



 **FIRST 5**  
**BUTTE COUNTY**  
**CHILDREN & FAMILIES COMMISSION**

**2010-2015 Strategic Plan**

**FIRST 5 BUTTE COUNTY  
CHILDREN AND FAMILIES COMMISSION**

**June 2010**

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# INTRODUCTION

## WHO WE ARE

“Early childhood is both the most critical and most vulnerable in any child’s development. Our research, and that of others, demonstrates that in the first few years of life the ingredients of intellectual, emotional and moral growth are laid down. If they are not, it is true that a developing child can still acquire them, but the price rises and the chances of success decrease with each subsequent year. We cannot fail children in these early years.”

--From *The Irreducible Needs of Children*, T. Berry Brazelton, MD and Stanley I. Greenspan, MD

First 5 Butte County Children and Families Commission (the Commission) is responsible for evaluating and prioritizing the needs of young children and their families in the county, developing a strategic plan that promotes a comprehensive and integrated system of early childhood development services that addresses community needs, determining how to invest its funds, and evaluating the effectiveness of programs and activities funded in accordance with the strategic plan.

The Commission has limited dollars to spend, but understands that by making strategic investments—that is, using dollars to prevent problems and intervene early for children and families—actually saves money in the long term. For example, according to the Centers for Disease Control, children from low-income families who have their first preventive dental visit by age one are not only less likely to have later restorative or emergency room visits, but their average dentally related costs are almost 40% lower over a five year period than children who receive their first preventive visit after age one. Numerous studies show that home visiting programs with other intervention programs designed to strengthen the family, far outweigh the initial investment because more costly interventions, including clinical and foster care, can be averted. Investments in prevention and early intervention are not only less costly, but they produce more desirable outcomes for children and their families.

All of the Commission’s actions are informed by research on brain development. At birth, a baby’s brain is only about one-quarter the size of an adult’s. It grows to about 80% of adult size by three years of age and 90% by age 5. Research supports that:

- Family is the child’s first teacher. Positive and enriching experiences support children’s optimal development and warm, loving relationships with caring adults build the foundation for lifelong learning, behavior, and health.
- In the early years, all aspects of development and learning are linked. Progress in one area affects progress in the others. This means that in order to support a

child's preparedness for school, we must pay attention to the child's needs for protection, nutrition, health, affection, and more.

- By providing children with safe, nurturing and stimulating environments, parents and caregivers influence long-term growth and development.

Put simply, when infants and children begin life healthy, loved, and supported, their futures are brighter. They have the foundation to reach their highest potential in school and beyond. These early childhood development realities are the basis for Proposition 10, the California Children and Families Act, which in turn resulted in the formation of First 5 Butte County.

## **HOW OUR PLAN WAS DEVELOPED**

Each county commission is required to develop and adopt a strategic plan to guide funding decisions and provide information on how the Commission will measure progress toward achieving its goals.

First adopted in November 2000, the Commission's strategic plan is reviewed and revised annually. The revisions of the plan are completed with input from the Commission's advisory committees, including the Child Abuse Prevention Council, Children's Services Coordinating Council and Local Child Care Planning Council. In developing the 2010 strategic plan revision, the Commission sought to acquire a broad spectrum of input from both the population being served and the population providing services. To that end, input ranged from surveying parents and kindergarten teachers to reviewing local data, family needs assessments and recent research. The Commission also participated in key informant interviews.

For more details on the methodology of our strategic plan development, please see Appendix A.

### ***History and Requirements of the Commission***

Following the passage of Proposition 10, the Butte County Board of Supervisors formed the First 5 Butte County Children & Families Commission and established a dedicated trust fund for Proposition 10 funds. This nine-member Commission represents the diversity of issues that lead to successful early childhood development.

A requirement of the state laws governing the County Commissions is to ensure that money from the Children and Families Trust Fund is not used to replace or "supplant" existing local funding for programs and services. In other words, Proposition 10 funds must be used to increase the level of services available.

# ACCOMPLISHMENTS AND LESSONS LEARNED

## ACCOMPLISHMENTS OF THE COMMISSION

Over the last decade, the Commission has evolved its focus and approach to achieving the important results sought for children, their families and the community. The Commission has begun to take a holistic approach to readying children for success by ensuring their optimal development, health and wellbeing. This approach has resulted in the following noteworthy accomplishments for children, families, providers and systems:

- CHILDREN**
  - Increased access to early mental health assessment and services
  - Increased access to oral health screening, prevention and treatment
  - Appropriate immunizations delivered due to the Immunization Registry
  - Targeted outreach to parents, teachers and students at low-performing schools towards enhanced school readiness
  - Increased early literacy activities for infants, toddlers, and preschoolers
  - Babies born free of alcohol and drugs to mothers successfully treated for substance abuse
- FAMILIES**
  - Increased access and linkages to mental health resources
  - Educated and supported parents in being their child's first teacher
  - Provided intensive parenting/life skills instruction and home visiting services
  - Increased families' confidence and skills in supporting early development, literacy and life-long learning
  - Promoted family functioning and linkages to important resources for at-risk families
- PROVIDER**
  - Raised the awareness of early childhood educators, parents, and administrators of the value of student preparedness prior to Kindergarten entry.
  - Enhanced understanding and acknowledgement of the social, emotional, cognitive, developmental differences and needs of children across the systems that support children in Butte County
  - Increased skills and knowledge among early childhood educators by providing guidance and educational support to hundreds of early childhood educators and care providers, thereby improving the quality of the learning environments they maintain for young children

- Enhanced the coordination and delivery of Early Mental Health Services amongst providers throughout Butte County (Strong Starts Behavioral Health Partnership)
- Invested strategically in infrastructure and provider capacity so that the benefits to the community outlast the initial investments. Examples include the Mobile Dental Clinic, CARES Program, and the Immunization Registry.
- Developed comprehensive Initiatives via a thoughtful, Commission-driven process that focus on primary prevention efforts.

**LESSONS LEARNED**

As the Commission embarked on developing the 2010 strategic plan, Commissioners and staff reflected on key lessons learned over the past decade that could inform and strengthen the plan. This included observation of the characteristics that when present, improve the chances that an effort is successful:

Planning	Thoughtful and thorough planning is a key to success. This includes identifying the appropriate partners for an initiative, engaging them in the planning process, and building on existing strengths.
Involvement	Commissioner initiated efforts that involve the Commission in planning translate into successful partnerships and more effective implementation.
Shared Ownership	Leadership and buy-in by providers and recipients within a system provides the greatest opportunity for lasting systems change.
Alignment	It is essential to find partners whose values align with the Commission, who are passionate about the changes needed, and willing to partner and change to be successful. When identifying programs to fund, it is important to ensure the program is aligned with Commission objectives rather than structured to accomplish separate goals and then artificially molded to fit the Commission objectives.
Investment Strategies	The Commission has learned that funding decisions need to be customized and tailored; there is not a generic formula that can be applied to determine the most valuable investments. Some projects lend themselves to sustainability and will outlast the initial investment. Other projects won't be self-sustaining but still have the potential for long-lasting value within the community. Investment intent and strategy are important considerations for the Commission now and in the future.

- Accountability**      Accountability through regular monitoring of results achieved and progress made is essential to maximize the Commission’s investments. Defining and tracking outcomes from the inception of a program increases the ability to measure the impact of interventions. This, coupled with a willingness to reallocate funding when results and outcomes aren’t being achieved is essential.
- Communication**      The Commission has identified improved communication as a priority. Determining target audiences and appropriate, effective messages will help move this effort forward.

