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COMMUNITY LEVEL INDICATOR REPORT

Prepared for:
First 5 Marin Children & Families Commission

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I. BACKGROUND

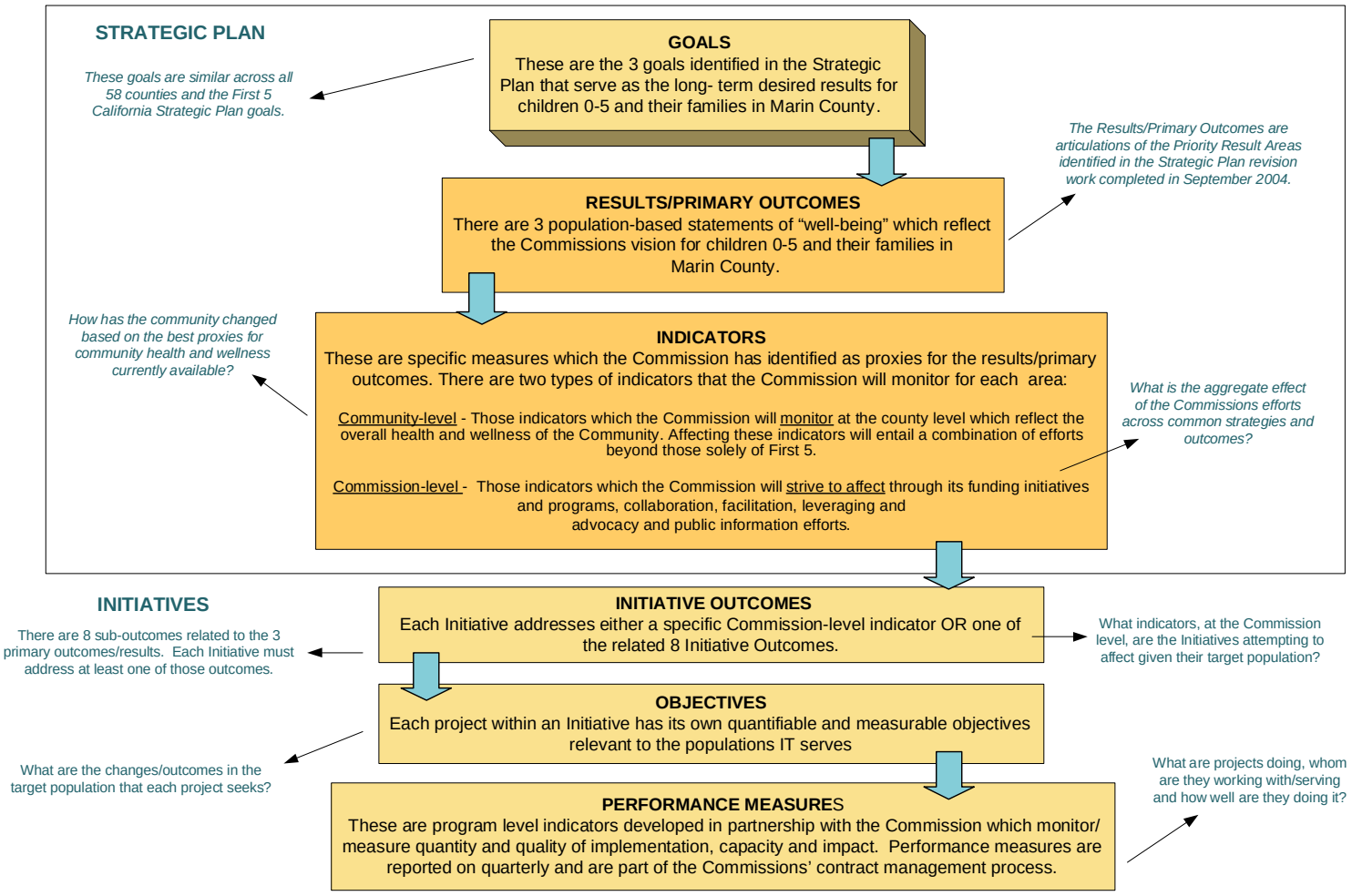
The purpose of this report is to provide baseline information to First 5 Marin as it implements strategic initiatives developed as part of its strategic plan revision process (started June 2004).

The indicators presented in this report were developed through a collaborative process with First 5 Marin staff and the local evaluator (JDC Partnerships) as part of developing an evaluation framework. The evaluation framework ties indicators to the Commission's Strategic Plan goals and priority results. Indicators are the types of data against which progress and success will be measured, and will be monitored at two levels, community and initiative. For the purposes of this report, however, only community medications will be presented.

Figure 1.

First 5 Marin Evaluation Levels Diagram

August 21, 2004



Community indicators are those measures for which the following criteria tend to apply:

- Supported by research as being the best "proxies" for intended results;
- Reliable and valid trend data is available; and
- National, regional and local agencies track the data.

The First 5 California Evaluation Dictionary developed by ChildTrends and SRI International, published in February 2004 was a key resource for this report. The Dictionary provides extensive background information on indicators related to First 5 efforts including those in the areas of maternal and child health, health access, system change and infrastructure. For each indicator profiled, information is provided on the pros/cons, rationale, what institutions/efforts use the indicator, sensitivity, potential data sources…etc. The Dictionary was created to support not only the State evaluation effort as well as that of local First 5's who are undertaking their own evaluation efforts. It is with that spirit in mind that excerpts were generously taken. As practioners, we thank ChildTrends and SRI for this tremendous contribution to the field of early child development and the practice of evaluation.

Structure of Report

This report has two key sections. The first section, Indicators provides an overview on what an indicator is and isn't, can and cannot do and a list of the community indicators in the First 5 Marin evaluation framework. The second section, Community Indicators presents the following information on each of the lead indicators: rationale/use, data source, time period, notes (and caveats if necessary) and currently available trend data on the lead indicator itself for both Marin and California. If available, benchmarking data has been provided from Healthy People 2010.

II. INDICATORS

An indicator is a measure, for which data are available, that indicates, or moves with, a condition that we are interested in monitoring, such as the well being of children and their families.[1] Indicators can serve two functions:

- Provide descriptions: indicators can inform citizens, practitioners, and policy makers about the circumstances of child well being in society as a whole or within a particular program. Indicators can track trends and patterns, and can identify areas of concern as well as positive outcomes. For example, a decrease in the number of low-birth-weight infants is a sign of positive child outcomes, whereas an increase in childhood obesity is an area of concern.

