Strengthening Home Visiting in Contra Costa County: A Landscape Analysis to Inform System Alignment and Workforce Development

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Prenatal to Five Fiscal Strategies

About Prenatal to Five Fiscal Strategies

Prenatal to Five Fiscal Strategies is a national nonprofit founded by Jeanna Capito and Simon Workman that seeks to address the broken fiscal and governance structures within the prenatal to five system with a comprehensive, cross-agency, cross-service approach. The nonprofit is founded in a set of shared principles that centers on the needs of children, families, providers, and the workforce. This approach fundamentally rethinks the current system to better tackle issues of equity in funding and access.

For more information about P5 Fiscal Strategies, please visit: www.prenatal5fiscal.org

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Executive Summary

Over the past decade, Contra Costa County has expanded and diversified its home visiting system, increasing funding, program models, and service capacity to support families during the critical prenatal-to-five period. This Home Visiting System Analysis, commissioned by First 5 Contra Costa and conducted in partnership with the Home Visiting System Building Collaborative (HVSBC), offers a comprehensive view of the county's current home visiting landscape, identifies persistent service gaps, and outlines strategic opportunities to strengthen the system's infrastructure, workforce, and equity.

The analysis draws from fiscal data, population-level risk indicators, and stakeholder input gathered over a 6-month collaborative process. It reveals a countywide system that has grown more robust, but also more complex — characterized by multiple funding streams, varied eligibility criteria, and fragmented access pathways. The report culminates in a set of system-level recommendations and an implementation plan, anchored in a shared commitment to improving coordination, workforce sustainability, and equitable access for all families.

Major Findings

- **Significant Growth in Funding and Capacity**:
  - Across the county, 20 distinct programs currently offer home visiting, parent education, or related perinatal services as a primary or enhanced service component. These programs are administered by eight entities and implemented by 13 community-based organizations and public agencies.
  - Total home visiting funding increased by 38% from FY24 ($13.6M) to FY25 ($18.8M), accompanied by a 41% increase in estimated enrollment capacity (from 1,735 to 2,441 families). Federal funds, especially through Title XIX (Medi-Cal), became more prominent, while local funding also grew substantially—tripling in share from FY24 to FY25.
- **Programs with Highest Investment and Capacity**:
  - Nurse-Family Partnership (NFP),Child & Family Bond, and Early Head Start (EHS) increased revenue significantly between FY24 and FY25, accounting for 59% of funding and 37% of enrollment capacity in FY25.
  - Of the five programs that focus on parent education and perinatal support, Black Infant Health (BIH) accounted for 48% of enrollment capacity in FY25.
- **Persistent and Emerging Service Gaps**:
  Despite gains, notable gaps remain in serving:
  - First-time parents not eligible for NFP (NFP served only 14% of Medi-Cal–enrolled first-time birthing persons in 2024)
  - Asian American, Pacific Islander, and Indigenous families, who lack culturally tailored home visiting programs
  - Families facing behavioral health risk factors (e.g., prenatal depression or IPV), with only one-third of estimated need met through dyadic mental health home visiting slots
- **System Vulnerabilities**:
  31% of FY25 home visiting funding is tied to Medicaid and CalWORKs — making the system susceptible to federal and state policy shifts. Programs like NFP, Early Connections, and Child & Family Bond will need flexible local and state funding to remain resilient.
- **Workforce Strain and Need for Coordination**:
  HVSBC members emphasized the need for shared core competencies, reflective supervision, and stronger mechanisms for cross-program referrals and coordination. As home visitors confront complex family needs, burnout and turnover remain risks without additional supports.

Recommendations

The Home Visiting System Building Collaborative developed and prioritized strategies through a participatory planning process. The resulting recommendations focus on building long-term system resilience and improving outcomes for families:

1. **Advance Workforce Development** (Selected as a foundational lever for system strengthening):
    - Launch a Home Visiting Workforce Academy to support shared onboarding, training, reflective supervision, and leadership development.
    - Develop sustainable and inclusive career pathways, from high school through advanced credentials.
    - Foster peer connection and learning across agencies through communities of practice and shared training opportunities.
2. **Support System Infrastructure**
    - Strengthen Medi-Cal billing practices, develop shared data systems, and promote coordinated funding strategies.
    - Conduct regular needs assessments and track system performance using both administrative and community-informed data sources.
3. **Improve Equity and Access**
    - Expand access for underserved populations by better aligning models with population needs, supporting culturally relevant programs, and partnering with community-based organizations.
    - Prioritize outreach to families often overlooked in traditional data, including refugees, linguistically isolated households, and justice-involved parents.
4. **Establish Ongoing Governance**
    - Form a Home Visiting System Steering Committee to guide implementation, monitor progress, and maintain cross-agency alignment.
    - Consider an ad hoc working group to oversee the development and launch of the Workforce Academy.
5. **Commit to Continuous Quality Improvement**
    - Routinely assess population-level impact and use findings to refine strategy, reallocate resources, and identify areas for deeper investment.

Introduction

In November 2024 First 5 Contra Costa engaged Prenatal to Five Fiscal Strategies (P5FS) to conduct a landscape analysis of the county's home visiting system. The effort built upon a prior fiscal mapping project supported by First 5 California Home Visiting Coordination funding, through First 5 Policy Center technical assistance, which focused on four evidence-based or evidence-informed home visiting models. That project revealed that Contra Costa's home visiting ecosystem is broader and more complex than initially captured. In response, First 5 Contra Costa contracted directly with P5FS to engage in a discussion series with home visiting and family service leaders and conduct a more comprehensive system analysis of the Contra Costa home visiting system

This report reflects that broader lens. It synthesizes data from public sources, fiscal analysis, and constituent input to assess population need, service capacity, and funding structures in Contra Costa County. Also included is a collaboratively developed implementation plan, created by discussion series partners, to strengthen and align home visiting services in the county.

Approach to Analysis

Between January and May 2025, P5FS facilitated five virtual system-building meetings and one full-day, in-person retreat with home visiting constituents across the county. Throughout this report, this group is referred to as the Home Visiting System Building Collaborative (HVSBC). The meetings served three purposes: (1) to foster a shared understanding of the county's home visiting programs and system infrastructure; (2) to reflect on strengths, gaps, and opportunities for alignment; and (3) to develop an action plan that sets direction for coordination and system growth. The roster of participants in this discussion group can be found in the appendices.

Between meetings, P5FS conducted individual follow-up interviews and gathered program-specific information from participating agencies to supplement fiscal and enrollment data. The final in-person convening marked the culmination of this process and produced a roadmap of strategies, milestones, and action steps to guide the county's home visiting system-building work over the next three to five years.

This report is not intended as a static description of services or need. Rather, it weaves together population-level data, fiscal analysis, and insights from local program implementers to inform actionable opportunities to strengthen Contra Costa's home visiting system.

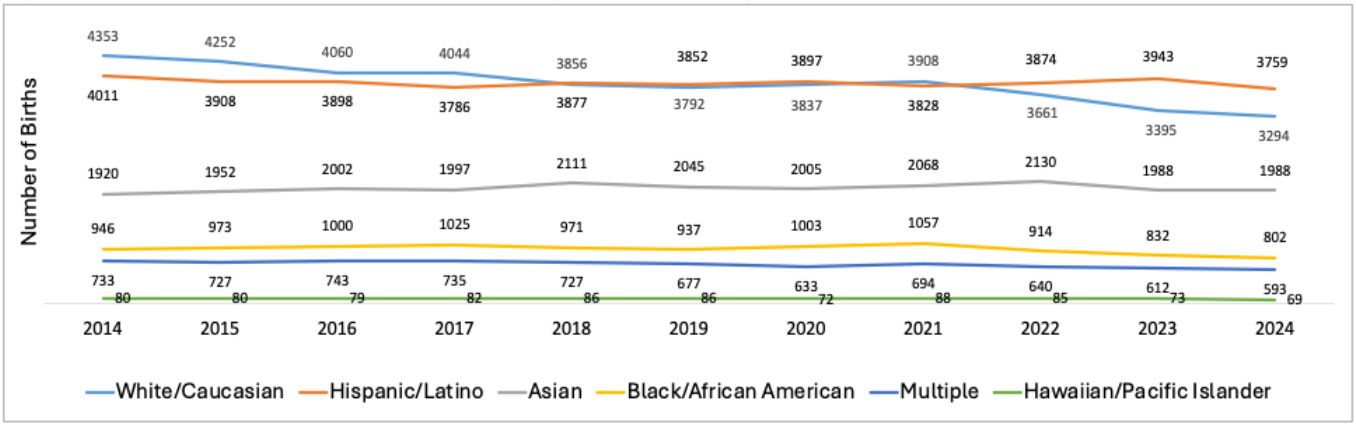
I. Birthing Population Overview

Birth Trends and Demographic Shifts

Between 2014 and 2024, the number of births in Contra Costa County declined by 13%, from 12,503 total births to 10,844. The most significant drop occurred among White birthing persons, whose birth numbers fell by 24% over the decade. Meanwhile, births among Asian families increased slightly (4%), and birth rates among other groups remained relatively stable. As a result of these shifts, Latino births now outnumber White births annually — reversing the dynamic from a decade ago.

Although the COVID-19 pandemic caused a temporary uptick in births across most racial and ethnic groups, the county has resumed a downward trend since 2022[1].

Figure 1: Births to Contra Costa Residents, by Race/Ethnicity, 2014-2024



Medi-Cal coverage among infants under age 1 has fluctuated over the past decade, from a high of 46.7% in 2015 to a low of 39.4% in 2020. Rates began to rise again between 2022 and 2024, reflecting both economic conditions and eligibility expansions.[2]

[1] California Comprehensive Birth Files 2014–2024, California Birth Reallocation Files 2014–2024, accessed through the Vital Records Business Information System (VRBIS) by Contra Costa Health.

[2] California Health & Human Services; Medi-Cal Eligibility Data System (MEDS) https://data.chhs.ca.gov/dataset/eligible-individuals-under-age-21-enrolled-in-medi-cal-by-county/resource/08ecb2a4-1e1d-45d2-8354-cbd5389cd43d

Adolescent Births: A Case Study in Data-Informed Strategy

Adolescent births have declined sharply, falling 52% between 2014 and 2024. However, teen birthing persons continue to face significant socioeconomic disadvantages. According to data from the 2019-2021 Maternal and Infant Health Assessment survey for Contra Costa County, an estimated 99% of adolescent birthing persons live below 100% of the Federal Poverty Level — a higher proportion than any other demographic group. For comparison, 58% of Medi-Cal birthing persons and 61% of WIC participants fall within this income threshold.[1]

In 2024, 71% of adolescent birthing persons in the county resided in zip codes ranked below the 50th percentile on the California Healthy Places Index (HPI), underscoring their exposure to structural and environmental risk factors.[1] These indicators help illustrate the unique needs of this subgroup and the potential for targeted support.

The Adolescent Family Life Program, administered by Contra Costa Health and funded by the Title V Maternal and Child Health Block Grant, is currently the only home visiting program designed specifically for adolescent birthing persons. With a budget of roughly $240,000, the program reaches about 25% of eligible adolescent birthing persons in the county. An additional $250,000-$300,000 investment — whether through Title V expansion, flexible local funds, or philanthropy — could potentially double the program's reach, improving outcomes and disrupting intergenerational cycles of disadvantage.

This case reflects the HVSBC's approach: combining demographic insights, fiscal context, and programmatic realities to identify concrete, high-impact opportunities for system strengthening.

II. Key Environmental and Policy Shifts, 2000–2024

Understanding the evolution of Contra Costa's home visiting system requires attention to broader contextual shifts — both policy-based and demographic — that have shaped family well-being, public health priorities, and funding availability over the past two decades. This section outlines key demographic and economic changes and the resulting service gaps, followed by a discussion of how public agencies and community partners have adapted in response. Section III then provides a comprehensive overview of the current system and the organizations involved.

Demographic and Economic Change

In 2017, the Urban Displacement Project published an analysis of demographic and housing trends in Contra Costa County, detailing the relationship between rising rents, regional economic pressures, and the displacement of low-income households of color between 2000 and 2015.During this period, the county experienced a 55% increase in low-income households of color — a rate substantially higher than the regional average. The geography of this shift varied: Richmond's low-income Black population declined while its low-income Hispanic population grew, and cities such as Antioch and Pittsburg saw large increases in low-income Asian, Black, and Hispanic households. During the same period, inflation-adjusted median rents rose by more than 30% in several parts of the county, including Brentwood, Concord, Richmond, Pittsburg, and Hercules. These economic shifts disproportionately

impacted communities of color. Notably, rent increases did not significantly affect low-income White households, suggesting a racially disparate impact of economic pressures.[3]

Service Concentration and Geographic Gaps

Public investment and service delivery have historically concentrated in the central and western regions of the county. Meanwhile, growth in the eastern region, especially Antioch and the surrounding areas, has outpaced the expansion of services. The California Healthy Places Index ranks Antioch in the bottom 10%–15% of California communities in terms of community conditions that support health and well-being. In contrast, the county overall ranks in the 92nd percentile, highlighting intra-county disparities in opportunity and infrastructure.

