First 5
Tulare County

STRATEGIC PLANNING
NEEDS ASSESSMENT

Prepared to support
the Commission's
2023-2028 Strategic Planning

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 report provides the background that will allow the Tulare County First 5 Commission to more strategically plan and guide its future community investments to achieve desired results. The Commission engaged Barbara Aved Associates in November 2022 to research and prepare the report. The report is organized into 5 sections: community indicator (statistics) data and community input (Parts I and II); highlights of key evaluation results (Part III); for those who might be interested in reading it, an overview of systems-level and sustainability considerations we prepared for another First 5 client's strategic planning process, at their request (Part IV); and, two SWOT analyses (one reflecting internal, the other the external input) and summary considerations (Part V).

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 54 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. The formerly-used *Parent Survey* was re-designed to learn more about the current needs and experiences of Tulare's County's 0-5 children and families. The link to the English/Spanish survey was widely distributed in November 2022 to host organizations and placed on social media platforms to make parents and other caregivers of children 0-5 aware of it. Some organizations also administered the survey to clients in hard copy to take advantage of their presence at the site. A total of 534 parents/caregivers 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. 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 with individuals who could inform the assessment (see Attachment 2). Fourteen of the 16 names that were given to us responded and participated. We looked for universal themes and common perspectives, and tailored some questions to interviewees' specific areas of expertise to delve deeper into ideas for improvement strategies.

Commissioners and staff also participated in individual interviews using many of the same structured questions we posed to the Key Informants; this opportunity afforded historical perspectives as well as input concerning planning, programming, evaluation and other operational issues (Attachment 1).

Key Evaluation Findings

The last 5 years of our evaluation reports were reviewed for findings that could inform the current strategic planning. We were specifically looking for conclusions/recommendations regarding approaches that have increased parenting knowledge, skills, and practices; strategies that facilitated access to services; interventions that promoted children's developmental progress; and capacity-building for grantees. A brief summary of highlights from those reports is included.

Others' Approaches

We conducted a brief literature search and spoke with a selection of 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 Tulare County.

Other Local Needs Assessments

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

- Tulare County Office of Education – Early Childhood Education Program 2020-2021 Annual Report
- Tulare County Community Health Needs Assessment and Community Health Improvement Plan (Tulare County Public Health)
- Tulare County Oral Health Needs Assessment (Tulare County Public Health)
- Valley Children's 2022 Community Health Needs Assessment

An Additional Note about Data

Virtual learning during the COVID-19 pandemic created significant challenges in identifying experiences such as domestic violence and children experiencing homelessness, and in staying in touch with families. Accordingly, some data sources used to calculate estimates have to be viewed with more caution than usual.

FINDINGS

Overview of Selected Tulare County Child Demographics and Socioeconomic Indicators

Child Population by Age Group (2021)

- Age 0 - 7,075
- Age 1 - 7,051
- Age 2 - 6,973
- Age 3 – 7,153
- Age 4 – 7,426
- Age 5 - 7,647

43,325

CA Department of Finance, Race/Ethnic Population Detail

Births by Mother's Race/Ethnicity

- African American 1.1%
- American Indian 0.6%
- Asian 2.7%
- Hispanic/Latina 66.5%
- White 27.3%
- Multiracial 0.9%

CA Department of Finance, Race/Ethnic Population Detail

Top non-English Languages Learners, K-12th Grade (2021-22)

- Spanish - 96.5% (24,620)
- Arabic - 1.2% (293)
- Lahu - 0.7% (243)
- Tagolag - 0.3% (75)

CA Department of Education, Demographics by Language Group

3rd Grade Reading Proficiency (n=7,516) 2021-2022

- Above standard - 10.9%
- Near standard - 58.3%
- Below standard - 30.8%

California Assessment of Student Performance/Progress

Special Education Enrollment (2018)

	0-2 y/o	3-5 y/o
Intellectual disability	--	73
Speech or language impairment	36	485
Other health impairment	879	84
Autism	--	216

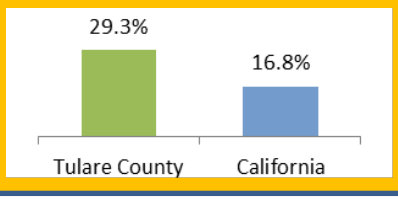
CA Department of Education, Special Ed Division

Health Insurance Coverage (Ages 0-5)

- Insured (97.6%)
- Employment-based (32.2%)
- Public Coverage (68.7%)
- Uninsured (2.4%)

UCLA CA Health Information Survey, 2021.

Percent of Children < Age 18 Living Below Poverty Threshold (2020)



U.S. Census Bureau, American Community Survey,2010-2020 5-Year Estimates

3rd Grade Math Problem Solving (n=7,584) 2021-2022

- Above standard - 12.8%
- Near standard - 45.0%
- Below standard - 42.3%

California Assessment of Student Performance/Progress

Agenda item #1

PART 1: 2022 DATA DASHBOARD (Statistical Data)

Child and family demographic trends help project potential needs for education, child care, health care, and other services. Demographic projections, socioeconomic conditions and health status indicators point to the need to invest in programs and policies that nurture and help all children reach their potential, particularly those facing disadvantage, and to align service systems with shifting demographics, such as increasing racial and ethnic diversity.

The dashboard below displays Tulare 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 54 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. And, non-use of services does not always mean services were not needed; it may instead imply access challenges.

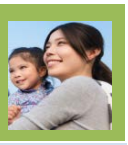
Tulare County status is compared to statewide averages using the rubric below:

⇧ = 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	Tulare County	California	Compare
DESIRED RESULT: HEALTH **Children grow up physically and mentally healthy** 				
Access to Prenatal Care (Adequate/ Adequate Plus Prenatal Visits)	The percent of women who begin early prenatal care (in the first trimester of pregnancy).[1]	82.3% (2020)	87.9%	⇩
	The percent of births with mothers receiving adequate number of visits.[2]	78.5% (2020)	73.6%	⇧
Low Birth Weight	The percent of babies born with low birth weight (<2500 grams).[3]	6.4% (2020)	6.9%	⇧
Infant Mortality	The number of deaths of children less than one year of age per 1000 live births (rate).[4]	3.84 (2019)	4.17	⇧
Maternal-Infant Substance Exposure	The rate of neonatal abstinence syndrome (infant withdrawal from maternal substance abuse diagnosis per 1,000 birth hospitalizations).[5]	2.2 (2018-2021)	2.7	⇧
	The number of babies born annually substance exposed (Applying national low-end estimates of 11.2% of all live births).[6]	761 babies of 6,796 births (2021)	N/R	N/R
Births to Adolescents	The rate of births per 1,000 females ages 15-19.[7] Ranked 46th worst among the 46 California counties with >20 teen births in the reported year	20.3 (2019)	11.4	⇧

Result Area	Indicator	Tulare County	California	Compare
HEALTH, cont.				
Births by Selected Indicators	Births by total live births in the reporting period.[8] (An indicator for fertility rate/family size)	(2018-2020 avg) First birth = 30.5% Second or third birth = 49.1% Fourth birth or more =20.4%	First birth = 39.5% Second or third birth = 48.3% Fourth birth or more =12.2%	N/R
	Births by receipt of WIC.[9] (An indicator for poverty status)	(2018-2020 avg) No = 40.2% Yes = 59.8%	No = 63.2% Yes = 36.8%	⇩
	Births by unmarried marital status.[10] (Non-marital births = higher risk of adverse birth/social and financial outcomes)	(2018-2020 avg) 52.1%	38.3%	⇩
Breastfeeding	The percent of women who initiate in the hospital any or exclusive breastfeeding after childbirth. [11]	Any / Exclusive (2019): 90.8% / 55.7% HOSPITAL — Any — Exclusive Adventist — 82.1% — 37.3% Kaweah D — 91.4% — 54.5% Sierra V — 89.6% — 60.5%	Any 93.7% / Exclusive 70.0%	⇩
	The percent of women who continue at the time of follow-up breastfeeding for at least 3 mos.[12]	Follow-up (2016-18) Any, at 1 mo. 73.6% Exclusive, at 1 mo. 41.3% Any, at 3 mos. 51.8% Exclusive, at 3 mos. 22.8%	Any, at 1 mo. 86.0% Exclusive, at 1 mo. 47.8% Any, at 3 mos. 70.6% Exclusive, at 3 mos. 33.5%	⇩
Immunization	The percent of children fully immunized by entry into kindergarten.[13]	(2019-20) 98.6%	95.8%	⇧
Oral Health: Utilization	The percent of all children ages 2-11 with a dental visit in the last 12 months. [14]	(2021) 74.4%	75.0%	⇔
	The percent of children ages 2-11 with Medi-Cal with a dental visit in the last 12 months. [15]	(2019) 33.3% ages 1-2 61.6% ages 3-5	32.8% ages 1-2 56.1% ages 3-5	⇔
	The percent of women with a dental visit during pregnancy.[16]	(2016-2018) 41.2%	44.3%	⇔
Status	Oral health status – preschool/ Head Start dental screenings.[17]	(2018-19) 36.6% avg	N/A	N/R
Risk Factors	The percent of children age 0-11 who the day before drank sugary beverage other than soda.[18]	(2018) 48.6% - none 39.2% - 1 glass 12.2% – 2 or more	51.0% - none 30.0% - 1 glass 19.0% - 2 or more	⇔
Air Quality	The number of days with Ozone levels above regulatory standard.[19]	(2019) 59	11	⇩
Asthma	The rate of children's asthma hospitalizations per 10,000 residents.[20]	(2019) Age 0-5 = 17.9	Age 0-5 = 14.8	⇩

Result Area	Indicator	Tulare County	California	Compare
HEALTH, cont.				
Nutrition	Percent of 5th graders who are overweight or obese.[21]	(2018) 19.2% (overweight) 24.9% (obese)	17.2% (overweight) 18.9% (obese)	⇩
	Percentage of 5th graders meeting 6 of 6 Healthy Fitness Zone fitness standards.[22]	21.4% (2018-19)	22.2%	⇔
	The proportion of women who are overweight or obese before pregnancy.[23] (influences the risk of obesity for the child)	(2016-18) 28.9% (overweight) 33.3% (obese)	26.8% (overweight) 24.5% (obese)	⇩
	The percent of children who eat 5 or more servings of fruit/vegetables daily.[24]	45.2% (2020)	38.6%	⇧
Children's Mental Health	The number of hospital discharges for mental health issues per 1,000 children and youth ages 5-14.[25]	1.5 (2020)	2.5	⇧
Emotional Well - Being	The percent of adults reporting family life impairment last 12 months due to emotional health issues.[26]	(2021) None 78.4% Moderate 13.2% Severe 8.4%	None 74.1% Moderate 15.4% Severe 10.5%	⇔
Maternal Mental Health	The percent of women with postpartum depression.[27] (*Can adversely affect children's emotional and behavioral outcomes.*)	17.3% (2016-18)	12.3%	⇩

Result Area	Indicator	Tulare County	California	Compare
DESIRED RESULT: STRONG FAMILIES **Parents and other caregivers have the knowledge and resources they need to provide a nurturing environment**				
Family Structure	Percent of families living with own children ages 0-5 by type of householder.[28] (*Defined as a householder and 1 or more other people related to them by birth, marriage, or adoption.*)	(2021) Married couple 13.9% Male/no spouse 18.4% Female/no spouse 15.1%	Married couple 20.5% Male, no spouse 21.1% Female, no spouse 15.3%	⇩
	Percent of children ages 0-17 living with grandparents who provide primary care for one or more grandchildren in the household (no parents).[29]	9.8% (2021)	8.8%	⇩