**FIRST 5 BUTTE COUNTY CHILDREN AND FAMILIES COMMISSION  
SUMMARY OF INVESTMENTS TO DATE**

The Commission has made a number of significant investments since its formation. As revenue declines, the Commission must further refine and focus its resources to have the greatest impact on children ages 0 through five and their families. This chart below reflects investments made through 2010:

<b>Result Area</b>	<b>Total Investments</b>
<b>Improved Family Functioning</b> <i>Sample Strategies:</i> → Home Visitation → Parent Education → Family Literacy	<b>\$4,646,383</b>
<b>Improved Child Development</b> <i>Sample Strategies:</i> → School Readiness → Provider Capacity → Early Mental Health	<b>\$8,219,751</b>
<b>Improved Health and Wellness</b> <i>Sample Strategies:</i> → Health Insurance → Nutrition/Fitness → Oral Health → Breastfeeding → Home and Sleep Safety Campaigns → Drug & Alcohol Programs	<b>\$5,116,139</b>
<b>Improved Systems of Care</b> <i>Sample Strategies:</i> → Immunization Registry → <a href="http://www.HelpCentral.org">www.HelpCentral.org</a>	<b>\$1,040,098</b>
<b>Total</b>	<b>\$19,022,371</b>

# MISSION, VISION AND GUIDING PRINCIPLES

This section describes the vision, mission and guiding principles that guide all aspects of the Commission decision making.

## VISION

The Commission envisions a future where all children are healthy, loved, nurtured, and ready to succeed in school

## MISSION

To improve the lives of children from the prenatal stage through age five, and promote their optimal development

## GUIDING PRINCIPLES

The Commission uses principles to guide its actions and decisions. These principles include:

- Honoring the diversity of families
- Identifying children, family and community strengths and needs
- Supporting a comprehensive and collaborative system that facilitates optimal service delivery
- Practicing wise stewardship
- Ensuring program quality, accessibility and accountability
- Supporting health promotion programs, including tobacco prevention and cessation programs and services
- Monitoring results to support outcome-based programs and practices

# COMMISSION PRIORITIES

This section describes the Commission priorities related to Children’s Health, Family Strengthening, School Readiness and Systems Integration.

## SELECTING PRIORITIES

Addressing community needs requires a thorough understanding of the issues facing children and families and the ability to prioritize in order to determine how best to invest limited resources to improve the status of target populations. Traditional prioritization techniques, however, often do not provide a cohesive way to compare diverse issues to each other. As a result, prioritization decisions are typically made based on “gut feeling” and can be heavily influenced by last-minute lobbying by constituencies, with only sporadic (if any) attention ultimately paid to the data and criteria used to make decisions.

To select priority areas for inclusion in the First 5 Butte County Strategic Plan, Commissioners adopted and were trained on a rating process to help differentiate between potential priority areas after considering data, demographics, community input and parent and provider feedback. The purpose of the rating process was to create an objective way to compare priority areas to each other.

The Rating Scale provided a relative value for each area, not an absolute value, using a scale from 1 to 10. Four points on the scale were explicitly defined, allowing Commissioners to use the midpoints to reflect their opinions for items that fall “between” the definitions for the four defined points.

## DECISION CRITERIA

Each of the four decision criteria was rated separately for priority areas being considered, using the following definitions. Four categories were adopted by the Commission. They included:

**Extent of Need.** The extent to which children age 0 through 5 and their families have needs that are not currently being met, as evidenced by:

- The degree to which disparities or gaps exist in addressing the need (disparities may be evaluated by geographic area, linguistic or demographic group)
- The number of people (or groups, in the case of issues affecting organizations) with the need

**Impact of Investment on Those Affected.** The degree to which the investment, if made, will make a tangible difference in the lives of children and families as determined by:

- The ability to invest sufficiently to make an impact
- The evidence base exists to demonstrate that investments can have an impact on people's lives: children, parents, family units and others

**Assets and Infrastructure.** The extent to which evidence exists that there are assets and sufficient infrastructure in place to address the priority area in Butte County, as determined by:

- The involvement of community agencies to help address the issue
- The degree to which existing services meet the need
- The degree to which infrastructure is in place in the community agencies to sufficiently address the issue

**Accountability.** The extent to which positive solutions can be measured in Butte County based on principles of Results Based Accountability and First 5, as evidenced by:

- The potential to measure results with clear evaluation criteria
- The degree to which opportunities exist to produce economic savings that can be reinvested to sustain efforts related to the issue
- The level of public will – the priority placed on the issue by the community

Based on the results, recommendations were developed and presented to the Commission. Following discussion the Commission:

1. Established six priority areas to include the top four and two additional focused priority areas.

There four main priorities to be addressed in this strategic plan include:

- Child Neglect and Abuse Prevention
- Ability of Families to Meet Their Basic Needs
- Healthy Births
- Oral Health

Two additional priorities in the plan shall include:

- School Readiness
- Access to Healthcare Services

Setting priorities was essential to the Commission because of the declining tobacco tax revenue. All priority areas are considered equally important to ensuring the health and well-being of young children. However, the Commission is not able to fully invest in

each priority. Priority areas rated were informed by previous funding of the Commission to some degree. These priorities were ranked using the criteria adopted by the Commission. An “A”, “B” or “C” grade was assigned to each priority area in order to differentiate them.

The results of Commissioner ratings include:

**RATINGS BY GRADES**

Potential Priority Areas	Need	Impact	Assets/ Infrastructure	Account- ability
<b>Result Area: Improved Family Functioning</b>				
Child Neglect and Abuse Prevention	A	B	B	B
Ability of Families to Meet Their Basic Needs	A	B	B	B
<b>Result Area: Improved Health and Wellness</b>				
Childhood Obesity	C	B	B	C
Healthy Births	B	A	B	A
Oral Health	A	A	A	A
Early Mental Health	C	B	C	B
Access to Healthcare Services	C	A	B	A
<b>Result Area: Improved Child Development</b>				
Children's Social/Emotional Health	C	C	C	C
School Readiness	B	A	C	A
Quality Early Care, Education	C	B	C	C



# ROLES OF THE COMMISSION AND STAFF

This section describes the role of the Commission as it relates to activities of the strategic plan.

## ROLES OF THE COMMISSION

To address the priorities established by the Commission in this strategic plan, the Commission may play one or more of the following five roles:

- **Planners**—The Commission will actively engage in identifying programs and initiatives to implement and will provide leadership, guidance and feedback in planning the programs and initiatives.
- **Funders**—The Commission will review the resources needed to implement programs and funding and will allocate funding to support desired programs and initiatives.
- **Educators**—The Commission will provide information to select target audiences to educate the public and other stakeholders about research, programs and initiatives that are a priority in the strategic plan.
- **Advocates**—The Commission will advocate on behalf of children ages 0 to 5 and their families and in support of programs and initiatives that ensure children’s health, family functioning, school readiness and the integration of systems to serve children and families.
- **Conveners**—The Commission will bring together providers, communities and other stakeholders to solicit information, opinions and ideas for implementing the strategic plan.

## ROLES OF COMMISSION STAFF

This section describes the role of the Commission Staff as it relates to activities of the strategic plan. The Commission Staff plays one or more of six key roles that are complimentary with and support the Commission’s roles in implementing the strategic plan. They include:

- **Planners**—The Commission Staff will collect research and information about proposed programs and initiatives that may address the priorities in the strategic plan, share that information with the Commission and make recommendations regarding future programs and initiatives.

- **Fund Allocation**—The Commission Staff will identify the resources needed to implement programs and funding, design and implement a fund allocation process and implement the fund allocation process to support desired programs and initiatives.
- **Educators**—The Commission Staff will collect and package information and identify target audiences to educate the public and other stakeholders about research, programs and initiatives that are a priority in the strategic plan.
- **Advocates**—The Commission Staff will identify key messages and outlets for advocacy on behalf of children ages 0 through 5 and their families and in support of programs and initiatives that ensure children’s health, family functioning, school readiness and the integration of systems to serve children and families.
- **Conveners**—The Commission Staff will identify key providers, communities and other stakeholders to solicit information, opinions and ideas for implementing the strategic plan, design and implement opportunities to convene key groups as necessary to engage the community.
- **Oversight**—The Commission Staff will actively engage with funded partners and initiatives to define outcome measures, approve evaluation tools and monitor progress in achieving desired results.



# DESIRED RESULTS, OUTCOMES AND INDICATORS

It was the intent of the Commission for this strategic plan to build upon accomplishments and lessons learned by focusing on Commission Initiatives to address six priority areas. Initiatives shall consist of a coordinated effort working towards specific desired results that are Commission driven, while engaging key partners /community in the planning process.