- Monitor efforts: indicators can be used to track outcomes that may or may not require intervention of some kind.

Indicators ***will not allow*** for causal attributions. Changes seen in the indicators will not allow for statements such as "First 5 Marin programs or strategies single-handedly caused improved outcomes for children and families at the program or community levels." Only a rigorous program evaluation can determine whether or not a program is responsible for changes in child and family outcomes and in most cases the type of intervention and available resources will still prohibit definitive statements of causation.

Indicators ***will allow*** for statements such as, "Positive changes are occurring in the areas being targeted by First 5 Marin investments and activities. Children are healthier, their parents feel more supported and are better skilled in utilizing activities that promote positive child development, and children, parents and schools are better prepared at kindergarten entry."

In addition, changes in indicators do not explain why changes are occurring; instead, they highlight whether or not changes are occurring. To understand why changes may be occurring, the larger context would need to be taken into account in the analyses as well as program evaluation that likely includes long term tracking.

The table below presents the Community Indicators and the related priority result included in the First 5 Marin Evaluation Framework.

[1] Hauser, R. M., Brown, B. V., & Prosser, W. (Eds.). (1997). *Indicators of children's well-being*. New York: Russell Sage Foundation.

Figure 2: First 5 Marin Community Level Indicators

PRIORITY RESULTS	COMMUNITY LEVEL INDICATORS
Children have optimal health and well-being	#/% of eligible children enrolled in (comprehensive) health insurance
	#/% of children in normal weight range from 0-5
	#/% of children identifed in a child abuse case and number of those with substantiation
	#/% of child abuse/neglect cases in which there is not a recurrence within a 6-month period
	# and % of children aged 0-2 who receive a well-baby check-up in the last 6 months.
	#/% of children ages 3 -5 who receive annual dental exams
Children are ready for school.	#/% of children determined to be "ready for school" based on assessments administered by teachers/parents…etc.
	#/% of children who enter kindergarten with preschool experience.
	#/% of children identifed w/special needs who are referred to developmental services pre-K
Public policies support children.	#/% of public policies offered and/or enacted related to our three strategic results
	Potentially others to be developed

III. COMMUNITY INDICATOR ANALYSIS

This section presents a profile of each of the Community Indicators grouped by the Priority Results identified in the revised Strategic Plan. Profile components include:

- Rationale: A combination of bullets and narrative explaining the value of the indicator and what other organizations/efforts track the indicator at a national, regional, state or local level.
- Data Background: Sources of data are identified, time period of data and any notes or caveats that help explain the tracking methodology and/or its limitations are included.
- Benchmark: Healthy People 2000 or Healthy People 2010 goals/objectives are provided for comparison if available.
- Trend Analysis: Data for Marin County and California (if available) are plotted.

The primary sources of data for this report are the 2001 Marin Community Health Survey Children Ages 0-5 (Field Research Corporation and Marin County Department of Health and Human Services) and the California Health Information Survey(collaborative project of the UCLA Center for Health Policy Research, the California Department of Health Services, and the Public Health Institute.) The following is background on both data sources.

- 2001 Marin Community Health Survey Children Ages 0-5[2]
  This study, conducted in 2001 between June - October 2001 was the first large-scale, scientific study to collect information about the health and health care among Marin County adults, children (ages 0-17), and seniors (65+).

  4821 interviews were conducted by telephone in English or Spanish. Respondents were selected through a random probability sample of Marin County adults age 18 or older. Extended interviews were conducted in 313 households where there was one or more children age 5 or younger. The sample was developed through a random-digit (RDD) methodology, which gives both listed and unlisted households in the County and equal chance of being selected. In households with more than one adult, one respondent was randomly selected using the "most recent birthday" selection procedure. Average interview length = 30 minutes. The cooperation rate was 46%.

- California Health Information Survey[3]
  CHIS is a telephone survey of adults, adolescents, and children from all parts of the state. To date, the survey has been conducted every two years starting in 2001 (55,000 + households). CHIS 2005 is preparing to enter the field and due to funding from First 5 California and several local Commissions will include additional questions targeting children ages 0-5.

  CHIS employs a number of specific methods. First are the methods used in the design of the random-digit-dial (RDD) sample and the design of the geographic and ethnic over-samples. Next are the methods used in the administration and management of that sample with CATI (computer assisted telephone interviewing) technology. There are also the various methods for data collection, interviewing, and quality control. After the data are collected, they are processed in preparation for data file creation. Finally, the computational methods are used for response rates and in constructing sample weights

  UPDATE: On June 1st, 2005, The First 5 Marin Children and Families Commission approved a motion to provide $100,000 in funding to the CHIS for Fall 2005 administration of the survey. This action, done in partnership with the County of Marin's Department of Health and Human Services ($140,000), will result in a sampling of 3000 households in Marin yielding approximately 300 0-5. This will greatly

[2] Field Research Corporation and Marin Department of Health and Human Services, *2001 Marin Community Health Survey Children Ages 0-5.*, 2001. page 3

[3] http://www.chis.ucla.edu/methods.html Retrieved 05/26/05

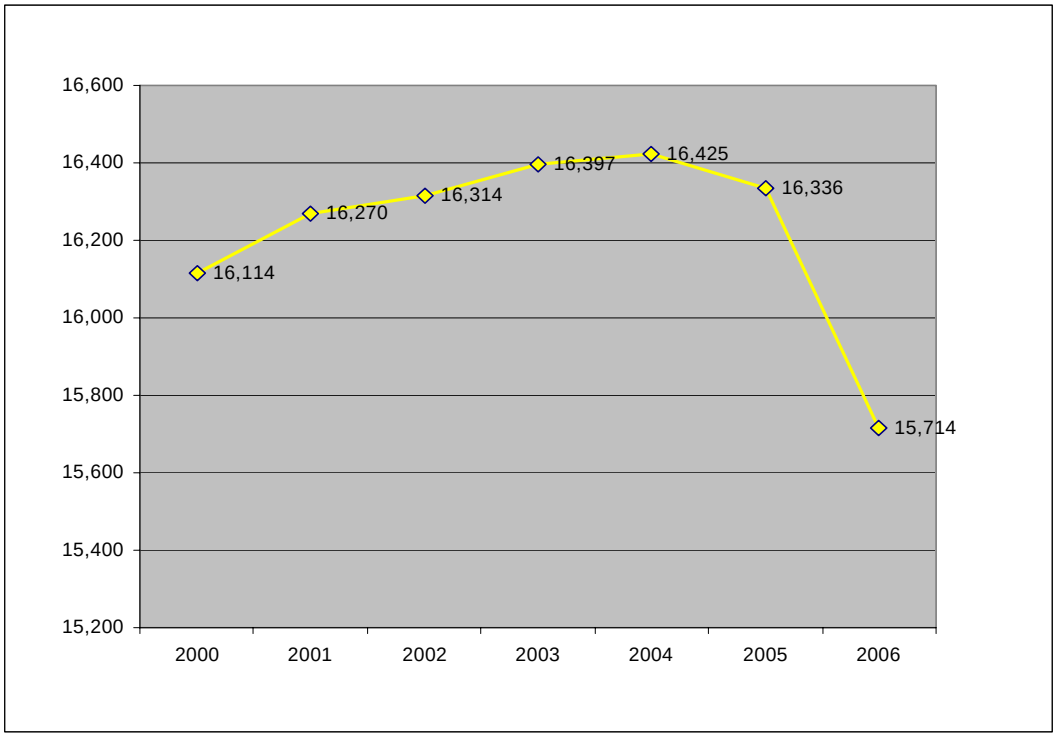
increase the statistical accuracy of the CHIS data. This report will be updated accordingly when the new data becomes available. Thus, the specific trend data to follow should be viewed as informational only.