Result Area	Indicator	Tulare County	California	Compare
STRONG FAMILIES, cont.				
Child Abuse and Neglect: **Suspected and Reported**	Rate of children with *reported* (allegations) cases of abuse and neglect per 1,000 children.[30]	(2021) By child age < age 1: 83.3 ages 1-2: 54.8 ages 3-5: 63.7	By child age < age 1: 62.4 ages 1-2: 41.2 ages 3-5: 43.5	⇩
Substantiated	Rate of children with *substantiated* cases of abuse and neglect per 1,000 children.[31]	(2021) By child age < age 1: 31.3 ages 1-2: 7.6 ages 3-5: 6.5	By child age < age 1: 21.1 ages 1-2: 8.2 ages 3-5: 6.9	⇩
Foster Care	Rate of first entries into foster care per 1,000 children age <18.[32]	(2020-21) < age 1: 12.5 ages 1-2: 4.5 ages 3-5: 3.3	< age 1: 11.8 ages 1-2: 3.2 ages 3-5: 3.6	⇩
	The percent of children who re-entered foster care within 12 months.[33]	(2020-21) 11.1%	8.6%	⇩
Domestic/Intimate Partner Violence	The number of domestic violence calls for assistance.[34]	(2020) 2,502 (was 1,359 in 2018)	NA	N/R
	Percent of women who experienced physical or psychological intimate partner violence during pregnancy.[35]	(2016-18) 9.0%	5.8%	⇩
Unintentional Injury Hospitalizations	The rate of hospitalizations due to non-fatal unintentional injuries per 100,000 children ages 0-4.[36]	(2015) 125.1	191.2	⇧

<table>
<tr><th>Result Area</th><th>Indicator</th><th>Tulare County</th><th>California</th><th>Compare</th></tr>
<tr><td colspan="5">DESIRED RESULT: EARLY CARE AND DEVELOPMENT
Children enter school ready to learn – cognitively, social-emotionally and physically  </td></tr>
<tr><td rowspan="3">Unmet Need and Availability of Child Care</td><td>Number and percent of children income eligible and qualifying for state/federally-subsidized programs for infants and toddlers (Table 1), and percent of unmet need for those programs (Table 2).[37]</td><td colspan="2">(2018)
Table 1<table><tr><td></td><td>Age 0-1</td><td>Age 1-2</td><td>Age 2-3</td></tr><tr><td>Percent</td><td>39%</td><td>44%</td><td>46%</td></tr><tr><td>Number</td><td>2,644</td><td>3,243</td><td>3,802</td></tr></table>Table 2<table><tr><td>Percent of unmet need</td><td>Age 0-1
80%</td><td>Age 1-2
80%</td><td>Age 2-3
79%</td></tr></table></td><td rowspan="2">N/R</td></tr>
<tr><td>Number and percent of children income eligible and qualifying for state/federally-subsidized preschool (Table 1) and percent of unmet need for preschool (Table 2).[38]</td><td colspan="2">(2018)
Table 1<table><tr><td></td><td>Age 3</td><td>Age 4</td><td>Total</td></tr><tr><td>Percent</td><td>91%</td><td>85%</td><td>88%</td></tr><tr><td>Number</td><td>7,622</td><td>7,304</td><td>14,926</td></tr></table>Table 2<table><tr><td>Percent of unmet need</td><td>Age 3
74%</td><td>Age 4
35%</td><td>Total
55%</td></tr></table></td></tr>
<tr><td>The estimated percent of children with parents in the labor force for whom licensed child care is available.[39]</td><td>(2019)
16.2%
(83.8% unavailable)</td><td>24.5%
(75.5% unavailable)</td><td>⇩</td></tr>
<tr><td>Preschool Enrollment</td><td>Children ages 3 and 4 not enrolled in preschool.[40]</td><td>(2019)
67.4%</td><td>50.4%</td><td>⇩</td></tr>
<tr><td>Early Literacy</td><td>The percent of children ages 0-5 whose parents read stories or look at picture books with them.[41]</td><td>(2021)
Daily 43.3%
3-6 x/week 22.4%</td><td>Daily 53.9%
3-6 x/week 26.3%</td><td>⇩</td></tr>
<tr><td rowspan="2">Reading and Math Proficiency</td><td>The percent of 3rd grade children at grade-level proficiency in overall English Language Arts/Literacy.[42]</td><td>(2021-22)<table><tr><td>Standard Exceeded</td><td>13.4 %</td></tr><tr><td>Standard Met</td><td>17.6 %</td></tr><tr><td>Standard Nearly Met</td><td>25.4 %</td></tr><tr><td>Standard Not Met</td><td>43.7 %</td></tr></table></td><td>(2021-22)<table><tr><td>Standard Exceeded</td><td>22.8 %</td></tr><tr><td>Standard Met</td><td>19.4 %</td></tr><tr><td>Standard Nearly Met</td><td>22.6 %</td></tr><tr><td>Standard Not Met</td><td>35.3 %</td></tr></table></td><td>⇩</td></tr>
<tr><td>The percent of 3rd grade children at grade-level proficiency in overall Math.[43]</td><td>(2021-22)<table><tr><td>Standard Exceeded</td><td>10.5 %</td></tr><tr><td>Standard Met</td><td>21.3 %</td></tr><tr><td>Standard Nearly Met</td><td>24.3 %</td></tr><tr><td>Standard Not Met</td><td>44.0 %</td></tr></table></td><td>(2021-22)<table><tr><td>Standard Exceeded</td><td>19.1 %</td></tr><tr><td>Standard Met</td><td>24.4 %</td></tr><tr><td>Standard Nearly Met</td><td>22.1 %</td></tr><tr><td>Standard Not Met</td><td>34.4 %</td></tr></table></td><td>⇩</td></tr>
<tr><td>Language</td><td>The percent of the population age 5-17 who speak a language other than English at home.[44]</td><td>(2021)
22.8%</td><td>16.5%</td><td>N/R</td></tr>
<tr><td>English Language Learners</td><td>Percentage of students considered “long-term English learners 6+ years.” [45]</td><td>(2020-2021)
23.7%</td><td>18.1%</td><td>⇩</td></tr>
</table>

Result Area	Indicator	Tulare County	California	Compare
DESIRED RESULT: INTEGRATIVE AND COLLABORATIVE SERVICES AND OTHER COMMUNITY DETERMINANTS OF WELL-BEING **Communities are engaged in supporting and prioritizing children**				
Poverty	The percent of families with related children of householder under age 5 in poverty.[46]	(2021) 17.9%	10.4%	⇩
	The percent of students eligible for the free and reduced-price school meal program.[47]	(2021) 75.5%	58.9%	⇩
Food Security	Percent of adults <200% FPL unable to afford enough food (food insecure). [48]	(2021) 37.5%	39.0%	⇔
	The percentage of children ages 0-17 living in households with limited or uncertain access to adequate food.[49]	(2019) 23.0%	13.6%	⇩
Educational Attainment	The percent of population age 25+ HS/GED diploma or higher.[50]	(2022) 72.6%	84.2%	⇩
	The percent of births by education of mother.[51] (Higher education = better child status)	(2018-2020 avg) Less than HS = 19.2% HS grad = 33.4% Some college = 34.2% College grad = 13.2%	Less than HS = 11.4% HS grad = 25.5% Some college = 27.4% College grad = 35.8%	⇩
Homelessness	The percent of public school students recorded as being homeless at any time during the school year.[52]	(2018) 3.1%	4.5%	⇧
	The number of people experiencing homelessness (January Point-in-Time Count).[53]	(2022) 922 258 = chronic homelessness 632 = slept unsheltered 11% = with children	NA	N/R
Tobacco Use: Adult Smoking	Percent of individuals age 18+ reporting current cigarette smoking.[54]	(2018) 5.8 %	6.2%	⇧
Maternal Tobacco Use	Prevalence of any maternal smoking 3 months prior to pregnancy.[55]	(2016-2018) 8.0%	8.6%	⇧
Exposure to Lead	The percent of children ages 0–5 screened with elevated blood lead levels (lead greater than or equal to 4.5% µg/dL).[56]	(2020) 1.44%	1.21%	⇩
Adverse Childhood Experiences (ACES)	Prevalence of adults reporting ACES.[57]	None 33.6% 1 22.6% 2 8.9% 3 10.6% 4+ 24.3%	None 32.7% 1 19.8% 2 14.4% 3 11.8% 4+ 21.2%	⇔

DASHBOARD SUMMARY
(54 Indicators)

DESIRED RESULT (n = number of indicators assessed)	Tulare COUNTY COMPARED TO CA
Health (n = 27)	⇧ 8 ⇩ 10 ⇔ 6 N/R 3
Strong Families (n = 9)	⇧ 1 ⇩ 7 ⇔ 1 N/R 0
Early Care and Development (n = 7)	⇧ 0 ⇩ 6 ⇔ 0 N/R 1
Other Community Determinants (n = 11)	⇧ 3 ⇩ 6 ⇔ 2 N/R 1

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)

PRIORITY AREA TRENDS

ORAL HEALTH

Figure 1. Percent of Tulare County Children with Medi-Cal with an Annual Dental Visit

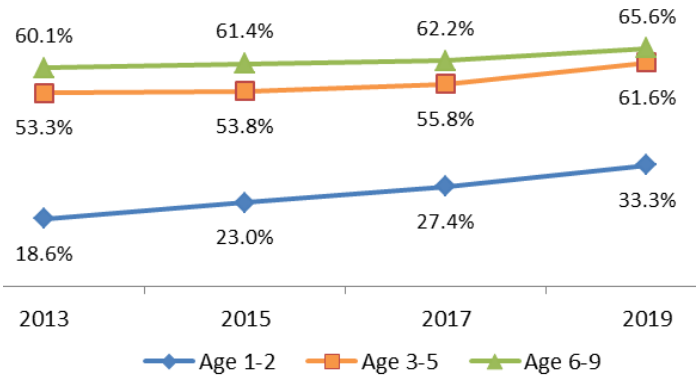
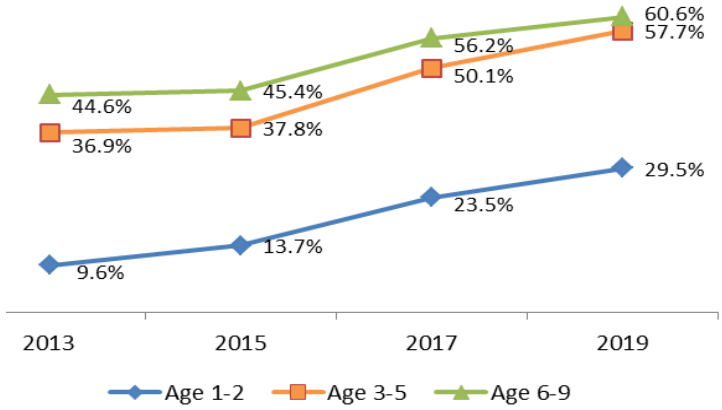


Figure 2. Percent of Tulare County Children with Medi-Cal with Use of a Preventive Dental Service



Source: CA Department of Health Care Services. Medi-Cal Dental Division.
Annual Dental Visit = Percentage of members who had at least one dental visit during the measurement period.
Use of Preventive Service = Percentage of members who received any preventive dental service during the measurement period.

