted pre-COVID-19.) We asked them to distinguish "gaps" from "needs" as something *needed* might already be being addressed in the community, adequately or otherwise, while a *gap* represented something more glaringly unfulfilled or unmet. Over half of the interviewees cited as a major gap "parent knowledge about good parenting" and the lack of resources to support this learning (Figure 1). Some thought parents seemed afraid to parent their children and were not engaged enough ("*sitting on a park bench watching your child play while you're on your cell phone is* not *engagement*")—the consequences of which, they observed, were an increasing number of children with behavioral issues and children with learning difficulties such as language development ("*the children are 'communicating' with a cell phone; that's not learning how to talk*"). Interviewees stressed the need for *early* identification of problems—and intervention.

Figure 1. Top Four Gaps Identified Relative to the 0-5 Population* (n=20)

- Parent engagement and resources to improve parenting.
  - Parenting skills are a key factor in long-term child outcomes.
- Childcare for working parents, especially with infants and toddlers.
  - A number one barrier for parents to seek/keep a job.
- Transportation system inadequacies.
  - Limits access to services, contributes to no-show rates, intensifies social isolation.
- Lack of affordable housing.
  - Results in too many children being raised in unsafe, unstable environments.

* In order of frequency of mention.

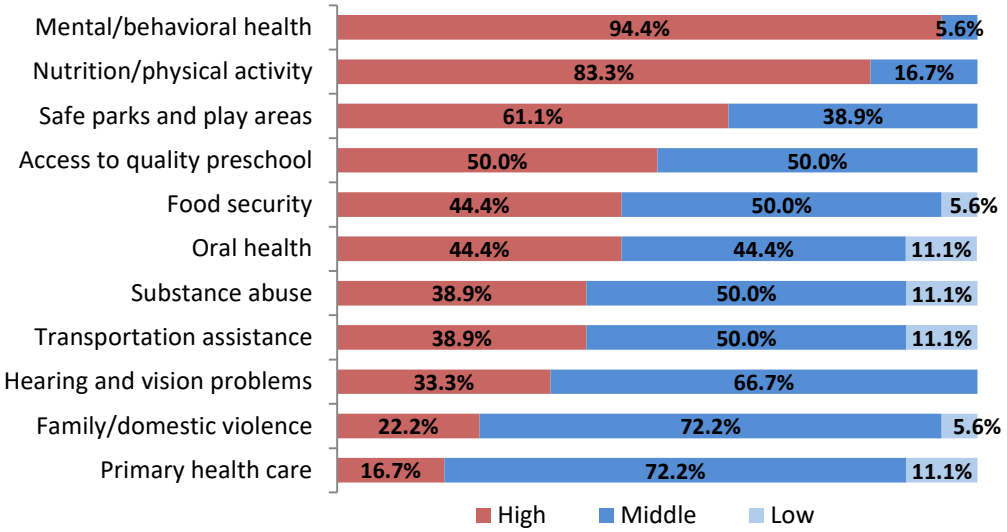
Finding appropriate, affordable and high quality childcare for 0-5 was believed to be "painfully difficult and absent." Transportation was said to *"come up in all conversations"* despite the transportation benefit available to Medi-Cal managed care plan members. Although not as "crazy" as some places in the state, the cost of affordable housing in Merced was acknowledged as still beyond the means of many families ("….*obviously transient families can't be found for follow-up when there's a problem*"). A point was also made that the presence of so many UC Merced students has taken up apartments and other rental properties that would otherwise be available to low-income families—and contributed universally to higher rents in the community.

Additional insightful comments included the following:

- *"The numbers of kids with social and emotional health needs has been growing, but more importantly the severity is increasing greatly. How much more can the early childhood education community take on in the absence of parent involvement?"*
- *"Communities have too few places to recreate—to come together, socialize and establish relationships."*
- *"There's a big gap for the people who don't qualify for anything—not poor enough for public benefits, not affluent enough to pay for services themselves."*
- *"Sometimes the diagnosis doesn't qualify people for services; not bad off enough, but not well off enough either."*
- *"Health equity and other opportunities to optimize life sometimes get short shrift as a core value."*
- *"Leadership seems deaf to some of these issues—better parent awareness, family violence."*
- *"Maternal depression/postpartum depression—this keeps coming up in so many programs as a risk factor for child development."*

Given their knowledge of the extent of community need, *and where other monies are currently or expected to be available,* the interviewees ranked how much of a priority certain issues should be for First 5 funds over the next 5 years (Figure 2). The issue of children's behavioral/mental health was nearly universally believed to be a high priority (94.4% agreement) followed closely (83.3%) by the need to address poor nutrition and inadequate physical activity. Other areas such as hearing and vision problems, substance abuse and primary health care were viewed as important but less of a priority for First 5 to take on. Although not a specific problem First 5 was asked to solve, a number of individuals highlighted the lack of affordable housing and the impact homelessness has had on families in the county—all of these issues are exacerbated by homelessness, they said—and until families' basic living needs are met, to ensure safe, stable homes, kids' health and learning were going to be compromised "no matter what strategies you put into place."

Figure 2. Key Informants' Relatively Ranked Priorities for First 5* (n=21)



*By rank order for highest priority.

Recommended Priorities/Grant Strategies

Challenged with making suggestions for what interventional strategies *they* would implement "if in charge of First 5 funds," to effectively address the gaps and needs they had identified (Figures 1 and 2 above), many of the Key Informants viewed home visitation as a "high return practice" (Figure 3 below). Some suggested creating more incentives for home-based care options. More family support—particularly parent education—within the context of home visits as well as community settings (e.g., project fatherhood), was advocated by at least half of the individuals. The second most common suggestion—which can also be addressed by home visitors—is early screening and identification ("get eyes on kids early before they have problems"). It's not enough, people said, for schools and pediatricians just to do assessments but to *refer* for further evaluation or treatment—and monitor family follow-through.

Five individuals thought the best way to address multiple issues was to put more money into nutrition education (emphasis on prevention such as reducing intake of sugar-sweetened beverages and junk food) and physical activity (emphasis on lowering screen time). Three individuals would want First 5 to use its funds to support a couple of comprehensive 1-stop shopping hubs, such as Family Resource Centers, to bring services closer to where families live especially in outlying communities; for example, offering linkage to training and employment for families who've lost benefits. The need for more collaboration was mentioned by several of the interviewees. One individual had observed "a shifting in First 5 funding that seems like there's more competition now and less collaboration."

Figure 3. Suggested Program/Grant Strategies for Impact

- Home visitation programs; reach out more to children with special needs.
- Do more early ASQ screening and referral.
- Nutrition education and promotion of physical activity.
- Strategies that promote collaboration, e.g., work toward shared outcomes.
- Support a hot-line or other means (e.g., 2-1-1) of making people aware of resources—location, eligibility, and current capacity.
- Open more childcare slots for low-income working parents.
- Provide money for grantees to offer incentives like childcare and transportation to promote attendance at parent education events.
- Create and/or help support Family Resource Centers (best practice model).
- Policies that address ethnic/racial equity.
- Messages and other educational interventions that address marijuana use (including vaping) during pregnancy based on increased use patterns providers are observing.
- Sponsorships that create recreational opportunities for low-income families.
- Fund local campaigns that promote read/sing/play with your kids using more creative communications (e.g., grocery bags, banners across G St.).
- Incentivize businesses to create scholarship programs and buy into the social impact
- Integrate training for trauma informed care in all First 5 programs ("and in everybody's care system").
- Anything that moves parents toward becoming greater advocates for their children.

*In rank order by frequency mentioned

Under-Utilized Opportunities

The opportunities—current or future—First 5 could be underutilizing or perhaps not taking sufficient advantage of to accomplish its goals, according to about half of the Key Informants who responded to this question, are listed in Figure 4 below. Some of them said they not know if the Commission was aware of these prospects, but certainly could be.

Figure 4. Potentially Underutilized Opportunities or Resources

- New home visitation programs
- New state preschool funds.
- New city and county housing monies.
- Use of local library branches that can serve as community gathering places as well as sponsor early literacy events.
- A strong 2-1-1 system in place that provides comprehensive, accurate referral information to callers.
- Collaborative opportunities with the local food bank.

Duplication

It is notable that when asked about this, only one of the 21 interviewees could think of a *possible* example of an unnecessary or wasteful duplication of programs or services in Merced County—fluoride varnish. Most people shared the belief expressed by one interviewee, "I think we don't have enough services, nor have them in enough places, not that we have too many."

Support to the Provider/Professional Community

Capacity-building for local organizations that need either a boost in grantwriting skills or an appropriate fiscal agent to be able to implement their proposed program was the most common suggestion for ways First 5 could be more helpful to the provider/professional community (Table 1 on the next page). Interviewees acknowledged that "there are only so many strong players in Merced County" but some who remarked "First 5 should push back on the big agencies" believed there were other organizations that could be "brought into the fold" with a little help. One example was to connect more with programs like the business schools at UC Merced or CSU Stanislaus and explore opportunities for pro bono consultation by faculty or graduate students.

People also thought First 5 should take a more visible leadership role in being the champion for children and families ("they recognize the 'little hand' [logo] but don't necessarily see the people out in the community behind it"). A couple of individuals remarked that First 5 "used to be a bigger presence in the community—and used to have a robust Technical Advisory Committee—but not so much in recent years." Many agreed First 5 was "so primed to be able to influence change regionally" but didn't take enough advantage of it. The recommendation to play a greater convener role "and tackle selected issues" was also mentioned as another way to affect systems change.

Suggestions around education opportunities were for workshops, summits, brown bag lunches and similar events—speakers with cultural awareness—that provide information about best practices, "not just sharing statistics on what you've been doing or who you've been funding [as in the past]."

Table 1. Recommendations for More Provider/Professional Support

Opportunity	Strategy
Build capacity of local organizations	▪ Sponsor a grant-writing workshop every couple of years ▪ Sponsor a workshop to increase internal evaluation skills ▪ Identify a fiscal partner to serve as an administrative agent ▪ Offer or arrange for coaching/mentoring
Take on more of a convener role	▪ Bring more people to the table around issues, promote awareness and advocacy through communications strategies, advocate, and build more diverse partnerships ▪ Do more community outreach, e.g., pop-ups at events to distribute educational materials
Sponsor educational opportunities	▪ Bring in trainers ▪ Bring in expert speakers ▪ Support more evaluation activities ▪ Take advantage of UC Merced faculty expertise
Promote collaborative activities	▪ Create new or partner with existing (and diverse) groups ▪ Require grant applicants to demonstrate collaborative strategies

Missing Stakeholders

Most of the interviewees could not identify stakeholders or communities they thought First 5 wasn't hearing enough from; several thought First 5 had "been good about" reaching out. But when they did name a group it was generally African Americans whose needs they said might not being well-enough addressed. A second-mentioned group was business community leaders. "Missing voices from the public in Los Banos/Dos Palos" (i.e., the Western part of the county) was noted by one individual.