These geographic imbalances were formally recognized in 2022, when Contra Costa County developed a Comprehensive Prevention Plan as part of its implementation of the Family First Prevention Services Act. The plan highlighted the need to expand access to family support, parenting education, and behavioral health services in East County, with a particular focus on Antioch.[4]

Shifting Roles and Funding Strategies

As intra-county disparities became more pronounced over the past two decades, many agencies across Contra Costa County adjusted their strategies to better meet family needs. Among them, First 5 Contra Costa, the Family and Maternal Child Health (FMCH) Department at Contra Costa Health (CC Health), the Employment and Human Services Department's (EHSD) Children and Family Services (CFS) division, and several early childhood behavioral health providers undertook notable shifts in infrastructure and funding approaches. While not an exhaustive list of system actors, the examples below illustrate the types of strategic adaptations that have shaped the county's evolving home visiting landscape. Section III expands this view by detailing the full range of programs and implementing organizations active in Fiscal Year 2025.

Historically, First 5 Contra Costa served as a funder of home visiting services, supporting the implementation of Welcome Home Baby. Over the past five years, however, First 5 has strategically shifted from direct service funding to focus on system mapping, coordination, and capacity-building. It has played a key role in helping local organizations connect to other funding sources, such as Measure X, and in building bridges between home visiting providers and the county's Family Resource Centers to strengthen coordination and connect families with resources.

The role of the Family and Maternal Child Health (FMCH) Department at Contra Costa Health (CC Health) has also evolved. In recent years, the department has secured Perinatal Equity Initiative (PEI) funds to launch community-based doula services and a Black fatherhood initiative aimed at addressing racial disparities in perinatal outcomes.

The Employment and Human Services Department's (EHSD) Children and Family Services (CFS) division has made substantial strides in infrastructure development. Over the past three years, CFS has used Family First Prevention Services Act (FFPSA) funds to build internal capacity and prepare to draw

[3] Urban Displacement Project & University of California, Berkeley. Contra Costa County Regional Early Warning Toolkit (2017). Retrieved from https://www.urbandisplacement.org/wp-content/uploads/2021/08/cc_final10_26.pdf

[4] Contra Costa County Employment and Human Services Department. (2023, July). *Comprehensive Prevention Plan*. Retrieved from https://www.caltrin.org/wp-content/uploads/2023/07/Contra-Costa-CPP-7.24.23.pdf

down Title IV-E dollars. This has included training staff in evidence-based practices such as Motivational Interviewing and investing in group-based parent education through programs like the Nurturing Parenting Program led by the Child Abuse Prevention Council.[5]

Additionally, early childhood mental health providers have expanded both their service scope and funding base in recent years, often with creativity and resilience, but not without strain. We Care Children's Services and Early Childhood Mental Health Program — two of the county's three major early childhood mental health providers — have leveraged new state resources, including grants from the Children and Youth Behavioral Health Initiative (CYBHI), to enhance service delivery. With this funding, they have implemented new home visiting programs, such as Parents as Teachers (PAT), and expanded access by providing home visiting and dyadic therapy services to families previously ineligible due to Medi-Cal enrollment requirements. Yet, the reliance on short-term grants and continuous pursuit of new funding sources places these organizations in a vulnerable position. For instance, with CYBHI funds set to sunset, providers are actively seeking ways to sustain services like PAT. These efforts illustrate both the growing convergence of behavioral health and home visiting supports and the critical need for stable, long-term investments to ensure continuity of care for families with young children..

Together, these policy shifts and funding strategies reflect a more diversified and dynamic landscape — one that offers increased opportunity for alignment, shared investment, and the emergence of a more integrated system.

III. Current Home Visiting System

Today, Contra Costa County's home visiting landscape is broad and multifaceted. For the purposes of this analysis, the term *home visiting system* includes not only traditional evidence-based and practice-informed home visiting models, but also group-based parent education programs and perinatal supports such as doula services. While these interventions differ in structure, they share a common goal: to promote parent and child well-being during the prenatal and early childhood periods. By including these related services, the HVSBC applied a more inclusive lens to reflect the supports families often engage with before, during, and after home visiting.

Across the county, 20 distinct programs currently offer home visiting, parent education, or related perinatal services as a primary or enhanced service component. These programs are administered by eight entities and implemented by 13 community-based organizations and public agencies, with an estimated combined capacity to serve approximately 2,500 families with children under the age of five per year.

If current birth trends persist, Contra Costa County is projected to have approximately 10,225 birthing persons in 2025 (measured as unique birthing individuals, not total births). This means that, in theory, up to 23% of pregnant and parenting persons could access some form of home visiting or parent education service. However, when accounting for program eligibility requirements and target population criteria — including income thresholds, age limits, or referral pathways — this estimated reach is substantially lower for some population subgroups.

[5] Ana Kaye and Alysia Dellaserra (Contra Costa County Children and Family Services), virtual meeting, April 4, 2025.

It is also important to note that the estimated 2,500 enrollment slots do not equate to 2,500 unique families served. Many families engage with more than one program across the perinatal and early parenting period. For example, a mother may receive support from CoCo Doulas and later transition into Early Head Start, while her partner participates in the Fatherhood Initiative — meaning three slots may be attributed to one family. This is not duplication, but rather families navigating a complex system to meet a continuum of needs. While 2,500 slots may seem substantial, it only begins to address the level of support needed across the county, particularly given eligibility limitations and high levels of risk in some communities.

Table 1 provides an overview of available programs for pregnant and parenting families in Fiscal Year 2025. These include:

- **Group-based parent education and perinatal support programs** (e.g., Black Infant Health, Nurturing Parenting Program, and doula services),
- **Evidence-based and practice-informed home visiting models** (e.g., Nurse-Family Partnership, Parents as Teachers),
- **Specialty home visiting programs** targeted to families involved with the child welfare system, affected by substance use or mental health challenges, or experiencing complex risk factors.

While most of the programs listed are designed for families with children from the prenatal stage through age five, some also serve families with older children and are not exclusively tailored to the birth-to-five population (e.g., Nurturing Parenting Program). However, these related programs remain important components of the larger ecosystem of services accessed by families with young children. This list may not capture every parent education program in the county, but it reflects a reasonably comprehensive picture of the services most connected to and coordinated with home visiting infrastructure.

Table 1: Programs for Pregnant and Parenting Families, Fiscal Year 2025

Program	Eligibility	Program Duration	Administering Entity*	Implementor*	Capacity**
Group-based intervention, parenting classes and consultation, delivery support					
Black Infant Health	Black women, 16 and older, pregnant or postpartum with infants up to 6 months old	20 weeks	CC Health	CC Health	320
Nurturing Parenting Program	Families receiving social services	15-22 weeks	Children & Family Services	Youth Services Bureau; CAPC	180
Fatherhood Initiative	Black fathers with infants ages birth-1	12 weeks	CC Health	Aspiranet	50
Coco Doulas	Black birthing persons	Up to 13 months	CC Health	FIERCE Advocates	120
Triple P	Varies based on Triple P service	Varies	C.O.P.E.	C.O.P.E.	
Evidence-based, evidence-informed, practice-informed home visiting					
Prenatal Care Guidance	Unrestricted, typically Medi-Cal	3 visits	CC Health	CC Health	250

Program	Eligibility	Program Duration	Administering Entity*	Implementor*	Capacity**
Everyday Moments	None	6 weeks	We Care	We Care; VistAbility	100
Adolescent Family Life Program	Birthing persons aged 21 or younger	12-24 months	CC Health	CC Health	50
Nurse Family Partnership	First time moms; 28 weeks pregnant or less; Medi-Cal eligible	Up to 30 months	CC Health	CC Health	230
Parents as Teachers (Thrive)	Low-income families pregnancy - K	Up to 3 years	We Care	We Care	75
Perinatal & Attachment Therapy	Paid service unless Medi-Cal eligible client	Up to 6 weeks postpartum	We Care	We Care	30
Early Connections	Medi-Cal EPSDT	24 weeks	We Care	We Care	200
Perinatal Circle of Care	None	Pregnancy – age 1	Early Childhood Mental Health Program	Early Childhood Mental Health Program	96
Child & Family Bond	Medi-Cal EPSDT	24 weeks	Early Childhood Mental Health Program	Early Childhood Mental Health Program	300
Early Head Start	Gross income at or below 100% of FPL	Pregnancy – age 3	EHSD, CSB; Unity Council	Unity Council; Aspiranet	370
Specialty home visiting related to child welfare services, SUD, mental health services					
Differential Response	Referred from child welfare services	6 months	Children & Family Services	Youth Services Bureau; Catholic Charities; Pacific Clinics	
Family Preservation	Referred from child welfare services	6 weeks	Children & Family Services	Pacific Clinics	70
Intensive Family Services & Family Maintenance	Referred from child welfare services	6 months	Children & Family Services	Children & Family Services	
Parent Child Support Services	CalWORKs; Referred for SUD/mental health	Varies	VistAbility	VistAbility	
Intensive Care Coordination	Referred from Children & Family Services	Varies	VistAbility	VistAbility	

Program	Eligibility	Program Duration	Administering Entity*	Implementor*	Capacity**
* The terms *Administering Entity* and *Implementor* are used to distinguish between agencies that manage funding and infrastructure (Administering Entity) and those that deliver direct services (Implementor). In many instances, a single agency serves both roles.					
***In instances in which capacity was left blank, capacity data was not furnished.*					

These programs differ not only in service delivery model, but also in duration and intensity. Most are short-term: 60% of all listed programs last six months or less. Only six programs offer services for one year or longer. This variation has implications for both program planning and potential long-term impact of home visiting services.

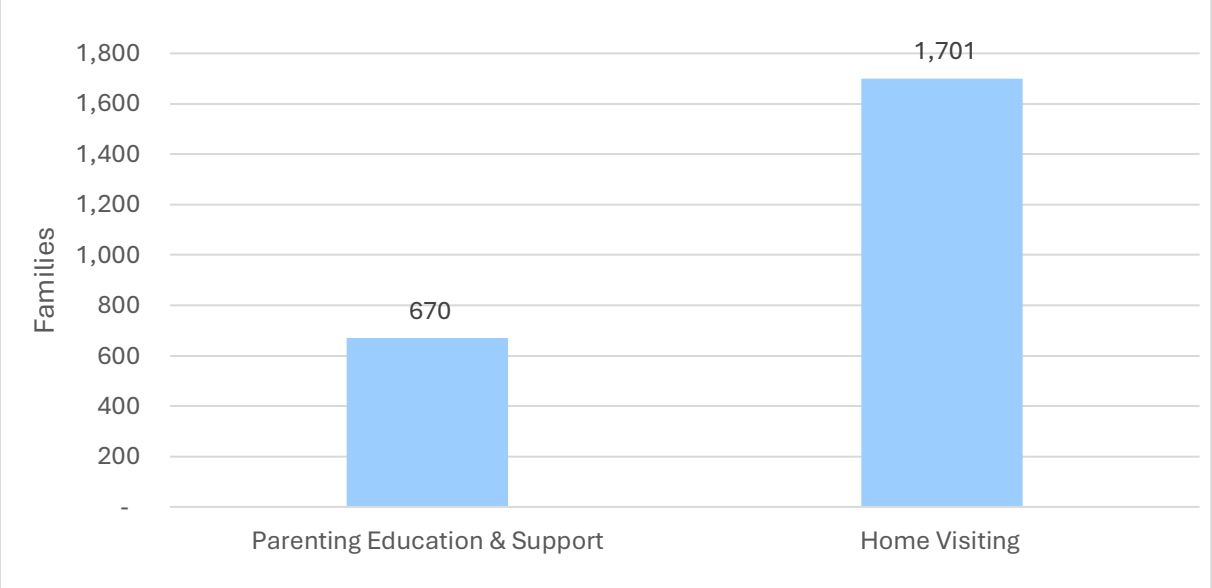
The Department of Children and Family Services (CFS), in the Employment and Human Services Department, plays a central role in the county's specialty home visiting landscape. CFS directly implements two post-court programs — Intensive Family Services and Family Maintenance — and subcontracts with Youth Services Bureau, Catholic Charities, and Pacific Clinics to operate Differential Response and Family Preservation services. CFS also serves as a referral partner to VistAbility's Parent Child Support Services and Intensive Care Coordination programs, which provide home-based support for families navigating reunification or significant hardship such as substance use disorder.[6]

Three agencies — We Care Children's Services, Early Childhood Mental Health Program, and VistAbility — anchor the county's early childhood mental health home visiting capacity. These organizations leverage EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) funding via contracts with the county's behavioral health department to provide home-based dyadic therapy for Medi-Cal-eligible children and families. These services meet the definition of home visiting in that they involve regular in-home contact with a provider trained in infant and early childhood mental health, though they differ from traditional home visiting in their clinical scope and funding mechanism. Additional details on EPSDT billing and coverage are included in the Funding Landscape section.