BREASTFEEDING

Figure 3. Women with Any Breastfeeding at Time of Birth

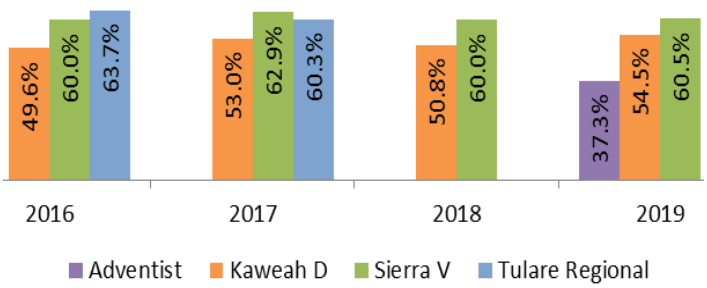
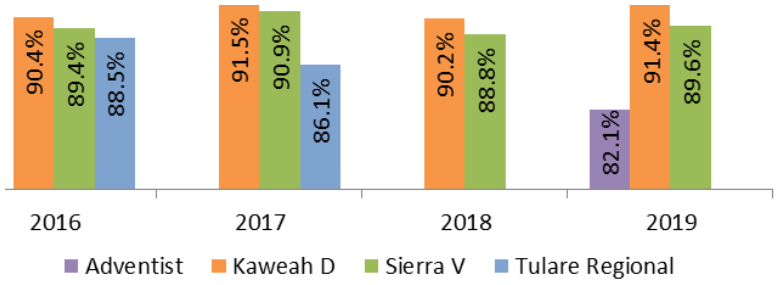


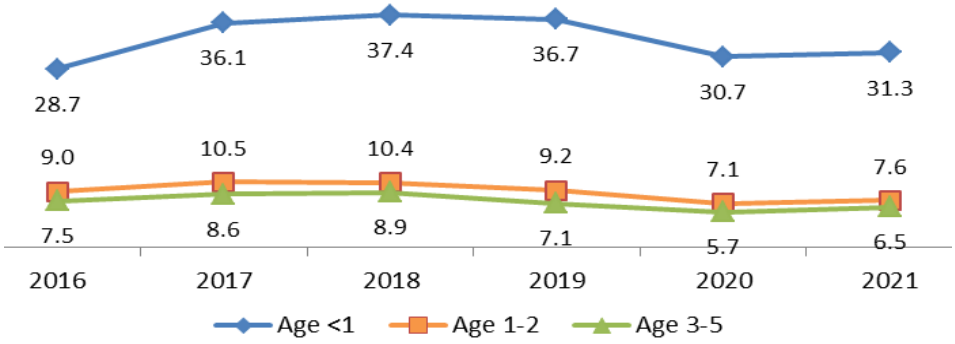
Figure 4. Women with Exclusive Breastfeeding at Time of Birth



Source: CA Department of Public Health. Newborn Screening Form.

CHILD ABUSE AND NEGLECT

Figure 5. Rate of Tulare County Children with *Substantiated* Cases of Abuse and Neglect per 1,000 children



Source: The California Child Welfare Indicators Project (CCWIP).

PART II: COMMISSION & COMMUNITY INPUT

"We're already looked to as the 'community convener' because of the pandemic." – Commission 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, the Parent Survey, and Grantee Focus Group. The perspectives of these groups generally aligned with the dashboard data presented above.

COMMISSION AND STAFF INTERVIEWS

Eight of the 9 Commissioners, along with the 5 staff, completed one-on-one telephone interviews about community needs, grant-making, evaluation, and internal operations; the input is combined as "the Commission" in the summary that follows. The interviews were conducted in November – December 2022.

LOOKING OUTWARD (COMMUNITY)

Highest Needs and Concerns

The Commission was asked to identify the highest needs/most significant problems facing Tulare County's 0-5 families *relative to First 5's mission/sphere of influence.* Addressing parent and child poor mental/emotional health topped the list of nearly everyone's feedback (Figure 1). "Ineffective parenting"—seen as leading to everything from children's behavioral issues to childhood obesity to keeping dental treatment appointments— was also a commonly-mentioned concern. At the same time, some of the causes of poor parenting were recognized as a simple lack of information, or the result of family dysfunction caused by substance use, incarceration or "living in survival mode."

Figure 1. Most Commonly Identified Needs for Tulare County's 0-5 Population

HIGHEST NEEDS

- Parent and child mental/emotional well-being
- Children's oral health (access and utilization + oral health status)
- Parenting skills/parent engagement
- Access to good quality food (+ adoption of healthy choices)
- Affordable preschool/infant care slots

NEXT-HIGHEST NEEDS

- Safe, affordable housing
- Access to specialty care
- Timely access to referrals

In addition to the need for parents to learn more about and make healthier food choices for their families—and, for some, to have more access to high-quality food—the other major concern cited was children's oral health: low-value assigned to it by many parents; dental fear as a barrier to utilization; continuing high rates of dental decay; lack of follow-through to referrals for treatment ("*it's a no-show population*"); provider unwillingness to see children under age 3 (*"limited acceptance of the best-practice 'First Tooth First Birthday' [FTFB]"*); and access to services because few local dentists accept Medi-Cal patients.

Other concerns mentioned that some of the interviewees weren't certain First 5 could "do much about" —some as a result of or made worse by the economic fallout from COVID—but considered too important not to mention included the following:

- Affordable child care and preschool slots
- The lack of affordable housing
- Homelessness
- High teen pregnancy rate (with "apparent" cultural/intergenerational tolerance for the problem)
- Reading and math scores

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 interviewees asked to prioritize the problem areas they had identified (Figure 2), with no presumption about the strategies for addressing them. The purpose was to assess the extent of accord among the interviewees. It was understood that all of the concerns mentioned were interconnected, and all have a direct or indirect impact on each another.

Figure 2. Commission's Top-Ranked Priorities for First 5

- Mental/emotional/behavioral health
- Oral health
- Breastfeeding promotion
- Nutrition
- Early literacy

Intervention Strategies

The most common responses to the question of what types of program strategies or approaches should be supported to impact the identified needs are listed on the next page (Figure 3). The Commission felt strongly that home visitation should remain a key strategy; this was also recognized as an opportunity to address emotional/behavioral health. Another 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 (CBOs) to help address the priorities included skill building of existing CBO staff and ensuring they have an adequate workforce, as well as the idea one person raised 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 to increase the applicant pool.

Program approaches to support an oral health (OH) priority—coordinated with Public Health's OH program—included more intensive parent and community education (including around consumption of sugary beverages) and direct provider engagement around *FTFB* with the help of the local medical and local dental societies. The extensive mental health background of the newest Commission member, Ms. Ortiz, was specifically referenced by several individuals as being an asset to support approaches that could respond to the critical need to provide more family emotional support services.

Figure 3. Commission's Suggested Program/Grant Strategies for Greatest Impact

- Home visiting programs
- Approaches that promote mental health, particularly maternal mental health
- Stronger breastfeeding program across the county (i.e., all hospitals participate)
- Support services for working parents, especially single parents (e.g., reimbursement options for limited-engagement childcare "respite")
- CASA-like programs (e.g., adult/child mentoring, parent-to-parent coaching)
- Capacity-building for community-based organizations (CBOs)
- Tailored outreach for underserved populations
- Education/information for the public about available resources
- More attention on trauma-informed practices
- Reimbursement options for transportation assistance
- More awareness strategies for elected officials and other public leaders/policymakers
- Increase timely referrals to specialists (e.g., provider recruitment, patient navigation)
- Conduct a service inventory and identify funds going to each type of service, would help to bridge funding

Commission Roles and Relationships and Additional Opportunities

In general, the Commission felt comfortable with the strength of its partnerships with community-based organizations and public agencies. The relationships were seen as being collaborative and in many cases the alignment of one another's missions had helped to leverage First 5 resources. It was clear that the Commission views its grantees as valued partners and, through site visits and performance monitoring, offers technical assistance and other supportive measures to the organizations.

The interviewees also believed First 5 had been responsive in supporting the professional/ provider community; however, some thought it could perhaps be more proactive in reaching out to individual

primary care providers (e.g., helping pediatricians and OB-GYNs make a greater connection with the dental community); CBO capacity building (e.g., helping prospective applicants in grant seeking to make them competitive for First 5 and other funders); bringing in experts from the outside (e.g., offering or sponsoring workshops in grant writing, grantseeking, and evaluation capacity), and continuing to offer educational sessions on top-need specific subjects similar to what has been provided through the Commission's home visiting program.

LOOKING INWARD (INTERNAL OPERATIONS)

Grantmaking Approaches

In addition to direct services funding, many Commissions have shifted to playing a greater role in the community as a "catalyst/convener" and, in some cases, as a policymaker/advocate. The First 5 Tulare interviewees, for the most part, however, said they were comfortable with the current balance of funding direct service programs and being supportive to the community in other ways (e.g., capital grants, responding to emergencies during COVID). According to one individual, "*we're already pretty good at bringing people together around the table on specific issues.*"

Several of the interviewees, however, did seem open to the idea of setting aside some amount of funding to support a specific priority problem over a longer-than-usual term—understanding that doing this would mean a tradeoff in reducing funds that are responsive to applicant-identified problems. (Note: given that the Commission is now more than half-way through its current 3-year grant cycle, this should be an area to explore during the strategic planning sessions.) One interviewees questioned whether there might be a certain amount of redundancy in services in Tulare County, i.e., various funders/dollars paying for the same services at some of the same agencies, and suggested this might be looked at a little more closely as First 5 funds diminish.

There was little to no interesting in increasing involvement in other roles beyond direct community grantmaking such as policy development. One individual pointed out that the First 5 Association "*tracks policy issues and looks for opportunities to advocate,*" so it was really not necessary for local First 5s to initiate regional or statewide policy changes, though they could be supportive.

Evaluation

According to all of the interviews, staff and the Commissioners have found the evaluation work of BAA insightful, helpful in identifying the strengths of funded programs and as well as pointing out the things that need to improve, and providing a balance of information in relation to the Commission's focus areas. One Commission member mentioned the annual and other ad hoc evaluation reports "*go beyond just listening to the [positive] grantee presentations*" (which they said they enjoy). Other comments included *"incredibly thorough;" "every year it gets richer;" "so much better than in the past;" "the evaluation work makes the financial reports 'come to life.'"*

When asked about potential future changes in either the information (more of something? less of something?) or the annual report, one interviewee suggested creating a one-page executive summary amendable to posting on First 5's website, perhaps in iconographic format.

One of the Commissioners inquired about the "next steps" that were taken (or not taken) following presentations of the reports—i.e., what happens to the Consultant recommendations for individual grantees and to the Commission? They understood that a client is not "obligated" to act upon an evaluator's recommendations, but said it would be helpful for accountability to know what actions had been taken. (Note: this might be another area to explore during the strategic planning sessions.)

Internal Operations

Staff and Commissioners alike expressed a great deal of satisfaction with the management (and management style) of the organization. As an organization, First 5 was viewed as being accountable, responsive ("*vested in community success*"), fair, and promoting a positive and supportive working environment. Staff were acknowledged for their expertise and for things like "going after other money" to expand programs. No one identified any operational issues that could benefit by being looked at in the strategic planning process except perhaps visibility.

