

## Appendix A

### Information Brief on Nurse Family Partnership ([NFP](#))

Overview: The NFP is an evidence-based home visiting model that serves first-time, low-income mothers during pregnancy through two years postpartum. It includes one-on-one home visits by a trained public health nurse to participating clients. The NFP National Service Office (NSO) supports local agencies and operating agencies and provides training, evaluation services and ongoing consultation for the development of NFP programs.

Target Population: Maternal Health, Child Health, Child Development and School Readiness, Reductions in Child Maltreatment, Reductions in Juvenile Delinquency, Family Violence, and Crime, Positive Parenting Practices, Family Economic Self-Sufficiency.

Research shows favorable outcomes in pregnant women, infants and children 1-2 years.

NFP was one of the seven home visiting models that have been determined to meet the evidence-based criteria established by HRSA and ACF and the extensive review conducted by the Home Visiting Evidence of Effectiveness Review (HomVEE) Study.

The following link takes you to the NFP HomVee model review:

<http://homvee.acf.hhs.gov/document.aspx?rid=1&sid=14>

The HomVEE Study identified 86 studies of NFP published between 1979 and 2009. Of these, 20 studies were eligible for review. Taking into account all of the review results as of January 2010, which include all high- or moderate-quality impact studies for this program model regardless of publication venue, this program model has 64 favorable impacts (statistically significant) and 6 unfavorable or ambiguous impacts. NFP received the highest rating of the seven models meeting the evidence-based criteria from HomVEE.

Favorable impacts were demonstrated for the following primary outcome measures: Child Development and School Readiness; Child Health; Family Economic Self-Sufficiency; Maternal Health; Positive Parenting Practices; and Reductions in Child Maltreatment. In addition favorable secondary outcome measures were found in: Child Development and School Readiness; Child Health; Family Economic Self-Sufficiency; Maternal Health; Positive Parenting Practices; and Reduction in Juvenile Delinquency.

#### Minimum Start-up Cost/Budget

For a 2010 start-up, the minimum number of clients NFP requires to launch a Home Visiting program is 100 families. Personnel costs for the 100 families pays for one Nurse Supervisor, four Nurse Home Visitors and a Data Entry /Support person. Additional costs include administrative costs, NFP services, travel costs, and additional

materials/measurement tools cost. Typical costs for the first year (based on 2010) are \$488,164 and for 3 years is \$1,448,556.

#### Timeline for Implementation of the Nurse Family Partnership (NFP) Model

Local Health Jurisdictions (LHJ) interested in implementing the NFP program must evaluate their readiness by assessing current and potential capacity to serve the required at-risk population. The timeline for individual program implementation varies and is dependent on many factors including prior experience in assisting high-risk, low-income families to obtain services, the ability to hire qualified staff, manage data collection and evaluation, and community support for maximizing outreach and improving the network of referral linkages.

Assuming adequate funding has been encumbered, no major policy or administrative obstacles are encountered, and an implementation plan has been approved, the first step is to hire the nurse supervisor, who then hires other team members and prepares work space, orders and organizes materials, and develops a referral system. NFP staff then completes orientation and training. Time for accomplishing this may vary from a few weeks to several months.

In general, the timeline for expansion of existing NFP programs is approximately 2-4 months. The timeline for starting new NFP programs is approximately 3-9 months. These timelines are broad and should be used for general guidance only as program implementation is influenced by multiple variables, including but not limited to, the LHJs capacity and readiness to start and/or expand a program.

## Appendix B

### Information Brief on Healthy Families America ([HFA](#))

Overview: Healthy Families America (HFA) is an evidence-based program in which families must be enrolled prenatally or within the first three months after an infant's birth. Once enrolled, services are provided to families until the child enters Kindergarten. Individual programs select the specific characteristics of the target population they plan to serve and creates its own program plan. HFA is designed for parents facing challenges such as single parenthood, low incomes, childhood history of abuse, substance abuse, mental health issues, and /or domestic violence.

HFA is designed to help families manage life's challenges by building on their strengths, rather than focusing on correcting weaknesses.

Target Population: Child Health, Child Development and School Readiness, Reductions in Child Maltreatment, Positive Parenting Practices, Family Economic Self-Sufficiency, Linkages and Referrals

Research shows favorable outcomes in: Pregnant Women, Birth-11 months, 1-2 years, 2-3 years, 3-4 years, 4+ years

HFA was one of the seven home visiting models that have been determined to meet the evidence-based criteria established by HRSA and ACF and the extensive review conducted by the Home Visiting Evidence of Effectiveness Review (HomVEE) Study. The following links you to the HFA HomVee model review:

<http://homvee.acf.hhs.gov/document.aspx?sid=10&rid=1&mid=1>

The HomVEE Study identified 142 studies of Healthy Families America published between 1979 and 2009. Of these, 36 studies were eligible for review: this program model has 30 favorable impacts (statistically significant) and 3 unfavorable or ambiguous impacts for the full sample. HFA received the second highest rating of the seven models meeting the evidence-based criteria from HomVEE.