Additional Comments and Recommendations

Other comments and recommendations from these interviews that are important to share with you are displayed below in Table 2. The statements are verbatim, and in no particular order.

Table 2. Additional Input from Key Informants

Recommendation	Comment
▪ "Share this Needs Assessment report with the community." ▪ "Hold convenings around the Data Dashboard that's been developed for this Needs Assessment." ▪ "Develop the capacity of the First 5 staff around fiscal management and budgets so they can help local organizations and do more around evaluation." ▪ "Take a risk, take a bolder approach around policies that affect 0-5 kids."	▪ "First 5 has a reputation of holding grantees accountable (e.g., with monthly reports) but staff doesn't always respond to it except with specific questions." ▪ "We get little in the way of evaluation feedback." ▪ "Merced County has too much siloed funding, so funding gets diluted. ▪ "Many have parochial interests around their issues, making collaboration a challenge." ▪ "There is a bigger role for First 5 to play incentivizing businesses to buy into the social impact of poorly raised kids."

PROVIDER/PROFESSIONALS SURVEY

"Parents want to learn about themselves. Not just tools to raise their children but they want tools to understand their own behaviors." — Provider Survey Respondent

In late March – early April 2020, 12 providers/professionals—some of whom were current or previous First 5 Merced grantees—provided input to the Commission's strategic planning process through an emailed survey.[*] First 5 developed the mailing list and according to staff sent out about 100 surveys. The responses were sent directly to us to assure respondent anonymity and encourage candor. In some cases, several agency staff contributed to the survey feedback. We used similar questions—mostly open-ended in this case—to those asked of Commissioners and the Key Informants and used thematic analysis to look for common patterns and opinions. Despite the small sample size, these informed perspectives add insights about specific community concerns, needs and gaps, and perceptions about First 5 and suggestions about future direction.

Top Concerns and Needs

Asked to think about the desired result areas of First 5, the respondents identified what they believed were the most pressing 0-5 population concerns and needs *that First 5 should address* over the next 5 years. The need for greater promotion of the health and well-being of young children and their families was the consistent theme that arose from these surveys. Poor parenting role models for themselves, disparities in knowledge about child development, "self-interest," and "living in chronic survival mode," and "use of non-educational screen time" were mentioned most frequently in relation to concerns expressed about inadequate parenting responsibilities (Figure 1). Some felt that parents had left child raising to professionals, for example schools. Several respondents who identified this concern suggested that growing attention on ACES (and trauma informed care) provides a platform for helping parents develop better parenting skills. One individual believed the "main purpose of First 5 should be to raise the bar of parental responsibility and connectivity."

Figure 1. Five Top Needs and Concerns Relative to the 0-5 Population* (n=12)

- Parent responsibility for their children
- Maternal -infant mental health
- Children's behavioral issues affecting learning
- Support for early childhood education and educators
- Positive cultural identity (Hmong children in particular)

*In order of frequency mentioned

Maternal and child mental health, including children's "increasing intensity" of behavioral issues ("partly a result of ACES"), and recognition of the need for more and better quality child care and preschool opportunities were also specifically cited as top issues. Concerns specific to the Hmong

[*] Our original plan had been to hold focus groups—some were already scheduled—where we could engage in dialogue with community professionals. However, due to COVID-19 meeting restrictions, we used a written survey instead.

community such as children "not continuing to fall behind in education" and "achieving more positive cultural identity" were identified within the context of building personal resilience. Also pointed out was concern about supporting families with children that have a clinical diagnosis or other special needs as well as addressing families' transportation difficulties.

Additional insightful comments related to the top needs included the following:

- *"Often times children who experience mental health/social-emotional difficulties also have parents and family members dealing with the same issues."*
- *"There's a high need to educate parents in a culturally sensitive way."*
- *"Parents need help to understand why and how literacy-building activities can be integrated in their everyday activities."*
- *"There was a time when the concept of 'family' was revered and protected; today the concept is so fluid as to have no meaning."*
- *"If there's anything we're learning from this COVID-19 and shelter-in-place is the need to understand how to play, teach, and respond to our children's different behaviors."*

Impactful and Systems-Level Strategies

The providers recommended a number of strategies First 5 should consider supporting to most effectively address the top needs they had identified—strategies that should be reflected in future RFPs. Figure 2 below lists the most commonly advocated approaches.

Figure 2. Funding Strategies that make the Most Impact

- Family Resource Centers
- Parenting classes that emphasize emotional connectivity
- Post-partum screening and evaluation and wraparound services
- Building a regional shared agenda to promote children's health and well-being
- Promoting and supporting the profession of early childhood educators
- The Promotores model, directed to education
- Investments in organizations and leaders people trust
- Support for parent advisory committees
- Training for professionals and others in trauma informed care

Trauma informed care, high ACES scores and robust wraparound mental health services were repeatedly referenced in describing recommended program investments. This included support for resilience-type curricula for families as well as professionals (with modifications appropriate to each sector), empowering parents to become their child's first teacher, earlier screening and referral, and investing in leadership and mentoring. One group suggested First 5 should create and implement a shared agenda in Merced County about how best to promote the health and well-being of the 0-5 population—and then invest in building the capacity and infrastructure to implement that agenda. They recommended the agenda development include a wide group of stakeholders including CBOS, schools, businesses, health care providers and others.

Regardless of approach, the key features of any programs for supporting families (including single parents and teen parents) should reflect best practices; that is, be evidence-based, offer more than one option, be collaborative and multidisciplinary, and reflect diverse programing. Although it is best to use evidence-based practices, First 5 was cautioned to ensure that underserved populations such as monolingual parents who usually are not part of this evidence-based research be served appropriately through modified programming. One individual stressed the importance of being able to analyze results to identify successes.

Funding Priorities

The survey respondents were asked to rank in importance 12 main concerns *as they related to the use of First 5 funds.* (Note that the Commission and Key Informants responded to the same 12 items during the interviews, ranking them as Higher, Lower or Mid Priority.) Of highest priority—similar to all input received from the strategic planning process—was mental health: inclusive of social-emotional-behavioral health and maternal mental health (Table 1). Six (54.5%) of the individuals who answered this question (1 respondent did not), placed the item in the first rank. The mean scores in the table indicate the relative ranking of the other 11 items.

Table 1. Relatively Ranked Priorities for First 5 (n=11)

Priority Areas	Ranking	Mean Score
Mental/behavioral health	1	2.36
Primary health care	2	5.18
Access to quality preschool	3	5.36
Family/domestic violence	4	6.27
Food security	5	6.64
Housing	6	6.73
Nutrition/physical activity	7	6.81
Hearing and vision problems	8	7.18
Substance abuse	9	7.45
Safe parks and play areas	10	7.73
Oral health	11	7.82
Transportation assistance	12	8.36

Support to the Provider/Professional Community

Suggestions about ways First 5 could be more helpful in supporting the provider/professional community included:

- Professional development and training for Early Educators with research-based strategies for supporting children and families. Offer follow-up support and guidance afterwards in the classroom in implementing the information that was learned.
- Books and other educational materials for distribution to families.
- Serve as a convener for one of the strategic plan priority areas, inviting all organizations and other stakeholders with an interest in that issue, and finding more ways to work collaboratively.

- Partner with UC Merced departments of psychology and sociology for in-service placing and teacher development.
- Have the Commissioners participate more in community events, make themselves more present at project sites to see what's being accomplished.
- Commission members should use First 5 influence to integrate more systems change in the political arena. Push community leaders to understand the importance of children 0-5 and push that agenda at the highest levels in budget talks, etc.

Feedback about First 5

About half of the respondents provided feedback to the question that was directed specifically to current or former grantees. The question asked whether the person had experienced any operational concerns, grantee-funder relationship issues or other organizational behavior issues with First 5 that should be improved. The following were the verbatim comments offered:

- *"Improve coordination of tracking expenses between First 5 and service providers."*
- *"Billing at year-end would be smoother if First 5 would send a copy of its expense spreadsheet at each month end (we requested a copy 3 times with no response)."*
- *"First 5 should explore partnerships and leveraging with LPC as the forum that connects direct service systems – many of which are included in this survey – to families."*
- *"Mini grants are great, but if you want impact you have to be willing to spend more on grant-funded programs."*
- *"Make larger grants and continuously fund for 2+ years to become a self-sufficient program."*
- *"If the grants continue to be small, it will discourage people from applying because it's not worth the time, energy and effort."*
- *"While the state focus on Read/Speak/Sing [sic] initiative is wonderful, something similar at the community level would be great. We are seeing more and more children with behavioral concerns as well as language and other developmental delays due to excessive use of phones, iPads and other screens."*
- *"The process of working with First 5 has been painless and professional, and the people enjoyable."*
- *"There is a lack of communication between First 5 and the grantees that are under a fiscal sponsor, sometimes resulting in the fiscal agent interacting with First 5 in ways that do not benefit us; for example, not being included in the administration of our own grant. When we've tried to interact with First 5 replies go through the fiscal sponsor and we're not included. A clarification about this policy is needed."*

One individual specifically mentioned being appreciative that providers were invited to provide input to the strategic planning process ("I like that they're being open about the process of this strategy") and hoped the invitation to participate was not "a token appearance" to be included and "all of our comments and thoughts will be considered, addressed and counted."

PARENT SURVEY

"I would like to have some help getting my child to eat a variety of things."
– Parent Survey Respondent

INTRODUCTION

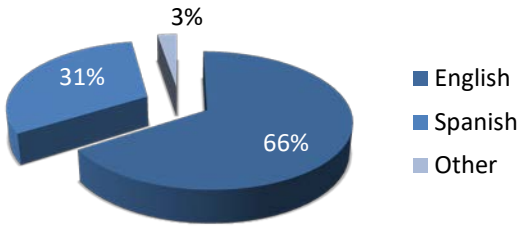
The 16-question *Parent Survey* (Attachment 2) was distributed to parents and other caregivers through local grantee and other service organizations to help the Commission learn more about families who can benefit from First 5-funded services and what their needs are. We also developed a Survey Protocol and held an orientation session via conference call with the participating organizations to standardize its administration. Eligible respondents included any parents/caregivers raising children ages 0-5 receiving services from these organization as well as other families of young children who could be reached at community locations in the community.

Parents completed the surveys between January and March 2020 and agency staff collected and submitted them to First 5 for transfer to the consultant. The data were cleaned, coded and entered into an Excel spreadsheet for analysis. Some of the qualitative data (open-ended questions) were quantified to gain more concise views of parents' experience. It should be noted that the surveys were conducted pre-COVID-19.

