



Supporting Perinatal Health Through Home Visiting and Utilizing the CHW Medi-Cal Benefit Welcome Baby: Road to Resilience (WB:R2R) Program

Aliados Health Promising Practice

PROMISING PRACTICE OVERVIEW

Welcome Baby: Road to Resilience (WB:R2R) is a First 5 Yolo program that provides perinatal and postpartum nurse home visiting services that are inclusive of resource navigation and health educations support to low-income residents of Yolo County. WB:R2R supports families giving birth with Medi-Cal or no health insurance by offering a nurse home visit within the critical one to two weeks after birth. Families also receive a follow-up call with a nurse at approximately three months postpartum, with additional nurse follow-up as needed. The program identifies families with higher needs and connects them to longer-term home visiting services and community resources when appropriate. The nurses with WB:R2R are also certified as Community Health Workers (CHWs), and they provide health education and resource navigation under the CHW scope. This allows the program to align an effective nurse-led model with CHW billing while maintaining continuity and quality of care.

AIM

To support as many families as possible that are giving birth with Medi-Cal or no health insurance in Yolo county with RN and CHW services such as health navigation and home visiting programs .

MEASURES

- # of perinatal clients screened and assessed
- # of clients that received in-clinic navigation, nurse visits, and Long-Term Home Visiting (LTHV) services
- Overall program outcome on clients such as prenatally enrolled in home visiting, screening for mental health, receiving and continuation of receiving services such as lactation for at least 6 months
- Program outcomes for children such as avoiding the need to enter child welfare services, exclusively breastfeeding at 3 months, up to date on well-child visits and immunizations
- Program outcomes for parents such as receiving medical postpartum visits, improvement in parenting skills, reduction or abstinence of alcohol, drug and tobacco use, improvement in depressive symptoms.

In a survey of families who received services, 99% mentioned that they would recommend the program to their peers





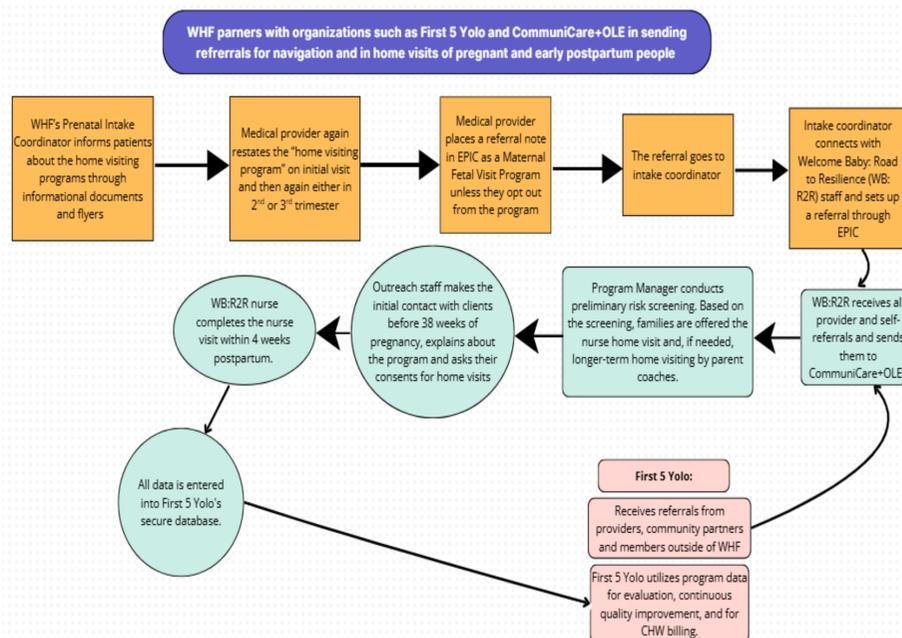
In fiscal year 2024-2025, there were 392 nurse home visits.

ACTIONS TAKEN

WB:R2R operates as a coordinated system of care, with Winters Healthcare Foundation playing a central role in identifying and referring families. Winters Healthcare Foundation staff inform patients about WB:R2R at multiple points during pregnancy, including through the prenatal intake coordinator and again by the primary care provider at the initial visit and, when appropriate, later in the second or third trimester. In addition, WB:R2R accepts referrals through the program website. Families may self-refer or be referred by healthcare or social service providers outside of Winters Healthcare Foundation, ensuring multiple entry points into the program. Winters Healthcare Foundation serves a large Spanish-speaking population. WB:R2R includes a Spanish-speaking nurse and multiple Spanish-speaking staff, supporting a strong cultural and language match between families and the care team.

WORKFLOW

Supporting prenatal and postpartum families through referrals to Navigation and Home Visiting Services



RESULTS (July 1st, 2024-June 30th, 2025)

Majority of clients served through this program are Hispanic/Latino (63%). Approximately 7 out of 8 were either a Medi-Cal member or uninsured. For families who received WB:R2R services, 100% were screened for depression and anxiety, 97% received lactation support, and of those who enrolled in long-term home visiting, 87% received services for 6 months or more. Almost all the children of clients avoided the need to enter child welfare services (98%), showed higher rate on exclusively breastfeeding at 3 months (50%), up to date on well child visits (93%) and on immunizations (79%) as compared to the Yolo county rate which is 42%, 40% and 58% respectively. Almost all parents completed their medical postpartum visits (98%). These parents showed improvement in parenting skills (96%), reduced or did not use alcohol, drugs or tobacco (84%) and to those who initially had depressive symptoms improved after 6 or more months of home visits (91%).

LESSONS LEARNED

Strong coordination between Winters and WB:R2R has enabled more seamless, family-centered care during the perinatal and postpartum period by aligning referral, communication, and follow-up processes across systems. While CHW reimbursement supports the program, it does not fully cover costs, and WB:R2R continues to braid funding to sustain this integrated system of care. The transition to use of the EPIC electronic health record from Google forms has improved efficiency, security, and communication, supporting timely and coordinated follow-up with families.