Despite First 5 staff's increased presence in the community—since this issue came up during the last strategic planning—attending numerous community events, sitting on or chairing various advisory committees, etc., a couple of Commission members thought "*not a lot of people know what First 5 is*" (beyond in some cases knowing about the branded give-aways and other promotional products). They wondered whether increased branding (e.g., billboards, internal and external bus signs) would help make the work of the Commission more visible, as well as promote First 5 messages. In that regard, however, several interviewees, including Commission members themselves, identified the importance for each of the Commissioners to play a greater role in having a stake in the community by making others in their "spheres of influence" more aware of what First 5 is all about—becoming a champion for specific community problems—and what difference it makes. In that regard, one said, "*we need to be pushed more, push us more*." In support of that comment, another said, "*ask us how we can become more engaged, draw us in with specific opportunities.*"

Agenda item #3

KEY INFORMANT INTERVIEWS

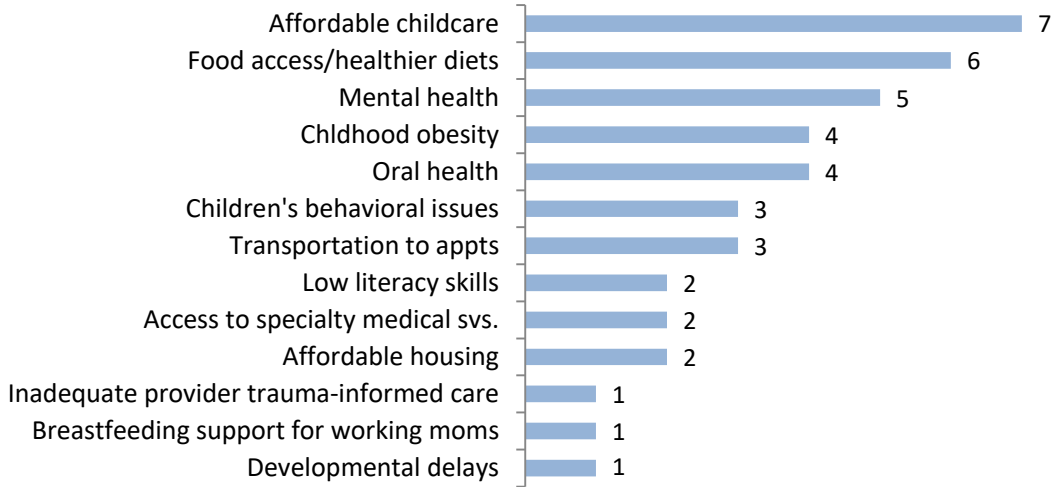
"We need to focus on keeping our kids healthy so they can engage in early learning and development."
– Key Informant Interviewee

Key Informants' views about community needs, barriers, opportunities and recommendations are described below. Their input about First 5 as an organization is summarized in the SWOT chart on page 46.

Highest Needs

Thinking about First 5's Result Areas, and given their knowledge of the extent of community need, the Key Informants were asked to identify the highest concerns facing Tulare County's 0-5 children and their families. As Figure 1 shows, finding affordable, high quality childcare (cited by 50%) topped the list—especially in the "off hours" for parents who work different shifts from one another or evening shift. This was acknowledged to be a number one barrier for parents to seek/keep a job. A close second issue concerned food and nutrition: access to affordable high-quality food ("*painfully unavailable for many families*"), lack of knowledge about healthy food choices ("*what parents are choosing to put in their grocery cart*") and shopping and meal preparation, and over-consumption of fast food and sweetened beverages. Relatedly, concern about the long-term effects of childhood obesity was specifically mentioned by 4 (29%) individuals.

Figure 1. Highest Needs Identified by Key Informants for 0-5 Children and Families, by Frequency of Mention (n=14)



*Interviewees could identify more than one issue.

Maternal and other depression, higher levels of anxiety, relationship difficulties—some of it fueled by substance abuse—was recognized to be a continuing problem without enough delivery system capacity to address it. Factors included long waits for mental health appointments, lack of insurance coverage (or, when covered, limited scope of benefits and high copayments), and inconvenient service hours. The subset of children's behavioral/mental health was also called out with "k*ids not*

knowing how to behave in a classroom because so many missed months/years of attendance due to COVID;" *"kids even getting expelled from preschool*;" and "*children reacting to parents' instability*" cited as some of the evidence.

The need for more parents to recognize the value of early childhood oral health—and *utilize* their children's dental benefits—along with making dental services more accessible to the Medi-Cal population was also described to be a high need. Transportation to appointments was said to *"come up in all conversations about access to services."*

Although not a specific problem First 5 was thought to be able to solve, two individuals highlighted the lack of affordable housing and the impact homelessness has had on families in the county—exacerbated by COVID. As one of them pointed out, "*until families' basic living needs are met, to ensure safe, stable homes, kids' health and learning are going to be compromised no matter what strategies you put into place*."

Additional insightful comments included the following:

- *"There's a recognition that mental health for kids is at a crisis point."*
- *"Our educational system [*for young children*] seems behind relative to other counties."*
- *"We really need to work with parents to have them re-learn how to parent" [*because of the impact of the pandemic*].*
- *"We need to offer more parent education opportunities, but it's not for lack of trying. The most vulnerable families are more resistant and less willing to open up their homes to scrutiny."*
- *"Many kids left unattended to and on their own during COVID have low language development; who knows how long it'll take for them to catch up with some of their peers?"*
- *"Maternal depression/postpartum depression—this keeps coming up in so many programs as a risk factor for child development."*

Grantmaking Approaches

When asked what they would like to see First 5 support more of, less of or do more effectively in the way it makes grants one individual suggested that "*money has to be spread more thinly*" [not clear whether this meant same spread but less money, or narrower spread with same level of funding?]. "B*eing more intentional about priorities*" was believed to be necessary when reducing funding levels. Another made the point that First 5 funds "*always has to represent a blend*" regardless of the percentage of required match, though it was acknowledged that some organization have a stronger infrastructure to be able to do this. One interviewee recognized that "*grantees understand the limits of what they can do; they can't solve every problem*."

Most of interviewees who were most familiar with First 5's grantmaking history said they were "*ambivalent*" or "*torn*" about the idea of carving off a portion of funding and directing it to one major priority area because of negative impact it would have on the availability of funding to support grantee-identified needs. As one of these individuals stated, "*Tulare has a lack of funding for direct services; the gaps are too big to shift away from organizational support; we don't have an infusion of*

philanthropic dollars other places have." Another believed "*there would be a price to pay for shifting direction in grantmaking.*" The others who were able to comment were generally more supportive of building an initiative around one selected priority while continuing to be responsive to other community needs, and thought both approaches had validity. One individual noted that all grantmaking involved in creating systems needed to be made through the lens equity, diversity and inclusion.

When asked about what happens when operational grants that support personnel come to an end one Key Informant, in favor of continued direct support, believed if the program was deemed successful based on agreed-to metrics (assuming metrics had been identified) school districts, at least, would pick up the cost of the position(s).

A couple of people said First 5 should be "creative" when developing the strategic plan in how to make funding adjustments due to diminishing dollars; another said "be more strategic." When pushed to offer specific examples or recommendations the responses ranged from "*it is a real challenge*" to "*it's something they have to wrestle with*;" not particularly helpful!

Suggested Strategies

Regardless of any future changes that might be made to its grantmaking practices, the Key Informants offered opinions about high impact services and strategies First 5 should consider supporting to address the priority needs they had identified. They were asked to make these suggestions in light of where other monies are currently available or expected to be—to the extent they were aware—in order to reduce the potential for duplication. Table 1 on the next page shows this list with specific examples included.

Many of the Key Informants viewed home visitation as a "high return practice." More family support—particularly parent education—within the context of home visits as well as community settings (e.g., fatherhood-type projects), was advocated by at least half of the individuals. A number of the interviewees cited as a major gap "parent knowledge about good parenting" and the lack of resources to support this learning.

Another 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 and ensure family follow-through with supportive services ("*you'd think a parent would be motivated to get their kid's dental decay taken care of without being pushed or incentivized to do it, but that's just not always the case*"). Three individuals would want First 5 to support more Family Resource Centers, to bring services closer to where families live especially in outlying communities.

When making suggestions for approaches to help people in unstable living conditions it was understood that First 5 could not pay for sheltering or structures; rather, several people suggested any services—dental screening, play groups, book giveaways, nutrition education—that could be imbedded at those sites would be a valuable role.

Table 1. Suggested Programs/Grant Strategies for High Impact

- Home visitation programs; be more deliberate in reaching out to families at high risk, e.g., children with special needs, an incarcerated parent. Connect classrooms to the home by supporting a cohort of coaches.
- Programs that show parents how to successfully parent, especially for first-time parents ("*need to talk about the realities of what to expect—the negatives as well as the positives; awareness can help begin to build resilience*").
- Incentives to various provider types for creating more 0-3 childcare capacity, especially with expanded hours, prioritizing single parents and lower-income families ineligible for subsidies.
- Nutrition education, especially for pregnant women, e.g., classes with hands-on cooking that can also serve as a food giveaway when needed; integrate information about early childhood oral health vis-à-vis sugar-sweetened food and beverages.
- Early screening and referral (e.g., ASQs, ACES for developmental issues, oral health to identify problems) with a follow-through component.
- Provide money for grantees to offer incentives like childcare and transportation, especially rural families, to promote attendance at parent education events.
- Create and/or help support Family Resource Centers (a best practice model).
- Integrate training for trauma informed care in all First 5 programs ("*and in everybody's care system*").
- Opportunities where early literacy can be promoted, e.g.,0-5 books in the waiting rooms of non-traditional as well as traditional places such detention centers.
- Support services imbedded at some of the affordable housing units and homeless shelters, e.g., onsite early literacy programs, day care, play programs ("*this would be considered 'high touch' "*).
- Support for the cost of operating a 3-year-old classroom (preschool).
- Any means (e.g., 2-1-1) that make people aware of resources—location, eligibility, and current capacity—with help for navigating them.

*In rank order by frequency mentioned though there were many "tie votes."

Support to the Provider/Professional Community

Ideas about how First 5 could be more helpful are summarized in Table 2 that begins on the next page. In many cases these suggestions supplement the ways First 5 has always helped but some of the specific examples for expansion are helpful.

Capacity-building for local organizations that need either a boost in grant-writing skills or an appropriate fiscal agent to be able to implement their proposed program was one suggestion offered, saying new entities might be able to be "*brought into the fold*" with a little help.

Some people also thought First 5 should take a more visible leadership role in being the champion for children and families (beyond participating in countywide or agency-specific committees and coalitions).

One person remarked that First 5 was "*so primed to be able to influence change locally and even 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.

Two individuals thought First 5 did not need to step into a convener and other roles "*because others have this role*." In particular, the Community Care Coalition—on which First 5 sits—was mentioned. And, the First 5 Association covers policy development. For the remainder who *did* think First 5 could play more of a convener role around specific issues, one individual felt First 5 could be a convener for figuring out how the health clinics and community-based organizations could deal with the staffing shortages so many are experiencing that are limiting the availability of services to many people ("*help us in filling the gaps, especially post-pandemic*" [in a way that doesn't "rob Peter to pay Paul" of course]).