A. Context

To provide context for the analysis of the community level indicators, population data for children 0-5 is provided for both the County of Marin and the State of California.[4] [5] This data is derived from population estimates based on the 2000 Census.

In reviewing the population trends, consider that Marin has a significant undocumented population that is likely not accurately reflected in the estimate. However, the projection is consistent with statement about the "graying" of Marin and the fact that is one of the counties with the oldest populations. The high cost of housing and living in general in Marin probably contributes to the decreasing number of children 0-5.

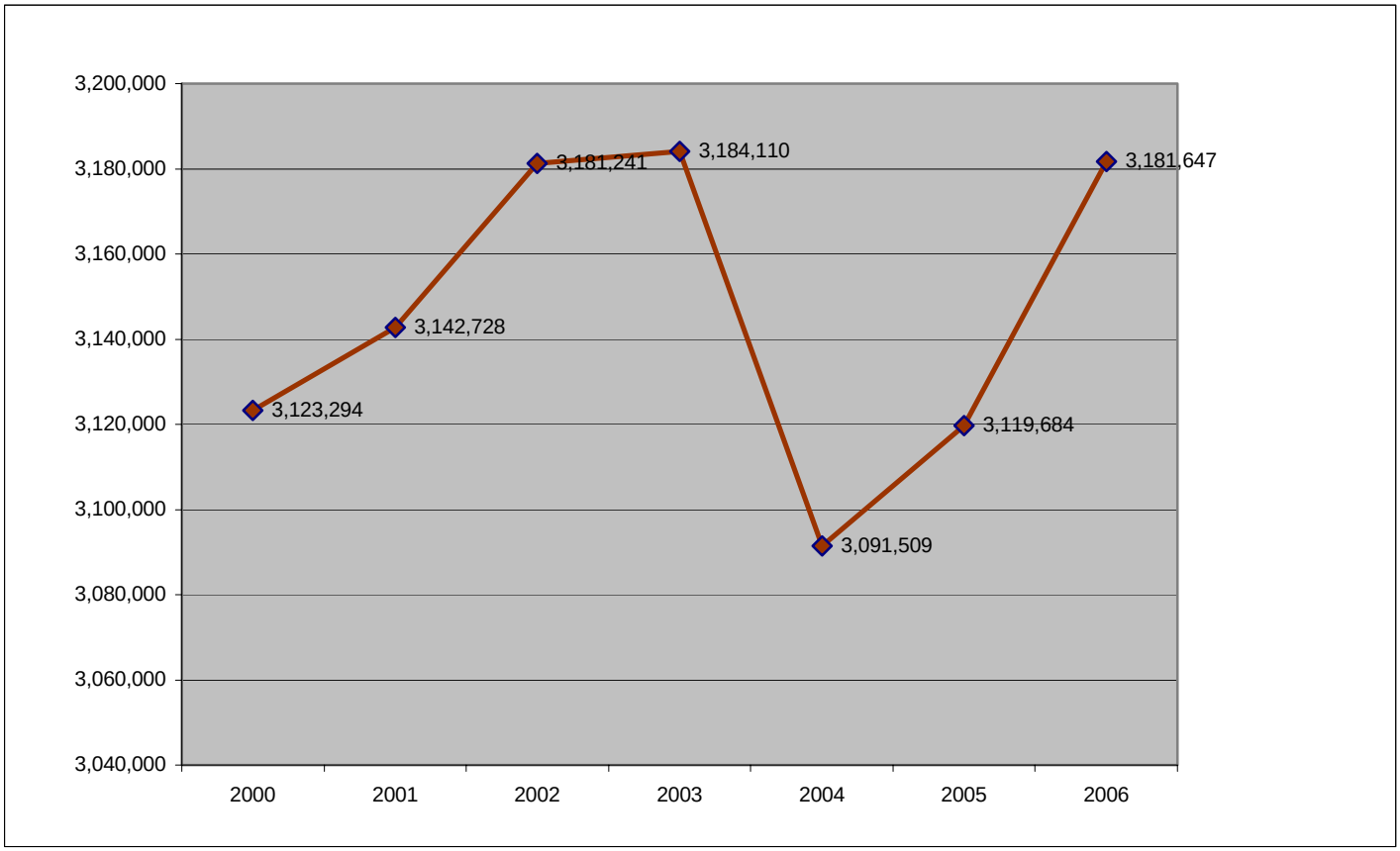
Figure 3: Number of Children 0-5, County of Marin



[4] http://www.dof.ca.gov/HTML/DEMOGRAP/DRU_datafiles/Race/RaceData_2000-2050/Marin.txt
Source: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, May 2004 . Retrieved 5/26/05

[5] http://www.dof.ca.gov/HTML/DEMOGRAP/DRU_datafiles/Race/RaceData_2000-2050/California.txt
Source: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050.Sacramento, CA, May 2004. Retrieved 5/26/05

Figure 4. Number of Children Ages 0-5, State of California



B. Priority Outcomes and Related Community Indicators

PRIORITY OUTCOME 1- CHILDREN HAVE OPTIMAL HEALTH AND WELL-BEING

Community Indicator 1:
Number and percentage of children who have health insurance (including vision and hearing screening)

Rationale[6]
Health insurance facilitates access to health care. Health care is important for promotion of health and prevention of disease.