RESULTS

A total of 1,338 surveys was received—a very robust sample—74.3% completed in English and 25.7% in Spanish. Two-thirds (66%) of the total group reported English as "the language my child and I speak most of the time at home," 31% reported speaking Spanish, and 3% Other (Figure 1). The survey parents represent a slightly lower proportion of those reporting they speak a language other than English at home in 2011-2015 in Merced County (45.2%).[55]

Figure 1. Language Typically Spoken at Home with Child (n=1,338)

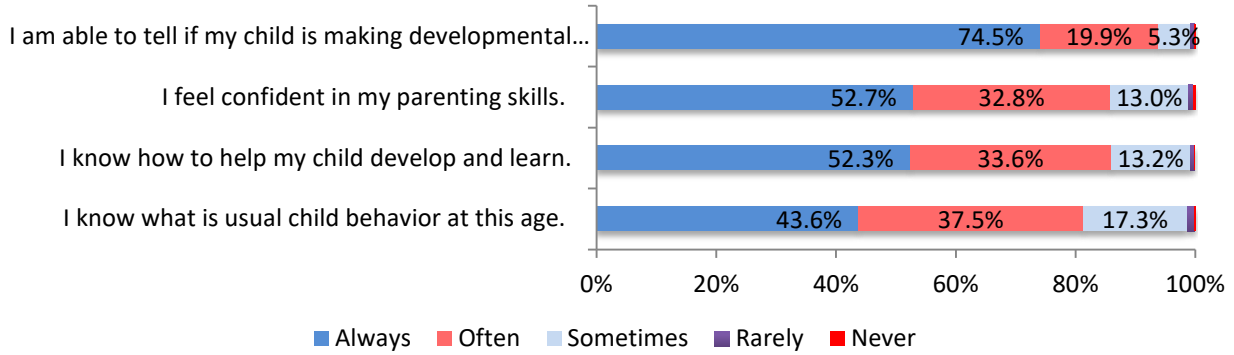


Parenting

Overall, the respondents expressed having a great deal of confidence about important aspects of parenting. The area where they felt most self-assurance was in their ability to tell if their child was making progress in growth and development (Figure 2). They expressed a little more doubt when it came to knowing what usual child behavioral issues are; 1.7% did report they "rarely" knew about it.

None of the parents marked the response choice “never” concerning their confidence about any of the 4 questions.

Figure 2. Parent Confidence Concerning Parenting (1,338)



Note: Because "Rarely" and "Never are so minute, data labels (percentages on the graph) Are not included as they were overlapping.

Utilization of Services and Barriers

Access to preventive health services is one of the Commission’s primary Desired Outcomes result areas, with use of oral health services being a general marker for access. Close to one-fifth (19.2%) of parents reported their child had not had a dental visit in the last 6 months (Figure 3). There were various reasons given for no-dental-visit but in general reflected parents not taking responsibility, with close to half (47.8%) describing some sort of lack of action on their part, e.g., “just haven’t gotten around to it;” “I’ve procrastinated;” “I forgot” (Table 1 on the next page).

Figure 3. Children with a Dental Visit in the Last Six Months (n=1,341)

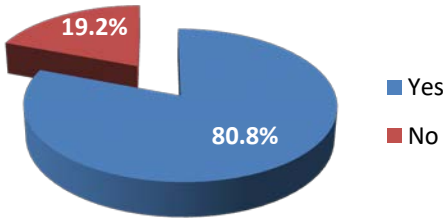
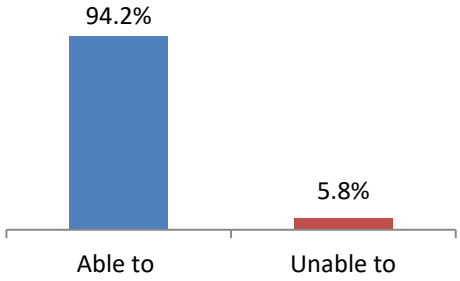


Figure 4. Parents Ability to Get or Delayed Getting Necessary Health Care for Child in the Last Year (n=1,295)



Despite access to healthcare through enrollment in Medi-Cal Managed Care for many of these families, a small proportion, 5.8%, of the parents/caregivers reported not being able to get or delayed getting necessary health care for their child in the last year (Figure 4). The main reasons provided by the few respondents who described barriers were problems getting an appointment, insurance change (usually related to employment status), and failing to keep the appointment.

Table 1. Main Reason for No Recent Dental Visit (n=75)

Reason	Percent
Just haven't gotten around to it/low priority/procrastinating	47.8%
Appointment is coming up soon	10.6%
Don't know where to go/how to set it up	9.4%
Thinks child is too young (or parent was told so by MD or DDS)	8.4%
Missed the appointment; need to reschedule	7.7%
In process of switching dental providers	7.0%
Child "has no problems so no need to go"	4.9%
Waiting for something related to Medi-Cal or private insurance	3.6%
Medical or special needs issue	0.5%

Healthy Behaviors

The families reported a mix of healthy eating behaviors. Their average number of daily servings of fresh fruit and vegetables is higher than the national average, and nearly three-quarters appear to eat most of their meals together as a family (Table 2). However, their children's consumption of fast food appears to be higher than the average for children in the U.S.,[56] and consistent with findings reported above in the Data Dashboard (35.1% ate fast food 2 times in the last week in Merced (52.7% for low-income); 18.1% statewide).[57]

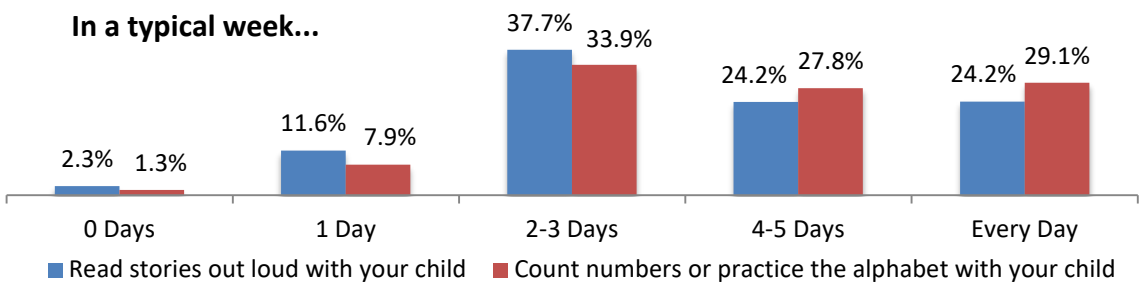
Table 2. Families' Nutrition Practices

	Frequency					
Number of	0	1	2	3	4	5+
Servings of fresh fruit or vegetables, yesterday	2.3%	9.9%	36.1%	30.5%	11.5%	9.7%
Times child ate fast food, in the last week	22.5%	43.8%	22.5%	7.5%	2.1%	1.6%
Number sodas or sweetened drinks child drank, in the last week	36.4%	29.9%	18.2%	9.9%	2.9%	2.7%
Number of days parents eat a meal with their children, per week	1.0%	0.7%	3.4%	10.9%	10.9%	73.1%

Enrichments or Detractions from Early Learning

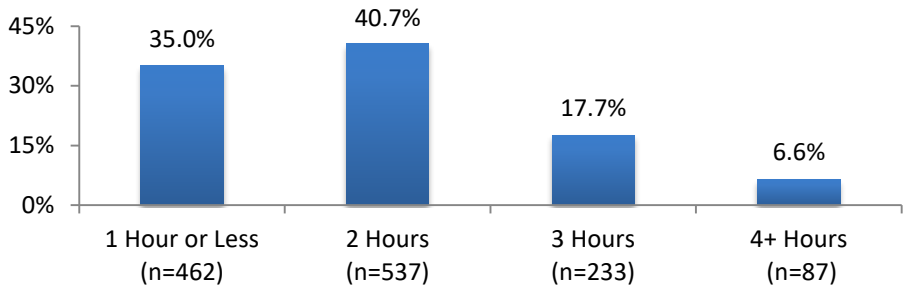
Research is very clear that reading to a child promotes brain development. One-quarter (24.2%) of the parents reported they read stories aloud with their child every day, and the same proportion reported doing so 4-5 times in a typical week (Figure 5); an even higher proportion count numbers or practice the alphabet with their child this often. However, 2.3% and 1.3%, respectively, said they never engaged in either activity with their child.

Figure 5. Number of Days Parent Reads or Sings with Child (n=1,327)



Screen time is "an inescapable reality of modern childhood." On average, the study most quoted (now 10 years old) shows that children ages 2-5 spend 32 hours a week in front of a TV—watching television, DVDs, DVR and videos, and using a game console.[58] Children in the surveyed families *may* watch TV less often than other children may, according to these parents' responses. Just over one-third (35%) reported 1 hour a day in a typical weekday, and 40.7% reported 2 hours (Figure 6).

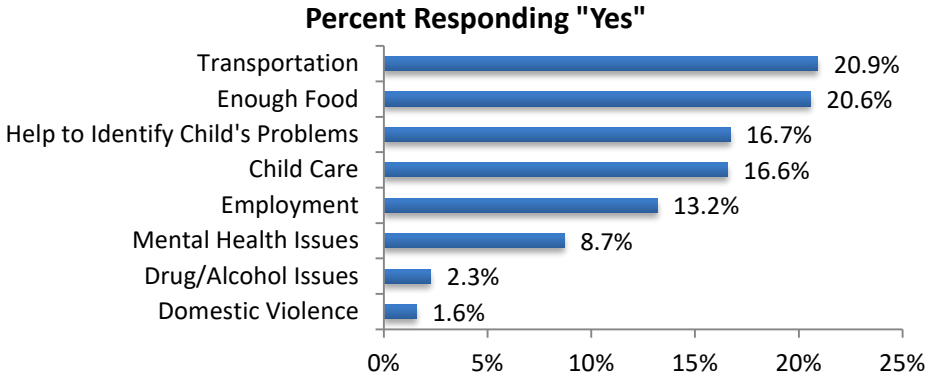
Figure 6. Children's Screen Time per Day (n=1,319)



Parents' Highest Concerns and Needs

The survey respondents were asked to think about the needs of their family and then mark which of 8 issues families often worry about were worrisome for them. As Figure 7 indicates, concerns about transportation and having enough food received the most responses, followed closely by the need for help in identifying problems (such as behavior, vision, speech, autism) and finding childcare. Domestic violence and substance abuse were relatively less of a worry for these parents.