Among the estimated 2,300 to 2,500 families served annually through parent education and home visiting, approximately 28% participate in group-based or parent education programming, while the remaining 72% are enrolled in home visiting or dyadic therapy models. Within the non-home visiting category, Black Infant Health accounts for approximately half of all families served. Within home visiting, four programs — Early Head Start, Nurse-Family Partnership, Early Connections, and Child & Family Bond — comprise 65% of the total capacity, despite representing only 40% of the non-specialty home visiting offerings.

[6] Because complete data were not available from CFS, capacity numbers for specialty child welfare-related home visiting programs are not included in this estimate.

Figure 2: Annual Service Capacity, by Program Type, FY25



Fragmentation and Cross-Agency Awareness

While the scale of services in Contra Costa County is not insignificant — nearly one in four birthing persons could plausibly access home visiting or parent education[7] — the absence of system coordination remains a challenge. The county lacks a central coordinating body, shared referral infrastructure, and common planning or assessment framework. As a result, it is difficult to determine whether families are being matched to the programs that best align with their needs, or to what extent families are aware of the available options.

This service gap was discussed throughout the HVSBC discussion series. Many program directors, supervisors, and frontline home visitors shared that they were unaware of home visiting or parent education programs outside of their own organizations. In fact, the convenings marked the first time the two Early Head Start grantees had discussed aligning recruitment and enrollment practices. This underscores a critical opportunity: Greater awareness of program models, eligibility criteria, and funding streams can significantly strengthen referral pathways and improve families' access to the most appropriate supports.

IV. Funding Landscape

Contra Costa County's home visiting and parent education system is supported by a diverse mix of federal, state, and local funds. This section provides an overview of total funding, key funding streams, and how those resources are allocated across programs and implementing organizations.

[7] This theoretical reach does not reflect actual or equitable access. Families often move through multiple programs to meet different needs at different times, and some slots serve as feeder services rather than long-term interventions. Moreover, substantial variation in program eligibility, target populations, and intensity means that many families with significant need remain unserved.

In Fiscal Year 2025, 17 distinct funding sources supported home visiting, parent education, or perinatal services. These totaled $18.8 million, with Title XIX Medicaid (Medi-Cal) match representing the largest single source. In fact, Title XIX dollars exceeded the next largest funding stream (Office of Head Start) by 64%.[8]

Key Funding Streams and Flow of Funds

Funding flows vary by source. In some cases, federal dollars are passed through state agencies before reaching counties or local implementing partners. In others, local departments draw down reimbursements or match dollars directly from the federal source. The most commonly leveraged sources include:

- Title XIX Medicaid (Medi-Cal): Accessed directly by some programs (e.g., Nurse-Family Partnership) or through contracts with Behavioral Health for EPSDT services (e.g., We Care, ECMHP).
- Office of Head Start: Provides federal funds to Early Head Start grantees (EHSD and Unity Council).
- State General Funds (SGF): Flow through the California Department of Public Health (CDPH) to support programs such as Black Infant Health and Adolescent Family Life Program.
- CalWORKs: Used by EHSD to support Early Head Start expansion.
- CYBHI (Children and Youth Behavioral Health Initiative): One-time state investment leveraged in FY25 by Early Childhood Mental Health Program and We Care.

One notable funding mechanism — Medi-Cal Specialty Mental Health Services (SMHS) or EPSDT (Early and Periodic Screening, Diagnostic and Treatment) via County Behavioral Health — is used by Contra Costa's three early childhood mental health providers to deliver home-based, dyadic therapy to Medi-Cal-eligible families. These services are funded through a county behavioral health contract, which blends federal, state, and local dollars as shown in Table 2.

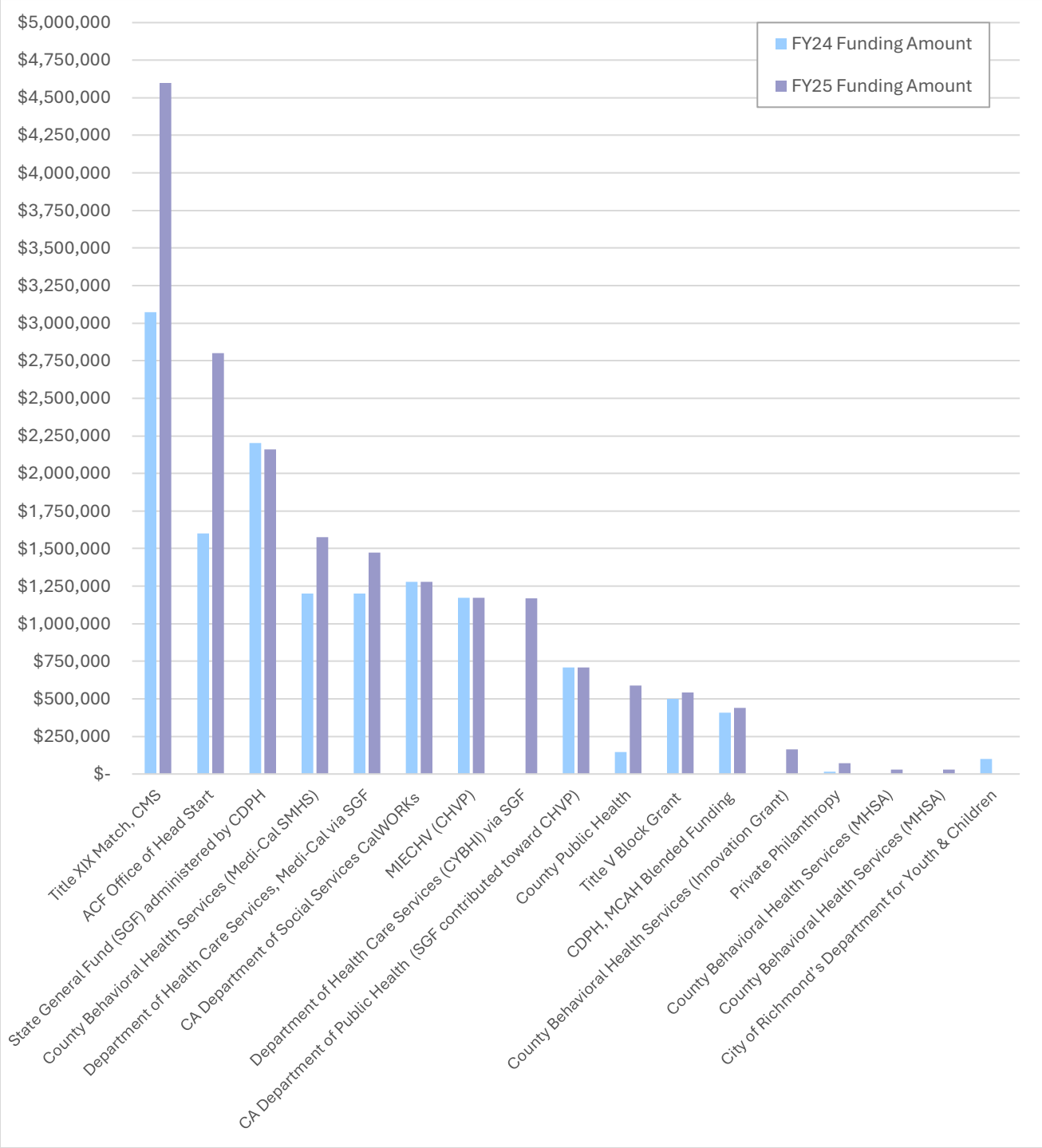
Table 2: EPSDT Funding Breakdown

Funding Stream	Description	Typical Share
Title XIX (Federal Medicaid)	Covers 50% of allowable EPSDT costs for children under 21	~50%
State General Fund (SGF)	Covers 50% of the non-federal share (i.e., 25% of the total cost)	~25%
County Behavioral Health Funds	Covers remaining 25% as local match, drawn from 1991 and 2011 Realignment (sales tax, VLF revenue)	~25%

This EPSDT cost-sharing model underpins key programs such as Perinatal & Attachment Therapy, Early Connections and Child & Family Bond, which together account for nearly one-third the county's home visiting funding in FY25.

[8] Funding totals account for 13 of the 20 programs referenced in this brief. Fiscal data were not available for Triple P, Parent Child Support Services, Intensive Care Coordination, or the four specialty home visiting programs offered by Children & Family Services (Differential Response, Intensive Family Services, Family Maintenance, Family Preservation).

Figure 3: Funding by Source, FY24 and FY25



System Growth and Program-Level Funding Shifts, FY24-FY25

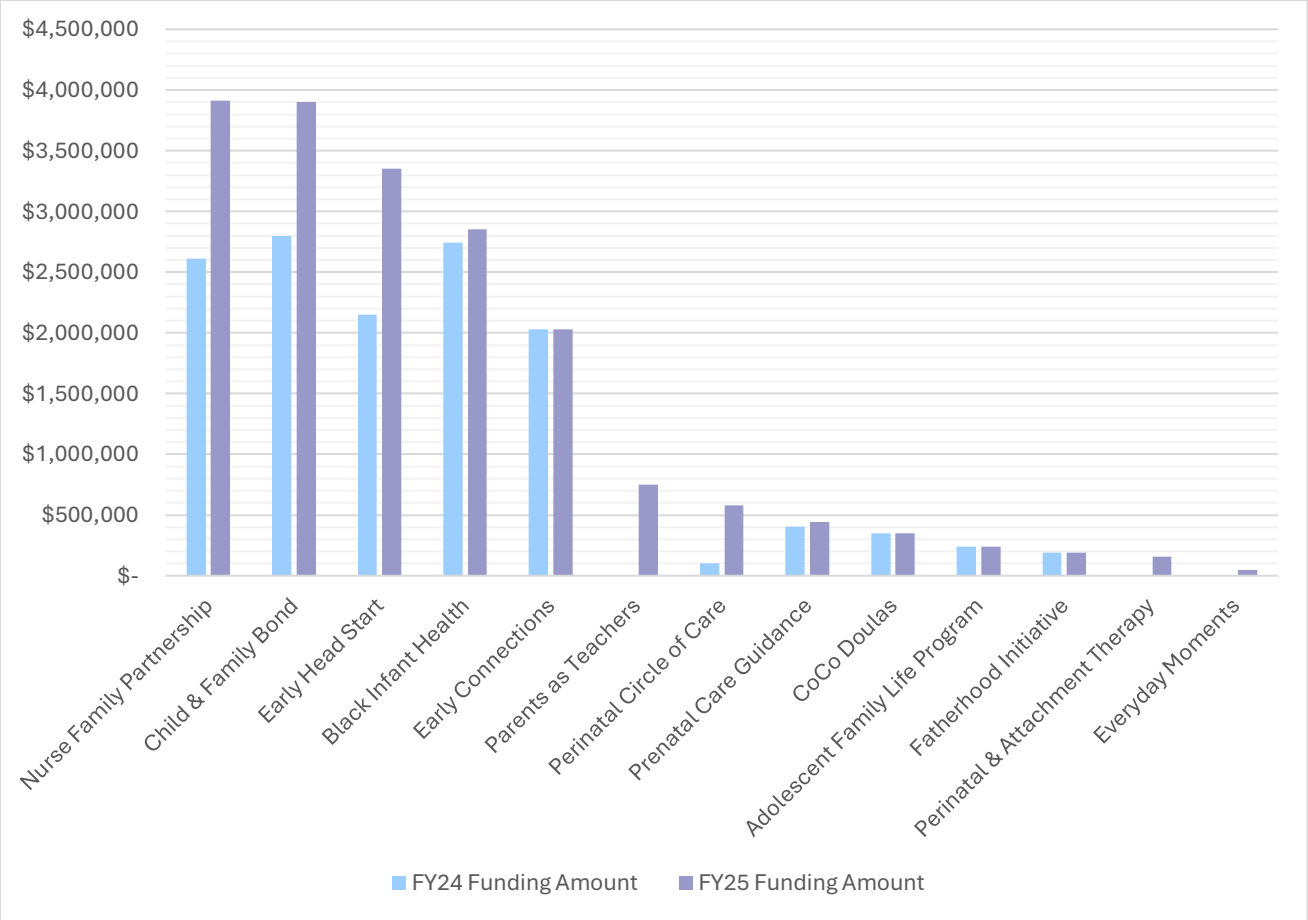
Between FY24 and FY25, home visiting and parenting-related funding in Contra Costa County grew by $5.2 million — a 38% increase. This growth was driven by new revenue streams and expanded use of existing funds, including:

- Nurse-Family Partnership (NFP) leveraged Title XIX match for the first time, leading to a 50% budget increase.
- Early Childhood Mental Health Program's Perinatal Circle of Care began drawing CYBHI funds, which nearly quintupled the program's budget.
- Unity Council received its first EHS home-based contract in Contra Costa, contributing to a 56% increase in EHS funding countywide.