Favorable impacts were demonstrated for the following primary outcome measures: Child Development and School Readiness; Child Health; Linkages and Referrals; and Positive Parenting Practices. In addition favorable secondary outcome measures were found in Child Health; Family Economic Self-Sufficiency; Positive Parenting Practices; Reduction in Child Maltreatment; and Reduction in Juvenile Delinquency.

#### Start-up Cost/Budget

For FY2011/2012, start-up costs to launch a Home Visiting program for 100 families would include personnel costs for one Program Manager, one Supervisor, one Family Assessment Worker/Parent Resource Visitor, four Home Visitors and a Data Entry/Support person. Additional costs include administrative costs, non-personnel

costs, HFA Services to insure model fidelity, and additional materials/measurement tools cost. Typical costs for the first year are \$318,950 and for 3 years is \$960,554.

#### Timeline for Implementation of the Healthy Families America (HFA) Model

Local Health Jurisdictions (LHJ) interested in implementing the HFA program must evaluate readiness by assessing their current and potential capacity to serve the required at-risk population. The timeline for individual program implementation varies and is dependent on many factors including prior experience in assisting high-risk, low-income families to obtain services, the ability to hire qualified staff, manage data collection and evaluation, and community support for maximizing outreach and improving the network of referral linkages. Connection to referral sources and collaboration with other programs is an important first step to implementation readiness.

In general, the timeline for expansion of existing HFA programs is approximately 2 months and includes the time it takes to hire additional (new) staff and for them to attend orientation training. Existing programs should already have an agreement with referral sources which can take additional time if not already available. For non-HFA home visiting programs that have staff but are learning the HFA model, the start-up time will be 3-4 months. For brand new HFA programs, start-up time may be 4-6 months. These timelines are broad and should be used for general guidance only as program implementation is influenced by multiple variables, including but not limited to, the LHJs capacity and readiness to start and/or expand a program.

# Appendix C

## Example of Home Visiting Program Supportive Data and Information Table

### Sacramento County's Profile

Poverty Rate<sup>1</sup>  
 First Time Mothers on Medi-Cal<sup>2</sup>  
 Mothers under 25 years and without a high school diploma<sup>3</sup>  
 Number of At Risk Communities to Target in Part B of Survey  
 NFP Client Number  
 HFA Client Number

> 90th percentile
75th - 89th percentile
75th - 89th percentile
One to Two
879
1794

Maximum # of "High Risk Communities"

Estimated Number of Clients Based on NFP and HFA Methods

#### Summary of Home Visiting Needs Assessment Indicator Performance

The following table summarizes indicators from the *California Statewide Home Visiting Needs Assessment*, specific to the indicated county. Indicators presented, except those marked with "+", were required by the first federal Supplemental Information Request (SIR). The indicators not federally required were included for at least one of the following reasons: a key stakeholder identified it as a priority, the literature demonstrates the ability of its being altered by home visiting intervention, and/or the indicator is measured on state and county levels. Indicators are grouped by six domains.

The table also presents the indicated county's percentile range for each of the Needs Assessment indicators. For every indicator, the indicated county's rate is assigned a percentile based on the distribution of all counties. The percentile could fall into the following categories: Too few events<sup>4</sup>; up to the 49<sup>th</sup> percentile; 50<sup>th</sup> to 74<sup>th</sup> percentile; 75<sup>th</sup> to 89<sup>th</sup> percentile; and 90<sup>th</sup> percentile and above.

Domains	Indicators	Percentile
Newborn/Infant Health	Premature birth	50th - 74th
	Low birth weight infants	50th - 74th
	Infant mortality	< 50th
	Prenatal care <sup>†</sup>	< 50th
	Breastfeeding <sup>†</sup>	50th - 74th
Child Health	Children with special needs <sup>†</sup>	< 50th
	Foster care <sup>†</sup>	75th - 89th
Maternal Health	Prenatal substance use <sup>†</sup>	50th - 74th
	Maternal depression <sup>†</sup>	75th - 89th
	Short birth interval <sup>†</sup>	50th - 74th
Family Characteristics	Domestic violence	< 50th
	Child maltreatment	50th - 74th
Community Characteristics	Poverty	< 50th
	All crime rate	75th - 89th
	Juvenile crime rate	< 50th
	School drop-out rate	75th - 89th
	Unemployment	< 50th
Substance Abuse	Marijuana use	50th - 74th
	Non-medical pain reliever use	> 90th
	Illicit drug use	75th - 89th
	Binge alcohol use	50th - 74th

Home Visiting Needs Assessment Indicators

Note(s):

- Source: American Community Survey, 2005-2009. Rate calculated by dividing families below 185% FPL with children under 5 by all families with children under 5.
- Source: Birth Statistical Master File, 2009. First time mothers had no previous live births. Mothers used MediCal either for payment of delivery or prenatal care services.
- Source: Birth Statistical Master File, 2009.
- Events <20 are designated as too few events, removed due to unstable rates.