Figure 7. Issues Parents Worry About the Most



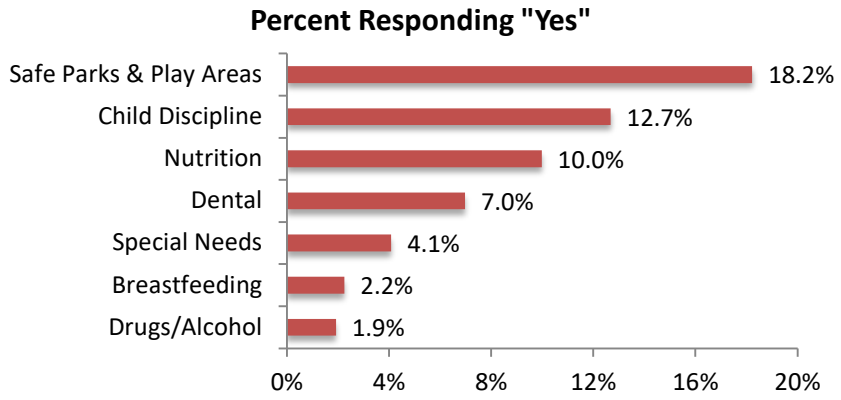
Community Resource Needs

Parents were asked to identify needs for information or services they wanted help with but could not find in the areas of Health and Development and Early Care and Education and Other Family Resources. *It is notable—and unexpected—that over 80% of parents reported needing no help for any of the issues asked about in the survey.*

Health and Development

Parents most frequently wanted, or needed help for their family but could not find, safe parks and play areas (reported by 18.2% of respondents), help or resources related to child discipline (12.7%) and nutrition (10%). Dental and special needs were also concerns but to a lesser degree (Figure 8 below).

Figure 8. Needs Related to Health and Development

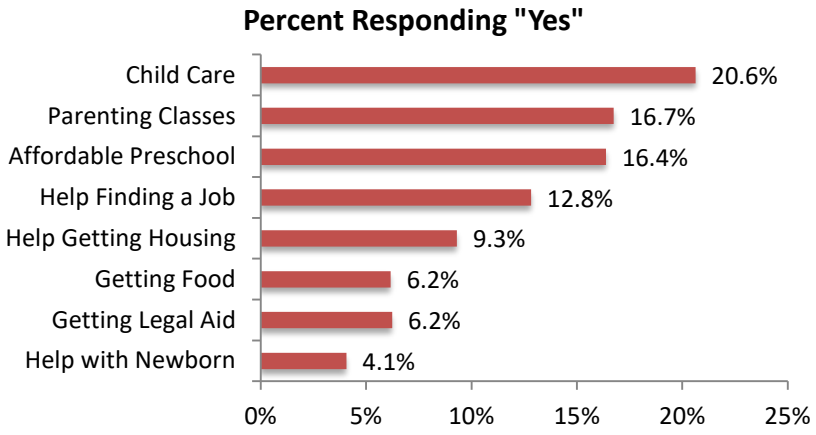


A small handful of parents, 17 of them, wrote in "Other" needs that were not on the list. These varied widely and in no particular order included looking for nearby family activities and social opportunities, helping children learn healthier eating habits and watching less TV, paying bills, help with "chores," and concerns about when children reach adolescence, saving for college, and safety within the community.

Early Care and Education and Other Family Resources

Needing help and not finding resources for child care (20.6%), parenting classes (16.7%) and affordable preschool (16.4%) received the highest proportion of affirmative responses for the items shown in Figure 9. Practical matters such as help related to housing, food and legal services seem to be less of a concern. Only 3 parents wrote in "Other" needs but all were a variation on child care issues (affordability, eligibility, etc.).

Figure 9. Needs Related to Early Care and Education and Family Resources



PART III: PROGRAM/OPERATIONAL ISSUES

"Literacy education takes a generation before you see a difference. It has to be a long-term commitment."
– Key Informant Interview

ORGANIZATIONAL PERSPECTIVES

Five of the 8 Commissioners who were on the Commission at the time this strategic planning process began agreed to an interview, and along with the 3 staff who were interviewed, offered input about First 5 internal/operational/issues. The modified SWOT chart below summarizes this input. (Note: perspectives about community needs, grantmaking, etc. were reported above in Part II of this report.)

Table 1. Modified SWOT Analysis

Strengths (Internal)	Weaknesses (Internal)
▪ Experienced, knowledgeable team. ▪ Staff who are very approachable and committed to First 5 issues and the community. ▪ ED's openness to new ideas/approaches and Commission's responsiveness to this ("*A refreshing start*"). ▪ Positive name recognition and reputation. ▪ Establishing collaborative programs (e.g., with MCOE). ▪ Good interaction/communication between staff and Commissioners. ▪ Commission recognizes needs of communities. ▪ Awareness of the need for strategic planning in view of financial projections (declining dollars). ▪ Good buy-in/support from Board of Supervisors. ▪ Good diversity/mix among the Commissioners. ▪ Ability to tap into resources/save money by being housed within Public Health	▪ Unfilled positions that limit capacity for the work, including keeping updated and sharing learning. ▪ Haven't done a good enough job with evaluation; we don't look for outcomes ("*Have we asked the right questions*?") ▪ Some Commissioners are very engaged; some could be more proactive than they are. ▪ Figuring out how to spend our money ("*Maybe we need a better way of reaching the community with our funds*"). ▪ Haven't been as helpful as we should for encouraging new, eligible applicants. ▪ Inefficiencies—need to simplify/streamline some administrative processes ("*Some are strangling us*"). ▪ Staff (and Commissioners?) not visible enough in the community ("*No time to attend events*"). ▪ Not necessarily getting everything in perspective; not looking at the big picture enough. ▪ Unnecessary bureaucracy/low visibility because housed within Public Health.
Opportunities (External)	**Threats (External)**
▪ New First 5 CA monies for IMPACT, Early Literacy. ▪ Staff experience/skillsets allows quick response when opportunities arise. ▪ Governor's focus on early childhood = potential increased dollars to support preschools. ▪ More visibility could = more partnerships (e.g., with business community), leveraging (e.g., with local foundation), stimulate health messaging opportunities (e.g. nutrition campaign), increasing awareness and potentially behavior change.	▪ Declining First 5 dollars statewide. ▪ Short- and long-term impact/unknowns of COVID-19

The main internal items that rose to the top, in order of frequency of mention, included as strengths having highly capable staff, a "new start" with the current Executive Director, and Commission engagement (but with varying levels); recognized challenges included inadequate staffing capacity, burdensome bureaucracy and dissatisfaction with evaluation. Interestingly, First 5 being housed within Merced County Public Health was viewed by some as an asset (strength) and by others as a weakness as evidenced by some of the comments in the SWOT chart above. Externally, a number of opportunities were identified such as the Governor's strong interest in early childhood education; other than citing the declining First 5 dollars statewide, no one identified any potential "threats" such as new policies, regulations, laws, leadership changes, political milieu, recruitment challenges, etc., which could affect what First 5 is able to do. Note that all insights reflected in this report are pre-COVID-19.

Evaluation-Related Issues

Funders regularly make decisions regarding renewal, expansion and replication of programs. To do so effectively, decisions have to be based on evaluation data that answer relevant questions—using evaluation feedback to inform decision-making. Overall, the Commissioners felt First 5 historically has "not done a good enough job in evaluation," and all of them expressed dissatisfaction and under-use of this component of the program. The staff generally echoed the same sentiments.

Some of the Commissioners mentioned feeling "suppressed" when asking for data but implied this was "more in the past." Some stated they either did not know what had been done or had asked for but not received what they were looking for; some had received performance data when they had asked for outcome results: for example being told the number of parents attending a class vs. knowing what those parents learned as a result (e.g., the percentage who demonstrated x% knowledge gain). Some expressed frustration at asking for detailed information but getting it "always put in only positive terms."

Several individuals thought grantees should be using more standardized assessments and other appropriate evaluation tools in their programs, such as the ASQ and pre/posttests that match curricula. A couple of the Commissioners acknowledged the challenge of measuring change/impact (e.g., behavior change) but still remarked more should be done in this area. Staff felt evaluation was "basically just completing the required annual First 5 CA evaluation [performance numbers] report" without providing any "lessons learned'' data.

The current evaluation contractor—who began after the funded programs had already started with little opportunity to influence individual grantee evaluation plans—developed a detailed *Evaluation Plan for FY 2018-19–FY 2020-21*, some of which has been implemented (for instance, Quarterly Learning Group meetings with contractors, to which the Commission has been invited, focus groups and interviews, development of a Theory of Change through a facilitated group process, and development of a comprehensive set of Outcome Definitions). Documents from some of these efforts have been delivered while others have not, for various reasons. (The 2019 Evaluation Report and Executive Summary are in still in process at this time.) However, it was clear in the Commission interviews that Commissioners seemed unaware of what has occurred or been produced as "evaluation" because none of them referred to these efforts/products when we asked about evaluation (e.g., "Do you feel you have the evaluation information you need to make decisions?"). It may be that what has been produced at this point is known about but not what the

Commission expects will lead to "lessons learned" information. This is an operational area where perhaps clearer understanding about expectations may be beneficial.

We noted that in recent RFPs, e.g., Strong Families/Direct Services, do require applicants to address evaluation in their proposals by stating:

> *Part G: Evaluation Approach (suggested length – 1/2-page maximum) Describe the proposed evaluation plan that highlights the effectiveness of the proposal. Include the specific change(s) expected or produced that will identify success. (i.e., what measurable indicators will be used?) Identify what methods to collect data on these indicators, as well as what staff, budgetary, or other resources are planned for evaluation.*

Despite what seem like clear instructions, staff observes that evaluation plans in proposals are generally very weak, evaluation tools are usually missing and data collection methods are typically meant to report only on performance indicators. While your contracts contain Scopes of Work (SOW) that show what is to be done, when and by how much, we were not shown any Evaluation Plans (usually taken from what applicants submit and then refined by Commission staff and/or the external evaluator). We've shared a sample grantee Evaluation Plan with staff you may want to consider using in future contracts.

Recommendations

The Commission interviews also generated specific recommendations relative to operational issues, some of which tie back to the comments shown in the SWOT analysis above. These are fairly straightforward as shown in Figure 3 below.

Figure 3. Commission Recommendations Regarding Operations

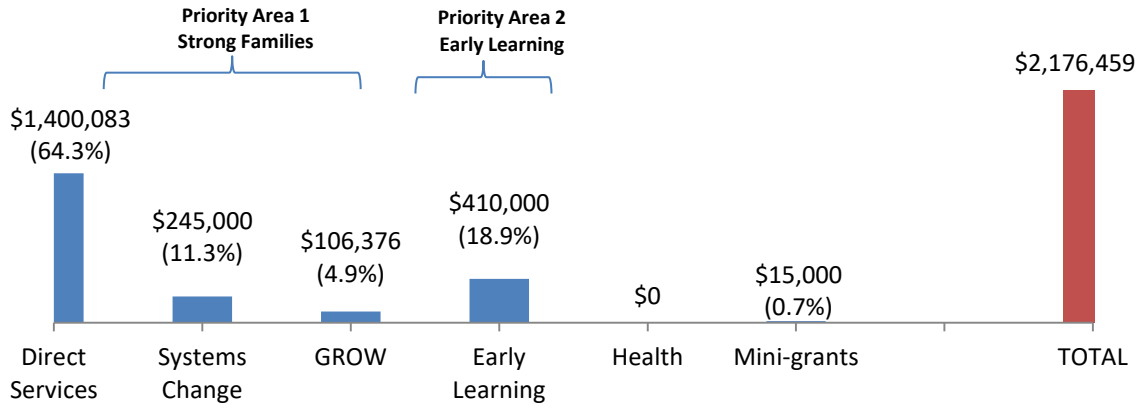
- Increase visibility of First 5 in Merced County.
- Find ways to minimize bureaucratic processes that hamper efficiency.
- Figure out a better way of how to spend our money, e.g., blend funding to reduce siloes wherever possible.
- Increase school districts' and others' involvement at Commission meetings.
- Use more committee structure as in the past.
- Share what we've learned more, but learn more through outcome evaluation.
- Reach out to more potential applicants, building capacity when possible.
- Emphasize the concept of *families* not just children as "the 0-5 population."
- Recruit and fill staff positions (with appropriately qualified personnel).