All states and many organizations use this indicator to monitor children's health.
- Healthy People 2010 tracks the number of people who have health insurance.
- Child Health USA, the Child Trends DataBank, KIDS COUNT, America's Children: Key National Indicators of Well-Being and the U.S. Department of Health and Human Services also track this indicator.
- This indicator is recommended by the National Outcome Work Groups.

Data Background
Source(s):
- 2001 and 2003 California Health Interview Survey (CHIS)
- 2001 Marin Community Health Survey Children Ages 0-5 (MCHS)

Time Period: 2001 and 2003

Notes:
- CHIS - Because of the small sample size of children 0-5 in Marin, these percentages should be considered estimates only as either the criteria for a minimum number of respondents needed was not met AND/OR it has exceeded an acceptable value for coefficient of variance.

Healthy People 2010 Benchmark(s): Objective 1.1 - Increase health care coverage for persons under the age of 65 to 100%, starting from a national baseline of 83% in 1997.[7]

Trend Analysis

CHIS

Figure 5: Percentage of Children in California and Marin who are Insured

	2001			2003		
	Est. N	**%**	**95% C.I.**	**Est. N**	**%**	**95% C.I.**
California	2,796,000	93.7	(92.8 - 94.5)	2,867,000	95.40%	(94.4 - 96.4)
Marin	15,000	95.4	(89.9 - 100)	19,000	100	100

MCHS

96% of children 0-5 are currently *covered by health insurance or some other kind of health care plan*.

[6] Child Trends & SRI International. (2004 February). *First 5 California: Child, family, & community indicators.* Sacramento, CA: California Children and Families Commission, pg 2D-1
[7] http://www.healthypeople.gov/document/HTML/Volume1/01Access.htm Retrieved 5/25/05

Community Indicator 2:
Number and percentage of children 0 to 5 years of age who are in the expected range of weight for their height and age.

Rationale[8]
Childhood obesity has nearly tripled in the past three decades. Obesity is associated with many negative health consequences.

Many national efforts have been using this indicator to monitor children's health and, more recently, the school readiness of children. The U.S. Department of Health and Human Services collects data on the prevalence of obesity and overweight at a national level.

Data Background
Source:

- California Department of Health Services, California Pediatric Nutrition Surveillance Trend Analysis: 1994-1998 and 2003. Retrieved data May 28, 2005 from URL: http://www.dhs.ca.gov/pcfh/cms/onlinearchive/chdpin.htm[9]

- 2001 Marin Community Health Survey Children Ages 0-5 (Page 24)

Time Period: 1994-2003 and 2001

Notes: Data from Child Health and Disability Prevention (CHDP) Program health exams are used to conduct the annual Pediatric Nutrition Surveillance Survey (PedNSS). Nationwide this survey has been conducted continuously since 1973.

In California, participation in PedNSS began in 1988.The purpose of PedNSS is to monitor simple key indicators of nutritional status (weight, height, hematology) among low income, high-risk infants, children and adolescents who participate in publicly funded health programs.

Years 1998-2002 reflect children ages 0-17. *Years 2002 and 2003 are for children ages 0 -4 (not including 5 year olds).*

Healthy People 2010 Benchmark(s): [10] [11]

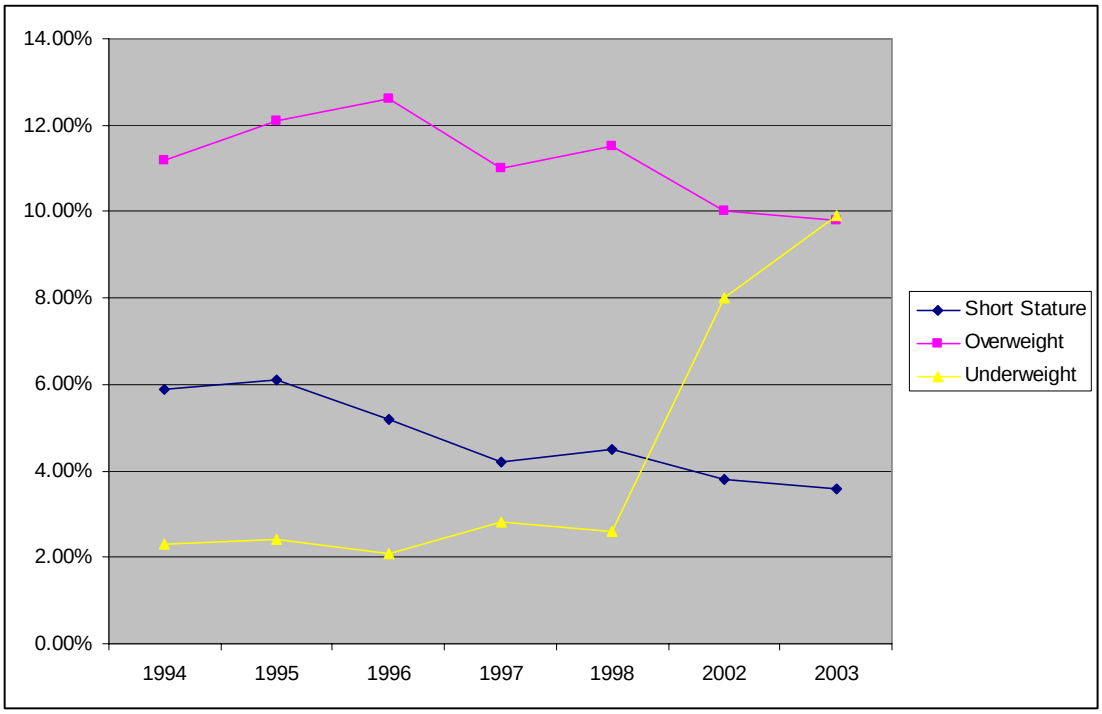
- Objective 19.4: Reduce growth retardation among low-income children under age 5 years to 5%, starting from a national baseline of 8% in 1997.

- Objective: 19-3a: Reduce the proportion of children and adolescents who are overweight or obese (ages 6-11) to 5% starting from a baseline of 11% for the period 1988-1994.