In the context of this Strategic Plan,

- *Desired Results* communicate the ultimate results and improvements towards which the Commission strives;
- *Outcomes* are used to demonstrate the impact, changes or benefits that result from certain activities or services; and
- *Indicators* are used to measure the progress towards achieving outcomes. That is, they describe observable, measurable characteristics or changes that represent achievement of an outcome.

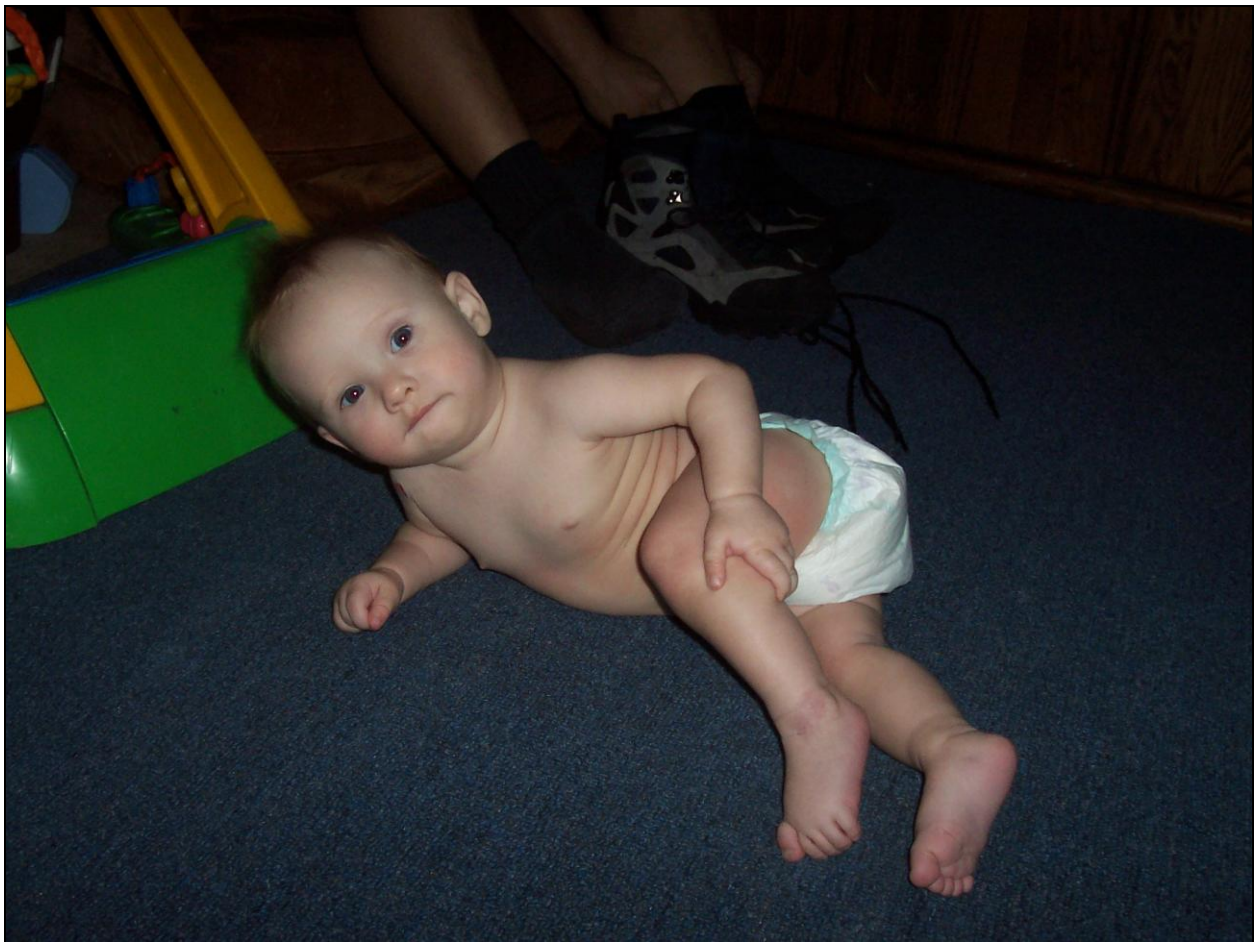
The Commission adopted three main Initiatives for the 2010-2015 strategic plan. They include:

- Family Strengthening (priority areas—neglect and abuse prevention, basic needs and school readiness). The proposed approach for planning would evaluate opportunities for implementation including concepts such as Home Visiting, and Family Resource Centers as potential mechanisms for service delivery. Planning shall focus on best practice interventions to implement desired results.
- Health (priority areas—healthy births, access to health care). The proposed approach for planning would evaluate opportunities for implementation including concepts such as Home Visiting, and Family Resource Centers as potential mechanisms for service delivery. Planning would focus on best practice interventions to implement desired results.

- Oral Health (priority areas—oral health). The proposed approach would be to focus on supporting and enhancing existing efforts and fostering integration into other initiatives.

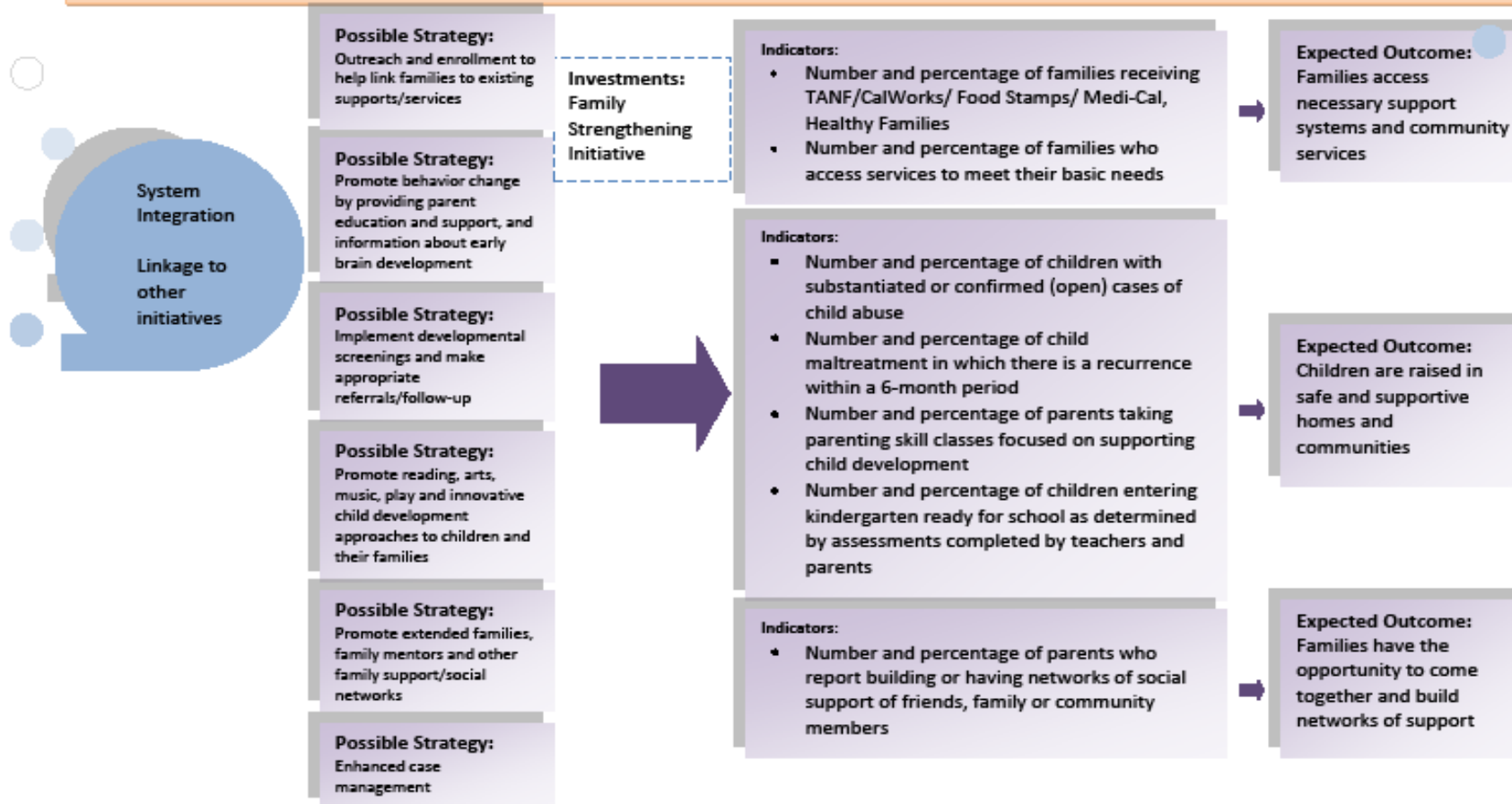
The Commission will continue to utilize discretionary revenue to respond to emerging needs and opportunities. Any project funded with discretionary revenue must have clearly defined desired results, aligned with the outcomes and indicators in this plan.