GRANT ALIGNMENT WITH PRIORITIES

A brief review of First 5 Merced's current contracts reveals that of total grant funding under Priority Area 1 (Strong Families) about 64% supports direct services, 11% supports systems change and close to 5% supports the GROW program. Under Priority Area 2 (Early Learning), about 19% of total

contracts support an early learning program. And, 0.7% of the expenditures support a number of mini-grants. Some of these projects support upstream principles (prevention), evidence-based and/or evidence informed programs and practices, and results-based approaches (Figure 4).

Figure 4. Current First 5 Merced Investments by Priority Area



Source: First 5 Merced, December 2019. Note: priority area categories as defined by First 5 Merced.

Overall, 80.5% of the total grant funds are supporting Priority 1 programs and 18.% are supporting Priority 2 programs. There are no currently funded contracts in Priority Area 3 (Health). Note, however, that the categorization by First 5 unavoidably obscures some of the overlapping and interrelatedness among the priority areas. For example, Health House/AFYA—the contract categorized under systems change—that is said to "address serious maternal/child disparities in Merced County" could also be considered a health-related priority area grant. The disproportionate amount of funds by Priority Area may also be a reflection of the RFPs that were issued at the time and the ensuing contract terms of the approved grants.

Issues to Consider

First 5 Merced has traditionally issued Requests for Proposals (RFPs) as a *responsive grantmaker* – defined as openness to receiving proposals and ideas from nonprofits and government agencies and allowing them to drive the priorities, i.e., requests are initiated by the applicant, rather than by a funder seeking them out. This approach was important in the early days of Prop. 10 in order to a) get money out the door quickly; b) be responsive to the needs applicants felt most keenly; c) pursue early promising practices; and d) demonstrate results with a wide range of models, programs, and approaches.

As a "mature" funder, it now makes sense, as you've learned more about specific Merced County needs and issues, to address them more strategically—*strategic philanthropy*—especially if you want to make a difference in a specific area. (Note: there is still room to do both types of grantmaking; for example, responsive grants through mini-grants but with perhaps a higher ceiling, e.g., <$10K.) These kinds of investments require a longer-term commitment—at least 3 years—with an RFP written to align directly with your strategic plan. Making more strategic funding decisions, you will want to determine your funding focus, tie decisions to the findings of this Needs Assessment, take advantage

of new opportunities (such as First 5 California priorities that provide additional dollars). Being able to clearly define how, to whom and for what purpose you will award grants will also provide applicants with a clear set of expectations.

A few of the issues and questions to think about—and discuss during our retreat—include the following:

- Declining funding levels do not allow for previous levels of funding to be maintained across the board and hard decisions have to be made for future RFPs. Some of the options to consider include funding fewer programs but funding them more deeply (vs. spreading the dollars more broadly); narrowing the priorities/focusing more on addressing certain problems? Focusing on selected geographic areas or neighborhoods?

- It's hard to narrow your focus when so many local needs are apparent. Some group will always think their issue/problem is being "ignored" and be disappointed. Funding more narrowly may also have potential negative consequences (e.g., missing a future opportunity, undesirable political impact). The Key Informants we interviewed largely support the idea of more strategic grantmaking, however; they understand there are always tradeoffs in ranking priorities.

- Because most ideas are already being worked on by other organizations or funders, you will likely want to partner with as many other funders, nonprofits, and government agencies you can.

- While you have to be prudent with public dollars, being too risk adverse can stifle creativity and progress.

- Be thinking about what information you want to learn from the things you fund. Are the ideas ones you can take to scale? Assuming there is a solid evaluation plan in place, what can the results (lessons learned) contribute to?

- How important is sustainability? Your last RFPs stated "*The grant funding is not to be used for programs that will only operate for the life of the grant. Rather, the funding will be targeted to kick-start new or existing programs that will continue forward with non-First 5 Merced County funding*." How solid were the applicants' plans for sustainability in the proposals you approved from these RFPs?

PART IV: OVERVIEW OF SUSTAINABILITY/ SYSTEMS-LEVEL CHANGE

"If there's a sustainability requirement [in the RFP] I don't apply; when the money is gone, my program would be gone." – Key Informant Interview

Sustainability Considerations

It is not uncommon for funding strategies to evolve over time starting with "casting the net widely for responsive applicants," to more strategic, longer-term grantmaking. As a result, the question arises, "What happens to these projects when our funding goes away?" "Will the program we fund continue in its current or similar form or will it dissolve along with our funding?" These are important questions a funder generally considers before making the grant, but especially needs to ask during the life of the grant if future funding is going to shift somewhat from direct services to support for more systems-LEVEL change strategies.

What Do We Mean by Sustainability?

Sustainability has traditionally been viewed narrowly as the act of decreasing dependence on one source of funding and shifting financial support for program implementation to a new funding stream. In reality, program and organizational sustainability is a much more complex process.

The term "sustainability" can refer to retained programs or services, or sustained impact. When most funders ask the question of longer-term sustainability, they refer to the former. The emphasis is on *sustainability of programs or services* that continue because they are valued and draw support and resources. This does not mean these programs or services necessarily remain as originally designed or created. Sometimes, sustainability comes with a refined definition of need, evolution of the services provided due to feedback, assessments or evaluations, and changes in owners and sponsors who may modify the objectives and strategies.

Sustained *impact* can occur with or without the retention of the initially funded program or service. Examples of sustained impact include changes in knowledge or attitudes (e.g., training of service providers; education of parents), adoption of desired behaviors (e.g., reducing sugar-sweetened beverages), new or improved policies (e.g., support for breastfeeding in the workplace), or increased capacity of local systems (e.g., additional bus lines in public transportation).

It is important to consider whether every funded effort *needs* to be sustained, and if so, is the goal sustained program or sustained impact, or both? The basic questions First 5 needs to ask—either upfront in making grants or certainly before funding ends—include:

- Does the effort need to be sustained?
- If so, is the current grantee the agency to sustain it? If not feasible (for whatever reasons), who else could absorb the work?
- If so, which parts are critical, if not all?
- What is a minimum level of needed sustainability to achieve the outcomes?

- Are we willing to fund that period or are partners needed?
- Are other funding options feasible given the target group?
- Who else supports the objectives and strategies? Public funders? Private Funders?
- What role will we play in helping identify those partners?

What Forms Can Sustainability Take?

Continuing a program or service can occur through a variety of means, some suggested below. The feasibility of each will depend on the program, target group, and interests of the service providers and their funding partners.

- Continued grant funding from the initial funder, e.g., First 5 Merced
- Funds from other sources – private or public
    - Grantees use the outcomes from their efforts to solicit support from other private funders, sometimes with the assistance of the initial funder
    - Government entities see the value of an effort and change policies and budgets to continue or expand an activity or service
    - A tax levy is introduced (such as Prop 10 tobacco tax)
- Donations from individuals or corporations
    - Solicitation of funds (sometimes with the assistance of the initial sponsor) are made to support a particular program
- Fees for services provided
    - After the initial grant or development period, those benefiting from the service personally contribute to the cost of the service
- Dues by members
    - Some program costs can be provided by a fee to participating families or other interested parties
- Royalties or commissions
    - Products created by the program or service can be sold with a percentage reverting back to the service provider

A key factor in strengthening program sustainability is the degree to which a grant applicant's objectives and strategies align with other partners, private or public. Potential public funding far outweighs private funding, and public priorities should be emphasized when evaluating a particular funding strategy or group of grant applicants. For instance, funding preschool and parenting efforts that align with public strategies will increase the likelihood of program success and sustainability. A good example of this is Governor Newsom's 2020-2021 state budget which includes early childhood priorities.

Likewise, funding local efforts utilizing strategies promoted by the federal government adds credibility to the locally funded effort and takes advantage of others' efforts, both of which support sustainability. One way to identify federal priorities is through the federal government grant search tool at https://www.grants.gov/web/grants/search-grants.html and using First 5 Merced's priorities as search criteria.

Other Factors that Increase the Probability of Sustainability

Besides aligning with public funding priorities, there are other factors First 5 Merced might consider that will increase applicants' long-term viability and help current grantees prepare for funding reductions. These include:

- Board support: Is it clear the Board is actively involved and broadly represents the community/service area? Should steps be taken to expand the membership to tap additional talent or resources (in alignment with Prop. 10 requirements)?
- Existing partnerships and networks: Is the applicant operating alone or are its programs supported by multiple funding partners? Leveraging the resources of others increases the potential impact and provides possible funding sources beyond the current grant period.
- Attraction of supporters: Does the organization utilize a network of individuals (stakeholders, influencers, "champions") who are aware of the organization, its efforts and successes are willing to share this information with others?
- Are the program objectives clear, feasible and easily articulated to others?
- Innovation: Is there anything unique or innovative (i.e., a novel strategy or a traditional one but used with a different population (e.g., fathers) that could draw positive attention leading to sustainability?
- Measuring outcomes and impact: Are formal evaluations a part of the program or services?
- Is there infrastructure in place to support data collection and data sharing across agencies and systems? Are successes *documented* in such a way as to attract other funders?
- Is it clear what aspects of the program are critical or essential for success? What can be eliminated if full funding is not available? Are the trade-offs in reduced funding still worth supporting the effort?
- Would an investment in some training and coaching to build or boost capacity help make a different to sustain the program?

Following are examples of how some historical programs—some with systems-level approaches—were sustained beyond the initial development and funding period that may have applicability to First 5 Merced County. Note that formal evaluations were a part of some of these efforts.

- California Department of Education endorsed a local grade 2 assessment program as a best-practice and recommended it for optional statewide use, increasing its impacts and sustainability.
- Community health coalitions in northern California were supported by a regional funder. Other foundations joined the effort by adding funding for certain priority communities and supporting complementary components, such as evaluation and dissemination of outcomes and findings.
- A key program of a nonprofit organization was valued by the community but the financial stability of the organization was at risk. The funding partners assisted the organization to dissolve and move the program and its resources to another agency with a similar mission, thereby sustaining the program and its impacts longer term.

