



STRENGTHENING HOME VISITING SYSTEMS IN CALIFORNIA

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THE ARGUMENT

A five-year, \$24 million investment supported California counties in developing more coordinated home visiting systems, with a focus on partnerships, referral pathways, data sharing, workforce supports, and sustainability planning.

01 | Why this work mattered

California has strong home visiting programs, but not a fully coordinated *system*. Family need outpaced available capacity, while counties navigated multiple models, funders, referral pathways, data requirements, and workforce challenges.

CORE SYSTEM GAPS

- High family need and uneven program capacity
- Fragmented referral pathways and data systems
- Multiple funders, models, and reporting requirements
- Workforce retention, training, and well-being concerns

THE REGIONAL CAPACITY GAP

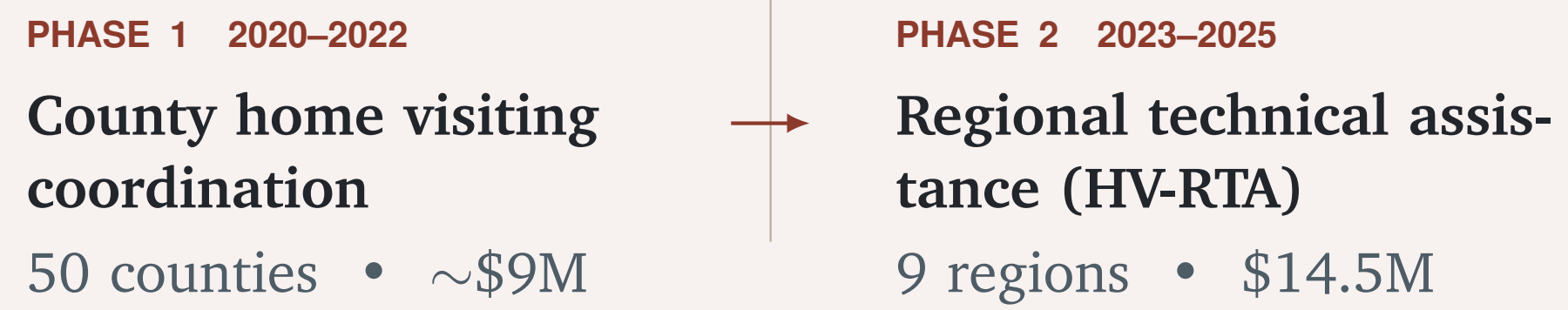


In every region, programs had capacity to serve fewer than one in three eligible low-income families with children under age 3.

Source: Child Trends regional supply-and-demand snapshot.

02 | A two-phase investment

In 2019, First 5 California approved up to **\$24 million over five years** to build a more sustainable, unified home visiting system.



THE DISTINCTION Phase 1 built county capacity. Phase 2 connected counties regionally for peer learning, shared tools, regional planning, and sustainability.

03 | Evidence base

- County and regional Annual Progress Reports
- F5CA Workforce Study: **900+** staff across 48 counties
- Child Trends supply-and-demand mapping and policy analysis
- Children Now and Gina Airey Consulting HV-RTA evaluation
- UC workforce well-being analysis
- Qualitative interviews and implementation reports

