First 5 Marin Strategic Refresh
2027-2029

First 5 Marin Advocacy Agenda:

- ☐ Paid Family Leave (county, state, federal)
- ☐ Local policy to support childcare centers and homes within new housing units
- ☐ Preventing further cuts to healthcare (HR1)
- ☐ Work with Department of Healthcare Services to provide clarity/directive to managed care plans that CHWs can be billed for whether volunteers or employees
- ☐ Ensure quality accessible data from a whole child/family perspective to understand gaps and inform decision making
- ☐ Eliminate gap of network of care that regional center provides vs. what is legal mandated by K12

Goal 1: Families are connected to services and resources			
Objective	**Key Performance Indicators**	**Strategies**	**Status**
1. Increase the number of families who successfully receive referrals, are connected to resources *AND* supported in navigating systems to access the services they need.	☐ Increase from 15 CHWs to 30 CHWs over 2 years (Data source = County) ☐ 20% increase in clients referred that are successfully connected to services (Data source = MBHI) (Baseline = 0) ☐ MBHI & UCSF Family Survey data ☐ 50% increase in referrals from PHP to Help Me Grow (Baseline = 5)	**1A. Further develop and refine CHW hub model** a. Support partners in the CHW CalAIM benefit b. Participate in statewide task force c. Increase local workforce pathways for CHWs d. Convene CHW cohort to provide timely accurate information and capacity building, empowered to connect to services i. Continuous improvement survey with CHWs	**1A.** In progress - First 5 Marin is already certified as a CHW Hub by state. 2 partners currently working to get contract with managed care plan **1B.** In progress **1C.** In progress - combined with Dula work, component of the current hub **1D.** In progress for last 8 months **1B.** In progress - braided funding

	☐ Increase doula care for Medi-cal families (baseline = 0)	**1B. Expand Enhanced Care Management capacity of Help me Grow to meet gap** a. Identify additional resources to expand staff capacity **1C. Convene ELCANs (Early Learning & Collaborative Action Network)** for cross-sector collaboration on early identification and intervention strategies **1D. Prioritize resourcing solutions to increase availability of local providers in underserved geographies** a. Through RFQ (Request for Qualifications) process b. Explore partnership with Sonoma County via Petaluma Health Center to leverage resources (operates in both Sonoma and Marin Counties) c. Increase coordinated entry and reduce barriers to accessing services	from: ● $50K from Behavioral Health Services Act (less than requested). ● Managed care plan dollars (sunsetting June '26) ● CA Department of Healthcare Services (sunsetting June '26) ● Fee for service Gap = support for outreach position **1C.** In Progress - ● Currently convened in West Marin, Marin City and Canal ● Plans to expand into Novato **1D.** a. Will address through 2027 RFQ process b. Begun initial conversations with First 5 Sonoma & Petaluma Health Center
2. Birthing families and families with children 0-2 receive increased services and supports that are responsive to family and child needs.	Measured through Maternal Behavior Health grant initiative: ☐ Number of families successfully utilizing services they were referred to (differentiate as a tag between Core Team services Vs. External Partner services) ☐ The number of families	**2A. Leverage and expand access to existing resource guides for post-partum providers** a. Ensure information is provided consistently and is up to date across Providers/CHWs/CBOs b. Continue to support and partner on early learning and care resource	**2A.** a. In progress through ELCANS, Help Me Grow, Care Collective b. In progress c. In progress as part of Curriculum Development Subcommittee of Care Collective d. Working with Public Health

	that received referrals within the core team, that report an improved ability to access supports and navigate services (from baseline to satisfaction survey) ☐ Number (and percent?) of families that report that the service(s) they received effectively met their need(s)	fairs, focus on hyper local in underserved geographies c. Provide information on criteria for an effective and evidence based PlayGroups model via Marin Family Care Collective parent cohorts d. Partner with County on development of a centralized resource/community information exchange **2B. See 1D**	and Blue Path Health to understand what a centralized resource/community information exchange such as a 211