- A health coalition in Cincinnati was sustained by bringing in more local partners (e.g., the local university) that brought in resources and had greater access to other resources. First 5 Merced has the advantage of its relationship with UC Merced and its many systems that can benefit local non-profits (e.g., the business school working to help strengthen local organizations' understanding of budgets).

- A family outreach effort was funded by a group of Sacramento funders to increase enrollment in a child health insurance program. After a few years—and evidence of success from a formal evaluation—funding was picked up and retained by other hospitals in the area.
- A program to help educate providers on assisting families with end-of-life issues was developed by a Sacramento coalition and funded by a local foundation. Stakeholder engagement was critical as success was dependent on buy-in. The program was tested and formally adopted by each of the hospitals in the region, receiving statewide attention, and leading to what have become systemic change and a long-term impact across the state.

Impact Sustainability - Not All Grants Need to be Sustained

A special role First 5 can play is in the funding of efforts that do not require a long-term sustainability strategy. These include development of training materials and curricula, education of service providers, research and assessments, community convenings, and capital support (e.g., safe playgrounds) to improve the design of programs and provision of services already being provided by others. These grantmaking approaches, which were endorsed by the key informant interviews, have impacts beyond the grant period and are particularly useful when funding availability is fluctuating significantly from year-to-year or, in the case of First 5, declining.

Systems-Level Investment

What Do We Mean by Systems Change?

The concept of "systems change" is challenging because people differ by what they mean and what they expect (including all of the individuals we interviewed for this report). The term can mean changes in policies, service delivery, organizational culture and practice that can expand or streamline access to services or reduce barriers for the target population. Investing in systems work can also mean institutionalizing something As funders reflect on their grantmaking history and ask how they can continue to sustain or increase their impact, they often get to the question: "How can we affect the systems associated with our grantmaking strategies?

Most funders believe direct service programs should be rooted within a larger system of support to have an impact large enough to change community-level indicators. That is, the most effective partnerships focus on the underlying social and economic determinants of health, rather than on meeting the individual needs. Addressing needs such as stable housing, accessible transportation, and good health on a person-by-person basis is less impactful than policies, systems, and environmental change that address issues for the entire population. Funders understand the complex needs of at-risk families often extend beyond what single programs can provide in isolation and many community-level issues negatively impacting families cannot be addressed with a service-level only

approach.[59] They also appreciate the fact that systems are interconnected sometimes function as a whole so that actions taken on one part may impact other parts, positively or negatively.

However, shifting systems and policies is a much more complex concept and takes more time than people realize. Systems change is a funding strategy that requires a high degree of knowledge of the issues and systems involved, a solid reputation as a funder, strong networks and partnerships (i.e., the relevant stakeholders that need to be at the table to facilitate change), a commitment of support, especially during the transition, tolerance for a higher level of risk, and a willingness to get involved in public policy—and sometimes politics—to achieve success. One essential element is understanding the power structure of the system and the readiness to change. This is no small endeavor that requires ample discussion and consideration before engaging such "systems change" strategies. But helping change systems can be one of the most impactful ways to make a difference, though this is not without risks and requires a deliberate, thoughtful approach before beginning.

Developing a relationship with representatives of the systems one wants to influence is a key success factor in system change. Obvious as it sounds, systems are managed by people. A funder can bring experience and knowledge and when they have a reputation as trustworthy, transparent, easy to work with and responsive to requests for information will have a higher likelihood of impacting these systems. Being supported by a network of service providers and/or community representatives is also helpful when trying to garner support in changing how systems work. Having representatives from the target systems with a sense of collective accountability in the funder's network is also essential.

It is important to appreciate that systems change can take years. Funders need to accept this up front and expect barriers and delays throughout the process. The following have been suggested as most relevant to enhancing readiness for change: [60]

- A high level of policy commitment that is translated into appropriate resources, including leadership, space, budget, and time.
- Incentives for change, such as intrinsically valued outcomes, expectations for success, recognition, and rewards.
- Procedural options from which those expected to implement change can select those they see as workable.
- A willingness to establish mechanisms and processes that facilitate change efforts, such as a governance mechanism that adopts ways to improve organizational health, using change agents who are perceived as pragmatic.
- Accomplishing change in stages and with realistic timelines.
- Providing progress feedback.
- Institutionalizing support mechanisms to maintain and evolve changes and to generate periodic renewal.

A common tendency is to think about some of these efforts as a time limited demonstration. Changes in leadership at the funder's organization (e.g., newly appointed Commissioners, newly hired staff) or

in the public systems are common, requiring restarts. This is one of the reasons systems change is risky from a grantmaking perspective. A new public leader—or shifts in the "political winds"—may not support a change that has been under development for years.

Because getting to a systems-change outcome takes time and patience, and developing interim measures of success for change strategies is critical. Evaluating systems efforts in ways that both capture their impact and inform their ongoing development can be a significant challenge. But, being able to demonstrate progress to leadership in both the funder organization and its partners is key to maintaining support for such strategies. This also means not being afraid to challenge or support policy makers when it best serves the change strategy.

Examples of Systems Change Strategies

An example offered by the Child & Family Research Partnership at the University of Texas[61] is easy to understand and aligns well with First 5's funding interests. Under the goal of "improving children's school readiness" and using access to healthy food as the evidence-based driver, the community identified two potential strategies: (1) a physical environment strategy to develop a community garden to increase access to healthy food; and (2) a public perception/awareness strategy of launching a public awareness campaign on nutrition's role in healthy child development. It's clear that as these strategies were accomplished, they became indicators of progress toward the larger goal. That is, even before the larger school readiness goal is met, the "system" was changing and community could show that by developing new community gardens, and launching public awareness campaigns that reached x number of people, they were improving children's access to healthy foods—which ultimately increases children's school readiness. (Of course the *outcome* one could measure in this school readiness example would be the percentage increase in children who were identified as school ready by passing their Kindergarten assessment.)

In another example, project directors in a child welfare initiative implemented by the federal Administration on Children, Youth and Families Children's Bureau[62] identified the following successful systems of care elements they believed would be sustained beyond the grant period. The funded strategies and reasons for success are useful for First 5 to consider and included:

- Integration of systems of care principles into child welfare policy manuals, Program Improvement Plans, and training curricula. As a result, systems of care principles and philosophy were infused into practice standards and approaches adopted by the child welfare and partner agency staff working with children and families.
- Commitment to collaboration among child- and family-serving agencies, which was facilitated and sustained by memoranda of agreements (MOUs) outlining cross-systems policies and structures for collaboration, information sharing, and accountability.
- Engagement of the community in the work of the child welfare agency, greater awareness among child welfare staff of the important role of the community as a resource for families, and a willingness among child welfare agency and community members to work collaboratively.
- Ongoing training for child welfare and other child and family-serving agency staff. In particular, several project directors identified cultural competence training as an important aspect of the

Systems of Care initiative that would be sustained because agency champions were willing to carry the work forward.

Examples from human service projects evaluated by Collective Impact[63] that led to systems-level changes and echo the elements above include:

- A focus on early changes around building legislative champions as part of the efforts to get successful adoption and implementation of policy change.
- Engaged and committed partners led to new alliances and programs, including citizen-led programs, such as resident engagement in seeding oyster beds, shoreline restoration projects, and support for voluntary practices undertaken by schools and businesses.
- Intentional communication strategies designed to build buy-in and public will to support the goals of the project.
- Implementation of modified curricula (such as for preschool-K) including expanded capacity of school leaders and teachers to implement it.
- The alignment and coordination of funding and services across multiple partners in the county, and the widespread adoption of a common system that goes beyond the funder requirements.

"Out-of-the-Box" Examples of Systems Change Strategies

It is important not to equate *innovation* with *invention*, or something altogether new (i.e., "here we go again, throwing out what we know"). Innovation can also be defined as making changes in something established, for example by introducing new methods, ideas or products and "out-of-the-box" systems thinking. There is definitely room for innovation in early childhood education—a system represented by challenges and demands that are consistent over time, and systems and structures that are hard to shift. Take the issue of the rise in challenging behaviors among young children (a trend that is common as a result of the increasing rates of childhood stress and adversity, mentioned by several key informants). First 5 funds may send teachers to training but unless those educators are connected to and supported by other adults (including parents) and given opportunities to consult with other educators, the impact stops there. To further affect the system, and in a model of continuous improvement, if this group of educators together could document behavior patterns and responses to the strategies they learned in training they might develop a new approach to addressing (and even preventing) challenging behaviors, and one worth sharing with the network of early educators in their city.[64]

Businesses represent untapped opportunities for engagement in systems change, and are seldom considered when forming important collaborations to implement community health and social strategies. Yet the same elements that are essential to business are important social determinants of health and well-being. Decent housing and its impact on physical and mental health represents an obvious area for engagement. In one rather out-of-the-box collaboration, real estate developers were engaged to better understand how they could conceptualize and implement health strategies in their multifamily projects. The factors the group determined to influence the health of residents were a) location, emphasizing access to community amenities; b) place making, for community building and social and mental wellbeing; and c) physical fitness opportunities through fitness

spaces. Although these developers were initially uncomfortable discussing health strategies "using a public health lens," the interdisciplinary conversations they were engaged in turned out to be valuable for considering ways to more rigorously adopt health strategies in this challenging building type. The learning from this example is generic enough to offer the following "tips" to First 5 should the Commission wish to engage with more Merced County business partners.[65,66]

- Some companies now recognize that their long-term value can advance further and faster with a community focus, i.e., a focus beyond the worksite; buying into social impact is now on the radar of more Merced businesses according to key informant interviews.
- Leadership buy-in specifically is critical; business leaders are needed who can communicate the value of engagement in community health to their peers.
- Community improvement requires multi-sector and multi-stakeholder engagement. The community development effort Restore Merced is one example of such engagement.
- One challenge is that sometimes no single entity feels ownership of, or has responsibility or accountability for, taking control and finding solutions.
- An important step is to identify and define the role of a convener in the community that could bring stakeholders together in a place of respect and trust; in the area of early childhood, First 5 is a natural for this.
- Identify the business case for companies to invest in community health and social change. These include reductions in health care spending through lowering the need and demand for health care; a reduced burden of illness leading to improved function; environmental and policy changes that make healthy choices the easy choices; stable or improved economic states, as healthy communities complement vibrant business and industry; increased healthy longevity; and preparation of a healthy future workforce through education and skill building.
- For each target organization and individual, pitches should be crafted to reflect their values.
- Recognize that businesses are already engaged in policy, advocacy, and philanthropy and that they participate on the boards of local community organizations. How can they do this with greater insight toward health and social impact?

Further research suggests the following specific steps for engaging businesses:

- Develop a strategic map of local partners.
- Prepare an "ask" that explains how the given business or coalition of businesses is particularly well-suited to address the issue.
- Recruit leaders as initiative champions.
- Focus on common problems.
- Implement a way to measure success and outcomes that demonstrate the impact of the partnerships; make others aware of your successes to encourage adoption.