The following section will further define the desired results sought within each result area, and provide outcomes and indicators that the Commission will use to evaluate the results of investments.



# Initiative: Family Strengthening

**Desired Results:** All families are well-equipped to help their children reach their optimal development and full potential.



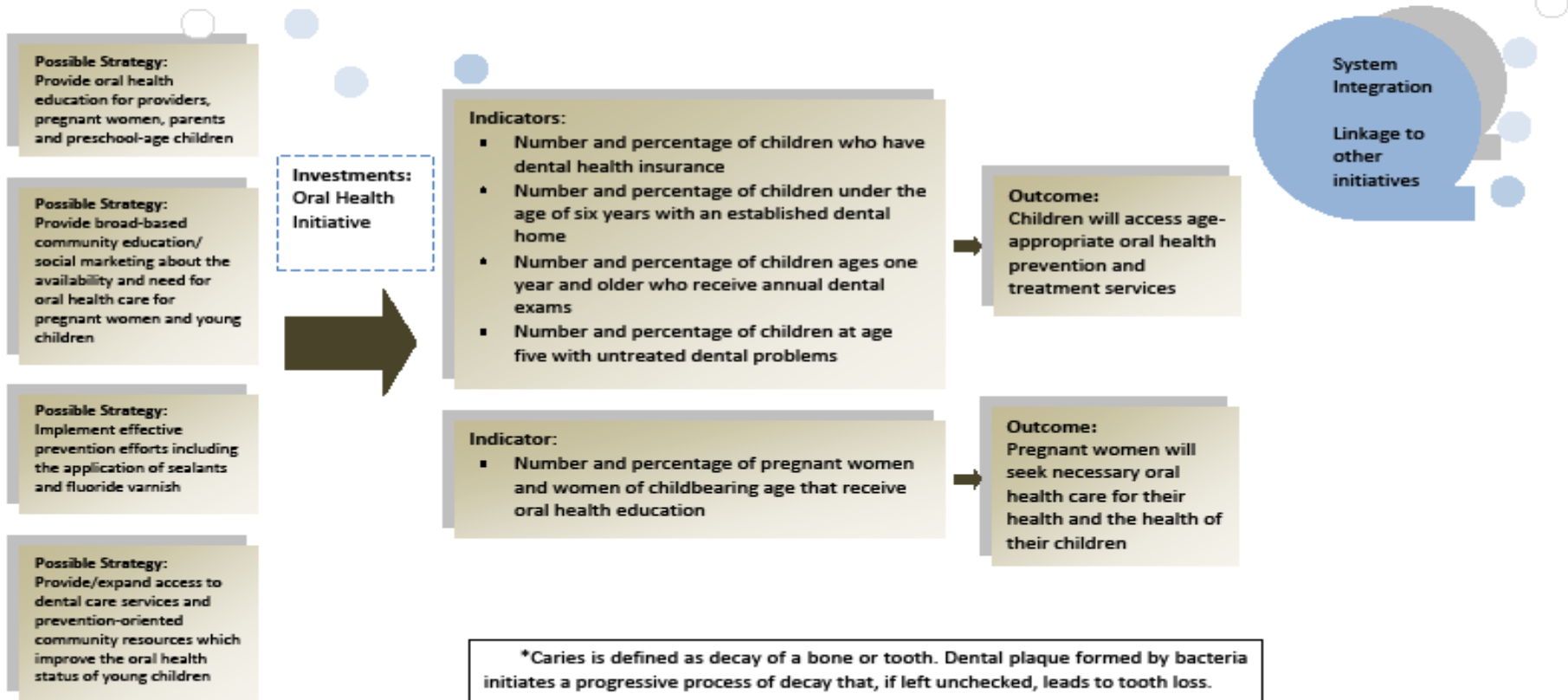
# Initiative: Health

Desired Results: All children are born healthy and reach their optimal health potential.



# Initiative: Oral Health

Desired Results: All children have optimal oral health (decay, cavities, etc.) and a reduction in early childhood caries\*.



# CONCLUSION

The First 5 Butte County Children & Families Commission's 2010 – 2015 Strategic Plan will be used to guide the policies, investments and work of the Commission and its staff over the coming five years. The plan is reflective of what can happen in a community that is dedicated to coming together to make a difference for its children. The Commission is committed to providing leadership and working with our community of parents and providers to help build a future where all Butte County children will be born healthy and valued; be safe, capable, healthy, strong and active learners; and grow up in a nurturing family and community that helps them achieve their full potential and be successful in life.



# APPENDIX A. ASSESSMENT OF COMMUNITY NEEDS

The Commission reviewed demographic data, community and parent surveys and input, outcomes data and evaluation data to best identify community need. A summary of the data that aided in setting priorities includes:

## DEMOGRAPHICS

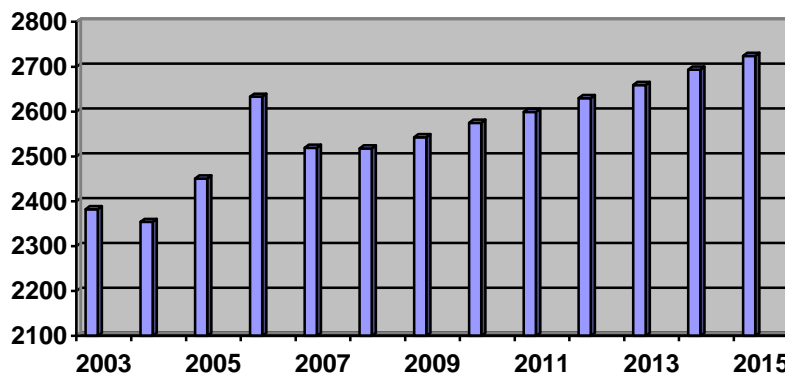
### ***Population***

According to the US Census Bureau, Butte County's estimated population in 2008 was 220,337. Children under the age of 5 years old represented 5.8% of the total population, or 12,780. The Commission funds programs/services for children under the age of 6 years old.

### ***Birthrates***

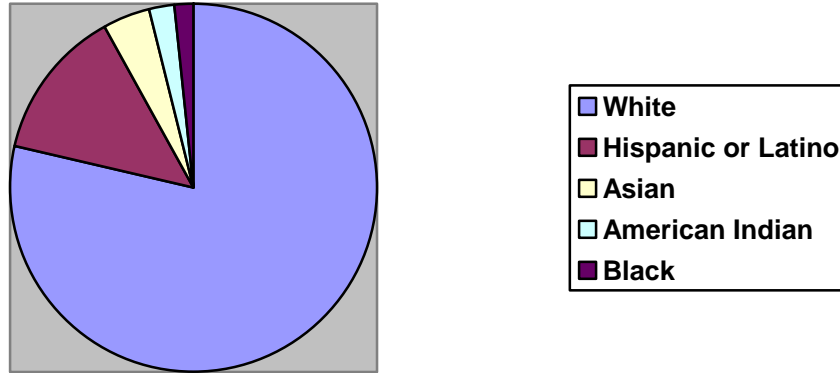
According to the California Department of Finance, birthrate projections are fairly steady with gradual, minor increases over the next six years. The following table is a depiction of past and projected birthrates in Butte County.