[8] Child Trends & SRI International. (2004 February). *First 5 California: Child, family, & community indicators.* Sacramento, CA: California Children and Families Commission, pg 4C-1
[9] Data from Child Health and Disability Prevention (CHDP) Program health exams are used to conduct the annual Pediatric Nutrition Surveillance Survey (PedNSS). Nationwide this survey has been conducted continuously since 1973. In California, participation in PedNSS began in 1988.The purpose of PedNSS is to monitor simple key indicators of nutritional status (weight, height, hematology) among low income, high-risk infants, children and adolescents who participate in publicly funded health programs.
[10] "Defined as height for age below the fifth percentile in the age-gender appropriate population using the 1977 NCHS/CDC growth charts." http://www.healthypeople.gov/document/HTML/Volume2/19Nutrition.htm#_Toc490383123 Retrieved 5/28/05.
[11] http://www.healthypeople.gov/document/HTML/Volume2/19Nutrition.htm#_Toc490383123 Retrieved 5/28/05.

Trend Analysis

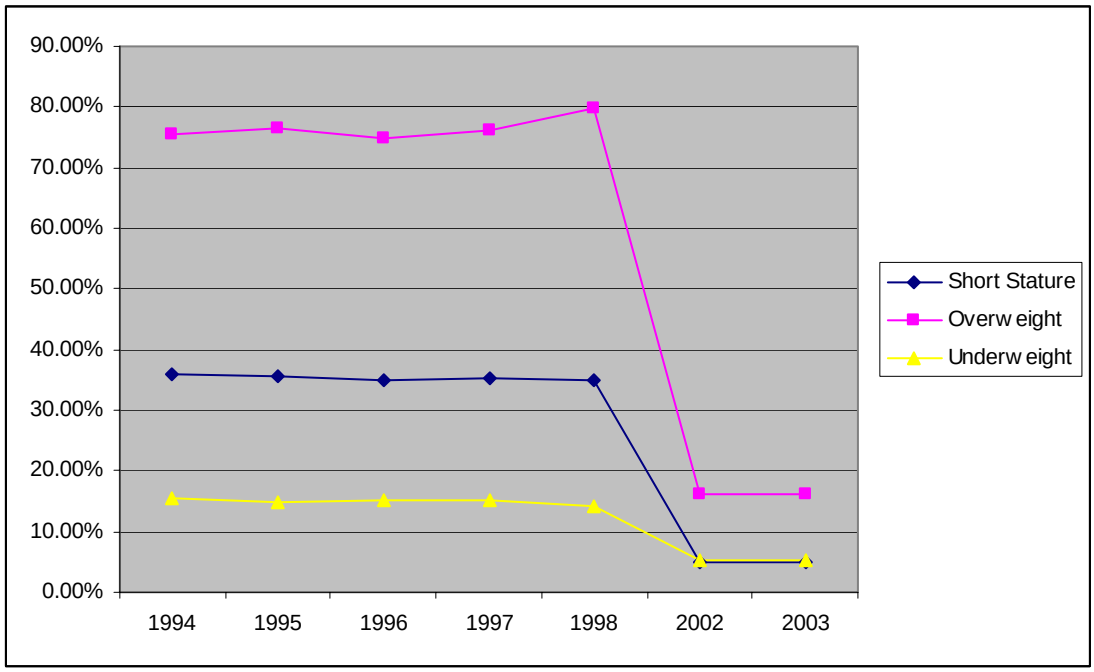
Figure 6: Percent of Health Assessments Exceeding National Standards
County of Marin



MARIN	1994	1995	1996	1997	1998	**2002**	**2003**
Short Stature	5.90%	6.10%	5.20%	4.20%	4.50%	**3.80%**	**3.60%**
Overweight	11.20%	12.10%	12.60%	11.00%	11.50%	**10.00%**	**9.80%**
Underweight	2.30%	2.40%	2.10%	2.80%	2.60%	**8.00%**	**9.90%**

Years 2002 and 2003 are for children ages 0-4 excluding age 5.

Figure 7: Percent of Health Assessments Exceeding National Standards
State of California



CALIFORNIA	1994	1995	1996	1997	1998	**2002**	**2003**
Short Stature	35.80%	35.70%	35.10%	35.20%	35.00%	**4.90%**	**4.90%**
Overweight	75.50%	76.60%	74.80%	76.30%	79.70%	**16.20%**	**16.20%**
Underweight	15.40%	15.00%	15.20%	15.20%	14.10%	**5.30%**	**5.40%**

Years 2002 and 2003 are for children ages 0-4 excluding age 5.

MCHS

45% of Marin children *ages 2-5 are at risk for being overweight or are obese*.

Community Indicator 3:

Number and percentage of children who have been identified as a victim in a child abuse referral and number of which have substantiations.

Rationale[12]

Child abuse and neglect can result in many short- and long-term negative outcomes. Child abuse and neglect can also result in direct negative academic consequences.

Several nationwide efforts monitor this indicator. The U.S. Department of Health and Human Services tracks this indicator to study health conditions and health care. [13]

Data Background

Source: Center for Social Services Research, University of California at Berkeley

Needell, B., Webster, D., Cuccaro-Alamin, S., Armijo, M., Lee, S., Lery, B., Shaw, T., Dawson, W., Piccus, W., Magruder, J., & Kim, H. (2005). Child Welfare Services Reports for California. Retrieved [June 17, 2005], from University of California at Berkeley Center for Social Services Research website. URL: http://cssr.berkeley.edu/CWSCMSreports/Referrals/rates.asp#countyrates