Five programs — NFP, BIH, Early Connections, Child & Family Bond, and EHS — accounted for 85% of the $18.8 million of tracked revenue in FY25, with NFP and Child & Family Bond each receiving $3.9 million.

Figure 4 depicts total funding by program in both FY24 and FY25 and highlights notable revenue increases between the two fiscal years. Seven of the 20 programs referenced previously in this brief are not included in the table, as fiscal data were not available.

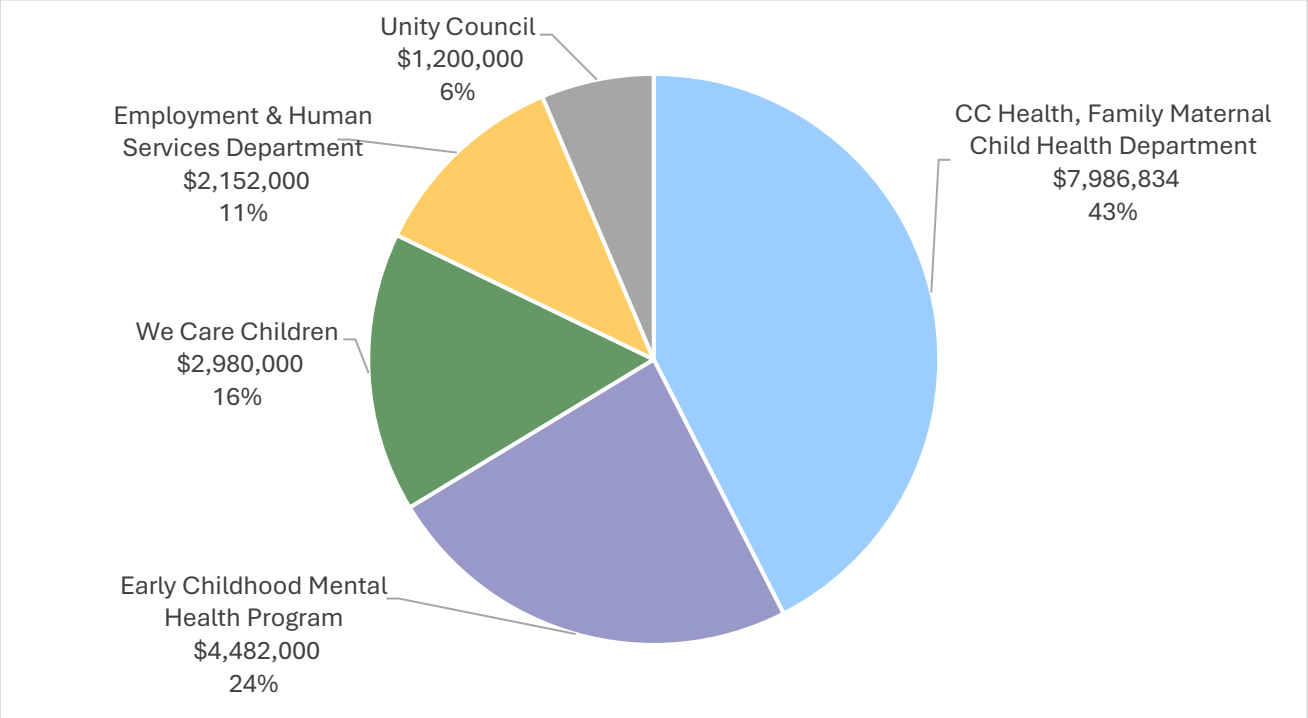
Figure 4: Funding by Program, FY24 and FY25



Organizational Footprint

Funding is concentrated among a small number of implementing organizations. Contra Costa Health's Family, Maternal and Child Health (FMCH) division received over 40% of all tracked revenue in FY25, followed by Early Childhood Mental Health Program, We Care Children, and the Employment and Human Services Department, Community Services Bureau. These four agencies collectively account for the majority of direct service funding, as shown in Figure 5, highlighting their central role in the county's home visiting and perinatal support infrastructure.

Figure 5: FY25 Funding, by Agency



It is important to note that fiscal data were not available from three of the eight agencies that administer home visiting and parent services – C.O.P.E., VistAbility, and Children and Family Services (CFS) – at the time of analysis. As such, their funding contributions are not reflected in the figures or visuals.[9] This limitation may understate the total investment in home visiting and the system footprint of these organizations, particularly in the areas of parent education and child welfare-related home visiting.

Source of Funds and Implications for Sustainability

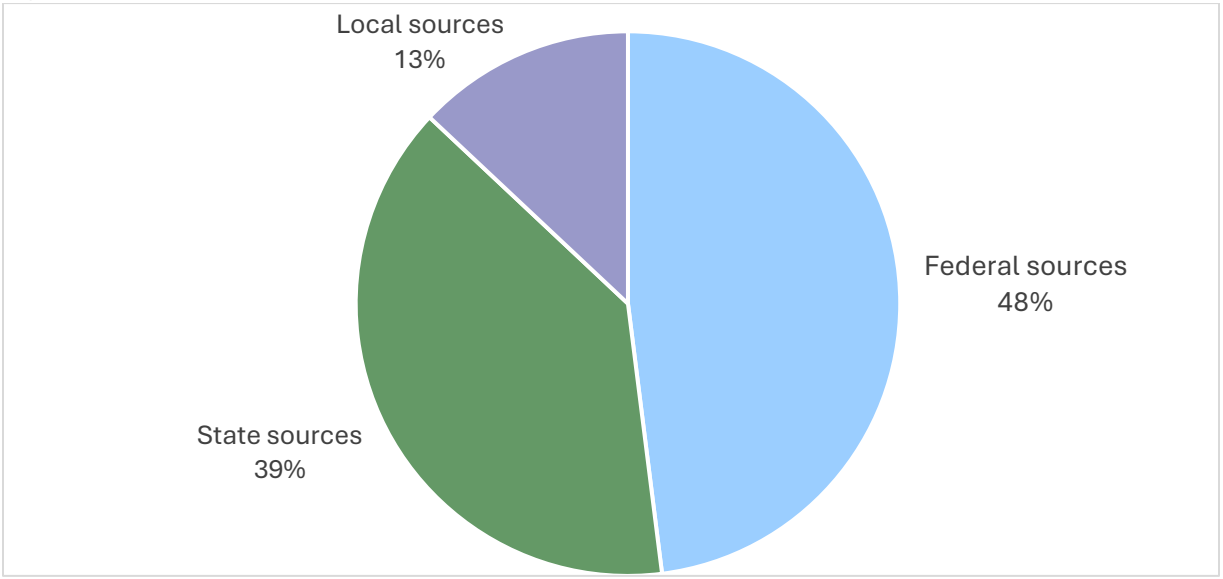
Changes in funding composition between FY24 and FY25 included:

- Federal funding grew from $6.3M to $9.1M — a 44% increase.
- State funding increased at a more modest rate.
- Local funding rose by 66%, driven largely by FMCH's $521K local investment in NFP.

[9] While programmatic information was collected for these organizations, fiscal data were not submitted in time to be included in the FY25 funding analysis.

As a result, in FY25, nearly half of funding came from federal resources, and two fifths from states sources. The remainder came from local sources, as shown in Figure 6.

Figure 6: Source of Funds, FY25



Fiscal Vulnerability: Anticipating Federal Shifts

Contra Costa County's growing reliance on federal funding — particularly Medicaid (Title XIX) and CalWORKs — raises potential vulnerabilities. While these funding streams have enabled important system expansion, they remain susceptible to federal and state-level policy changes that could impact eligibility criteria or administrative flexibility.

In Contra Costa County:

- 31% of FY25 home visiting and parenting-related funding is directly tied to these two streams.
- While major reductions are not imminent, even incremental policy shifts could create operational challenges for county programs.

Maintaining or expanding access to flexible state and local funds, especially for foundational programs like Nurse-Family Partnership, Early Connections, and Perinatal Circle of Care, will be critical to ensuring system resilience. In addition, the county can strengthen sustainability by exploring alternative funding mechanisms, such as:

- Leveraging Medi-Cal benefits such as Enhanced Care Management (ECM), Community Health Worker, or doula services
- Partnering with Medi-Cal managed care plans to integrate key home visiting functions into their service delivery and billing

Such strategies can embed core supports such as care coordination, mental health services, and parent education more deeply into the healthcare delivery system, reducing reliance on vulnerable categorical funds and building a more robust infrastructure for family support.

V. Assessing Home Visiting Need and Capacity

Understanding where and for whom home visiting services are most needed, and whether current programs are equipped to meet that need, is essential to guiding home visiting system development in Contra Costa County. This section presents a risk factor analysis for the birthing population, a summary of home visiting program capacity, and a preliminary gap analysis.

Prenatal Risk Factor Analysis

To estimate the size and characteristics of the population that may benefit from home visiting, this analysis draws on three core data sources:

- Medi-Cal enrollment as a proxy for elevated risk;
- The Maternal and Infant Health Assessment (MIHA) for insights into social, emotional, and behavioral risk factors;
- Healthy Places Index (HPI) data to assess neighborhood-level social determinants of health.

Each dataset provides a different lens into the socioeconomic and health-related risks experienced by birthing persons in the county. These data and the factors they represent are frequently indicative of families that are further from opportunity and thus may benefit from the programming offered in home visiting, parent education and perinatal support services.

Data were derived from the California Department of Public Health's MIHA dashboard and the county's birth file records for 2019–2021. MIHA data, collected from a stratified sample of birthing persons in the county (N=11,700 over the 2019–2021 period), were used to identify key risk indicators. While the original data are weighted to ensure population-level estimates, this report presents illustrative ratios based on the underlying survey counts. Where indicators are stratified by prenatal care payment source (i.e., Medi-Cal vs. non-Medi-Cal), this brief uses estimated subgroup totals to demonstrate directional differences in risk prevalence. For example, 80% of those who reported experiencing intimate partner violence (IPV) during pregnancy were enrolled in Medi-Cal, even though just 5% of all survey respondents reported experiencing IPV during pregnancy. These findings illustrate the degree to which Medi-Cal enrollment is a strong proxy for elevated risk across multiple indicators. Table x delineates this higher rate of risk indicators, among Medi-Cal population, compared to birthing population, and adds the dimension of those pregnancies at or below 100% of the federal poverty level.

Table 3: Risk Indicators Among Birthing Population Subgroups in CCC (2019–2021)

Birthing Population Subgroup	Percentage of Total Birthing Population	Used Medi-Cal as Prenatal Care Payment Source	Within 100% of FPL During Pregnancy
Total birthing persons	**100%**	**31.8%**	**24%**
Participated in WIC during pregnancy	29%	79%	61%
Moved due to problems paying rent or mortgage	6%	71%	57%
Experienced IPV during pregnancy	5%	80%	80%

Prenatal depression symptoms	16%	50%	38%
Cannabis use during pregnancy	6%	57%	43%
Had no practical or emotional support	5%	80%	60%

Demographic Distribution of Births and Risk Proxies

In addition to risk indicators, Table 4 summarizes the number of births and the prevalence of economic or environmental disadvantage by demographic group in Contra Costa County. Notable disparities appear in Medi-Cal enrollment, FPL status, and HPI ranking across the demographic groups. While teen parents made up just 2% of birthing persons in the county between 2019-2021, nearly all were within 100% of FPL and enrolled in Medi-Cal, a proxy for elevated risk. Teen parents, Hispanic and Black birthing persons (approximately 41% of the birthing population) and AIAN and NHPI (less than 1% of the population) were most likely to live in zip codes with less healthy conditions than 50% of all zip codes in the state.