**Birthrates in Butte County**



### ***Ethnicity***

The racial distribution of the county is 76.9% White (not Hispanic), 12.9% Hispanic or Latino, 4.1% Asian, 2.2% American Indian, and 1.7% Black. The table that follows shows this distribution.



### **Language**

One-eighth of the people living in Butte, or 27,542, speak a language other than English at home (US Census Bureau). Nearly one-fifth (19%) of children speak another language at home (Children Now County Data Book) – further, 84 Hmong children (46%) in Butte County under the age of six were identified as living in Linguistically Isolated Households; and, 779 or 27.4% of children in Butte County were under the age of six and identified as living in Linguistically Isolated Households, speaking Spanish.

## **ECONOMICS**

### **Parents in the Workforce**

According to the California Resource and Referral Network, there is not enough licensed child care to meet needs within the county. There is a licensed child care slot for only 31% of children ages 0-13 with parents in the labor force (*Child Care Portfolio*, California Child Care Resource and Referral Network, 2009).

### **Economic Factors**

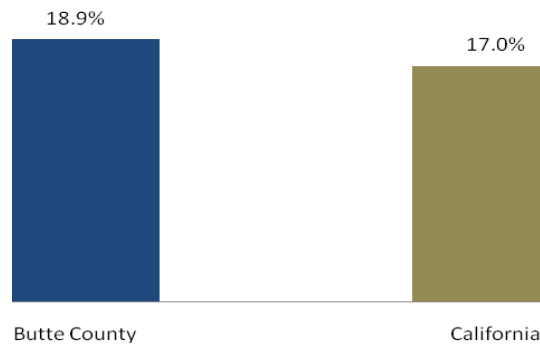
Butte County's unemployment rate exceeded the rate for the state every month in 2009. According to the California Employment Development Department, Butte County's unemployment rate rose from 12.5% in January 2009 to a high in December 2009 of 13.4%. The rates for California statewide for the same period ranged from 10.6% in January 2009 to 12.1% in December 2009.

### **Poverty**

According to the US Census Bureau, there are 37,678 persons (or 17.1%) living below poverty in Butte County. The percentage of children ages 0-17 living in poverty in Butte County is 18.9% - versus 17% statewide (OHIR Profiles 2005-2007). According to the US Census, 22.8% of families with children under 5 years old had been in poverty in the past 12 months (American Factfinder 2006-2008).

There were 3,640 children ages 0-5 living in poverty in 2008, compared to 2,082 in 2006 (American Community Survey 2006 and 2008, as provided in the 2009 Child Care Portfolio, California Child Care Resource & Referral Network).

### Percentage of Children 0-17 in Poverty (2005-2007)



Source: *County Profiles, data for years 2005-2007*, 2009 California Department of Health

Families that don't meet the poverty threshold may also have trouble affording basic needs. More than half (51%) of children in Butte County are in low income families. Children that are Latino are more likely to be in low income families than children from other racial or ethnic groups. The percentage of children under 18 in poverty is an indicator of risk factors that have implications for accessibility to health benefits and other services.

#### Butte County Children, Ages 0-17, in Low-Income Families

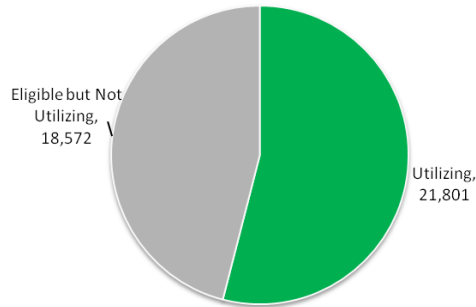
	All	African American	Latino	White	Native American	Other
<b>Butte</b>	51%	*	72%	46%	20%	53%

Source: Estimates from 2006 ACS, as presented in *California County Data Book, Children Now 2007*.

#### **Use of Benefits**

According to the California Food Policy Advocates, of the 40,373 persons in the county eligible for the federal food stamp program, less than half participate in the program. In 2009, 21,801 people, or 54% of the total eligible population were not participating in food stamps.

## County Participation in Federal Food Stamp Program



Source: 2008 Nutrition Profile, California Food Policy Advocates

## EDUCATION

### **Early Literacy**

According to Children Now, 92% of children ages 0-3 in Butte County read books at least three times a week (Data from CHIS 2005 as reported by Children Now 2008).

### **Preschool Enrollment**

More than half (56%) of children ages 3 and 4 are enrolled in preschool. Children that are Native American are more likely than children from other racial and ethnic groups to be enrolled in preschool (Children Now 2007).

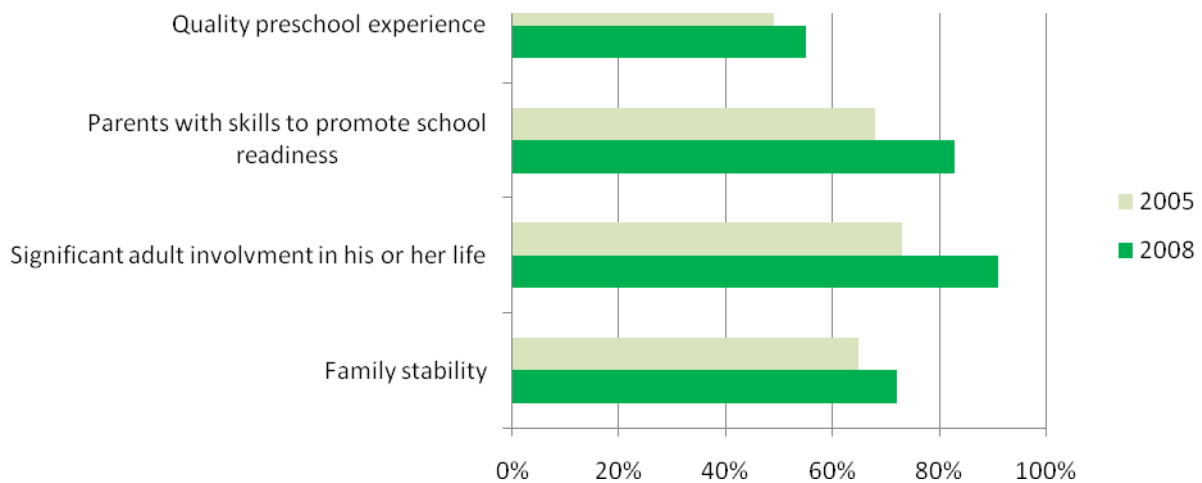
#### Preschool Enrollment, Ages 3 and 4 by ethnicity

	All	African American	Latino	White	Native American	Other
<b>Butte</b>	56%	*	66%	63%	83%	22%

### **Kindergarten Readiness**

In a 2008 survey of kindergarten teachers, more children had the kind of support that increases School Readiness than in 2005. Examples include quality preschool experience, parents with skills to promote school readiness, significant adult involvement, and family stability.

## School Readiness Support



Source: *Survey Results Report 2009 First 5 Butte County Children and Families Commission 2008 Kindergarten Teacher Survey*, Gloria J. Wyeth, M.A., Wyeth Consulting January 5, 2009

The survey also shows that preschool attendance appears to be an important factor in kindergarten preparedness. Overall, among those children who attended preschool, only 3.5% were assessed as Not Prepared, compared to 18.3% of children who did not attend preschool.

### **Special Needs**

Results for Children with Special Needs indicate that while more than half (53.3%) are Adequately Prepared for school, this group has the highest results for Not Prepared in every category, and is more than twice as likely as the general population to be Not Prepared for kindergarten.

### **English Language Learners**

Among English Language Learners, 53.9% were Adequately Prepared in the category of Speech, while only 38% were Adequately Prepared in the category of Emergent Literacy Skills, and 46% in the area of Pre-Academic Skills. ELLs are more often Minimally Prepared or Not Prepared in all of these areas than is the general population.