Selected Best Practice Interventions

Playgroups

First 5 Monterey County considers playgroups to be an important strategy to build protective factors within the community. They used the Strengthening Families Initiative to help guide the success they've had with strategies and programming. The details they provided for the steps necessary to achieve best practices [67] also have applicability across many other types of projects.

Early Identification and Referral

A number of examples from Help Me Grow California are consistent with what we heard as recommendations from key informants and include:

- To provide the value of early identification, and address the disparity in the diagnosis of children of color, First 5 San Bernardino and Riverside funded the development of the Autism Assessment Center of Excellence to be a "one-stop shop" that provides earlier and more accurate diagnosis and intervention for thousands of families.
- Alameda, Orange County and Contra Costa First 5s are building more strategic partnerships for sustainability in their early identification and intervention program for children with moderate delays. (The difference is that these children don't have access to free intervention services the state is mandated to provide to children with more severe delays.)

Behavioral Programs

Behavioral and mental health challenges encompass a range of behaviors and conditions. The community input for this report encouraged the Commission to recognize this area as a higher priority. A number of evidence-based interventions focusing on improving the knowledge, attitudes, and practices of parents of children with these behaviors have been described that might resonate with First 5.[68] For example:

- The Incredible Years Program addresses parental attitudes by helping parents increase their empathy for their children and educates parents about healthy child development, positive parent-child interaction techniques, and positive child behaviors.
- Parent Management Training (PMT) involves parents of children with externalizing behavior participating in therapy sessions to learn behavior management techniques to use with their children, leading to significantly greater changes in child behavior.

Home Visiting Programs

In recent years there has been an increase in the popularity of home visitation programs as a means of addressing risk factors for child maltreatment. This strategy also hopes to increase prenatal care, improve parent-child interactions and school readiness, promote healthy child development, improve positive parenting skills of caregivers, promote family self-sufficiency/ decrease dependency on social services, and improve primary health care access and child immunization rates. Not all models have provided evidence of effectiveness, however. Results from analyses of these programs show that *the most important factors for successful implementation are adequate training, supervision, and*

program monitoring. Fidelity (dependability, reliability) monitoring, in fact, has had the most significant effect on program outcomes. It is important for funders of home visiting programs to note that all of the models evaluated in a large federal Department of Health and Human Services review [69] that met the evaluation criteria:

- Had minimum requirements for the frequency of home visits and have pre-service training requirements.
- Were associated with a national program office or institute of higher education that provides training and support to local program sites
- Had specified the content and activities for the home visits.
- Specified minimum requirements for home visitor supervision.
- Specified minimum education requirements for home visiting staff.

Other best-practice examples of home visitation approaches with applicable findings for First 5 are:

The Merced County Office of Education Caring Kids program uses an evidence-based Strengthening Families approach aimed at increasing family stability, enhancing child-development, and reducing child abuse and neglect. The program services are comprehensive: parent education, home visiting, support group sessions and workshops, screening using ASQ:SE and individualized intervention with children with social-emotional delays. The program is well regarded and although available in all communities—to some extent—is likely to have limited capacity to serve more families.

The Building Healthy Children (BHC) collaborative successfully integrates home visitation into medical care of infants born to young, low-income mothers. Preliminary analyses demonstrate avoidance of indicated Child Protective reports and foster placement and high rates of preventive care for enrolled children.[70]

Perinatal home visitation programs, according to research, likely improve pregnancy and infant outcomes. Additionally, some visiting interventions addressing intimate partner violence have been effective in minimizing intimate partner violence and improving outcomes. This suggests that perinatal home visiting programs adding specific intimate partner violence interventions may reduce intimate partner violence and improve maternal and infant health.[71]

Fatherhood Programs

Efforts have grown that aim to reduce father absence; an example includes the well-regarded National Fatherhood Initiative (NFI).[72] NFI's mission is to transform organizations and communities by equipping them to intentionally and proactively engage fathers in their children's lives. Although we're not familiar with All Dads Matter in Merced County, this local program has similar goals and offers workshops, training, support and access to community resources for fathers seeking parenting education.

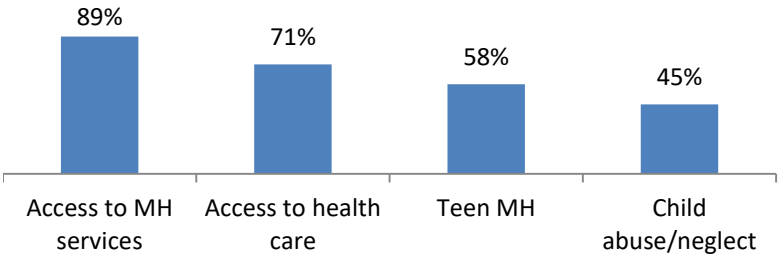
PART V: OTHER LOCAL NEEDS ASSESSMENTS

"Some of these parents don't have the role models they should have. They don't know what good parents look like." – Key Informant Interview

Overall, there was much congruence between local needs assessments and what we learned from this assessment. Similar needs and many of the same priorities were identified relative to children and families. Selected highlights from a couple of these other assessments, not already incorporated into other sections of this report, offer supplemental information of interest.

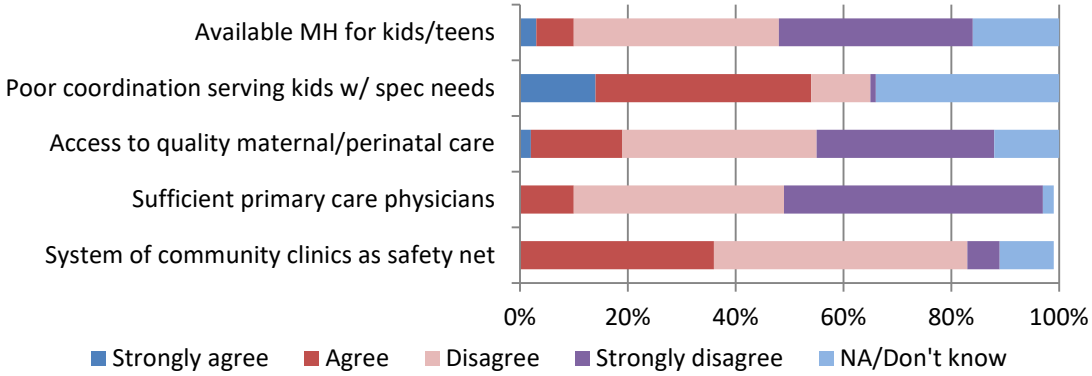
Maternal Child and Adolescent Health

Figure 1. Top 5 MCAH Health and Health Care Issues Cited as Most Important for Merced County (n=86)



Source: Merced County Public Health, Maternal Child and Adolescent 2018-20 Title V Needs Assessment.

Figure 2. Agreement about Selected Resources/Systems in Merced County (n=86)

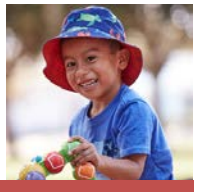


Source: Merced County Public Health, Maternal Child and Adolescent 2018-20 Title V Needs Assessment.

Figure 3. MCAH Best Practice Strategies

- Linkages between the hospital birthing unit and needed services in the community at time of birth is crucial.
- Need for programs to provide one-on-one counseling services to address postpartum depression.
- Providing early screenings, early intervention and strong family support.

Source: Merced County Public Health, Maternal Child and Adolescent Needs Assessment, 5/2/19.



ATTACHMENTS

"Once they're through with childhood immunizations some parents think they're through with preventive health services." – Key Informant Interview

ATTACHMENT 1

Commission/Staff and Key Informant Interviews

(In alphabetical order by first name)

Individuals	Affiliation/Organization
COMMISSIONERS AND STAFF	
Eva de Long	First 5 Commission
Gordon Arakawa, MD	First 5 Commission (at the time of interview)
Iantha Thompson	First 5 Commission (at the time of interview)
Kathleen Zimmerman	First 5 Staff
Lee Lor	First 5 Commission Chair
Marie Pickney	First 5 Staff
Paula Smith	First 5 Commission
Scott Waite	First 5 Executive Director
KEY INFORMANTS	
Amy Taylor	Merced County Libraries
Danny Royer	Merced Community Foundation
Dennis Haines	Merced County Office of Education, Family Resource Center
Donna Chin	Merced County Public Health
Donna Perry	Central Valley Regional Center
Heather Hertan	Yosemite Dental Society (Merced County Dental Society)
Jamie Johnson	Child Welfare Services
Jennifer Mockus	Central California Alliance for Health
Jennifer Rocha	Los Banos School District Preschool
Joey Chavez	City of Merced Parks & Recreation
Karen Lopez-Conde	Women Infants and Children (WIC) Supplemental Food Program
Karen Smith	CASA
Kimiko Vang	Merced County Human Services, CAL Works Home Visitation
Leslie Abasta-Cummings	Livingston Community Health Center
Linda Kaercher	Merced County Office of Education, Head Start
Manuel Alvarado	United Way
Melanie Cole	Merced City School District Preschools
Sol Rivas	Building Healthy Communities
Steve Roussos	Hlub Hmong Community Center
Tim Curley and Esthela de la Cruz	Valley Children's Healthcare
Yamilet Valladolid	Golden Valley Health Centers

FIRST 5 MERCED COUNTY
www.first5mercedcounty.org

ATTACHMENT 2

PARENT SURVEY

Dear Parent:
Thank you for taking the time to complete this survey about your children ages 0-5. It will help us learn how we can be more helpful to you and your family. Please try to answer every question and ask for help if you need it. Thank you.