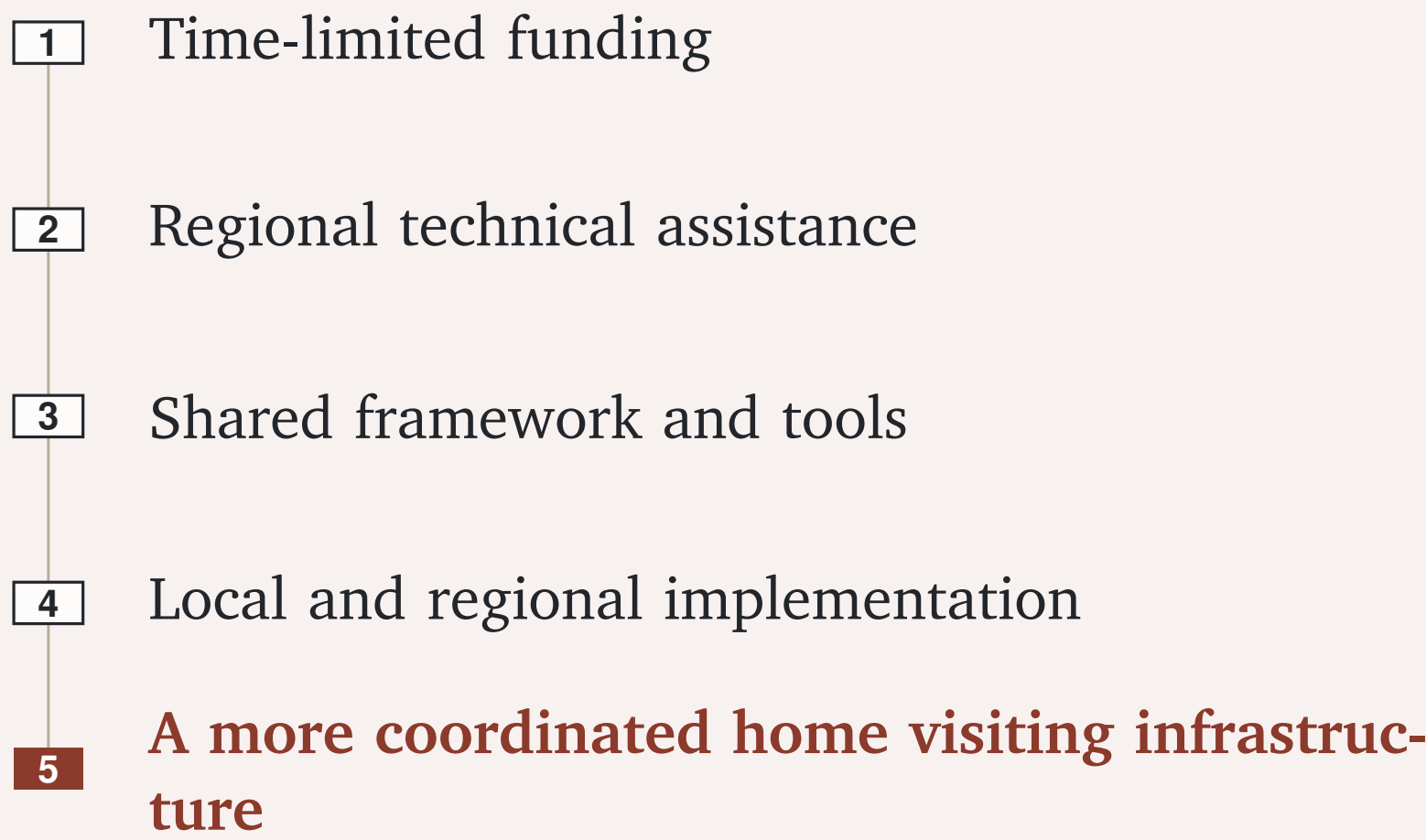
04 | Equity and family voice

Equity was not a separate add-on; it shaped outreach, planning, and workforce strategies.

- Parent leadership and civic engagement strategies
- Language access, trauma-informed practice, and Tribal-language resources
- CHW and Medi-Cal strategies to reach underserved families
- ZIP-code mapping to identify geographic disparities

05 | How change happened

The investment did not only fund services. It funded the *connective tissue* systems change requires: coordination, shared planning, peer learning, and technical assistance.



06 | Five essential components



07 | What regional TA delivered

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REGIONAL GRANTEES	TA DISCUSSIONS	STATEWIDE CONVENINGS	SHARED TOOLS
			Padlet, self-reflection guide

The TA structure created a statewide learning space for counties to share resources, compare strategies, strengthen relationships, and plan for sustainability.

08 | Workforce supports

EVIDENCE Reflective supervision was associated with *higher mindfulness* and *lower depressive symptoms*; supportive supervision was also associated with lower depression over time.

Source: UC workforce well-being analysis.

IN PRACTICE Regions used communities of practice, summits, training hubs, self-care supports, motivational interviewing, trauma-informed practice, and developmental monitoring.

09 | What improved

Regions built practical infrastructure that made coordination concrete.

DATA AND ACCESS

- LA County Data Lake and dashboard
- Santa Clara HVC and ZIP-code mapping
- San Diego Warmline and centralized intake
- “No wrong door” enrollment strategies

PARTNERSHIP AND REFERRAL

- San Diego Family Support Connection workgroups
- Orange County expanded collaborative
- Colusa local consortia and Help Me Grow entry point
- San Mateo quality roadmap

10 | What stuck, what stays fragile

FACILITATORS

- Regional relationships, shared resources, strategic plans
- CHW and Medi-Cal reimbursement exploration
- Local dashboards, regional meetings, resource hubs

FINANCING SUPPORT: FIRST 5 MEDI-CAL LEARNING COMMUNITY

- The First 5 Center’s Medi-Cal learning supports helped county commissions understand managed care, CHW benefits, and health-plan contracting as sustainability pathways.
- Participating counties used the learning community and individualized TA to stay current on Medi-Cal policy, strengthen MCP relationships, and prepare for billing, privacy, security, and contracting requirements.

BARRIERS

- Time-limited funding; loss of coordination staff and incentives
- Reduced funding and capacity constraints
- Ongoing need for TA, advocacy, and managed care contracting support

11 | Implications

- **Invest in infrastructure, not only services.**
- **Use regional structures** to scale peer learning.
- **Center family voice and equity** in planning, outreach, and data.
- **Pair workforce supports** with system coordination.
- **Plan for sustainability from the start:** relationships, data, workforce, and funding strategy together.

References and acknowledgements

KEY SOURCES Children Now & Gina Airey Consulting, *Home Visiting Regional Technical Assistance Final Report*; Children Now, *Five Essential Components to Strengthen Home Visiting*, *Centering Families*; Child Trends snapshots and policy recommendations; First 5 California, *Home Visiting Workforce Study*; UC final report on reflective supervision, mindfulness, and depression; county and regional Annual Progress Reports.

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