It was also suggested that those brought to the table should strategize around the data asking, what's changed? what's not changed? and identifying a champion (with accountability for follow-up) for each issue. It was believed that First 5's "standing in the community" (including its Commission members) would serve as an important catalyst for bringing about change. Accordingly, the individual offered the following recommendation:

> *"Someone needs to create an environment for us to create solutions, including looking at our mistakes. Share findings where we can all benefit; bring in people who can think bigger, who are non-parochial. How do we build on the resources that are already there? Who are the partners who can bring varied resources to sustain them?*

A related commenter noted:

> *"First 5 is good at convening, getting people in the room. So they should use it to develop an action plan, identify areas of responsibility, hold people accountable. Like the County's CHIP* [Community Health Improvement Plan] *but with accountability."*

An interesting idea put forth was that First 5 should use its influence in the community to advocate when things like updates to the county general plan occur or new housing development comes along for inclusion of 0-5-friendly policies and support, e.g., use of developer/impact fees to respond to identified needs.

Table 2. Recommendations Related to Provider/Professional Support (n=14)

Opportunity	Strategy
Build capacity of local organizations	▪ Sponsor a grant-writing workshop every couple of years. ▪ Sponsor a workshop to increase grant-writing and internal evaluation-building skills. ▪ Identify acceptable fiscal partners who could serve as an administrative agent for less sophisticated applicants.

Table continues on the next page

Increase convener role	▪ "*Use your megaphone*" (i.e., First 5's presence in the county) to bring more people to the table around issues; strategize around the data. ▪ Share the Data Dashboard with the community. ▪ Promote awareness and advocacy through communications strategies to groups not always reached through social media (e.g., "*talk about your program more, not enough people know what you do")*.
Sponsor educational opportunities	▪ Bring in expert speakers/trainers on high-interest topics, and expand the invitation to the "non-First 5 community." ▪ Sponsor provider training in developmental screening to increase identification of delays and problems earlier (e.g., hearing and vision)
Promote collaborative activities	▪ Create new or strengthen relationships with non-traditional groups (e.g., law enforcement who, as a result of the Key Informant interview, expressed interest in implementing ACES screening for its incarcerated population). ▪ Reach out to the local medical society (e.g., pediatric committee, MCH committee) to engage the organization in specific First 5 projects or even just specific "asks" of individual members.

Agenda item #3

GRANTEE FOCUS GROUP

"Collaboration is great but everyone tends to look at things from their own angle."
– Focus group participant

In mid-January we met with the First 5 Network of Providers (grantees) and facilitated a group discussion to obtain their perspectives about the updated First 5 strategic plan. About 25-30 people participated. We used similar questions as for the interviews to look for common themes and opinions. This information is consistent with what we heard from the Key Informants, Commissioners and staff. The grantee input about First 5 as an organization is included in the summary SWOT chart on page 47.

Top Needs and Concerns

Asked to think about the desired result areas of First 5 and the most pressing 0-5 population concerns that *First 5 dollars should address* over the next 5 years, participants stated it was "the need to improve parent-child interaction." This need was strongly endorsed by the entire group.

The unvarying theme of the discussion centered on parents having had poor parenting role models for themselves, disparities in knowledge about child development, "living in chronic survival mode," "being too busy with other things to pay enough attention to their kids," and allowing over-use of entertainment screen time as the main reasons for inadequate parenting responsibility. The "increasing intensity" of children's behavioral issues and poor social skills as a result of COVID isolation—impacting a child's ability to successfully participate in preschool—were observed by the school personnel who attended the meeting as one of the major manifestations of parental lack of engagement.

The other needs brought up as being important for First 5 support included recognition of the need for more and better quality child care and preschool opportunities, help for mental health issues—which tied back to the parenting issues—and breastfeeding promotion, mentioned by one participant.

Recommended Priority Area ⇨	**Improving Parent-Child Interaction**

Recommended Strategy

There was complete agreement that the best way to help parents become better at parenting was to provide one-on-one coaching/mentoring, including home visiting. Simply inviting parents and other caregivers to attend parenting classes, "which used to work fairly well prior to COVID for motivated parents," was viewed as inadequate on its own. Counseling, coaching, and helping parents learn how to find and navigate services, and following up to see that they followed through, providing education and materials, providing for basic needs until a family could be stabilized, and so forth were described as the specific "interventions" that should be supported. The group realistically

acknowledged having such intensive services was not only labor intensive but costly, and would require ongoing financial support—something these organizations could not guarantee sustaining themselves. Nevertheless, this was the main recommended priority for future First 5 support.

Shift in First 5 Role? Shift in Grantmaking Strategy?

The grantees:

- Did not see the need for First 5 to play more of a convener/catalyst role in the county than they currently do; they are very satisfied with the current level of First 5 leadership and didn't agree with the idea of "shifting gears" to expand this role.
- Did not support the idea of shifting money from the general community grants pot to create a special initiative. They did, however, agree that identifying a priority like improving parenting capacity could be the main focus of the next grant cycle RFP as long as applicants could address the issue through their own organizational approaches. They also expressed appreciation for First 5 staff allowing applicants to "think outside the box" in designing strategies—and being flexible to allow funded projects to make mid-year scope of work adjustments "when things do not go as expected."
- Did have two operational issues they would like to see changed: (1) the ability to roll over unused funds from year to year ("like we used to be able to do a few years ago") within their contract terms; and (2) lengthen contract terms from 3 to 5 years (one individual saying, "*because I feel dumb writing the same thing year after year in my proposals*"). Longer contract terms, they said, would also make it easier to recruit personnel who may be unwilling to accept a new position ("*which are all described in our system as 'grant-funded'* ") for so short a period.

Additional Feedback

Evaluation

The providers were satisfied with the evaluation requirements, said they found the information presented in the annual evaluation reports to be helpful (e.g., knowing which parts of their curricula could use strengthening) and used the data from our dashboards when applying for grants. They did not have any suggestions for future changes, i.e., more frequent reports, more types of information, different or less information, and they found the evaluation team responsive and the technical assistance readily available and helpful.

Other Feedback

Unlike some of the others we interviewed, nearly all of the grantees believed First 5 *was* a visible presence in the community. They specifically mentioned staff's attendance at community events. Those that commented on Commissioners' visibility said their presence was due to "their other role/job in the county" and not as representing First 5. Several of the participants mentioned being appreciative that providers were invited to provide input to the Commission's strategic planning process and recognized it as evidence of First 5 as a collaborative partner.

Several of the grantees commented on the lack of a "countywide database" –one that could be used by a variety of public agencies and non-profit organizations to coordinate intakes, record assessment results, make and track referrals, and reduce the potential for duplication. They mentioned the availability of such a system in other counties and suggested First 5 could take the lead in establishing this in Tulare County "at some point, despite the challenges." (Note: the same suggestion was made last year by the Home Visiting Coordination Advisory Group, which has similar members to this meeting's attendees.)

The participants were unable to offer any insights about emerging issues/changes coming—neither opportunities nor threats—that could affect what First 5 is able to do in the next 5 years, things that may not have been influential or important in the past but might be in the future.

Agenda item #3

PARENT SURVEY

"As new parents, each new stage is exciting (and a little scary), but we're so happy for this experience."
– Parent Survey Respondent

INTRODUCTION

An English/Spanish *Parent Survey* was available online as well as distributed in hard copy through local grantee organizations to help the Commission learn more about families' experiences and needs. Eligible respondents included any parents/caregivers raising children ages 0-5 receiving services from these organizations. The survey was available between early December 2022 and mid-February 2023.

RESULTS

A total of 538 surveys were received—62.1% completed in English and 37.9% in Spanish. Despite repeated promotion of the link through social media, only 49 (9.3%) of the surveys were submitted online. Although it is more labor intensive, administration of surveys in hard copy validates the advantage of asking someone to participate in a survey in person, *and having it completed onsite*, at least for this population. Slight over half (54.6%) of the respondents were young adults, close to 40% age 35+, and almost 7% age 15-20 (Figure 1). The survey parents had a fairly typical distribution of the "First 5" child population.

Figure 1. Age Group of Survey Respondents (n=528)

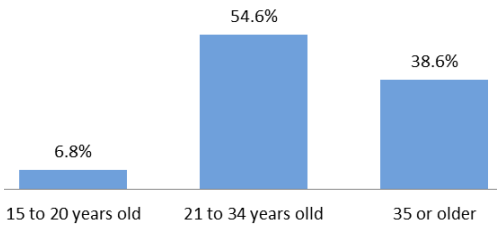
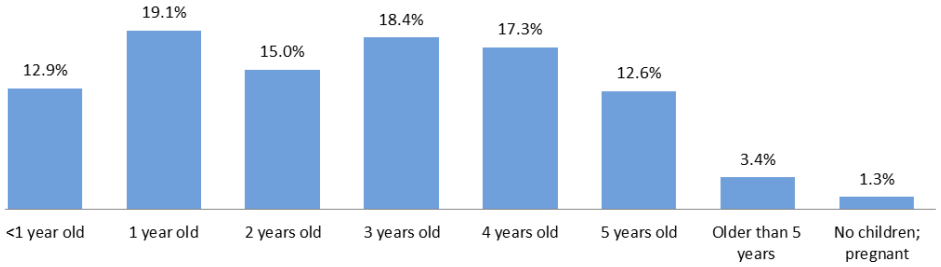


Figure 2. Age Distribution of Respondents' 0-5 Children (n=511)



As a proxy for income level, respondents were asked if they were currently receiving Cal Fresh; 62% reported that they were. We looked at differences between the English and Spanish-completed surveys and found that the results were fairly similar.

Positive Factors

Rather than asking parents, How are you doing?--which research shows inspires a scripted, reflexive response—we asked respondents to briefly describe what was going well for them and their family now. The question also set a positive tone. As Table 1 on the next page reflects, the most common responses (n=322) were fulfilment from family life, job security, attending school, putting parenting skills into practice, and having tangible resources such as a new car.

Table 1. Examples of Respondent Feedback to "What's Going Well in your Life"*

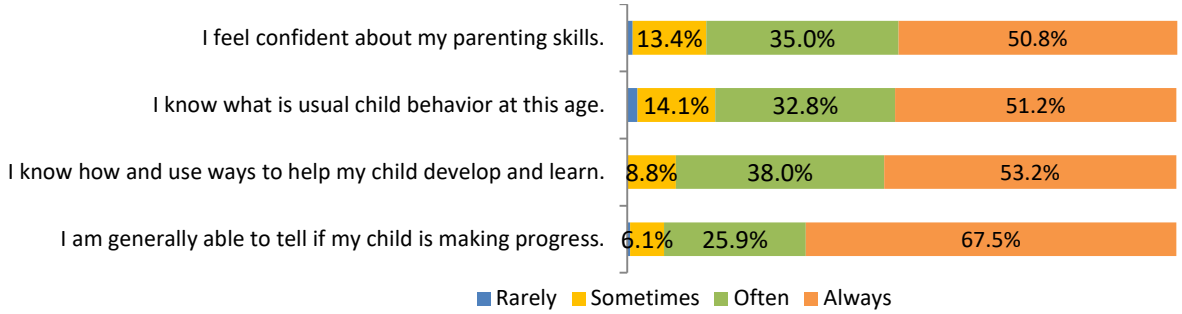
- We have secure income and child care with back up extended family support.
- Currently working on gentle parenting techniques, staying calm and redirecting my child's behavior.
- We are at peace and working.
- We're communicating more.
- The help we're getting from programs.
- Better eating, more family activities.
- Church and school, sell candy for extra income.
- Being able to talk about and solve problems.
- Making healthy choices now.
- Sober and good relationship with my parents
- Able to go to school.
- Just got a new car.
- Comfy home, food and money.
- Getting our lives back under control.
- Want to spend the rest of my life with this partner

***Comments are verbatim as written.**

Parent Knowledge and Confidence

Overall, the respondents expressed having a good 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 3). They expressed a little more doubt when it came to knowing what usual child behavioral issues were; 1.9% reported they "rarely" knew about it.