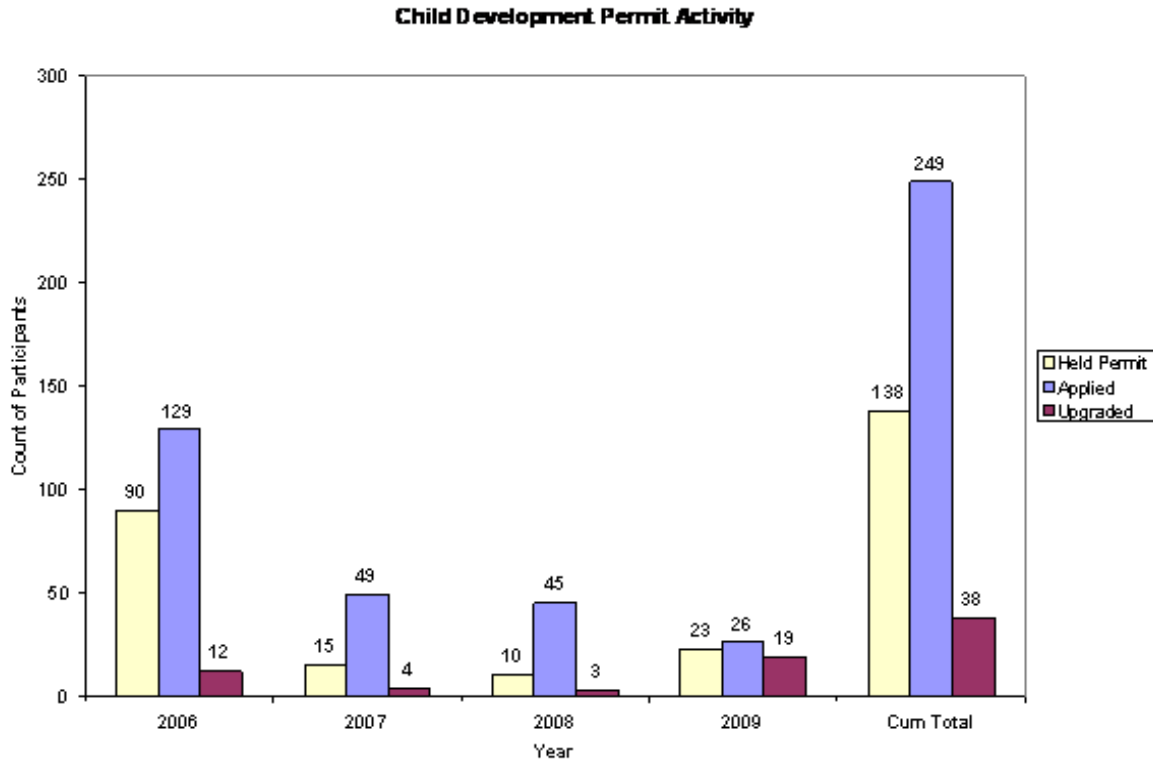
### **Quality Providers**

The CARES program was in effect from 2005/2006-2008/2009. Throughout this period 1,946 participants were enrolled. Out of that number, 86 were ineligible, 262 dropped and 1,598 qualified as awardees. There were a total of 8,252 professional growth hours which consisted of workshops/trainings and conferences and 4,133 college units completed by CARES participants.

To promote retention, each year there was a \$250.00 stipend bonus available for awardees who worked at the same site or program for 5 or more years. Out of 594

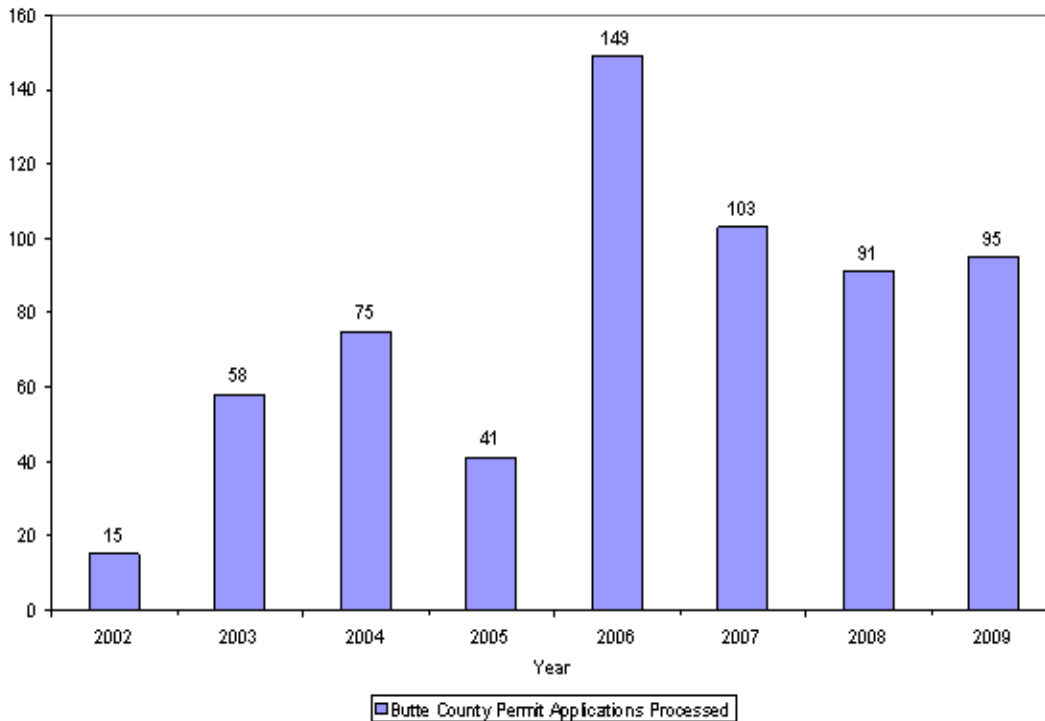
participants, 194 or 32.6% qualified for the stipend bonus (non-duplicated counts of participants).

The table below demonstrates the permit activity in child development according to year, whether the person held the permit, applied or upgraded. Obtaining upgraded status indicates enhanced quality in child development.



The table that follows shows the total number of permit applications processed in Butte County.

### Butte County Permit Applications Processed



## HEALTH

### ***Prenatal Care***

In Butte County, fewer mothers receive early prenatal care compared to the statewide rates: 77% versus 86%. Rates are lowest among Native American mothers, as the table below demonstrates.

### Mothers with Early Prenatal Care

	All	African American	Latino	White	Native American	Other
<b>Butte</b>	77%	74%	73%	81%	69%	*

(Children Now 2007 Scorecard)

More than one quarter (26%) of mothers do not begin prenatal care during the first trimester of pregnancy (California Health Status Profiles, three year average 2005-2007). The state average is 14.9%; Butte County ranks among the lowest counties for this indicator at number 46 (California Health Status Profiles, 3 year average 2005-2007).

According to Children Now, 95% of women receive prenatal care by the end of the second trimester (leaving 5% that do not). Rates are highest among White (97%) and

Latina women (96%) and lower among African American (90%), Asian (92%) and women of other race and ethnicities (91%). (Data from 2005, California Department of Health Services Department of Statistics as analyzed and reported by Children Now 2008)

**Infant Birthweight**

The percentage of low birthweight infants has increased in recent years, from 5.7% to 6.3% (2002-2005 and 2005-2007, respectively). However, the county rate for low birthweight is lower than the rate observed statewide, at 6.9%.

**Infant Mortality**

The infant mortality rate in Butte County was 6.9 per 1,000 for the years 2004-2006, slightly higher than the rate reported for 2002-2005 (6.3 per 1,000). (Please note that the rates reported for Butte County are based on a small number of events and have a relative standard error greater than 23%.) Congruent with data from the state, the rate is highest among Black/African American infants. The rate is also higher than that reported for California (5.3 per 1,000).