<sup>†</sup>Denotes supplemental indicators.

## **Appendix D - Geospatial Maps**

### Variable Definitions for Geospatial Hot-Spot Analysis

California's unique structure and make-up is a product of the size and diversity of the State's population and geography. California is the most populous State in the United States at an estimated 39.1 million people. California's population distribution is diverse as evidenced by having three of the ten most populous cities in the United States (Los Angeles, San Diego, and San Jose), and a county with only 1,200 residents (Alpine County). The size and varied distribution of California's population across many dense metropolitan areas and many geographically large rural and frontier areas must be considered when defining "Community" and when using data for geospatial mapping. For these reasons, no single map using a single form of a particular indicator can fully portray the entire statewide population. Typically, several maps are needed, using different forms of a particular indicator, in order to portray the entire population accurately. The geospatial hot-spot analyses provided for this HVP-RSI use data from the United States Census American Community Survey, 2005 – 2009, for families below 185% Federal Poverty Level (FPL) with any children under age five. Data for this indicator was analyzed using two different forms of the indicator: percent of population below 185% FPL and the count per square kilometer. Using percent of population allows for identifying areas where there exist a large number of families living in poverty relative to the overall size of the population in that area. Using count per square kilometer allows for identifying areas where there exist a large number of families living in poverty accounting for the population density.

### Geographic Unit of Analysis for Geospatial Mapping

The geospatial analyses included in this HVP-RSI use MSSA as the primary unit of analysis. Zip codes change frequently, often cross County boundaries, and often present considerable heterogeneity with regard to population and neighborhood characteristics. Other units of analysis based on census designations address many limitations of zip codes. Census tracts are small, relatively permanent statistical subdivisions of a county. Census tracts usually have between 2,500 and 8,000 persons and, when first delineated, are designed to be homogeneous with respect to population characteristics, economic status, and living conditions. Census tracts also do not cross county boundaries. Census tract boundaries are delineated with the intention of being maintained over a long time so that statistical comparisons can be made from census to census. However, the spatial size of census tracts varies widely depending on the density of settlement. Although census tracts are designed to be homogenous, they do not necessarily represent "community". Medical Service Study Areas (MSSAs) are census tract based geographic areas developed in California for the specific purpose of conducting needs assessments to identify disparities and unmet need, and were developed with community input so the designations would reflect neighborhood characteristics. MSSAs are comprised of several U.S. census tracts. In urban areas, MSSAs tend to be comprised of a larger number of census tracts that are small in area size but high in population counts. MSSAs in rural areas are typically comprised of a smaller number of census tracts and are less densely populated.

### Purpose of Hot-Spot Maps and Thematic Maps

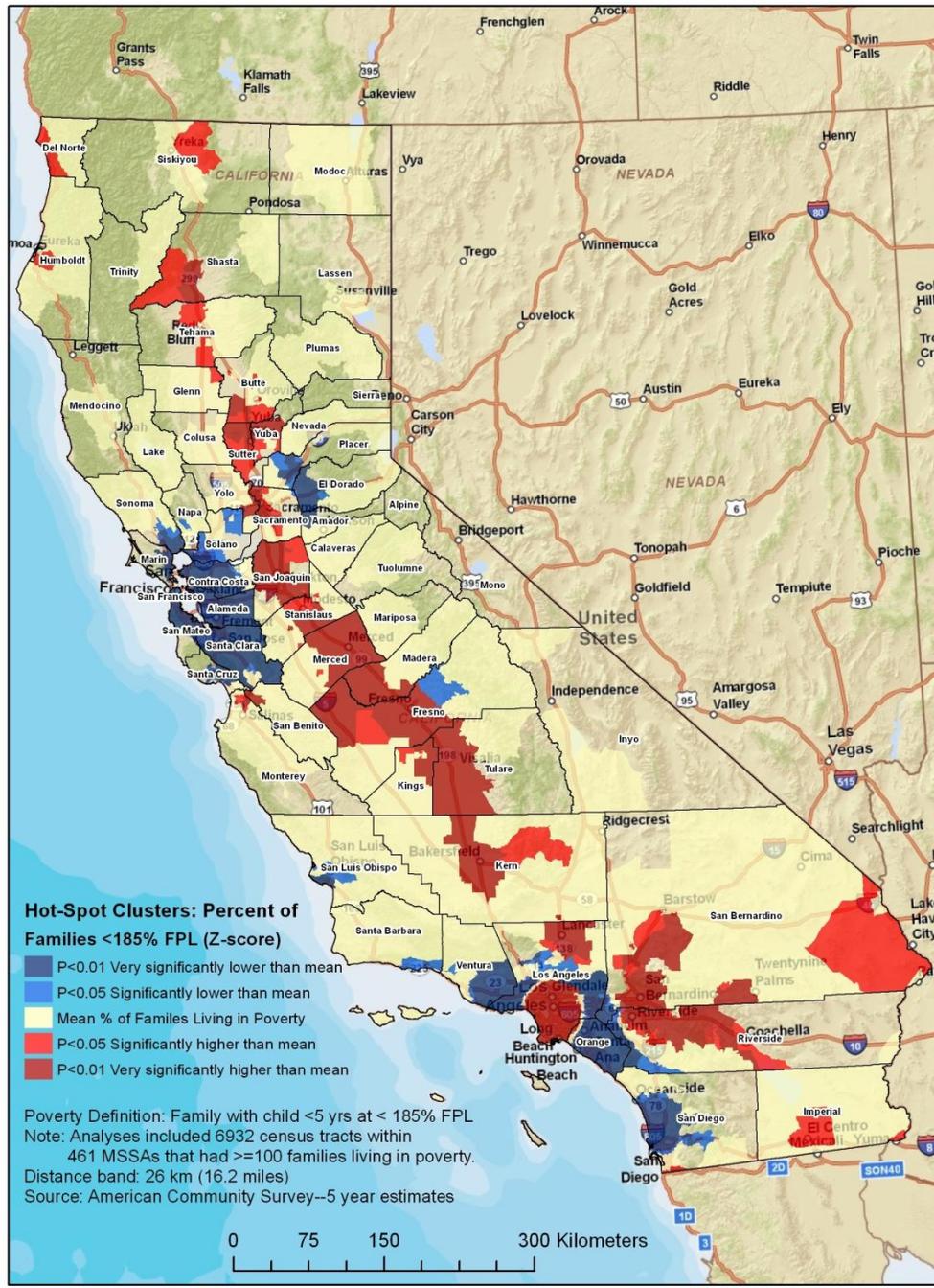
The maps presented in this HVP-RSI are of two types: geospatial hot-spot maps and choropleth thematic maps. These maps are provided to fulfill two very distinct purposes.