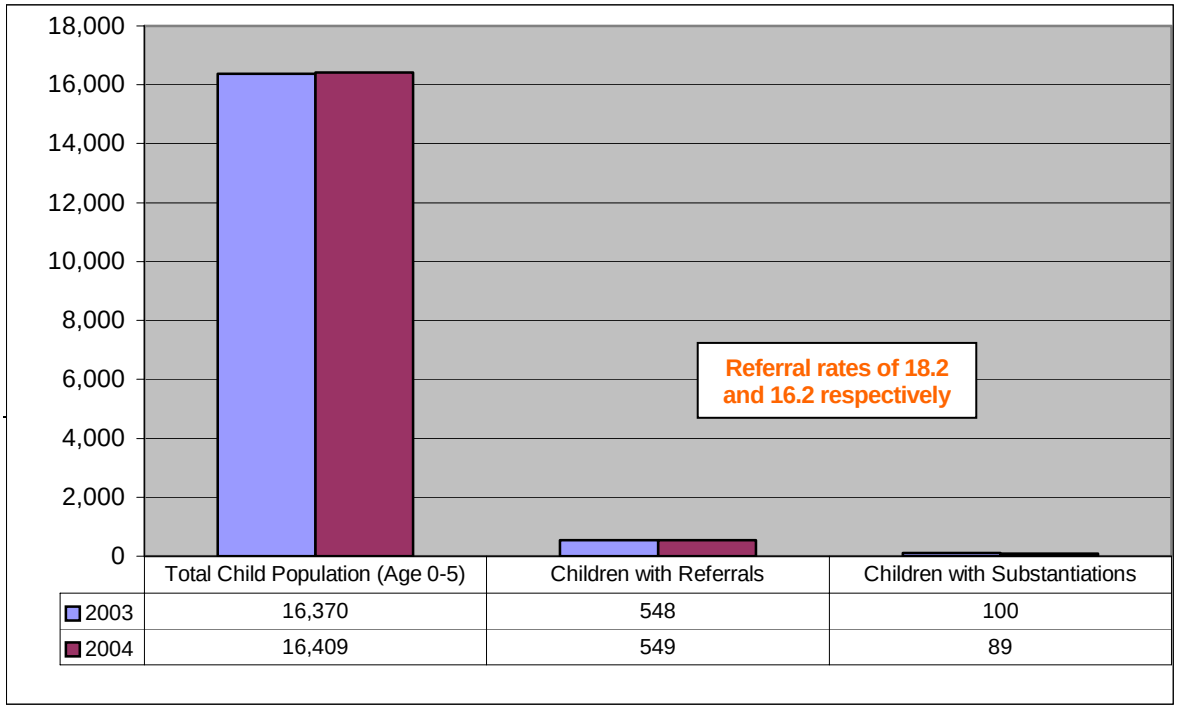
Time Period: 2003-2004

Notes: NA

Healthy People 2010 Benchmark: NA

Trend Analysis

Figure 8: Number and Percent of Children 0-5 in Marin County Who have been referred with Substantiated Cases of Child Abuse

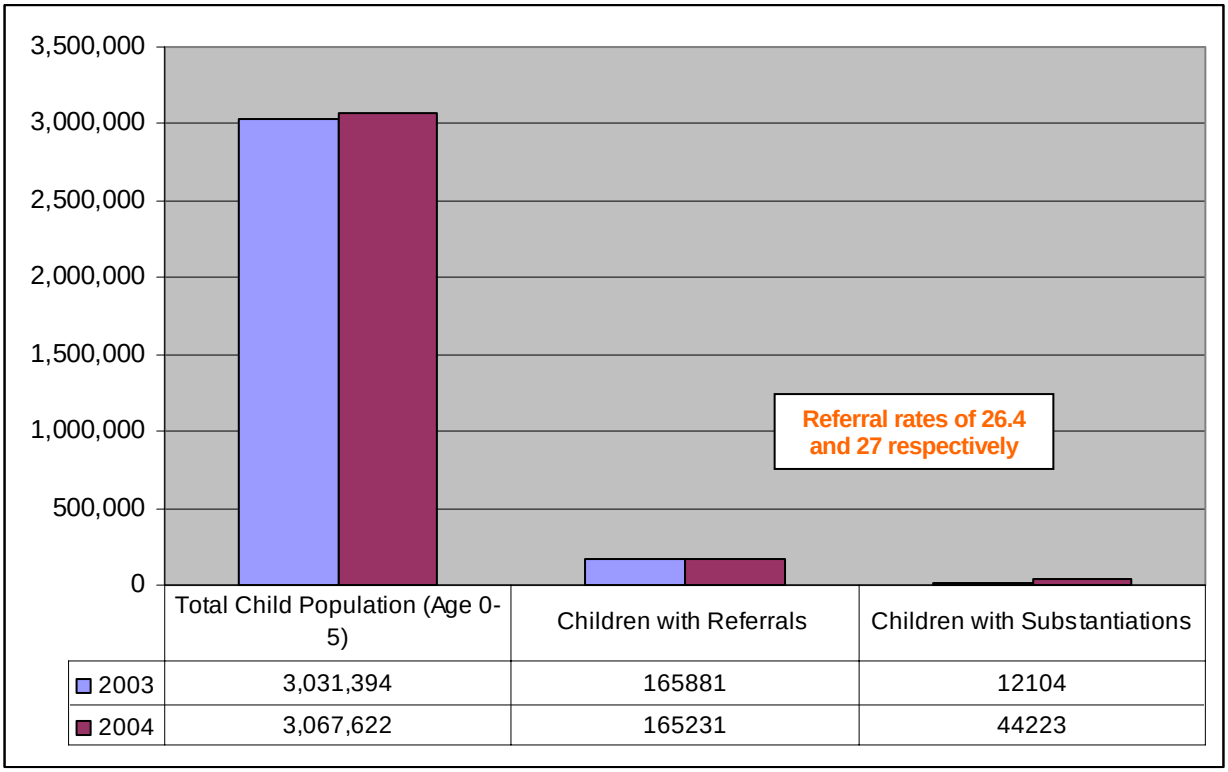


	Total Child Population (Age 0-5)	Children with Referrals	Children with Substantiations
2003	16,370	548	100
2004	16,409	549	89

[12] "Defined as height for age below the fifth percentile in the age-gender appropriate population using the 1977 NCHS/CDC growth charts.

[13] Child Trends & SRI International. (2004 February). *First 5 California: Child, family, & community indicators.* Sacramento, CA: California Children and Families Commission, pg 12A-1

Figure 9: Number and Percent of Children 0-5 in California Who have been referred with Substantiated Cases of Child Abuse



	Total Child Population (Age 0-5)	Children with Referrals	Children with Substantiations
2003	3,031,394	165881	12104
2004	3,067,622	165231	44223

Community Indicator 4:

Number and percentage of child maltreatment in which there is a recurrence within a 6-month period.

Rationale[14]

A recurrence of maltreatment is influenced by many factors such as the type of maltreatment, family characteristics, and services available to the family.

Although existing data do not show that a large number of children experience chronic maltreatment, such maltreatment remains a concern because of its obvious seriousness.

This indicator is tracked and reported annually at the national level by the U.S. Department of Health and Human Services (DHHS) as part of its tracking of trends in maltreatment. DHHS also reports percentages for selected states, including California.