Table 4: Births and Risk Proxies by Demographic Group, 2019–2021[10]

Demographic	2019 - 2021	% of Total Births	% of Subgroup >50th Percentile HPI	% of Subgroup Enrolled in Medi-Cal	% of Subgroup within 0-100% FPL
Total Births	**34,898**	**100%**	**37.3%**	**40.5%**	**22%**
First-Time Births	14,231	40.8%	35.2%	25%	21%
Births to Persons <20	759	2.2%	68.5%	95%	95%
AIAN Births	49	.1%	53.1%	N/A	N/A
NHPI Births	241	.7%	59.3%	N/A	N/A
Asian Births	6,044	17.3%	24.6%	9%	9%
Black Births	2,907	8.3%	58.3%	55%	45%
White Births	11,329	32.5%	16%	15%	8%
Hispanic Births	11,424	32.7%	60.5%	53%	38%

[10] Birth data reflect birthing persons, not total births, and were derived from the California Comprehensive Birth Files (2019–2021) and the California Birth Reallocation Files (2019–2021), accessed through the Vital Records Business Information System (VRBIS) by Contra Costa Health. In cases of multiple births (e.g., twins), only the first recorded birth was used to approximate the number of birthing persons. The percentage of birthers residing in zip codes below the 50th percentile of the Healthy Places Index (HPI) was calculated by based on address information from birth records. Estimates of the percentage of each demographic subgroup enrolled in Medi-Cal or living at or below 100% of the federal poverty level (FPL) are drawn from the 2019–2021 Maternal and Infant Health Assessment (MIHA) survey data for Contra Costa County, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/MIHA/Pages/DataTables2021.aspx.

Current Home Visiting Capacity and Gap Analysis

Contra Costa County is home to a wide array of home visiting programs, each serving specific population groups based on age, income, race/ethnicity, or other eligibility criteria. Programs range from group-based prenatal support to evidence-based, long-term home visiting models. A comprehensive comparison of population-level risk indicators and current home visiting capacity in Contra Costa County reveals several persistent and emerging service gaps. These gaps are not limited to service capacity alone, but extend to cultural and linguistic match for families, eligibility alignment, and accessibility for high-need populations. These include:

Access for Black Birthing Persons

Black birthing persons face disproportionately high risk indicators, including elevated rates of prenatal depression, economic hardship, and exposure to systemic inequities.[11] Recent investments tied to Contra Costa County's Perinatal Equity Initiative (PEI) have expanded services specifically for Black birthing persons. Programs such as Black Infant Health (BIH), CoCo Doulas, and the Fatherhood Initiative collectively have the capacity to serve an estimated 490 Black birthing persons annually. In 2024, an estimated 500 Black birthing persons were enrolled in Medi-Cal, meaning 98% of those individuals could be reached through PEI-funded programming.

However, when Medi-Cal eligibility is not considered, such as for uninsured or privately insured Black birthing persons, the system's reach is more limited. These targeted programs could serve only 62% of the total estimated Black birthing population in 2024. While this coverage reflects important progress — particularly in light of FMCH's strategic use of PEI funds to expand programming for Black birthing persons — it does not necessarily indicate that access is sufficient. The HVSBC noted that questions remain about whether these programs are effectively meeting the needs they were designed to address, particularly because they have only been operational for a short time. Continued investment in culturally responsive, community-informed, and rigorously evaluated services is essential to ensure that the county is not only expanding access but achieving meaningful impact.

Access for First-Time Parents

Contra Costa County's only evidence-based home visiting model that exclusively serves first-time, low-income parents (income determined by Medi-Cal eligibility) is the Nurse-Family Partnership (NFP). In 2024, an estimated 1,617 first-time birthing persons were enrolled in Medi-Cal, yet NFP had the capacity to serve only 230 of them (14%). Access to other models is limited for the remaining 1,391 first-time mothers who used Medi-Cal as a prenatal payment source, as well as for the additional 2,837 first-time parents who were not enrolled in Medi-Cal.

While these families theoretically qualify for alternative services, including Prenatal Care Guidance (250 slots), Parents as Teachers (75 slots), Everyday Moments (100 slots), and Perinatal Circle of Care (96 slots), total capacity remains low. Only 521 additional first-time families, representing 12.3% of the 4,228 not served by NFP, could be reached through these programs. This leaves a substantial unmet need across the first-time parent population.

[11] *Perinatal Equity Initiative: Five-Year Workplan for Contra Costa County.* February 2023. Retrieved from https://cchealth.org/mcah/pdf/PEI-Five-Year-Workplan.pdf

Unmet Need in Asian and Pacific Islander Communities

Despite the growing Asian population in Contra Costa County, the county does not maintain home visiting, parenting education, or perinatal programs designed to address the specific cultural needs of this group. Members of the HVSBC noted that certain Pacific Islander communities face distinct health disparities, pregnancy outcomes, and barriers to care that are often obscured when data are aggregated under the broad "Asian" category. While the analysis includes data disaggregated for Native Hawaiian and Pacific Islander (NHPI) populations, HVSBC members emphasized that other subgroups, such as Filipinos, may still face unique challenges that are not visible in existing data or adequately addressed through current services. These communities can experience a form of invisibility in both program design and data reporting.

The HVSBC also raised similar concerns regarding Indigenous populations that are frequently categorized as Hispanic. These communities may practice distinct cultural traditions, such as burying the umbilical cord after birth, and may require different forms of outreach, engagement, and service delivery than currently available programs provide. Like other culturally distinct groups, these Indigenous communities can become invisible in both data systems and programmatic decision-making, limiting the county's ability to design services that reflect their lived experiences and specific needs.

Access to Mental Health-Oriented Home Visiting

Perinatal mental health is a growing concern in Contra Costa County. Based on MIHA estimates, over 2,200 birthing persons in 2024 experienced either prenatal depression or intimate partner violence (IPV) — two key indicators of elevated need for dyadic mental health services. The system's capacity to respond to this need is limited: only 500 slots are available through Medi-Cal-funded dyadic mental health programs (Early Connections and Child & Family Bond), with only an additional 226 slots offered by programs designed to serve families outside the Medi-Cal system. Together, this represents coverage for just one-third of birthing persons estimated to face these challenges.

Service Capacity Synthesis

The gap analysis suggests that Contra Costa County's home visiting system is already equipped with a diverse portfolio of programs, supported by multiple funding streams, that collectively have the potential to meet the needs of many high-risk populations. Strong models are in place, and targeted investments — such as a modest increase in AFLP funding noted earlier in this report — could yield meaningful gains for specific populations. At the same time, the system's ability to fulfill this potential depends on how well its components work together. Beyond expanding access through new funding, the county can strengthen its home visiting system by improving coordination across programs, helping home visitors navigate and refer families across agency lines. A shared set of core competencies, anchored in the realities of the county's birthing population, would help ensure that families receive the services best aligned with their needs. Furthermore, HVSBC members emphasized the importance of reflective supervision in supporting home visitors, who often take on the stressful needs and complex situations of the families they serve, to reduce burnout and protect their well-being. They also noted that as the system continues to build capacity and improve alignment, future efforts should increasingly consider populations that are not always visible in traditional data sources, including refugee families and those incarcerated or recently released.

VI. Recommendations: Advancing a Stronger, Cohesive Home Visiting System

Over the past several years, Contra Costa County has taken meaningful steps to strengthen and expand its home visiting system. Investments through the Perinatal Equity Initiative, Family First Prevention Service Act, early and strategic use of specialty mental health funding for dyadic services, and intentional contracting strategies within child welfare demonstrate the county's ability to leverage funding sources, design responsive programs, and support vulnerable populations. At the same time, the analysis presented in this report highlights clear gaps in access for some populations and the need to build out infrastructure that supports coordination, workforce stability, and quality improvement.

The system is not starting from scratch. Contra Costa's landscape features a range of programs with varied funding streams and populations served a strong foundation to build upon. What is needed now is a shared system orientation — a way to assess progress across programs, to support staff working at the front lines, and to maintain a coherent, equitable strategy for addressing need as it evolves. In short, the county needs both infrastructure and alignment to keep up with its own ambition and success.

To support this goal, the HVSBC undertook a strategy development process in spring 2025. Through a series of convenings and a culminating retreat, the Collaborative reviewed population need, evaluated system priorities, and co-developed strategies using a structured, participatory approach. This process surfaced three core strategies to advance the county's home visiting system:

1. **Sustainable Infrastructure** — building shared data systems, Medi-Cal billing capacity, ongoing evaluation, and coordinated funding;

2. **Workforce Development and Retention** — supporting shared onboarding, training, reflective supervision, and clear career pathways;

3. **Equity and Access** — aligning models to population need, expanding culturally responsive services, and improving outreach to underserved communities.

After examining unmet need and analyzing risk factor prevalence, workgroup members applied criteria of feasibility, significance, and sustainability to refine and prioritize implementation goals.

Ultimately, the group identified workforce development as a foundational lever for advancing all three strategy areas. The Collaborative articulated a shared vision for workforce investment and outlined key strategies, milestones, and action steps now reflected in the **Home Visiting System Development Implementation Plan** (included as an appendix to this report).

The three strategies featured in the implementation plan are:

- **Launching a Home Visiting Workforce Academy:** A hub for shared onboarding, training, reflective supervision, and leadership development across home visiting programs.
- **Building inclusive and sustainable career pathways:** Expanding pipelines into the field, from high school and community college through more advanced training, with clear, supported progression.
- **Fostering peer connection and shared learning:** Creating space for cross-agency exchange, problem solving, and professional development.

Each strategy is backed by action steps, roles and responsibilities, and timelines for near- and longer-term milestones. These recommendations also support broader system-building goals, such as aligning competencies, standardizing quality expectations, and creating a culture of shared accountability across agencies.

While workforce development emerged as the Collaborative's priority, the strategy retreat also brought to light broader needs: the importance of system-level coordination, cross-agency communication, and ongoing reflection on how the system is meeting families' needs. The Collaborative envisions forming a **Home Visiting System Steering Committee** to carry forward this work, with a possible ad hoc group focused on the launch of the Workforce Academy. This structure would enable ongoing system assessment, promote fiscal and programmatic alignment, and create a more durable infrastructure for planning, implementation, and improvement. The scope and responsibilities of this Committee, in an initial draft form, are shared in appendix B.

Finally, to ensure continued alignment between population need and program capacity, the county should commit to **routine system-level assessments,** building from this landscape analysis. These efforts can:

- Use administrative and survey data to monitor risk indicators
- Track service gaps and waitlists
- Inform funding requests, program design, and model selection
- Prioritize populations often excluded from traditional data (e.g., refugees, incarcerated parents, linguistically isolated families)

This function can be housed within the Steering Committee or through a data workgroup that includes evaluation and planning professionals from partner agencies.

Contra Costa County's home visiting system reflects a dynamic, evolving network of programs committed to supporting families during the critical prenatal-to-five period. This analysis highlights the county's progress in securing new funding, expanding access for historically underserved populations, and developing a diverse array of models to meet community needs. Continued system strengthening — through increased coordination, shared competencies, and workforce investments — can help sustain and build on this progress. With focused leadership and collaborative infrastructure, the county is well-positioned to shape a more cohesive and responsive system of care for families with young children.

Appendix

A. Home Visiting System Building Collaborative Members

Table A1: Collaborative Members, by Organization

First 5 Contra Costa	Ruth Fernandez
	Liliana Gonzalez
	Jessica Keener
	Sandra Naughton
Contra Costa Health, FMCH	Jaime Baculpo
	Violet Barton
	Natalie Berbick
	Allwell M. Pinnock
	Thenisha Riggs
	Riza Wilford
	Nayeli Zavala
Unity Council	Jacqueline Smith
Aspiranet	Rosaura Palomera
	Jyotti Pannu
	Laurie Walsh
We Care Children	Shelly Kwak, LMFT
	Phuong Seltzer
Contra Costa Employment and Human Services Department (CSB & WSB)	Sarah Reich
	Aisha Teal

B. Contra Costa Home Visiting System Development Implementation Plan

(Developed May 2025)

This implementation plan is the product of the Contra Costa County Home Visiting System Building Collaborative's efforts to strengthen and align the county's home visiting system. Through a five-part discussion series, Collaborative members articulated system aspirations, surfaced service delivery trends and barriers, examined population needs and program gaps, and explored how other counties have approached system design.

Building on this foundation, the Collaborative participated in a full-day, in-person retreat to synthesize what they had learned. During the retreat, members reviewed three overarching "strategy buckets" that summarized the themes from previous sessions. Using agreed-upon criteria — significance, feasibility, and viability — they evaluated each strategy area and identified workforce development as the initial priority for coordinated system-building efforts.