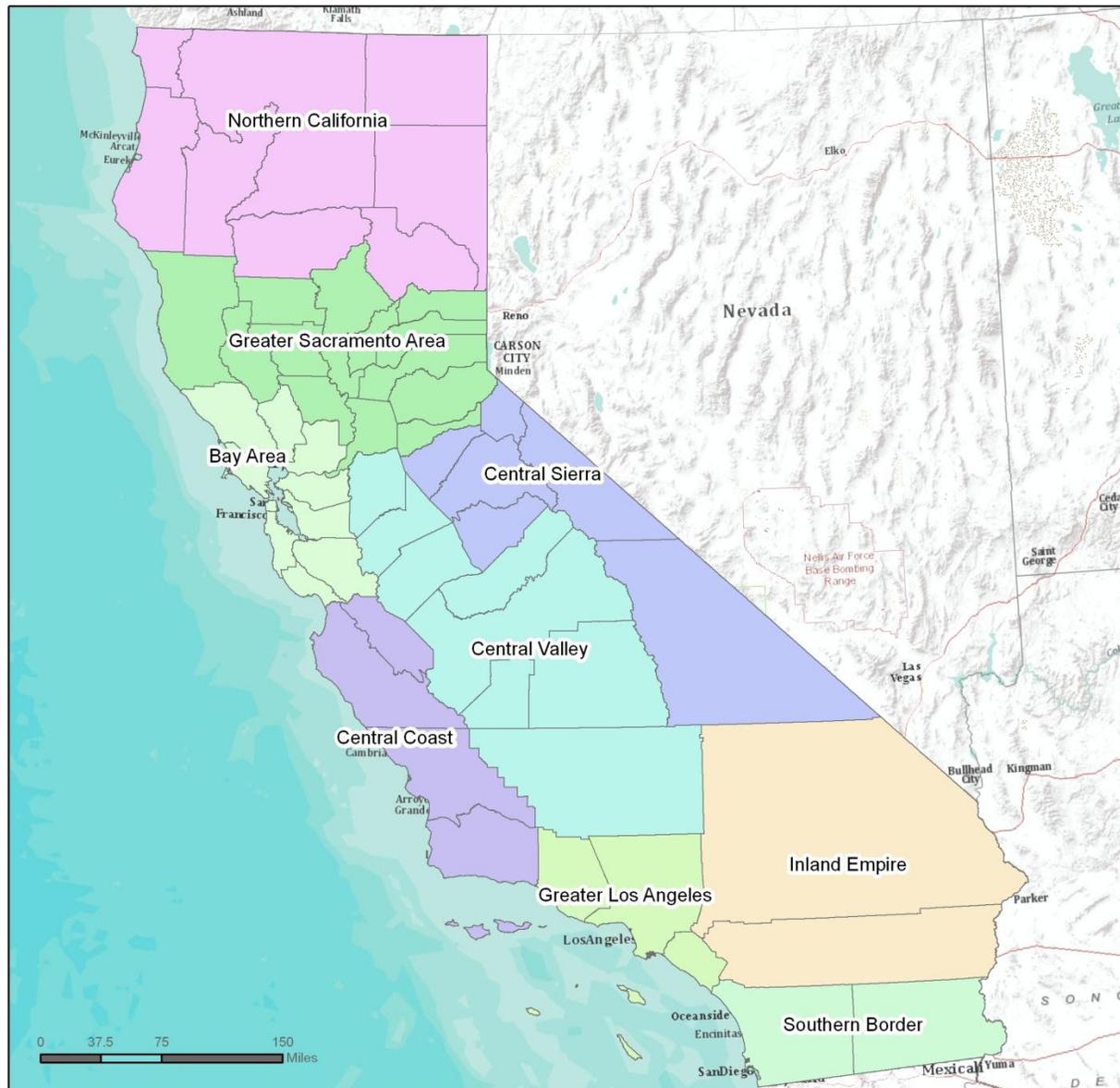
The Geospatial hot-spot analyses are intended to identify areas with greater poverty compared to all other areas of the State; these maps are not intended to identify the area of greatest poverty compared to the rest of a County or LHJ. Areas shaded **red** on the hot-spot maps have a statistically larger percentage living in poverty compared to the rest of the State or a statistically larger count per square kilometer living in poverty compared to the rest of the State.

