

Strategic Refresh 2027–2029



Goal 1 – Families are connected to services and resources

OBJECTIVE	KEY PERFORMANCE INDICATORS	STRATEGIES	STATUS
1 Birthing families and families with children 0–2 receive increased services and supports that are responsive to family and child needs	<i>Measured through Maternal Behavioral Health grant initiative:</i> - 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 that received referrals within the core team, that report an improved ability to access supports and navigate services (from baseline to satisfaction survey) - Number (<i>and percent?</i>) of families that report that the service(s) they received effectively met their need(s)	1A. 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 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 1B. See 2D	1A. In progress – 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 and Blue Path Health to understand what a centralized resource/community information exchange such as a 211

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2 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) - Increase doula care for Medi-Cal families (Baseline = 0)	2A. 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 2B. Expand Enhanced Care Management capacity of Help Me Grow to meet gap a. Identify additional resources to expand staff capacity 2C. Convene ELCANs (Early Learning & Collaborative Action Network) for cross-sector collaboration on early identification and intervention strategies 2D. 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	2A. 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 2B. In progress 2C. In progress – combined with Doula work, component of the current hub 2D. In progress for last 8 months 2B. In progress – braided funding 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 2C. In progress – - Currently convened in West Marin, Marin City and Canal - Plans to expand into Novato 2D. In progress – a. Will address through 2027 RFQ process b. Begun initial conversations with First 5 Sonoma & Petaluma Health Center

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 disseminate 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: i. Engage parent/family voice in prioritizing focus of resources (Monterey County as example) ii. Help facilitate facility conversion from PreK to Infant and Toddler classroom iii. Support quality in friend/family/neighbor care iv. Identify needs and missing infrastructure and resources, especially for focus populations (ie. special needs, immigration, BIPOC, ELL, socio-economic status) v. 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	1A. In progress - a. Will be addressed through upcoming RFQ process b. In progress through existing convenings 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 snapshots - 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. In progress - 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) 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	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.
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-speaking Doulas, with possibility of expansion to train the trainers