**Birth Cohort Infant Death Rate, 2004-2006**

	<i>Birth Cohort Infant Death Rate* Butte County</i>	<i>Birth Cohort Infant Death Rate California</i>
All Races	6.9	5.3
Asian / Pacific Islander	2.3	4.2
Black	19.6	12.3
Hispanic	3.4	5.2
White	8.2	4.7

\*Unreliable; relative standard error greater than 23%. Rates are based on the number of events per 1,000.

**Breastfeeding**

According to the California Department of Health, breastfeeding initiation in Butte County was 87.1%, slightly higher than the rate reported statewide (86.5%). Breastfeeding rates reported by the California Food Policy Advocates also show Butte County slightly above state averages (84.5% compared to 83.7% statewide).

Data on breastfeeding is also available by race and ethnicity. According to Children Now, 68% of Butte County newborns are breastfed exclusively while at the hospital. Rates are highest among White newborns (76%) and lowest among Latino newborns (59%), Asian newborns (30%) and newborns of other race and ethnicities (57%). (Newborn Screening Data 2006, CDHP, as reported by Children Now 2008 California County Scorecard).

**Pediatric Nutrition**

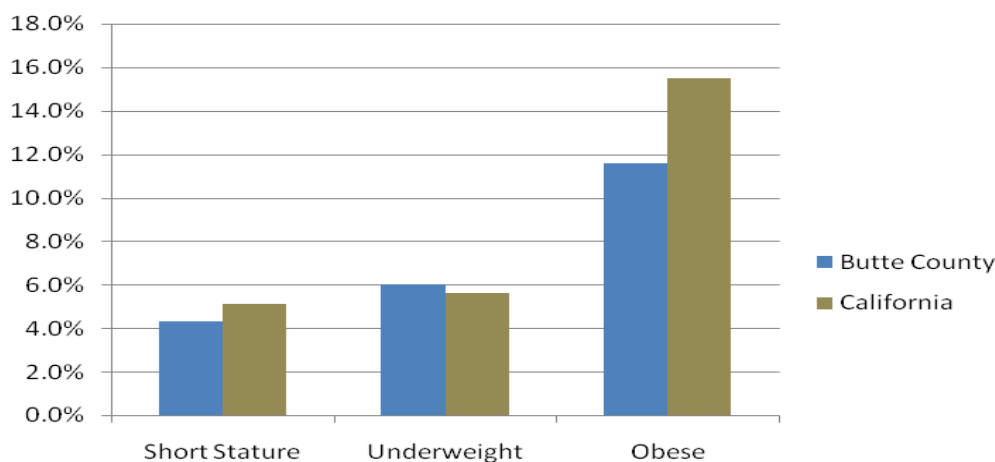
Pediatric nutrition as demonstrated by growth indicators shows that a subset of Butte County children are of short stature (<5th percentile for length-for-age), underweight (<5th percentile for BMI-for-age), or obese, (>95th percentile for BMI-for-age).

Children that are of short stature or are underweight are of concern for the following reasons: short stature can be due to one or more of many abnormal conditions, such as chronic (prolonged) hormone deficiency, malnutrition, disease of a major organ system, mistreatment, and exposure to certain drugs; and, children below the normal weight level may exhibit signs of becoming sick frequently, feeling weak and tired, have difficulty concentrating and have a possible stunt in growth or a postponed growth spurt.

In Butte County 4.3% of children birth to 59 months meet the criteria for short stature, 6.0% are underweight, and 11.6% are obese. Comparing these to statewide averages, Butte County has a higher percentage of children that are underweight, but lower percentages of children that are obese. Blacks (non-Hispanic) have the highest rates of children with short stature (6.3%). White, non-Hispanic children have the highest rates of children that are underweight (6.6%), and Hispanic (Latino) families have the highest rates of children that are obese (16.9%).

Among children older than 2 years in Butte County, 16.6% are overweight (between the 85<sup>th</sup> and 95<sup>th</sup> percentile BMI-for age). The state average for this group is 16%.

### Growth Indicators for Children 0-59 months (2008)



Source: 2008 Pediatric Nutrition Surveillance, Tables 16B, 16C

According to Children Now, nearly three-quarters (72%) of children ages 0-18 in Butte are within the healthy weight zone. However, only 60% of children that are Latino, and 68% of children that are African American or “other” race and ethnicities are within a healthy weight zone (data for 2006-07, California Physical Fitness Test Summary Data Files, as reported by 2008 California County Scorecard, Children Now).

### Health Status

In Butte County 80% of children (ages birth to 18) report “very good” to “excellent” health (CHIS, 2005, as reported by Children Now, 2008 Scorecard). This reflects a countywide improvement in recent years, and Butte ranks well within the state for this indicator.\* However, disparities exist among race and ethnic groups. While 86% of White children report “very good” or “excellent health,” less than half of all Latino children (49%) and African American children (47%) report “very good” or “excellent” health. More than two-thirds (68%) of Asian children and 72% of children with other race/ethnicity report “very good” or “excellent” health. (\*Trend data on from CHIS, 2001, 2003, and 2005 reported by Children Now, 2008 California County Scorecard).

### ***Health Insurance Coverage***

About 90% of children in Butte County have health insurance coverage, a rate lower than many other counties in California. Disparities exist among race and ethnic groups; while more than 93% of children that are White, African American, and Asian have health insurance coverage in the county, only 54% of children that are Latino and 85% of children of other race and ethnic groups have coverage (CHIS 2005, as reported in the 2008 California Scorecard, Children Now).

### ***Oral Health***

Approximately 82% of all children in the county see a dentist regularly. The rate is lower among children that are Latino (71%). (CHIS 2005, as reported in the 2008 California Scorecard, Children Now).

In the recent survey of Butte County kindergarten teachers, the rate of children with visible tooth decay increased between the study years (2005 to 2008). In 2005, kindergarten teachers reported that 10% of children had noticeable tooth decay, compared to 12% in 2008 (*Survey Results Report 2009 First 5 Butte County Children and Families Commission 2008 Kindergarten Teacher Survey*, Gloria J. Wyeth, M.A., Wyeth Consulting January 5, 2009).

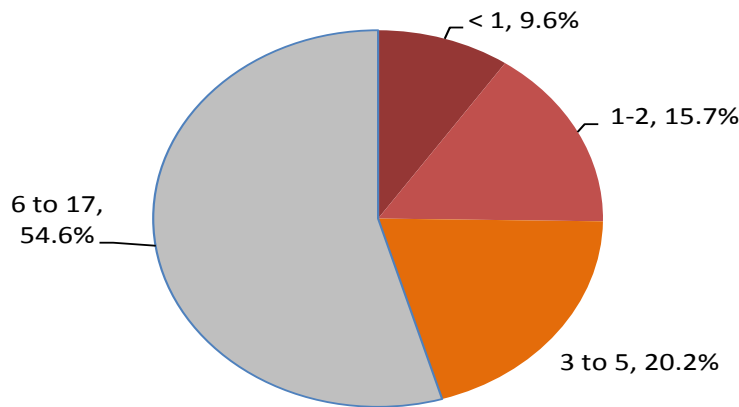
### ***Teen Births***

In Butte County births to adolescent mothers (ages 15 to 19) have declined in recent years from a rate of 30.9 to 28.8 (reported per 1,000, 2002-2005 and 2005-2007, respectively). The teen birthrate of 28.8 is lower than the rate statewide reported at 37.3.

### ***Child Abuse and Neglect***

In Butte County 2008, the youngest children made up nearly half of all children who were abused; 385 children ages 0-5 had substantiated child abuse. Many more had alleged abuse—these rates only reflect those cases that were substantiated.