The thematic maps, also referred to as choropleth maps, are intended to show the number of families with a particular characteristic in different parts of the LHJ. There are three choropleth maps available to LHJs when responding to this HVP-RSI: number of families below 185% FPL with any children under age five, estimated number of families likely to enroll in NFP, and estimated number of families likely to enroll in HFA. Information in these maps will be useful for LHJs in determining if a particular Community they consider “High Risk” is likely to meet minimum enrollment requirements for NFP or HFA.

# Hot-Spot Analysis: Percent of Families Below 185% FPL With Any Children Under Age 5

## Hot-Spot Analysis: Percent of Families Living in Poverty California Census Tracts, 2005-2009





Maternal, Child, and Adolescent Health

## Statewide Hot Spot Map Regions

Prepared by: Maternal, Child, and Adolescent Health Program, Center for Family Health, California Department of Public Health.



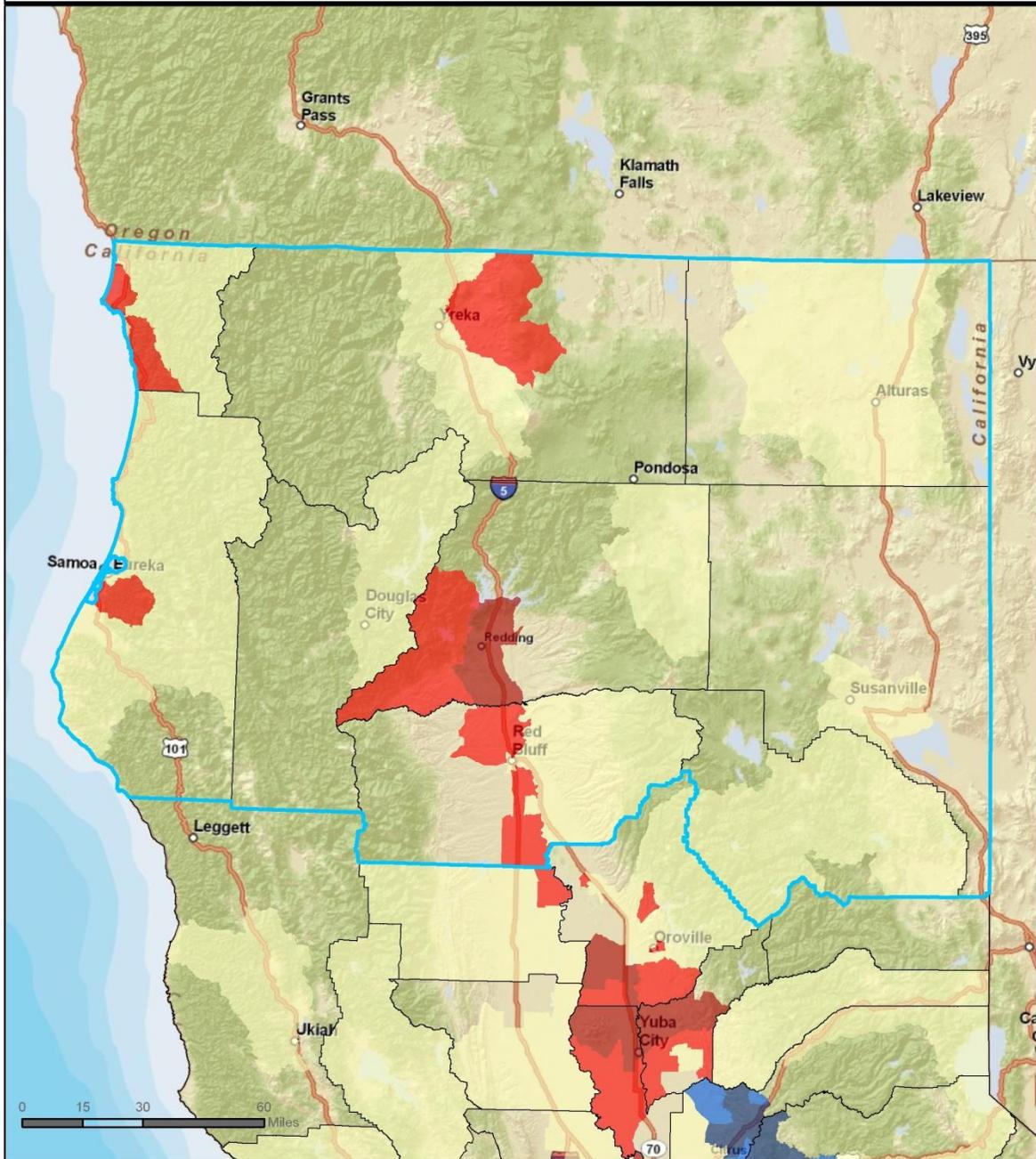
# Hot Spot Analysis: Percent of Families Living in Poverty California Census Tracts, 2005-2009 Northern California