Figure 3. Parent Knowledge and Confidence Concerning Parenting (n=522)



Note: Because "Rarely" was so small, data labels (percentages on the graph are not shown.

Utilization of Services and Barriers

Access to preventive health services is one of the Commission's Desired Outcomes result areas, so it was positive to see that 96% of the parents affirmed they had a usual place to go when their child was sick or they needed health advice. Only 7.2% had experienced an inability or delay in getting necessary health care for their child in the last year (Figure 4 on the next page). In a few cases, the reasons given included concerns about the quality of pediatric care, problems getting an appointment, "going through paperwork," and having the provider change the appointment multiple times. Getting regular dental check-ups—a frequent marker for health access—seemed to account for most of the delay or barriers.

Two-thirds (68.4%) of parents reported their child had not had a dental visit in the last 6 months (Figure 5), though the majority, 85.1%, had reported their child "has a regular dentist." There were various reasons given for no-recent-dental-visit but in general reflected parents describing some sort of lack of action or awareness on their part, e.g., "I just haven't done it yet;" "I'm not sure where to go;" "too hard to make an appointment."

Figure 4. Parents' Ability to Get or Delayed Getting Necessary Health Care for Child in the Last Year (n=509)

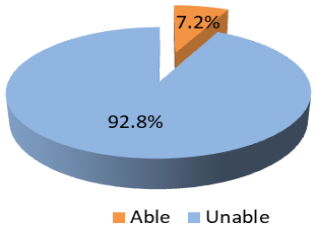
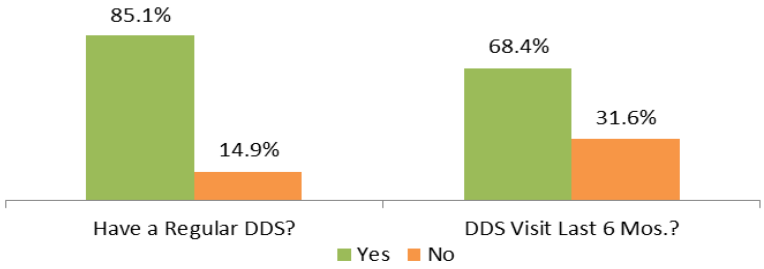


Figure 5. Children with a Dental Visit in the Last Six Months (n=517)



Healthy Choices/Behaviors

The families reported a mix of healthy eating behaviors. Their average number of daily servings of fresh fruit and vegetables, while higher than the statewide average as reported above appears not to have changed much since parents were asked about this 3 years ago (Table 2). In fact, only about 10% of parents reported previously and again this time serving their children 5+ fresh fruits or vegetables in a typical day. (*Overall, 45%* of Tulare County parents—a cross-section of *all* families—reported to the California Health Interview Survey (CHIS)[58] giving their children 5+ daily servings, demonstrating less access/choice for the families who receive services from grantee organizations.) Patterns of sugar-sweetened beverage consumption (sodas, fruit drinks or sports or energy drinks) also didn't differ much between the two survey periods, though the response choices were framed differently this time.

Table 2. Families' Nutrition Practices

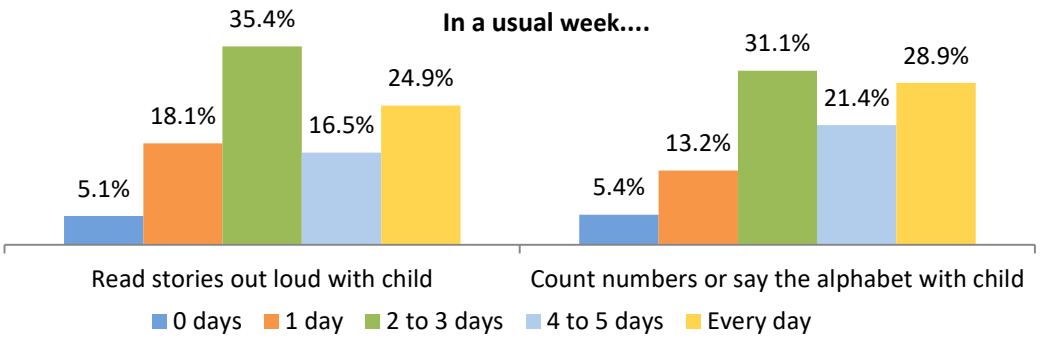
	Frequency					
Number of	0	1	2	3	4	5+
Servings of fresh fruit or vegetables, in a typical day	5.1% (2.3%)	8.8% (9.9%)	28.1% (36.1%)	32.1% (30.5%)	16.0% (11.5%)	9.9% (9.7%)
Number sodas or sweetened drinks child drank, over the course of the day	37.9% (36.4%)	43.5% (29.9%)	16.0% (18.2%)	2.7% (9.9%)	Didn't ask (2.9%)	Didn't ask (2.7%)

Note: The percentages in parentheses are responses from the 2019 Parent Survey.

Enrichments or Detractions from Early Learning

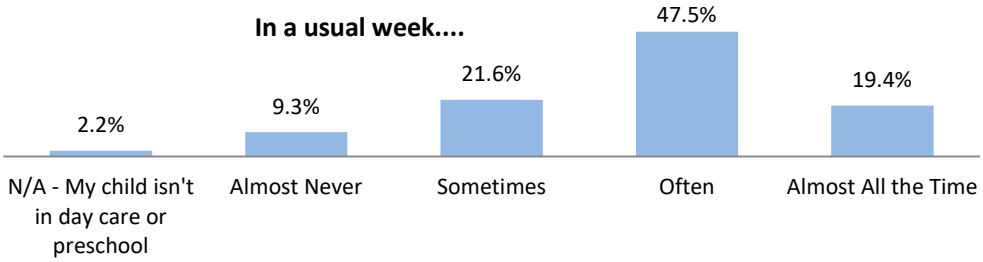
Research is very clear that reading to a child, no matter how young, promotes brain development. One-quarter (24.9%) of the parents reported they read stories aloud with their child every day in a typical week (Figure 6); a slightly higher proportion, 28.9%, counted numbers or practiced the alphabet with their child this often. However, 5.1% and 5.4%, respectively, said they never engaged in either activity with their child. These responses mirrored closely the previous Parent Survey.

Figure 6. Number of Days Parent Reads or Counts Numbers/Alphabet with Child (n=524)



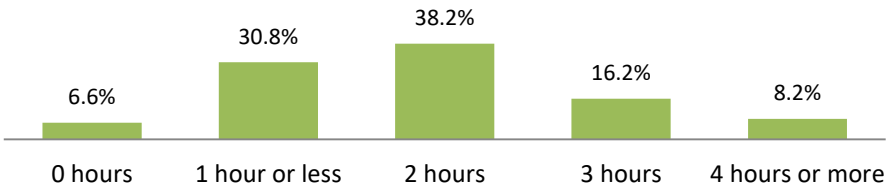
Children are generally excited to talk about topics that are important to them, including what they're learning or doing in preschool/day care. When parents express interest and talk with children in a responsive way, they encourage children's social and emotional development. These conversations help promote connection—and become even more important when "tougher" topics arise later. Almost 1 in 5 parents said they conversed with their child about learning "almost all the time"—and close to half (47.5%) did so "often"—while 9.3% said they "almost never did."

Figure 7. Frequency of Conversations with Child about What They're Learning (n=512)



Screen time is "an inescapable reality of modern childhood." Data support that COVID-19 has resulted in significant increases in children's recreational screen time compared to trends pre-pandemic.[59] In the current survey, in a typical weekday, 30.8% of children reportedly spent 1 hour a day, another 38.2% spent 2 hours, and 8.2% spent 4+ hours in recreational screen time (watching TV, playing video games or being on the computer) (Figure 8). The time spent was actually slightly *lower* than what was reported in the previous Parent Survey.

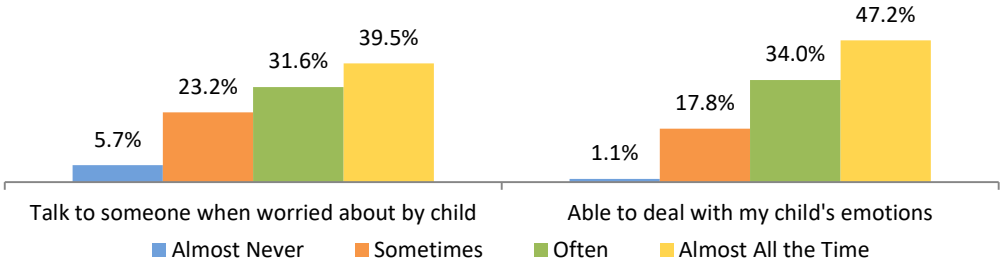
Figure 8. Children's Average Screen Time per Weekday (n=504)



Parents' Support Strategies

Worrying about a child's development is common and communicating those concerns to someone can be helpful for managing anxiety. Consequently, the survey asked how often the parent talked with someone when they were worried about their child. As Figure 9 indicates, 71.1% "often" or "almost always" did; however, 5.7% "almost never" did. In addition, the majority (81.2%) "almost always" or "often" felt able to deal with their child's emotions (note, however, parents still continued to express a need for more help with children's behavioral issues, discussed on the next 2 pages).

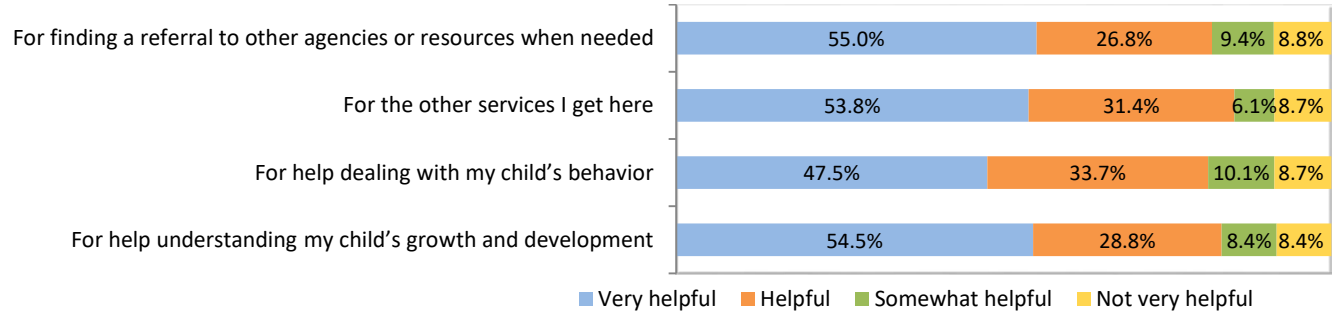
Figure 9. Parent Support Strategies (n=522)



Satisfaction with Services

Over 80% of the parents thought the services they had received from the survey host agencies were "very helpful" or "helpful" (Figure 10). They were only slightly less favorable when it came to the help they had received for dealing with their child's behavior.