This implementation plan outlines the Collaborative's roadmap for moving that priority forward. It includes one overarching goal supported by three interrelated strategies, each accompanied by milestones, action steps, and identified roles and responsibilities.

Each strategy includes a set of bolded milestones (labeled "M"), which represent significant markers of progress. The corresponding action steps beneath each milestone (labeled "A") are meant to be completed in sequence, with each step building on the one before it. Once all action steps under a given milestone are completed, the milestone itself should be achievable. While each milestone and its action steps are designed to progress sequentially, strategies interconnect in practice. Please see the Gantt chart following the implementation plan as an example of how strategies may overlap.

If the strategies below are implemented successfully, the county and its partners can expect meaningful improvements in workforce cohesion, retention, and system responsiveness — outcomes that are detailed at the end of this plan.

Plan Summary

Overarching Goal: Cultivate a connected home visiting workforce that is unified by shared competencies, supported through aligned training and peer relationships, and empowered with the knowledge and collaboration needed to strengthen service quality, coordination, and continuity for families.

- **Strategy 1 *(priority strategy)*:** Launch a county-wide Home Visiting Workforce Academy in FY28-29, established as a centralized hub for home visitor training, professional development, peer support, and credentialing, rooted in shared home visiting core competencies.
- **Strategy 2:** Leverage the Academy's shared competencies and training infrastructure to create clear, inclusive career pathways into and across home visiting roles, including CHWs, nurses, supervisors, and adjacent fields.
- **Strategy 3:** Develop and maintain spaces for regular, meaningful connection among home visiting professionals to strengthen peer support, reduce isolation, and encourage collaboration and knowledge-sharing across programs.

Table B1: Implementation Plan

Overarching Goal		
Cultivate a connected home visiting workforce that is unified by shared competencies, supported through aligned training and peer relationships, and empowered with the knowledge and collaboration needed to strengthen service quality, coordination, and continuity for families.		
Strategy 1 (Priority Strategy)		
Launch a county-wide Home Visiting Workforce Academy in FY28-29, established as a centralized hub for home visitor training, professional development, peer support, and credentialing, rooted in shared home visiting core competencies.		
Milestones & Action Steps		**Roles/Responsibilities & Timeline**
M 1.1: Secure interagency commitment and continue the work of the HV System Building Collaborative through the formalization of Home Visiting Workforce Development Ad Hoc		July – October 2025
A 1.11	Identify a lead agency to convene early work.	System convener HV System Building Collaborative members engaged in recruitment
A 1.12	Identify and recruit others to join the WFD Ad-Hoc.	
A 1.13	Develop and formalize a shared commitment among ad-hoc members to co-design and support the Academy vision.	
M 1.2: Establish a system development steering committee responsible for shepherding the design and implementation of the Workforce Academy.		October 2025 - June 2026
A 1.21	Draft a shared vision, purpose, and set of responsibilities for the steering committee. Define criteria for membership (e.g., representation from CBOs, public health, IHEs, ECE, caregivers, community organizers).	HV System Building Ad Hoc drafts scope System Convener facilitates alignment HV leadership, social justice organizations, Referral partners (e.g., clinics, Kaiser), Funders
A 1.22	Explore grant opportunities or pooled funding strategies to support early implementation planning and staffing.	
A 1.23	Recruit steering committee members.	
M 1.3: Define the foundational competencies and core values that drive the Academy's work.		October 2025 – June 2027
A 1.31	Review program evaluation criteria across the system and interview home visitors, supervisors, and families to determine what makes a proficient home visitor in CCC.	Data Analyst, Resource Archivist, Steering Committee, External consultant, IHE partners, CHW/ECM leads, Parents
A 1.32	Inventory current home visiting-related training offerings and professional development providers in the county.	
A 1.33	Identify gaps, duplication, and areas of strength when cross-reference training opportunities with home visitor success criteria.	
A 1.34	Draft the Academy's core offerings and their connections to home visitor competencies.	
M 1.4: Design and development of an Academy infrastructure conducive to the steering committee's broader system development goals.		June 2026 - January 2028

A 1.41	Research The Institute for the Advancement of Family Support Professionals (IAFSP) and other similar workforce hubs or training academies across the state and nationally.	Steering Committee, Grant Writer, Monitoring and Accountability partners
A 1.42	Identify promising practices in governance, credentialing, funding, and delivery models.	
A 1.43	Map Academy infrastructure, including key roles and responsibilities, finance strategies, and evaluation.	
A 1.44	Develop an evaluation framework that supports fund development and continuous improvement	
A 1.45	Explore grant opportunities or additional pooled funding strategies to support implementation.	

Strategy 2		
Leverage the Academy's shared competencies and training infrastructure to create clear, inclusive career pathways into and across home visiting roles, including CHWs, nurses, supervisors, and adjacent fields.		
Milestones & Action Steps		**Roles/Responsibilities & Timeline**
M 2.1: Design and dissemination of home visiting career pathway framework, publicized by the Academy.		June 2027 - January 2029
A 2.11	Document current roles (e.g., CHWs, PHNs, case managers) and typical entry pathways.	HV leadership, IHEs, Resource Archivist, System Convener, Workforce boards, ECM leads, Public health, Career technical education partners, Training providers, Communication leads, Social justice orgs., Community advisors, Caregivers, Organizers
A 2.12	Explore existing national (IAFSP) and state/local home visiting career pathways to inform CCC's approach.	
A 2.13	Host working sessions with supervisors, home visitors, workforce boards, and training providers to develop a career ladder design.	
A 2.14	Align WF core competencies with roles and levels, defining tiers of practice and related training needs.	
A 2.15	Engage interested IHEs to explore credentialing pathways that value both formal training and lived/professional experience.	
A 2.16	Map early ideas for stackable or tiered credentials.	
A 2.17	Formalize and integrate pathways with RAPs, CHW certification, ECM initiatives, and current funded efforts, and design pathways into supervision, peer mentorship, and adjacent fields (e.g., early childhood, mental health).	

Strategy 3		
Develop and maintain spaces for regular, meaningful connection among home visiting professionals to strengthen peer support, reduce isolation, and encourage collaboration and knowledge-sharing across programs.		
Milestones & Action Steps		**Roles/Responsibilities & Timeline**
M 3.1 Establish a sustainable, countywide forum for home visitor connection.		June 2027 - June 2028
A 3.11	Design a "Talk Story" series framework that includes monthly, thematic gatherings of home visitors that are informal and human-centered, without a fixed agenda.	System Convener, HV leadership, Community co-facilitators, HV

A 3.12	Launch a short-term pilot of in-person HV gatherings to assess participation, accessibility, and value.	Workforce Ad Hoc, Host organizations, Home visitors, HV supervisors, Peer leaders, Community partners, Data Analyst, Academy leadership
A 3.13	Engage home visitors in the design process by soliciting ideas to shape the format, topics, and facilitation approaches of these sessions.	
A 3.14	Determine who will host or support each session (rotating leadership, central facilitator, or partner organization).	
A 3.15	Develop a light evaluation tool to assess the impact of peer forums on home visitor satisfaction, connectedness, and retention.	
A 3.16	Institutionalize connection forums by integrating them into the Academy's ongoing responsibilities to ensure continuity.	

Intended Outcomes

- Greater knowledge and trust among home visiting organizations.
- Improved understanding of the home visiting system structure and funding across the workforce.
- Increased home visitor retention.
- More home visitors who reflect the racial, cultural, and linguistic backgrounds of the communities they serve.
- A higher proportion of trainings that are relevant and responsive to local community needs, informed by system-level input and assessment.
- Stronger home visitor self-efficacy and a greater sense of being supported and valued in their roles.

Table B2 provides a visual representation of the timeline and overlap between milestones across the three strategies in the implementation plan. Each bar represents the estimated start and end date for a milestone, color-coded by strategy.

Table B2: Implementation Plan GANTT Chart

	Oct 2025	June 2026	June 2027	June 2028	Jan 2029
Establish WFD Ad Hoc					
Establish HV System Steering Committee					
Define HV Competencies					
Develop Academy Infrastructure					
Develop Career Pathway Framework					
Peer Connection Infrastructure					

Strategy 1 | Strategy 2 | Strategy 3

C. Proposed Scope and Responsibilities for the Home Visiting System Building Steering Committee

Purpose and Scope

The **Home Visiting System Building Steering Committee** serves as the central leadership body guiding Contra Costa County's long-term home visiting system development efforts. While the committee's **initial focus will be to support the planning and launch of a countywide Home Visiting Workforce Academy**, its broader purpose is to advance coordinated, sustainable, and equity-centered system-building strategies across the home visiting landscape.

The Steering Committee will serve as a **cross-sector governance and coordination body**, ensuring alignment across major components of an effective home visiting system, including:

- **Governance and Administration**
- **Finance Strategies**
- **Assessment and Planning**
- **Implementation and Continuous Quality Improvement (CQI)**
- **Professional Development and Technical Assistance**
- **Monitoring and Accountability**

The committee will help set shared direction, facilitate alignment across agencies and programs, and build the foundation for a more integrated, equitable, and sustainable system that is responsive to the needs of families and providers.

Initial Responsibilities

In the first phase (FY25–FY28), the committee will focus on advancing the workforce development strategies outlined in the implementation plan, which include establishing a Home Visiting Workforce Academy and related infrastructure. Specific responsibilities include:

- **Vision and Oversight**
  - Co-develop a vision for a connected and supported home visiting workforce rooted in shared competencies and aligned training.
  - Provide leadership and accountability for implementation of the Home Visiting Workforce Development Plan.
- **Governance and Delegation**
  - Define and formalize the committee's structure, decision-making processes, and membership criteria to ensure representation from key stakeholder groups.
  - Maintain oversight of the Home Visiting Workforce Academy's development while retaining the flexibility to establish an **Academy-specific Ad Hoc** that can lead technical design and implementation activities.
- **Strategy Development and Alignment**
  - Maintain a sightline to other system-building opportunities beyond workforce development and assess when and how to expand the committee's strategic priorities.
  - Support integration of workforce strategies with related initiatives in early childhood, public health, and Medi-Cal transformation.
- **Resource and Partnership Mobilization**

    - Identify and support opportunities for pooled funding, grants, and in-kind contributions to advance system priorities.
    - Cultivate partnerships with local government agencies, community-based organizations, higher education institutions, and lived experience leaders.
- **System Assessment and Evaluation**
    - Guide development of an evaluation framework for the Academy and broader workforce initiatives that support continuous quality improvement and fund development.
    - Coordinate or commission assessments of home visiting system needs, service gaps, and family experiences to inform future priorities.
- **Communication and Engagement**
    - Champion transparency and broad communication across the home visiting field to ensure providers, families, and partners are informed and engaged in system-building efforts.
    - Serve as a connector across programs and sectors, strengthening referral pathways, data use, and shared accountability for family outcomes.

Time Commitment

- Estimated 12– to 18-month duration for initial steering term
- Monthly 90-minute meetings (with potential for subcommittee work in between)
- Occasional review of materials and participation in interviews, focus groups, or community events

Who Should Join?

We are seeking a diverse group of stakeholders who represent or work closely with:

- Home visiting program leaders and supervisors
- Current or former home visitors (including CHWs, PHNs, case managers, etc.)
- Community-based organizations
- Institutions of higher education
- Early childhood and public health systems
- Referring agencies (e.g., clinics, family resource centers)
- Social justice advocates and community organizers
- Parents and caregivers with lived experience in home visiting

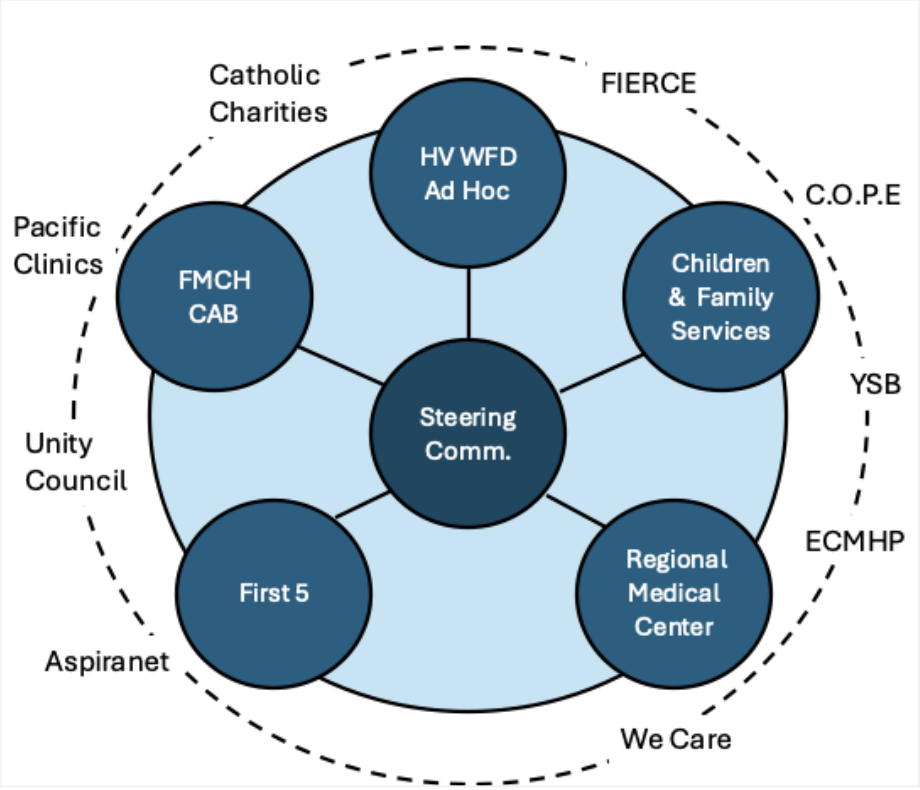
Why Join the Steering Committee?