Hot-Spots (26km): Percent of Families <185% FPL (Z-score)

- Low
- Moderate
- Moderate
- High
- High



Source: American Community Survey, 5 year estimates  
 Note: Families are below 185% Federal Poverty Level with at least one child under age 5.  
 Prepared by: Maternal, Child and Adolescent Health Program, California Department of Public Health.



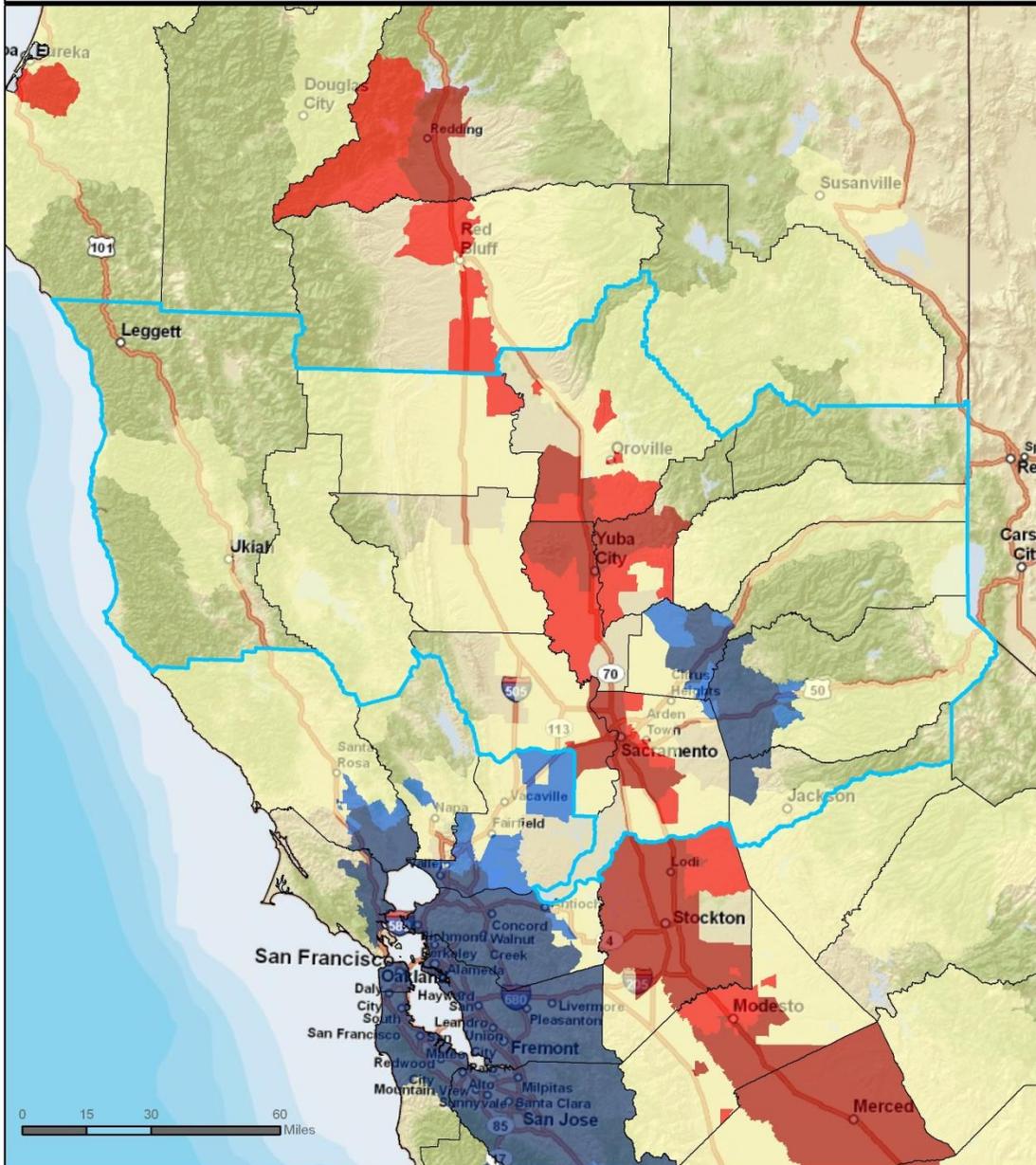
# Hot Spot Analysis: Percent of Families Living in Poverty California Census Tracts, 2005-2009 Greater Sacramento Area