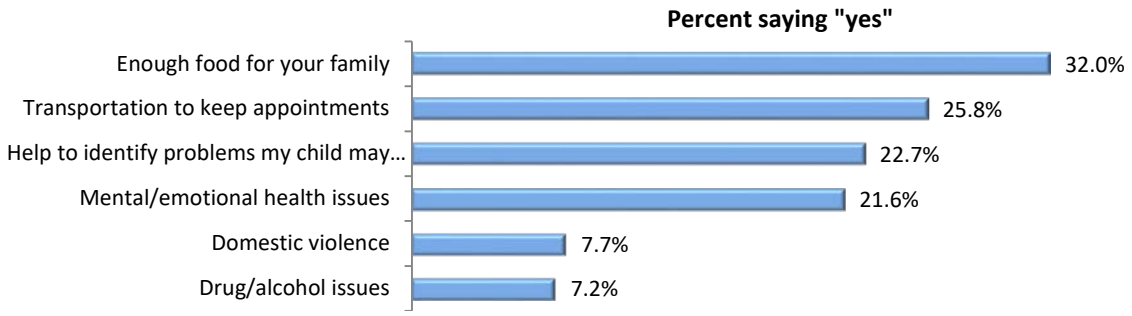
Figure 10. Perceptions about Helpfulness of Services (n=492)



Issues of Greatest Worry

Respondents were asked to "think about the needs of your family" and indicate which in a list of concerns "worry you a lot." Having enough food, reliable transportation and help identifying children's problems such as hearing, speech and vision were the most common worries (Figure 11). Some of the 10 written-in "Other" comments re-iterated the listed issues (e.g., drug use), but additional worries that were expressed included wishing for better communication with children, foster parent information, a husband's vision problem, and dealing with family loss.

Figure 11. Worrisome Issues to Parents (n=507)



Community Resource Needs

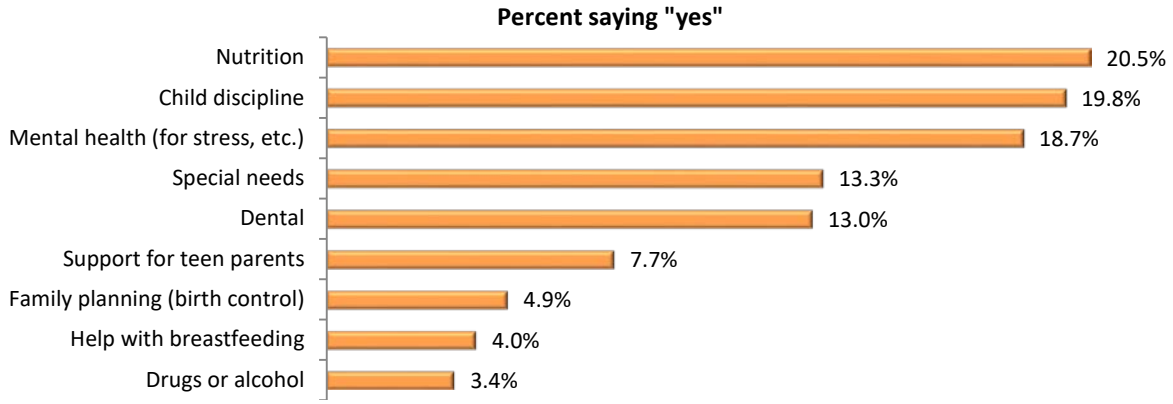
Worrying about an issue does not necessarily indicate a need for help to address it. That is why the survey specifically asked parents to identify the needs they wanted help with but could not find information about or referrals for in the areas of Health and Development, Early Care and Education, and Other Family Resources.

Health and Development

Parents most frequently (20.5%) wanted, or needed help for their family but could not find, information related to nutrition (healthy food choices, access to it), help or resources related to child discipline

(19.8%, which had been reported by 12.7% of parents in the earlier survey) and mental health services (18.7%; reported by 10% prior). Dental services and "support for teen parents" were also identified as needs but to a lesser degree (Figure 12 below). No one wrote in an "Other" in the space provided for it.

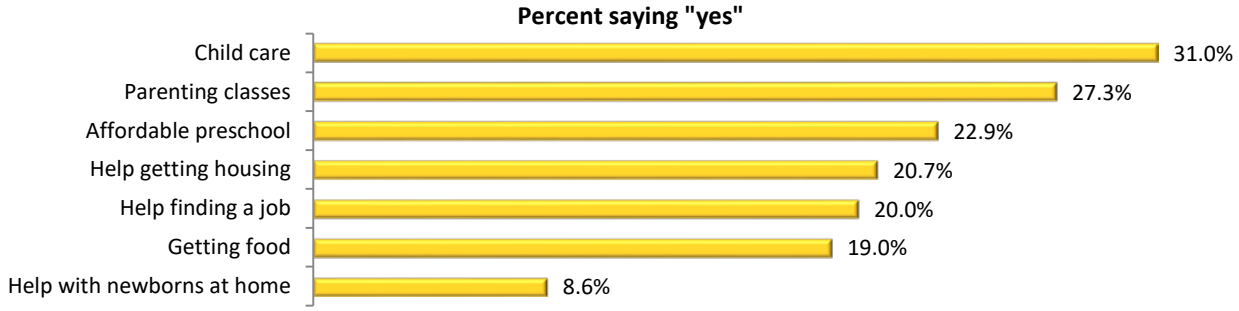
Figure 12. Needs Related to Health and Development



Early Care and Education and Other Family Resources

Needing help and not finding resources for child care (31.0%, reported by 20.6% of parents in the previous survey), parenting classes (16.7%, reported by 27.3% previously) and affordable preschool (22.9%, reported by 16.4% previously) received the highest proportion of affirmative responses for the items shown in Figure 13. Practical matters such as help related to housing, employment and food were identified by about 20% of the parents.

Figure 13. Needs Related to Early Care and Education and Other Family Resources

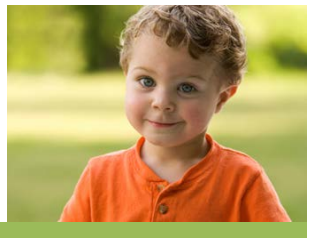


Eight parents wrote in "Other" experiences and needs for help that were not already part of those listed in the survey:

- The kids are afraid of their father, but he has joint custody; how do I change this?
- I'm not sure if my child is meeting her milestones, I worry about autism
- We need child care centers for people with evening work, shift work, field work
- I have temporary custody of sister's children. She is in jail
- Their father does not take mental health/abuse seriously
- I can't find classes for parents with disabilities [children's or parents'?]
- Services for children 0-5 are not easily accessible. Provider websites list things but when you actually call many have ended, will only serve certain demographics or have wait lists. It's very discouraging to follow a lead for a needed service only to find that it's unavailable

Agenda item #4

PART III: EVALUATION



"The last couple of years have really thrown us into a tailspin; the lack of in-person meetings didn't help in focusing." – Commission and staff Interview

HIGHLIGHTED RESULTS

The overall evaluation results and grantee success/challenge stories we've shared in our reports show that First 5 community investments have been sound and widely appreciated. For the most part, the grantee Evaluation Plans were aligned with the Commission's current *Strategic Plan* (2018-2023) and linked closely to program outcomes. A few key examples from the last 5 years of evaluation with implications for strategic planning include:

Result Area 1: Health

- The prevalence of dental decay from school screening has remained about the same in every year we have reviewed these data—about 36.6% on average—and despite oral health education efforts in the schools and community from an infusion of First 5 and Public Health dollars. These results suggest an access problem to preventive dental services due to a combination of parental factors/barriers (e.g., attitudes or limited knowledge about the importance of early care, overconsumption of sugar, transportation difficulties) and delivery system reasons (e.g., inconvenient office/clinic hours and locations, insufficient number of Medi-Cal providers, long waits for appointments).
- What foods parents chose to buy and serve their families—and the factors they considered when doing so—clearly changed in a more positive direction after completing the My Plate sessions each year; this is a strategy that could be taken to scale.
- Another positive outcome of First 5 support is the increase in initiation of breastfeeding. However, many workplace environments pose a challenge to breastfeeding, presenting a challenge for breastfeeding duration as we learned from the study we conducted for you last year; recommendations for improvement were provided.

Result Area 2: Strong Families

- CASA involvement resulted in children having significantly fewer placements, with a higher likelihood of achieving permanency, i.e., spending less time in foster care than the children in the County Welfare System not assigned to CASA.
- Supportive programs provided to parents during marital/domestic relationship separation and divorce can shield children from some of the parental conflict and reduce their anxiety and stress.

The pre/post assessments have consistently shown a significant increase in most of the types of parental behaviors that help to heal fractured family relationships and support children's learning.

- Participation in home safety education has consistently shown positive changes in parents' understanding and behavior change related to health and safety concerns.
- Fatherhood-type projects uniquely reach men in ways men may otherwise not participate. The spotty attendance we've seen at some of the sites could be more the result of logistics than lack of interest such as when work hours change. The high level of correlation between father contribution and children's sociability, confidence, and self-control warrants continuing to support projects that effectively engage fathers/grandfathers, perhaps in more peer-driven roles.

Result Area 3: Early Care and Development

- Questions about child behavior are among the most common of parental concerns, e.g., lack of self-regulation, acting out/disruption, sibling relationships. Parents provide feedback about inadequate understanding and feeling ill equipped or insecure about applying appropriate discipline methods. Age-appropriate curricula content, written materials, and parent classes give testimony to the value of these First 5 services.
- The A*ges and Stages (ASQs)* questionnaires continue to be a valuable tool for parents to identify areas of strength and where further evaluation might be needed. From sample reviews, it appears families have been appropriately referred when indicated by the assessment results.
- Book giveaways and activities that show parents the value of reading/telling stories to their children have payoffs in promoting early literacy; every post-assessment has shown increased frequency of these desired behaviors. Use of the library remains low, however.

Result Area 4: Systems of Care

- Incorporating ACES screening into parenting and other programs has begun to build a baseline of understanding about exposure to adverse childhood experiences for Tulare County children and adults. The aim is to document the type and extent of adverse life events people have experienced so therapists, case managers, home visitors, program planners, advocates and other providers can more explicitly address these issues.
- The Home Visiting Coordination component has been an exemplary model for the region. Its continued momentum is a testament to the Commission's positive history of promoting collaboration, nurturing community agency engagement and fostering trusting relationships.

Result Area: Grantee Capacity

- Each year, we have witnessed increased internal evaluation capacity among the grantees—more openness to suggestions, fewer mistakes, more consistency in data collection, use of more effective tools, and greater attempts to obtain post-results—which has led to more robust and useful findings.

IDENTIFYING ELEMENTS OF SUCCESS

In thinking about what the Commission wants to identify in its new strategic plan as "success indicators", we thought it might be of interest to share the following information with you as the distinction between indicators and performance measures is a new idea for many people. A local health department we recently helped with its strategic plan found the information below to be helpful.

What is the difference between indicators and performance measures?*

The Short Answer

Indicators are about *whole* populations.		Performance measures are about *client* populations.
Indicators are usually about peoples' lives, whether or not they receive any service.		Performance measures are usually about people who receive service.
Indicators are proxies for the well-being of whole populations, and necessarily matters of approximation and compromise.		Performance measures are about a known group of people who get service and conditions for this group can be precisely measured.

Full Answer

(1) Why is this important? We have a long history of holding individual agencies responsible for population well-being. No one agency, by itself can turn the curve on any indicator. It is unfair and unproductive to hold a single agency responsible. We need to reframe the way we talk about accountability for whole population results and indicators. Rather than say: "The Health Department [or other agency] is responsible for "all children being healthy," we need to say "The Health department is responsible for assembling a team of public and private partners and creating a community strategy to make all children healthy." The difference here is not just phrasing. It is the difference between having one agency to blame when things go wrong and accepting joint responsibility. It is the difference between expecting the Health Department to do it all by itself, and recognizing that this is not possible, that the contribution of many partners will be required.