Data Background

Source: Center for Social Services Research, University of California at Berkeley
Needell, B., Webster, D., Cuccaro-Alamin, S., Armijo, M., Lee, S., Lery, B., Shaw, T., Dawson, W., Piccus, W., Magruder, J., & Kim, H. (2004). Child Welfare Services Reports for California. Retrieved May 25, 2005 from University of California at Berkeley Center for Social Services Research website. URL: http://cssr.berkeley.edu/CWSCMSreports

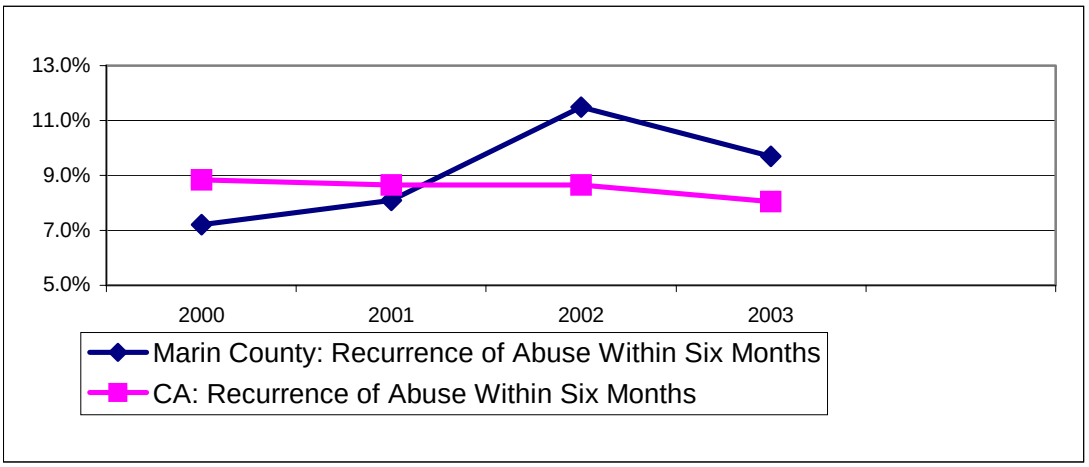
Time Period: 2000-2003

Notes: NA

Healthy People 2010 Benchmark:[15] Objective 15.33a: Reduce maltreatment of children to 10.3 per 1,000 children under age 18, starting from a national baseline of 12.9 child victims of maltreatment per 1,000 children under age 18 in 1998.

Trend Analysis

Figure 10: Percent of Child (0-5) Maltreatment in which there is a Recurrence within a Six Month Period



[14] Child Trends & SRI International. (2004 February). *First 5 California: Child, family, & community indicators.* Sacramento, CA: California Children and Families Commission, pg 12A-1

[15] http://www.healthypeople.gov/Document/HTML/Volume2/15Injury.htm Retrieved 5/25/05

Community Indicator 5:
Number and percentage of children ages 0-2 who receive a well baby check up in the last 6 month.

Rationale[16]
Well-baby and well-child visits have been shown to promote child health by reducing the incidence of illnesses and general health problems. Because they are preventive in nature, well-baby exams reduce health care costs by reducing the need for treatment of avoidable illnesses.

The standards established by Medicaid state that each checkup should involve a health history; a physical examination; an assessment of development, nutrition, dental status, and immunizations; vision and hearing screenings; blood work; and anticipatory guidance.

In California, data for well-child checkups for children receiving services through the Child Health and Disability Prevention Program are collected as part of the CA-MMIS medical data system.

Data Background
Source: 2001 Marin County Community Health Survey Children Ages 0-5 (page 69)

Time Period: 2001

Notes: Proposed question in CHIS 2005 Child Questionnaire Additional Modules: C

Healthy People Benchmark(s) There is no specific mention of this indicator in Healthy People 2010. However the following objectives related to vaccinations and a regular source of primary care are consistent with First 5 Marin's adoption of well-baby check-ups for ages 0-2 as important.[17]

- Objective 14-1: Increase the proportion of persons who have a specific source of ongoing care for children aged 17 and under, with a target of 97% starting with a baseline of 93% in 1998.
- Objective 14-22: Achieve and maintain effective vaccination coverage levels for universally recommended vaccines among young children, with a target 0f 90% for all vaccines recommended for children 19-15 months starting from a baseline ranging from 43% to 84% (depending on the vaccine) in 1998.

Trend Analysis

MCHS

81% of children age 0-5 saw a doctor for a well-*baby/child check-up in the last 6 months*

Comparing l**ower income to higher income households, it is 73% to 81%**

[16] Child Trends & SRI International. (2004 February). *First 5 California: Child, family, & community indicators.* Sacramento, CA: California Children and Families Commission, pg 2B-1
[17] http://www.healthypeople.gov/Document/HTML/Volume1/01Access.htm Retrieved 5/26/05

Community Indicator 6:
Number and percentage of children ages 3 -5 who receive annual dental exams.

Rationale[18]
Annual dental exams provide preventive care and facilitate early diagnosis and treatment of oral problems.

Dental problems are widespread among youth. Dental decay is one of the most common diseases among youth in the United States. More than three quarters of adolescents have at least one cavity or filling by age 17, and about one-fifth of all adolescents have one or more untreated caries, lesions, or active tooth infections.

Poor dental health can contribute to other health problems and difficulties in school. In addition, chronic dental problems in children can adversely affect self-image, concentration, school attendance, and school performance.

Many national and state efforts use this indicator to monitor children's school readiness. This indicator is collected by the National Center for Health Statistics. Child Health USA also tracks this indicator.

Data Background
Source: 2001 Marin County Community Health Survey Children Ages 0-5

Time Period: 2001

Notes: Potentially a question in CHIS 2005 Child Questionnaire Additional Module.

Healthy People Benchmark(s)

- HP 2010 Objective 21-2a. Reduce the proportion of young children with untreated dental decay in their primary teeth. (Target: 9 percent. Baseline: 16 percent of children aged 2 to 4 years had untreated dental decay in 1988–94.)[19]

- HP 2010 Objective 21-10. Increase the proportion of children and adults who use the oral health care system each year. (Target: 56 percent; Baseline: 44 percent of persons aged 2 years and older in 1996 visited a dentist during the previous year)[20]

Trend Analysis

MCHS

57% of children age 3-5 *saw a dentist in the last 6 months.*

68% have seen a dentist in the last year; *87% of last visits were for a routine check/up cleaning*

Hispanics are much less likely to have a seen a dentist in the past year: White-77%; Hispanic-32%; Black/other-66%

[18] Child Trends & SRI International. (2004 February). *First 5 California: Child, family, & community indicators.* Sacramento, CA: California Children and Families Commission, pg 5A-1
[19] http://www.healthypeople.gov/Document/HTML/Volume2/21Oral.htm Retrieved 5/26/05.
[20] http://www.healthypeople.gov/Document/HTML/Volume2/21Oral.htm Retrieved 5/26/05.

PRIORITY OUTCOME 2- CHILDREN ARE READY FOR SCHOOL

Community Indicator 7:
Number and percentage of children determined to be "ready for school" based on assessments administered by teachers/parents…etc.