Hot-Spots (26km): Percent of Families <185% FPL (Z-score)

- Low
- Moderate
- High
- High



Source: American Community Survey, 5 year estimates  
 Note: Families are below 185% Federal Poverty Level with at least one child under age 5.  
 Prepared by: Maternal, Child and Adolescent Health Program, California Department of Public Health.

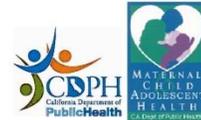


# Hot Spot Analysis: Percent of Families Living in Poverty California Census Tracts, 2005-2009

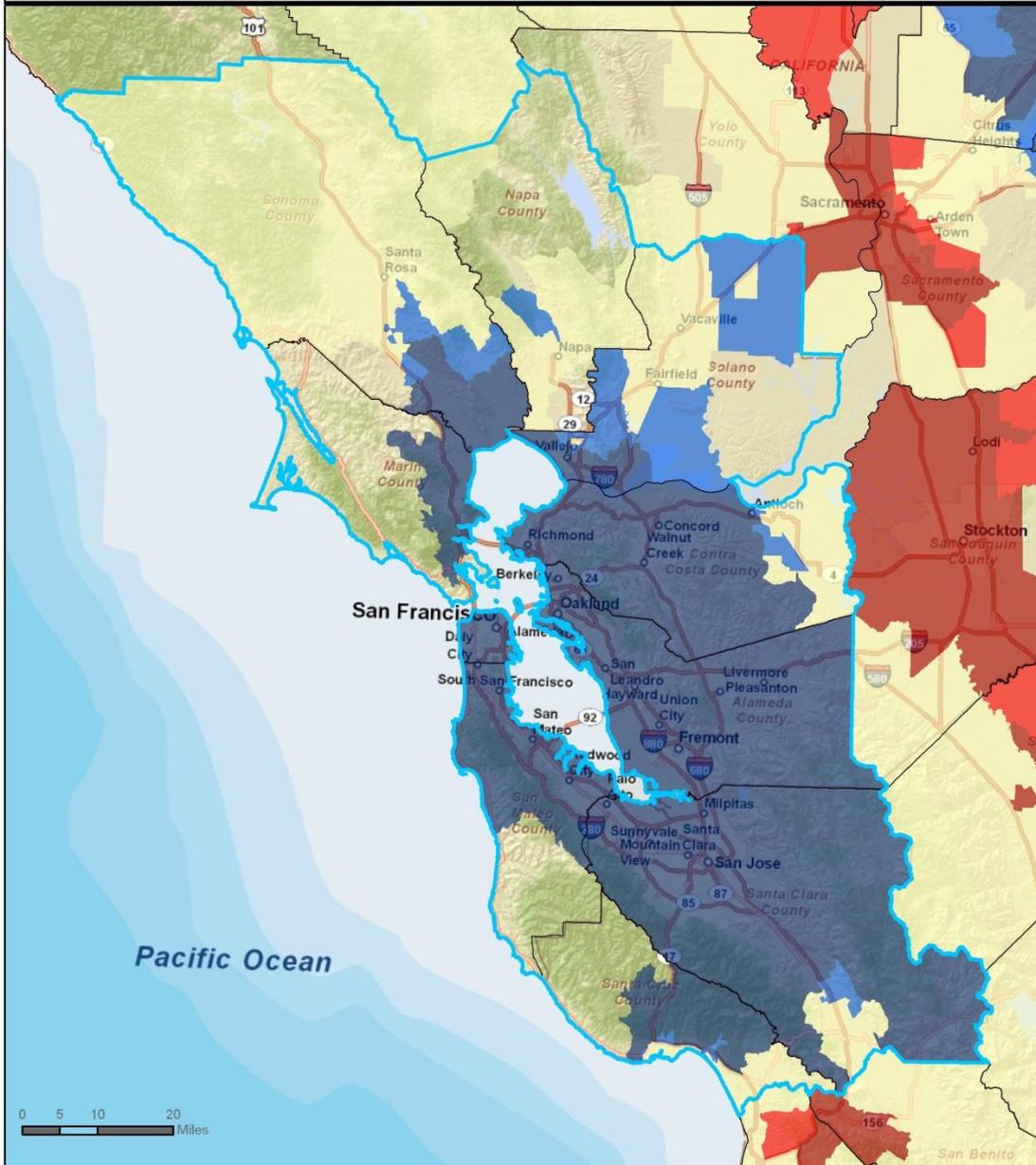
## Bay Area

Hot-Spots (26km): Percent of Families <185% FPL (Z-score)