Goal 2: Children have high-quality early learning experiences			
Objective	**Key Performance Indicators**	**Strategies**	**Status**
1. Increase availability of quality affordable licensed infant and toddler care	☐ Monitor and disseminating information about infant and toddler care and/or infrastructure (ELCAN accommodation rates) ☐ % First 5 resources focused on infant/toddler care TBD in RFQ process	**1A. Advocate for increased countywide investments to enhance quality infant and toddler care** a. Target % of First 5 resources for funded partners on quality infant and toddler classrooms (infrastructure) b. Continue to convene partners (Parent and Family Advisory; ELCANS; Grantees) for coordination and advocacy:	**1A.** a. Will be addressed through upcoming RFQ process b. In progress through existing convenings

		a. Engage parent/family voice in prioritizing focus of resources (Monterey County as example) b. Help facilitate facility conversion from PreK to Infant and Toddler classroom c. Support quality in friend/family/neighbor care d. Identify needs and missing infrastructure and resources, especially for focus populations (ie. special needs, immigration, BIPOC, ELL, socio-economic status) e. Identify opportunities to maximize existing resources, space and services **1B. Ensure public data collected by state and local agencies is equitably disseminated and widely available as information for decision making**	**1B.** ELCANs currently collect local data. Need to address local gap in certain data sources being equitably disseminated and widely available.

Goal 3: Children are Physically and Mentally Healthy			
Objective	**Key Performance Indicators**	**Strategies**	**Status**
1. Decrease amount of time it takes to access early intervention services	☐ Consistently utilize quarterly GGRC and SELPA data snap shots ☐ Monitor number of providers in underserved geographies (SLPs etc) ☐ Complete feasibility study of a local intermediary	**1A. Explore creating a local solution for delayed access to early intervention services** a. Explore potential of intermediary agency i. Look at ELI in Sonoma as a model b. Provide real time data and responsiveness as available **1B.** Explore closed loop referral system with Marin County HHS where clinical providers and community-based organizations can track referral outcomes and notes	**1A.** a. Exploration in progress, reviewing Sonoma County model **1B.** Currently convening meetings between Sonoma, Marin HHS around Community Information Exchange
2. Increase Development and Behavioral Health Screenings in underserved areas and with underserved populations	☐ 100% ASQ implementation in target geographies based on need (Marin City, West Marin, Novato, Canal) across both subsidized and unsubsidized ☐ Children ready for school, as measured by improvement on ASQ-3/ASQ-SE over time/Pre-Post	**2A. Review data to determine areas of greatest need** a. Expand data collection partners (ie. North Bay, CAM) b. Differentiate MCC and other sites (this data will be available soon through new database) **2B. Support Help Me Grow to increase use of ASQs:** a. Continue implementation of ASQs in areas of high need / highest gaps (Marin City, West Marin, Novato, Canal)	**2A.** Initial data is already available, but need to expand geographies and sector partners for more comprehensive data set **2B.** HMG continuing to provide training and support to preschools, Behavioral Health Services, CBO partners etc.

		b. Support Help Me Grow to work as intermediary to support and provide TA to clinics/pediatricians c. Leverage ASQ dashboard to promote ASQ utilization across all regions ○ Look into additional uses/expansion such as an app, digital access ○ Integration with EPIC d. Explore communications strategy to increase parent/caregiver awareness of ASQs	
3. Support development of a culturally relevant community healthcare workforce	☐ Increased access to culturally responsive Doulas and Community Health Workers	**3A. Increase availability of culturally responsive Doulas and Community Health Workers in underserved geographies** a. Promote availability/option of Spanish speaking Doulas b. Implement training through SisterWeb to increase Spanish speaking Doulas that can bill Medi-Cal c. Work with provider networks to increase connection and utilization	**3A.** Training starts June 14th for cohort of 20 Spanish speakers Doulas, with possibility of expansion to train the trainers