Rationale[21]
School readiness is important because children whose knowledge and skills are far behind those of their new classmates enter school at a disadvantage.

Children who have difficulty in the early school years face greater challenges throughout their school careers.

Monitoring school readiness can inform both practice and policies such as: 1) Identifying children's strengths and where they need more support; 2) Suggesting classroom pedagogical practices; and 3) Increasing local, state, and national awareness and accountability for the well-being of children. In addition, this indicator helps determine the supports that families and communities need for children's school readiness.

In California, the DRDP (on which the MDRDP is based) was developed by the CDE for use in pre-kindergarten, preschool, and the Head Start programs to monitor children's developmental progress. The DRDP was specifically designed to link to the K-12 standards in California, making it uniquely well-suited for use in evaluation of California's pre-kindergarten efforts. Currently, the DRDP is being revised for CDE, with extensive psychometric testing.

Data Background
Potential Source: First 5 Marin Children and Families Commission School Readiness Initiative Evaluations

Time Period: TBD

Notes: First 5 California conducts an evaluation of school readiness initiatives to which it provides matching funds to local Commissions. In Marin, this is the Canal School Readiness Initiative. Data from this Initiative is not representative of the whole of Marin County as the Canal site was selected not only because of its "readiness" to engage in such an effort but also because of its low API rankings.

As the local school readiness initiative spreads in Marin (potential sites include West Marin, Marin City, Novato and San Geronimo/Nicasio), data could be aggregated across initiative sites to provide a more accurate reflection of child 'readiness for school." As the local initiative is developed, evaluation components and related data collection requirements will be further explored.

Healthy People 2010 Benchmark(s): NA

Trend Analysis: NA

[21] Child Trends & SRI International. (2004 February). *First 5 California: Child, family, & community indicators.* Sacramento, CA: California Children and Families Commission, pg 10A-1

Community Indicator 8:
Number and percentage of children who enter kindergarten with preschool experience.

Rationale[22]
Participation in early childhood education programs can help low- and middle-income children prepare for school. Research on high-quality early intervention programs for low-income children and middle-class children has generally found that participation in educational programs before kindergarten entry is associated with better performance in the early years of school.

The U.S. Department of Health and Human Services uses a variant of this indicator as a measure of child well-being.

Data Background

Source: 2001 Marin Community Health Survey Children Ages 0-5 (page 91) and First 5 California School Readiness Initiative Evaluations (page 19)

Time Period: 2001 and 2004

Notes:

- First 5 California conducts an evaluation of school readiness initiatives to which it provides matching funds to local Commissions. In Marin, this is the Canal School Readiness Initiative. *Data from this Initiative is not representative of the whole of Marin County* as the Canal site was selected not only because of its "readiness" to engage in such an effort but also because of its low API rankings.

- Proposed Question in CHIS 2005 Child Questionnaire Additional Modules: I

Healthy People 2010 Benchmark(s): NA

Trend Analysis

MCHS

65% of children ages 3-5 *attend preschool*

First 5 California School Readiness Initiative Evaluation 2004

Figure 11: Percentage of Children (Statewide participating in Initiative) Who Have Attended Preschool

Question on Family Interview Survey	N	KEP Statewide data %	National Data %
Attended preschool, Head Start, or center-based child care program	3,612	60	67
Preschool program attended was a Head Start program	2,149	35	14
Preschool program attended was a state pre-kindergarten program	902	15	--

[22] Child Trends & SRI International. (2004 February). *First 5 California: Child, family, & community indicators.* Sacramento, CA: California Children and Families Commission, pg 8A-1

Community Indicator 9:
Number and percentage of children identified w/special needs that are referred to developmental services pre-K.

Rationale[23]
For many children aged 18 years and under, lifelong mental disorders may start in childhood or adolescence. For many other children, normal development is disrupted by biological, environmental, and psychosocial factors, which impair their mental health, interfere with education and social interactions, and keep them from realizing their full potential as adults.

Expanding effective services for children, particularly for those with serious emotional disturbance, depends on promoting effective collaboration across critical areas of support: families, social services, health, mental health, juvenile justice, and schools.

Data Background

Potential Source: Potential Source First 5 Marin Special Needs Mental Health Initiative

Time Period: NA

Notes: As this local initiative is developed, evaluation components and related data collection requirements will be further explored.

Healthy People 2010 Benchmark(s): There is no specific mention of this indicator in Healthy People 2010. However there are several objectives which when combined reflect the spirit in which First 5 Marin has adopted this indicator as a proxy for increased system and community capacity to be inclusive for children 0-5 with special needs.

- Developmental Objective 18.7: Increase the proportion of children with mental health problems that receive treatment.[24]
- Objective 6.9 - Increase the proportion of children and youth with disabilities who spend at least 80 percent of their time in regular education programs (Target: 60% with 45% baseline of children ages 6-21 for the 1994-1998 school year)[25]
- Developmental Objective 6.10 - Increase the proportion of health and wellness and treatment programs and facilities that provide full access for people with disabilities.[26]

Trend Analysis: NA

[23] http://www.healthypeople.gov/Document/HTML/Volume2/18Mental.htm#_Toc486932700 Retrieved 5/24/05.

[24] http://www.healthypeople.gov/Document/HTML/Volume2/18Mental.htm#_Toc486932700 Retrieved 5/24/05.

[25] http://www.healthypeople.gov/Document/HTML/Volume1/06Disability.htm Retrieved 5/24/05.

[26] http://www.healthypeople.gov/Document/HTML/Volume1/06Disability.htm Retrieved 5/24/05.

PRIOIRITY OUTCOME 3: PUBLIC POLICIES SUPPORT CHILDREN

Community Indicator 10:
 # / % of public policies offered and / or enacted related to our three strategic results

Rationale
Policies prioritize key issues and guide resource allocation and focus. By engaging the policy debate (local to federal), communities can become more engaged in the discussions and deliberations that affect their quality of life and that of their children. As a funder committed to improving the lives of children 0-5 and their families, First 5 Marin recognizes the limit of its fiscal resources and the value of influencing policies that affect the health and well-being of children as means to leverage and maximize its efforts.

Data Background

Potential Source: Local and state legislative tracking mechanisms.

Time Period: NA

Notes: First 5 Marin is in the early stages of developing its policy agenda and work plan. As in the other initiatives, an evaluation plan will be part of the final initiative design and implementation.

Healthy People 2010 Benchmark(s): NA

Trend Analysis: NA