Your Family:

1. What language do you and your child speak most of the time at home?

For the next few questions, circle the best answer:

2. I am able to tell if my child is making developmental progress (walking, talking, smiling, etc.)	a) Never	b) Rarely	c) Sometimes	d) Often	e) Always
3. I know how to help my child develop and learn.	a) Never	b) Rarely	c) Sometimes	d) Often	e) Always
4. I know what is usual child behavior at this age.	a) Never	b) Rarely	c) Sometimes	d) Often	e) Always
5. I feel confident in my parenting skills.	a) Never	b) Rarely	c) Sometimes	d) Often	e) Always

Healthy Habits:

6. Has your child had a *dental* exam in the last 6 months? *[Circle one]* a) Yes b) No (If not, why? _____)

7. In the last year were you unable to get or were you delayed in getting any necessary medical or dental care for your child? *[Circle one]* a) No b) Yes (If yes, what was the main problem? _____ _____)

These questions ask you about what happens in a usual week: *[Circle one]*

8. *Yesterday*, how many servings of fresh fruit or vegetables did your child eat?
   a) 0 b) 1 c) 2 d) 3 e) 4 f) 5 or more

9. In the *past week*, how many times did your child eat fast food?
   a) 0 b) 1 c) 2 d) 3 e) 4 f) 5 or more

10. In the *past week*, how many glasses/cans of soda or other sweetened drinks did your child drink?
    a) 0 b) 1 c) 2 d) 3 e) 4 f) 5 or more

11. In a *usual* week, how many days do you eat a meal with your child?
    a) 0 b) 1 c) 2 d) 3 e) 4 f) 5 or more

PLEASE TURN SURVEY OVER AND CONTINUE →

Early Education Experiences: *[Circle one]*

12. In a usual week, how many days do you or other family members read stories out loud with your child? a) 0 days b) 1 day c) 2-3 days d) 4-5 days e) Every day

13. In a usual week, how many days do you count numbers or practice the alphabet with your child? a) 0 days b) 1 day c) 2-3 days d) 4-5 days e) Every day

14. On an *average day*, how much time does your child usually spend on screen time (TV, iPad, cell phone video, etc.)?
    a) 1 hour or less b) 2 hours c) 3 hours d) 4 hours or more

Community Resources and Needs

15. Think about the needs of your family. Do any of the issues below worry you a lot? *[✓ yes or no]*
    *Then, put a big circle around the 2 things you said are your **biggest** worries.*

a)	Enough food for my family	__ No	__ Yes
b)	Transportation	__ No	__ Yes
c)	Mental/emotional health issues	__ No	__ Yes
d)	Drug/alcohol issues	__ No	__ Yes
e)	Domestic violence	__ No	__ Yes
f)	Help to identify problems my child may have (behavior, vision, speech, autism, etc.)	__ No	__ Yes
g)	Child care	__ No	__ Yes
h)	Employment	__ No	__ Yes
i)	Other (What? _____)		

16. What do you want or need help for your family *that you can't find*? *[✓ yes or no to all that apply]*

Health & Development

Dental	___ Yes	___ No
Nutrition	___ Yes	___ No
Child discipline	___ Yes	___ No
Special needs	___ Yes	___ No
Drugs or alcohol	___ Yes	___ No
Safe parks play areas	___ Yes	___ No
Help with breastfeeding	___ Yes	___ No

Other (what?)_____

Early Care & Education

Affordable preschool	___ Yes	___ No
Child care	___ Yes	___ No

Other _____

Resources for Families

Parenting classes	___ Yes	___ No	Help finding a job	___ Yes	___ No
Help with newborn at home	___ Yes	___ No	Help getting housing	___ Yes	___ No
Getting food	___ Yes	___ No	Other _____		
Getting legal aid	___ Yes	___ No			

Thank You!

When you're done, please hand the survey to the person who gave it to you.

REFERENCES

[1] March of Dimes, Peristats, 2016.
[2] California Department of Public Health, County Health Status Profiles 2019, Birth Cohort Perinatal Profiles.
[3] Ibid.
[4] Ibid.
[5] Ibid.
[6] California Department of Public Health, In-Hospital Breastfeeding as Indicated on the Newborn Screening Test Form Statewide and Maternal County of Residence by Race/Ethnicity: 2018.
[7] California Department of Public Health: MIHA Data Snapshot, Merced County, 2013-2015 Maternal and Infant Health Assessment (MIHA) Survey.
[8] California Department of Public Health, Immunization Branch 2018-2019, Kindergarten and Child Care Immunization Assessment Summary Data.
[9] UCLA California Health Information Survey, 2018.
[10] California Department of Health Services, Medi-Cal Dental Division, Denti-Cal Utilization (annual dental visit) by County, 2017.
[11] California Department of Public Health; Center for Family Health; Maternal, Child and Adolescent Health Program, *Maternal and Infant Health Assessment (MIHA) Survey, 2015-2016*.
[12] California Dental Association AB 1433 Pre-K Reported Data.
[13] Caregiver Survey, Merced County Oral Health Needs Assessment, December 2018.
[14] Statewide figure is an extrapolation from a similar question in UCLA California Health Information Survey, 2018.
[15] California Department of Education, Physical Fitness Testing Research Files, December 2018.
[16] California Department of Education, Statewide Assessment Division, 2018-19 California Physical Fitness Report.
[17] California Department of Public Health: MIHA Data Snapshot, Merced County, 2013-2015 Maternal and Infant Health Assessment (MIHA) Survey.
[18] UCLA California Health Information Survey, 2018.
[19] California Office of Statewide Health Planning and Development special tabulation; California Dept. of Finance, Population Estimates and Projections, 2000-2009, 2010-2060 (May 2019).
[20] Merced County Head Start, special data request, February 2020.
[21] Merced County HSA, Children's Services Branch. special data request, January 2020.
[22] California Department of Public Health: MIHA Data Snapshot, Merced County, 2013-2015 Maternal and Infant Health Assessment (MIHA) Survey.
[23] U.S. Census Bureau https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF
[24] U.S. Census Bureau, American Community Survey (Sept. 2018) as reported in kidsdata.org.
[25] U.S. Census Bureau, American Community Survey (Dec. 2018) as reported in kidsdata.org.
[26] California Child Welfare Indicators Project (CCWIP), UC Berkeley, Center for Social Services Research, 2019. https://ccwip.berkeley.edu/childwelfare/reports/AllegationRates/MTSG/r/rts/s
[27] Ibid.
[28] Webster, D, et al. California Child Welfare Indicators Project Reports. UC Berkeley Center for Social Services Research (Jul. 2019) as reported in kidsdata.org.
[29] Ibid.
[30] California Department of Justice Criminal Justice Statistics Center, Domestic Violence-Related Calls for Assistance (July 2018).
[31] California Department of Public Health: MIHA Data Snapshot, Merced County, 2013-2015 Maternal and Infant Health Assessment (MIHA) Survey.
[32] California Office of Statewide Health Planning and Development, Patient Discharge Data; California Department of Finance, Race/Ethnic Population with Age Detail.
[33] Merced County Collaborative for Child and Families.(2018). Merced County Early Learning & Care Needs Assessment. Merced County Office of Education.
[34] California Child Care Resource and Referral Network, California Child Care Portfolio (June 2018) as reported in kidsdata.org.
[35] Ibid.
[36] 2018-19 California County Scorecard of Children's Well-Being. https://www.childrennow.org/reports/
[37] UCLA California Health Information Survey, 2018.
[38] California Department of Education, California Assessment of Student Performance and Progress, English Language Arts/Literacy and Mathematics, 2018-2019.
[39] https://www.census.gov/quickfacts/fact/table/mercedcountycalifornia,CA/PST045218
[40] Population Reference Bureau, analysis of data from the U.S. Census Bureau's American Community Survey microdata files (Feb. 2018) as reported in kidsdata.org.
[41] California Department of Education. 2018-19 "At-Risk" and Long-Term English Learners (LTEL) by Grade.
[42] Personal communication with Stephanie Amezcua, United Way of Merced County, January 28, 2020.
[43] U.S. Census Bureau, American Community Survey (Sept. 2018) as reported in kidsdata.org.
[44] UCLA California Health Information Survey, 2018.
[45] As cited on kidsdata.org. *Children living in food insecure households*. (2019). Feeding America.
[46] https://www.census.gov/quickfacts/fact/table/Buttecountycalifornia,CA/PST045218

[47] California Department of Public Health: MIHA Data Snapshot, Merced County, 2013-2014 Maternal and Infant Health Assessment (MIHA) Survey.
[48] California Department of Education, Coordinated School Health and Safety Office, custom tabulation (May 2017) as reported in kidsdata.org. See also U.S. Department of Education, Early Childhood Homelessness State Profiles 2018 https://www2.ed.gov/rschstat/eval/disadv/homeless/early-childhood-homelessness-state-profiles.pdf
[49] California Department of Public Health: 2015-2017 Birth Statistical Master Files.
[50] Ibid.
[51] UCLA California Health Information Survey, 2018.
[52] California Department of Public Health: MIHA Data Snapshot, Merced County, 2013-2015 Maternal and Infant Health Assessment (MIHA) Survey.
[53] California Department of Public Health, Childhood Lead Poisoning Prevention Branch. https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/CDPH%20Document%20Library/2018_BLL_Maps_Tables.pdf
[54] Findings on Adverse Childhood Experiences in California. Center for Youth Wellness. https://centerforyouthwellness.org/wp-content/themes/cyw/build/img/building-a-movement/hidden-crisis.pdf
[55] U. S. Census Bureau, American Community Survey, 5-Year Estimates.
[56] Vikraman S, et al. Caloric Intake from Fast Food Among Children and Adolescents in the United States, 2011–2012. NCHS Data Brief No. 213, September 2015.
[57] UCLA California Health Information Survey, 2018.
[58] Nielsenwire. October 26, 2009. http://blog.nielsen.com/nielsenwire/media_entertainment/tv-viewing-among-kids-at-an-eight-year-high/
[59] Child and Family Research Partnership. A Framework for Evidence-Based Systems-Level Change. Policy Brief. July 2018.
[60] Adelman HS, Taylor S. Systemic Change for School Improvement. http://www.smhp.psych.ucla.edu/publications/systemic%20change%20for%20school%20improvement.pdf
[61] Child and Family Research Partnership. A Framework for Evidence-Based Systems-Level Change. Policy Brief. July 2018.
[62] DHHS. Administration on Children, Youth and Families Children's Bureau. Systems and Organizational Change Resulting from the Implementation of Systems of Care. November 2010.
[63] ORS Impact and Spark Policy Institute. *When Collective Impact Has an Impact. 2018.*
[64] Lesaux N, Jones S. What is innovation in early education and why is it crucial? Education Dive. February 2018.
[65] CPS Task Force (Community Preventive Services Task Force). 2013 annual report to Congress. 2014. [October 6, 2014] http://thecommunityguide.org/annualreport/2013-congress-report-full.pdf .
[66] Corcoran E, Locke R, Miller M. Tips for Engaging Local Businesses as Public Health Partners Journal of Public Health Management and Practice: September/October 2019 - Volume 25 - Issue 5 - p 518–521.
[67] https://www.first5monterey.org/userfiles/file/F5MCBestPracticesinPlaygroups.pdf
[68] National Academies Press (2016). Parenting Matters: Supporting Parents of Children 0-8: Targeted interventions Supporting Parents of Children with Special Needs, Parents Facing Special Adversities, and Parents Involved with Child Welfare Services.
[69] Home Visiting Evidence of Effectiveness Review: Executive Summary August 2017. https://www.acf.hhs.gov/sites/default/files/opre/homvee_executive_summary_august_2017_final_508_compliant.pdf
[70] Building Healthy Children: Evidence-Based Home Visitation Integrated With Pediatric Medical Homes. https://pediatrics.aappublications.org/content/pediatrics/132/Supplement_2/S174.full.pdf
[71] Sharps PW, et al. Current Evidence on Perinatal Home Visiting and Intimate Partner Violence. Journal of Obstet, Gyn & Neonatal Nursing. Volume 37, Issue 4, July–August 2008:480-491
[72] http://www.fatherhood.org/