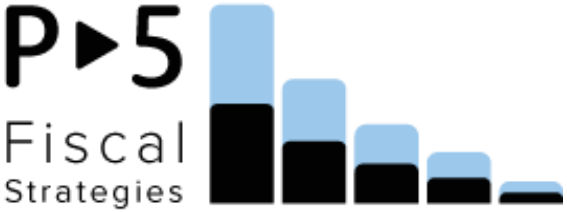
Becoming a member of the Home Visiting System Building Steering Committee is an opportunity to:

- **Shape the Future**
  Influence how Contra Costa County builds a more coordinated, equitable, and sustainable home visiting system—one that meets the needs of families, providers, and communities.
- **Lead from Within the System**
  Collaborate with peers across sectors to align efforts, improve service delivery, and design infrastructure that supports high-quality care and strong outcomes.
- **Advance Equity and Community Voice**
  Ensure that the perspectives of historically underrepresented communities, front-line staff, caregivers, and culturally rooted organizations are embedded in system design and decision-making.
- **Drive Innovation**
  Participate in designing innovative workforce strategies, such as the Home Visiting Workforce Academy and inclusive career pathways, that reflect local context and values.

- **Strengthen Connections**
  Build meaningful relationships with partners across public agencies, community-based organizations, advocacy groups, and educational institutions.
- **Promote System Accountability**
  Help define and uphold shared goals, evaluation strategies, and funding priorities that support transparency and continuous improvement.

Figure C1: Home Visiting System Collaborative





Strengthening Home Visiting in Contra Costa County: A Fiscal Overview

June 2025

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Prenatal to Five Fiscal Strategies

Fiscal Mapping

A home visiting fiscal map catalogues the funding that supports a community or region's home visiting programs over an established period of time. The map, presented in a series of tables below, organizes home visiting funding in Contra Costa County in fiscal year 2024-2025 by home visiting program and source (federal, state, local). Prenatal to Five Fiscal Strategies (P5FS) conducted a fiscal map analysis to assess Contra Costa County's home visiting, parent education, and perinatal support funding composition and to help constituents determine how to leverage funding, how to address funding gaps, and how to increase the efficiency of funding administration and implementation.

A. Funding Background

Contra Costa County's home visiting and perinatal support system is funded through a complex patchwork of federal, state, and local funding streams. These investments vary in terms of their stability, allowable use, administrative oversight, and mechanisms for drawing down funds. While not all funding is exclusive to home visiting, the programs included in this fiscal map reflect investments that support prenatal-to-five populations through home visiting, group-based parent education, and related perinatal services.

Medicaid remains the largest source of public funding supporting home visiting-aligned services in the county. Contra Costa draws down Medicaid dollars through multiple mechanisms, including Title XIX Medicaid Administrative Activities (MAA), Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) funds, and Targeted Case Management (TCM). These funding streams are primarily accessed by county public health and mental health agencies, allowing for reimbursement of specific service components — such as care coordination, assessments, and mental health treatment — within evidence-based home visiting models or dyadic therapeutic services. While powerful, Medicaid's utility is often limited by complex claiming protocols, reimbursement restrictions, and staffing requirements. As such, agencies must layer additional funding sources to fully support program infrastructure and staffing.

The county also benefits from state general funds and targeted initiatives, such as the California Home Visiting Program (CHVP), the Black Infant Health Program, and time-limited investments through the Children and Youth Behavioral Health Initiative (CYBHI) and the Perinatal Equity Initiative (PEI). These initiatives have expanded access to services, including the development of doula programs and culturally responsive parent education efforts. However, some of these investments are non-recurring or time-limited, placing a strain on implementing organizations to continuously pursue new sources of funding to sustain programs. By working collaboratively, system partners can further leverage funding streams currently accessed by standalone agencies. For example, the California Home Visiting Program (CHVP), administered by the California Department of Public Health's Maternal, Child, and Adolescent Health (MCAH) Division supports select evidence-based models, including Nurse-Family Partnership (NFP), Healthy Families America, and Parents as Teachers (PAT), by combining Maternal, Infant, and Early Childhood Home Visiting (MIECHV) dollars, State General Funds, Title V, and Title XIX. In Contra Costa, CHVP currently supports Nurse Family Partnership (NFP) through the county's local health jurisdiction (LHJ) – CC Health. However, CHVP funding has not yet been leveraged to sustain the recently launched Parents as Teacher (PAT) program operated by We Care Children, a community-based organization. This presents an opportunity: local public health and community providers could collaborate to explore CHVP as a potential funding mechanism for PAT, especially as the current CYBHI grant funding the program sunsets. Similarly, the PAT program may be eligible for Family First Prevention Services Act (FFPSA) dollars, administered through Children and Family Services.

Taken together, the funding streams mapped in this appendix demonstrate the breadth of investment and administrative complexity involved in sustaining home visiting and related services in Contra Costa County. As this appendix shows, layering and coordinating funding across departments is often necessary to maintain a range of services that address the diverse needs of families. Contra Costa County's fiscal map reflects this complexity — and underscores the importance of cross-agency collaboration to ensure sustainable funding for the full continuum of home visiting and perinatal support. The accompanying tables provide a snapshot of Fiscal Year 2025 funding by program and source, and administering entity.

B. Funding Overview

FY25 Funding Overview

- Home visiting, perinatal, and parenting support programs in Contra Costa County received $13.6M in FY24 and $18.8M in FY25 — a 38% increase year over year.
- Between FY24 and FY25, increases in Medicaid funding ($2.2M), Early Head Start funding ($1.2M) and newly implemented Children and Youth Behavioral Health Initiative (CYBHI) funds ($1.2M) accounted for 88% of the annual revenue increase.
- Medicaid and Medi-Cal funds, sourced from federal Title XIX match, State General Funds, and County Behavioral Health Services, totaled over $7.6M (or 41% of total funding) in FY25, making it the system's single largest funding stream.
- Altogether, 17 distinct funding sources supported the home visiting and perinatal support system in FY25, the largest of which were Medicaid, State General Funds, Office of Head Start, CalWORKs, CYBHI.
- Local funding sources, including County Public Health, County Behavioral Health Services, innovation grants, and local philanthropy, increased by 66% -- growing from 11% of total funding in FY24 to 13% in FY25.
- Nurse Family Partnership (NFP) received more funding than any program in FY25 ($3.9M), a 50% increase from FY24, driven by increased county investment and Medicaid match.
- Five programs – NFP, Black Infant Health, Early Connections, Child & Family Bond and Early Head Start accounted for 85% of the $18.8M of tracked revenue in FY25.
- No single program accounted for more than 21% of total funding in FY25.

C. Funding Tables

FY25 Home Visiting, Parenting & Perinatal Support Funding by Program

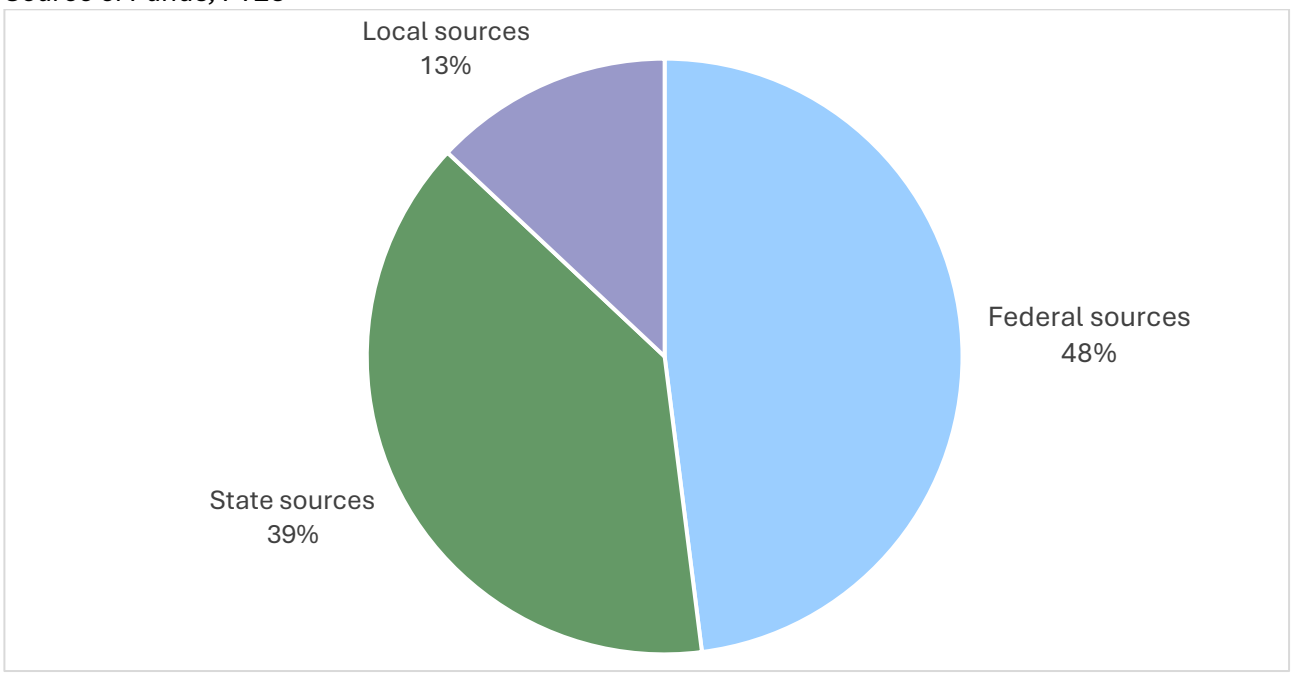
Program	Service Capacity	Federal Funding	State Funding	Local Funding	Total
Group-based intervention, parenting classes and consultation, delivery support					
Black Infant Health	320	$1,165,888.73	$1,621,477.00	$67,837.80	$2,855,203.53
Fatherhood Initiative	50		$190,000.00		$190,000.00
Coco Doulas	120		$350,000.00		$350,000.00
Total	490	$1,165,888.73	$2,161,477.00	$67,837.80	$3,395,203.50
Evidence-based, evidence-informed, practice-informed home visiting					
Prenatal Care Guidance	250		$440,334.00		$440,334.00
Everyday Moments	100			$45,000.00	$45,000.00
Adolescent Family Life Program	50	$239,156.00			$239,156.00
Nurse Family Partnership	230	$1,953,151.46	$1,438,043.00	$520,946.45	$3,912,140.91
Parents as Teachers (Thrive)	75		$750,000.00		$750,000.00
Perinatal & Attachment Therapy	30			$155,000.00	$155,000.00
Early Connections	200	$1,000,000.00	$500,000.00	$530,000.00	$2,030,000.00
Child & Family Bond	300	$1,950,000.00	$975,000.00	$975,000.00	$3,900,000.00
Perinatal Circle of Care	96		$420,000.00	$162,000.00	$582,000.00
Early Head Start	370	$2,802,000.00	$550,000.00		$3,352,000.00
Total	1,701	$7,944,307.46	$5,073,377.00	$2,387,946.45	$15,405,630.91
Grand Total	2,191	$9,110,196.19	$7,234,854.00	$2,455,784.25	$18,800,834.44

Changes in funding composition between FY24 and FY25 included:

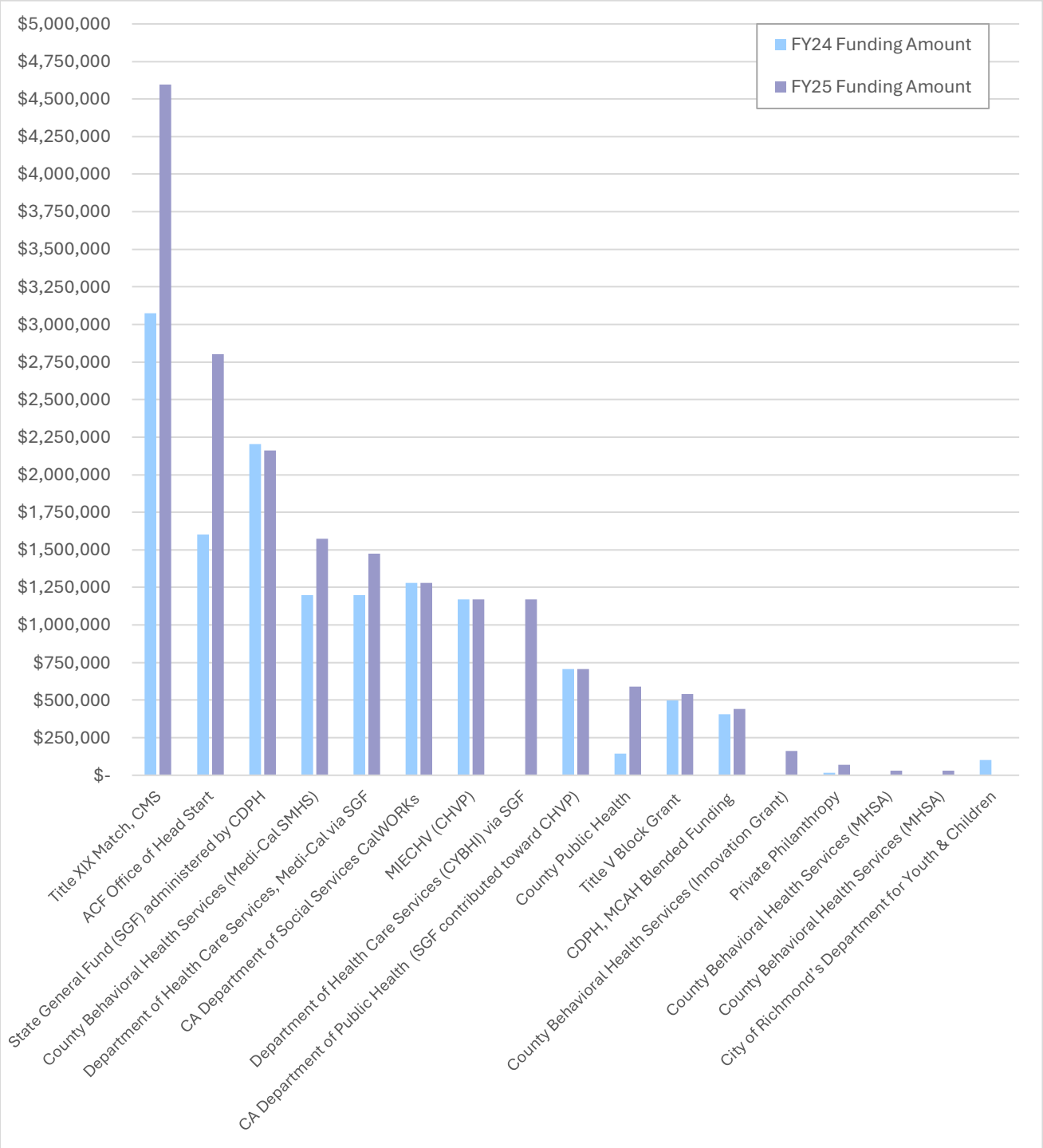
- Federal funding grew from $6.3M to $9.1M — a 44% increase.
- State funding increased at a more modest rate.
- Local funding rose by 66%, driven largely by FMCH's $521K local investment in NFP.

As a result, in FY25, nearly half of funding came from federal resources, and two fifths from states sources. The remainder came from local sources, as show in the following chart.

Source of Funds, FY25



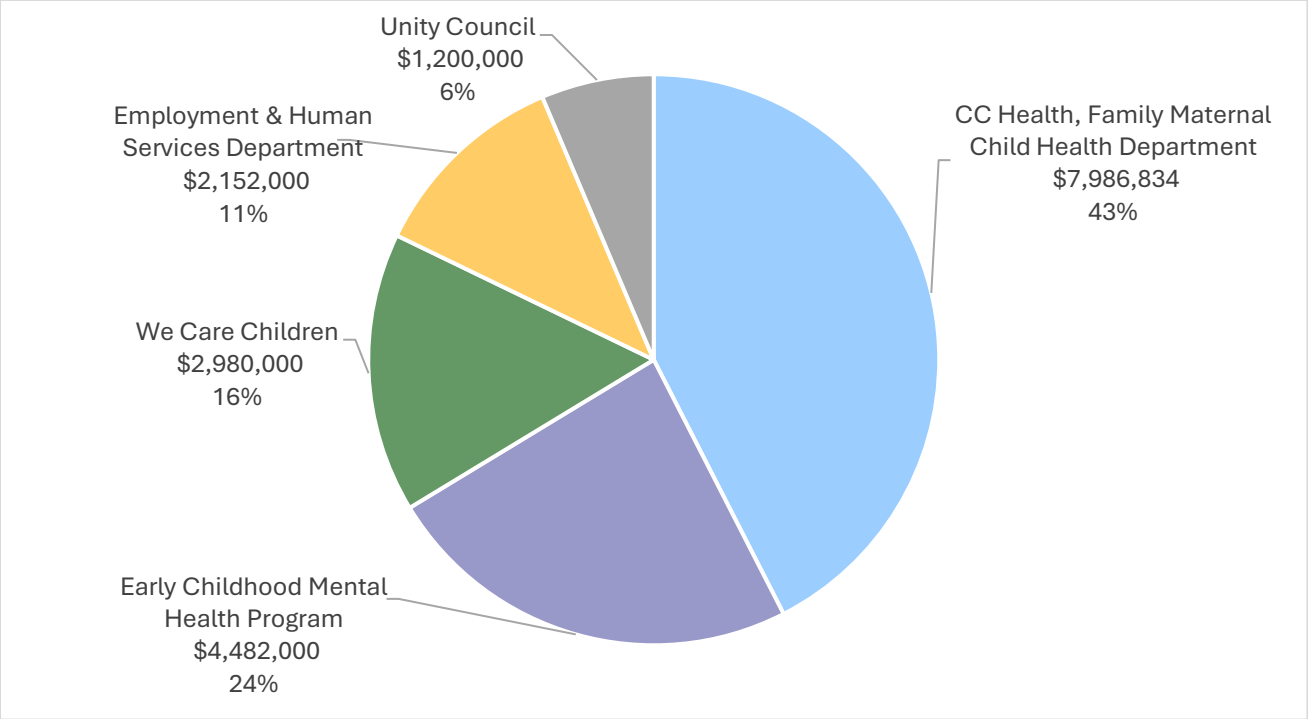
Funding by Source, FY25



Funding is concentrated among a small number of implementing organizations. Contra Costa Health's Family, Maternal and Child Health (FMCH) division received over 40% of all tracked revenue in FY25, followed by Early Childhood Mental Health Program, We Care Children, and the Employment and Human Services Department, Community Services Bureau. These four agencies collectively account for

the majority of direct service funding, as shown in Figure 5, highlighting their central role in the county's home visiting and perinatal support infrastructure.

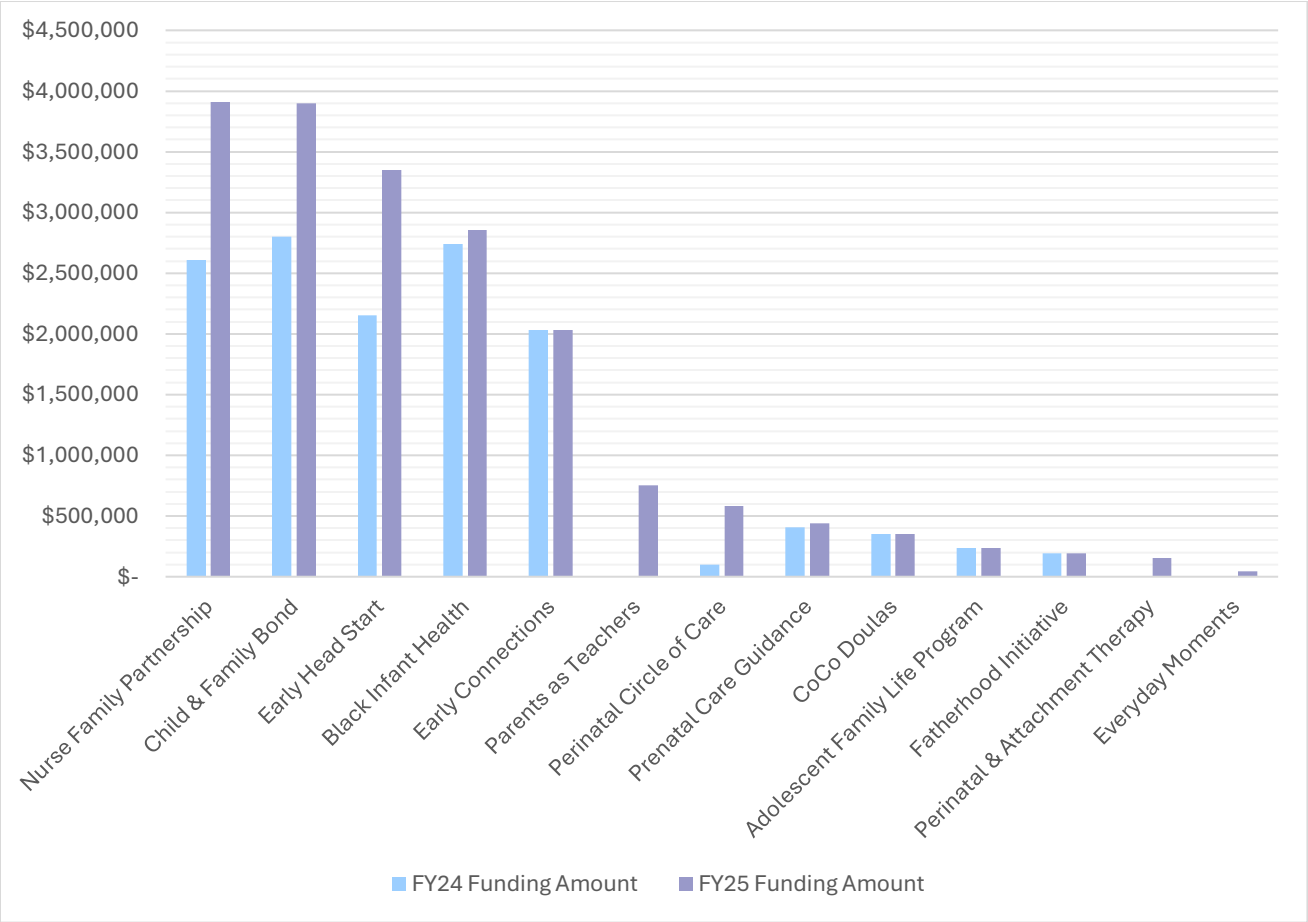
FY25 Funding, by Agency



It is important to note that fiscal data were not available from three of the eight agencies that administer home visiting and parent services – C.O.P.E., VistAbility, and Children and Family Services (CFS) – at the time of analysis. As such, their funding contributions are not reflected in the figures or visuals.[12] This limitation may understate the total investment in home visiting and the system footprint of these organizations, particularly in the areas of parent education and child welfare-related home visiting.

[12] While programmatic information was collected for these organizations, fiscal data were not submitted in time to be included in the FY25 funding analysis.

Funding by Program, FY24 and FY25



This fiscal analysis underscores both the breadth of investment and the challenges of sustaining a diverse home visiting and perinatal support system in Contra Costa County. While recent funding increases — particularly from Medicaid, CYBHI, and Early Head Start — have bolstered service capacity, continued coordination across agencies remains essential to maximize the impact of each dollar. With 17 distinct funding sources and considerable variation in stability, duration, and eligibility criteria, ongoing collaboration is needed to align resources, identify sustainable revenue streams, and respond to emerging family needs. As new programs are introduced and time-limited grants expire, Contra Costa has the opportunity to deepen cross-agency partnerships, explore strategic uses of existing mechanisms like CHVP and FFPSA, and build a more resilient infrastructure for families with young children. This fiscal overview offers a foundation for those efforts — illuminating not only what is currently resourced, but also where the system might go from here.