### Substantiated Child Abuse by Age Group



### Substantiated Child Abuse by Age Group

Age in Years	Children with substantiations in Butte	Percentage of Total (Butte)	Percentage of Total California
< 1	81	9.6%	12.3%
1 to 2	133	15.7%	13.3%
3 to 5	171	20.2%	17.1%
6 to 10	199	23.5%	25.5%
11 to 15	215	25.4%	24.0%
16 to 17	49	5.8%	7.7%
Total	848	100.0%	100%

Source: CSSR, Berkeley [http://cssr.berkeley.edu/ucb\\_childwelfare/RefRates.aspx](http://cssr.berkeley.edu/ucb_childwelfare/RefRates.aspx)

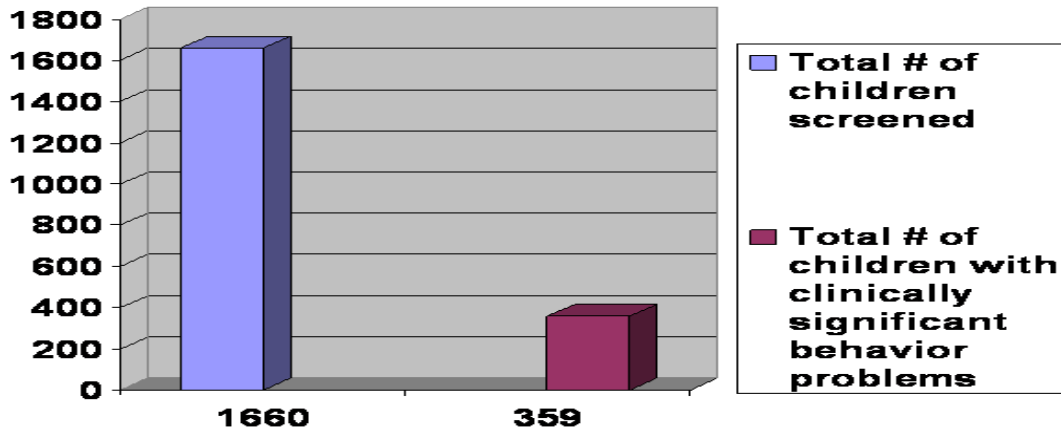
#### **Social and Emotional Well-being**

Among Butte County adolescents, 70% report feeling connected to an adult. Rates are highest among White adolescents (75%) and lower among Latino adolescents (62%), African American adolescents (64%), Asian adolescents (56%) and adolescents from other race and ethnicities (68%). (Data from 2005-07 WestEd as reported by Children Now 2008).

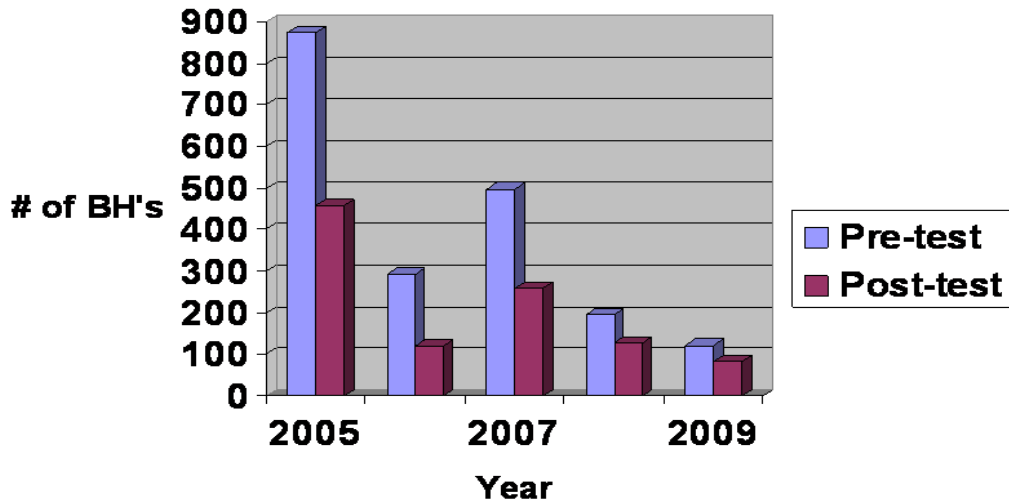
#### **Early Mental Health**

The three tables that follow demonstrate the numbers of children screened, pre and post intervention behavioral problems and the children 0-5 served with therapeutic child care.

### Total # of Children Screened from 2005-2009



### Total # of Clinically Significant Behavior Problems Pre & Post Intervention (Strong Starts Data)



# APPENDIX B. RESOURCE INVESTMENT/SPENDING PLAN

The First 5 Butte County Children and Families Commission completed a process of long range financial planning as a means to develop a spending plan to support its Strategic Plan. The financial plan serves as the guideline for future grant awards but does not authorize, mandate or appropriate funding.

The ten year projection takes into account that Proposition 10 sales tax revenues are predicted to decline regularly each year as efforts to curtail smoking among adults and teens become more effective, and other taxes on tobacco products are levied. The expenditure projections assume a cost of living adjustment each year only for Commission administration costs, but no significant increases.

This Financial Plan and Forecast is updated annually to reflect actual revenue and expenditures, and changing revenue outlooks. The assumptions used in development are reviewed at least annually to ensure their validity and effectiveness.

The funding approach of the Commission is to develop a five year investment strategy that will allocate 90% of revenue to support the three Initiatives and up to 10% of revenue to the discretionary fund. Actual funding by Initiative will be determined based on research and planning conducted during the first phase of implementation.

Discretionary Funding decisions will be made based on the parameters defined by the Commission. Revenue will be available for Fiscal Year 2010-2011.

The Commission will begin Planning for its three Initiatives with a goal to fund the Family Strengthening and Health Initiatives beginning July 2011. Funding for the Oral Health Initiative will carry over into the 2010-2015 plan and the Commission will continue its evaluation and planning activities in 2010. The financial plan can be found in the following chart:

Dollars in Thousands

	1	2	3	4	5
5/4/2010	2010/11 <i>Proposed</i>	2011/12	2012/13	2013/14	2014/15
<b>Beginning Fund Balance</b>	8,480.0	8,201.0	7,707.4	7,156.6	6,563.5
<b>Revenues</b>					
<b>Monthly Disbursements</b>	1,769.2	1,709.3	1,650.5	1,576.8	1,545.3
% increase or decline	8.39	-3.38	-3.44	-4.47	-2.00
<b>Matching Funds Programs</b>	190.0	.0	.0	.0	.0
<b>Surplus Monies Investment Fund (SMIF)</b>	3.0	2.8	2.5	2.3	2.1
<b>Augmentations</b>	8.0	.0	.0	.0	.0
<b>Miscellaneous</b>	.0	.0	.0	.0	.0
<b>Interest Earnings (currently approx 2.25%)</b>	184.5	246.0	269.8	250.5	229.7
<b>Unrealized Loss or Gain (Fair Market Value)</b>					
<b>Total Revenues</b>	2,154.7	1,958.1	1,922.8	1,829.7	1,777.2
<b>Use of Trust Fund</b>	279.0	493.6	550.9	593.1	635.8
<b>Investments/ Commitments/ Spending Plans</b>	2,433.7	2,451.7	2,473.7	2,422.8	2,413.0
<b>Program Contracts</b>	1,440.1	596.1	620.4	494.2	.0
<b>Available Spending Monies, Initiatives</b>	140.0	942.3	865.1	925.0	1,390.8
<b>Available Spending Monies, Discretionary</b>	176.9	170.9	165.1	157.7	154.5
<b>Evaluation Contracts</b>	71.6	47.3	58.7	5.0	5.0
<b>Available Spending Monies, Evaluation Contracts</b>	20.0	109.0	152.1	200.1	193.1
<b>Administration Contracts &amp; Prof. Services</b>	17.1	13.0	13.0	14.0	14.0
<b>Staff Salaries &amp; Benefits</b>	430.9	452.5	475.1	498.9	523.8
<b>Other operating, (before distrib. to any programs)</b>	117.1	120.6	124.2	127.9	131.8
<b>Total Invested/ Committed/ Planned</b>	2,433.7	2,451.7	2,473.7	2,422.8	2,413.0
<i>Program</i>	87%	85%	82%	83%	83%
<i>Evaluation</i>	5%	7%	10%	9%	9%
<i>Administration</i>	8%	8%	8%	8%	8%
<b>Designated for Long-term Sustainability (Revenues &amp; Fund Balance minus Investments)</b>	8,201.0	7,707.4	7,156.6	6,563.5	5,927.7