(2) People are used to using the word "indicator" interchangeably with "performance measures" to describe population and program measures. To distinguish them → indicators are measures which help quantify the achievement of a result. Performance measures are measures of how well public and private programs and agencies are working (e.g., the number of parents who attended a particular class).

*adapted from Mark Friedman, *Clear Impact.*

Agenda item #5

PART IV: OVERVIEW OF SUSTAINABILITY/SYSTEMS-LEVEL CHANGE

"The pandemic really brought a lot of us together; the camaraderie is terrific."
– Commission and staff Interview

We provided the following information last year for another local First 5 Commission to support their strategic planning process. That Commission wanted to give higher consideration to the concepts of systems change and sustainability in its next grantmaking cycle and requested the information as background. We are sharing this material with you for reflection as it may be a helpful guide in your own strategic thinking. It was co-written with Dorothy Meehan, MPH, CPA, formerly Senior VP of Sierra Health Foundation, who occasionally teams with Barbara Aved Associates.

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 to some extent 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., reduced consumption of sugar-sweetened beverages), new or improved policies (e.g., increased support for breastfeeding in the workplace), or increased capacity of local systems (e.g., additional bus lines in public transportation).

(*Collective impact*, on the other hand, refers to opportunities where an organization can align funding with a partner(s) to leverage its resources thereby maximizing the impact.)

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? Is bridge funding needed?

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
- 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 was Governor Newsom's 2020-2021 state budget with emphasis on 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'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 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 applicant's 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?
- 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 already or planned to be 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. 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 has the advantage of its relationship with a nearby university 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 program to help educate providers to assist families with end-of-life issues was developed by a broad-based 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 has become a 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 have been 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. 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.[60] 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: [61]

- 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.

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[62] is easy to understand and aligns well with First 5 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.

In another example, project directors in a child welfare initiative implemented by the federal Administration on Children, Youth and Families Children's Bureau[63] 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[64] 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, tossing away what we know"). Innovation can 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). 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.[65]

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 increase engagement with local business partners.[66,67]

- 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 businesses.
- 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.
- 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 early childhood development. This includes 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 and educated communities complement vibrant business and industry; 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, education 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 – use evaluation data! – 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 [68] 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 5s 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 and Contra Costa Counties' First 5s are building more strategic partnerships for sustainability in their early identification and intervention program for children with moderate delays.

Behavioral Programs

Behavioral and mental health challenges encompass a range of behaviors and conditions. The community input for this report [and for Tulare County] 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.[69] 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 [70] 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 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.[71]

- 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.[72]

Fatherhood Programs

Efforts have grown that aim to reduce father absence; an example includes the well-regarded National Fatherhood Initiative (NFI).[73] NFI's mission is to transform organizations and communities by equipping them to intentionally and proactively engage fathers in their children's lives.

Agenda item #5

PART V: SUMMARY

"Who would fill the void if we didn't fund what we fund?"
– Commission and staff Interview

ORGANIZATIONAL PERSPECTIVES

Using a SWOT (strengths, weaknesses, opportunities, threats) format as the basis for some of the questions we asked in the needs assessment process, the following chart (Table 1) summarizes the input from the Commission and staff interviews. The SWOT input from the Key Informants and Grantee Focus Group follows in Table 2. Although we separated the findings by the two groups, there were relatively few differences in perspectives.

Some of the "weaknesses" the staff/Commission mentioned are not included below as they were not meant to refer to *First 5's* weaknesses but rather were expressions of disappointment or frustration about the lack of progress in certain areas. These included: the high rate of children's dental decay; pediatricians and dentists not ensuring children make a first dental visit by the now-standard First Tooth/First Birthday; the relatively little interest shown by Kaweah Delta Hospital in engagement regarding breastfeeding promotion; lengthy delays between diagnoses (especially mental health) and receipt of treatment; and, not being able to do more in helping parents with mental health needs.

Table 1. Commission and Staff-Identified SWOTs (internal input)

	Strengths	Weaknesses
Internal Factors	▪ The "first point" organization for all issues 0-5 ▪ Talented, committed staff ▪ Flexible responses to needs/emergencies ▪ Team players (internally) ▪ Strong collabortation with community partners (externally) ▪ Genuine caring for the community ▪ Competent leadership ▪ Creativity of the staff ("*they push us*") ▪ Support for rural communities and not just cities ("*pays attention to funding in all parts of the county*") ▪ Staff looks for opportunities to bring in more money (for other organizations as well) ▪ Fiscally sound ▪ Improved visibility/awareness of First 5 in the community ▪ Potential for more mental health support with the addition of new Commissioner Ortiz ▪ Purchase of First 5's own building	▪ In some cases the better grantwriters are the applicants funded (i.e., poor grantwriters of worthy projects lower competitive chances of securing a grant); being "locked in" with continued funding to some agencies because of long funding history. ▪ Need to add evaluation data to the grant award process—First 5's or the applicant's from its other evaluations (if any). ▪ Not enough people know what First 5 does or when it is the entity supporting something—despite some of the branded giveaways. ▪ Need to be a little firmer about grantees meeting milestones. ▪ Could draw a little more on client voices/views. ▪ Need more emphasis that First 5 is for *all* 0-5 parents, not just low-income, high-risk. ▪ Need for Commission to see itself more as ambassadors of First 5 in the community. ▪ Not enough connection with the medical community, e.g., pediatricians.

Chart continues on next page

Table 1. Commission and Staff-Identified SWOTs (internal input), cont.

External Factors

Opportunities	Threats
▪ Additional state and federal funding for school districts related to early childhood ▪ Possible additional money for First 5 from tobacco tax ▪ Politically liberal state = more openess in supporting First 5 type goals ▪ Everyone caring about kids is neutral politically and can be capitalized on	▪ Dimishing First 5 funds/program sustainability ▪ Long-term impact of pandemic ▪ Some parents still unwilling to attend events due to fear of COVID/RSV risk ▪ More people anxious/stressed due to politically charged [state and federal] environment ▪ Housing shortages/high rents; exacerbated by increasing local population growth ▪ Climate change ▪ Some ethnic groups not open to hearing health/education messages unless by professionals from their own group ▪ Negative changes in workplace culture/ worker shortages/"*worker laziness*" ▪ Inflation; potential recession up ahead ▪ Tulare too conservative to grapple with tough issues like high teen pregnancy rate

Table 2. Key Informant/Grantee-Identified SWOTs (external input)

Strengths	Weaknesses
▪ Dedicated to their mission ▪ Good partnerships with other agencies ▪ Approachable ▪ Supportive, flexible funder ▪ Viewed in the county as the 1-stop shop for children 0-5 issues ("*puts a spotlight on it*") ▪ Financial support for programs not otherwise able to be funded ▪ Awarding Health Care Heroes is inspiring to do better ▪ Responsiveness to the community ▪ Support for new mothers ▪ Ahead of the curve on ACES	▪ Not reaching enough children outside of traditional agencies ("*what about the struggling parents who aren't the target populations?*") ▪ Arduous process for obtaining grants and accountability ▪ Should fund more intervention programs aimed at the period between birth and preschool (i.e., 0-3)
Opportunities	**Threats**
▪ Advancement in technology/software platforms (e.g., telehealth, social media) ▪ New generation being served is more tech savvy so may be getting better informed about parenting, etc. ▪ CalAIM funds, e.g., potential to address mild-to-moderate mental illness; coordinate services for families ▪ New CA Dept of Education early childhood-related funds ("*but lots of strings attached*") ▪ The Bullet Train (i.e., will increase access to the area) ▪ Universal Preschool	▪ Short- and long-term impact/unknowns of COVID-19 ▪ Staff turnover/shortages;ifficulty recruiting and retaining staff, especially pediatric providers ▪ Decreased First 5 funding ▪ General sense of tension/anxiety among people ▪ High cost of living, e.g., unaffordable housing ▪ More automation = need for re-skilling workers

Recommendations

The interviews 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 1 below.

Figure 1. Summary of Recommendations Regarding Operations*

- Increase visibility/branding of First 5 in Tulare County.
- Decide soon re any major changes to grantmaking strategies.
- Using evaluation feedback to inform decision-making.
- Increase parent involvement.
- Form an expert advisory committee.
- Reach out to more potential applicants, building capacity when possible.
- Emphasize that First 5 is for all 0-5 children and families.

*Not in any particular order of importance.

ADDITIONAL ISSUES TO CONSIDER

Funding Strategies. 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 or populations.

First 5 Tulare 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 Tulare 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). These kinds of investments require a longer-term commitment—at least 5 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 and CA Department of Education 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. Other thoughts:

- 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).

- 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 diminishing 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?

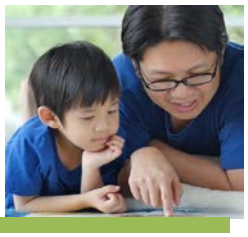
- How important is sustainability? How solid were the applicants' plans for sustainability in the proposals you approved from your last RFP? How has that worked out?

A few other internal issues to think about for discussion during our strategic planning committee meetings include:

Using evaluation feedback. What is the best way to address Commission-level evaluation recommendations? Set some aside (for later or permanently?) and prioritize others? Form committees to work on some? What is the best method of accountability for any steps taken?

Expert "panel" of advisors. Consider a way to retain the expertise/experience of Commissioners rotating off the Commission and occasionally convene them with a meaningful purpose, along with others (non-grantees to avoid a conflict of interest) such as parents who are known to be comfortable publically sharing their views, experiences and recommendations.

Broadening the Target Group. Reaching out to families who may have more means than others but still struggle with issues like child discipline and developmental delays and experience significant difficulty finding help has merit if First 5 is to be considered a program "for all 0-5 families." This recognizes the Commission's commitment to promoting a culture of diversity, equity and inclusion in advancing its mission to support programs where all Tulare County children will thrive.



ATTACHMENTS

"The last couple of years have really thrown us into a tailspin; the lack of in-person meetings didn't help in focusing." – Commission and staff Interview

ATTACHMENT 1

Commission and Staff Interviews

(In alphabetical order by first name)

COMMISSIONERS*
Christine Nelson, MD
Donna Ortiz
Karen Elliot
Maureen Bianco
Megan Ide, DDS
Pete Vander Poel
STAFF
Aaron Cooper
Christina Saucedo
Michele Eaton
Susy Ceja
Timberly Romero

*Completed interviews

Key Informant Interviewees

(In alphabetical order by first name)

Individuals	Affiliation/Organization
Adrianne Hillman	Salt and Light Works
Anita Ortiz	Tulare County Human Services (HHSA)
Donna Hefner	Sierra View Medical Center
Eric Sonnenfeld	Tulare Office of Education
Graciela Soto and Dawn Wells	Altura Center for Health
Irma Rangel	Turning Point of Central California
Jason Britt	Tulare County Administration
Jennifer Marroquin	Tulare City School District
Julianne Randolph, MD	Milestone Pediatrics
Kerry Hydash	Family Healthcare Network
Lorena Castillo	Tulare County Office of Education
Mark Gist	Tulare County Sheriff Department
Mary Alice Escarsega-Fechner	Tulare Community Services Employment Training (CSET)
Tim Hire	Tulare County Office of Education

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