- Low
- Moderate
- High
- High



Source: American Community Survey, 5 year estimates  
 Note: Families are below 185% Federal Poverty Level with at least one child under age 5.  
 Prepared by: Maternal, Child and Adolescent Health Program, California Department of Public Health.



# Hot Spot Analysis: Percent of Families Living in Poverty California Census Tracts, 2005-2009

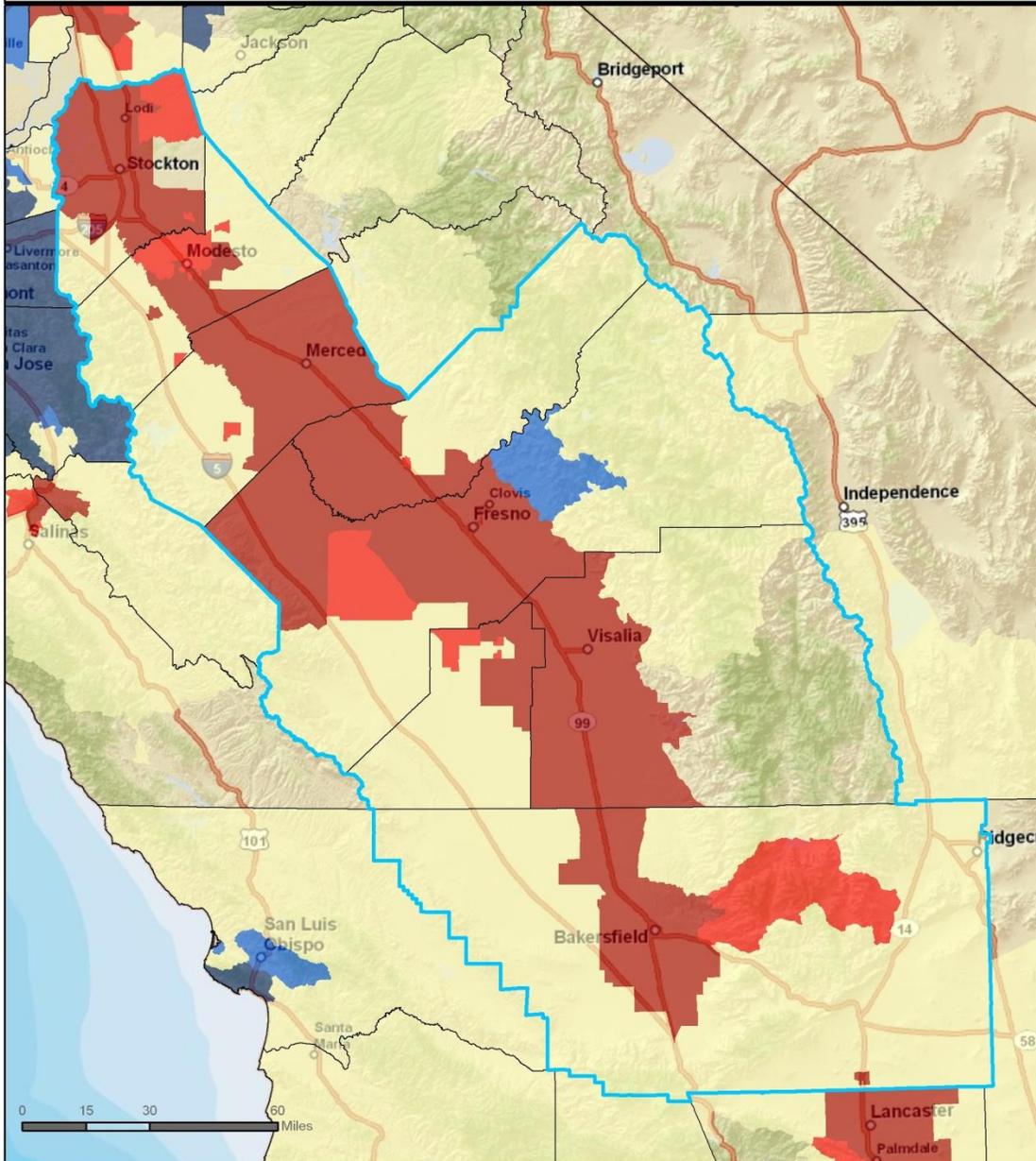
## Central Valley

Hot-Spots (26km): Percent of Families <185% FPL (Z-score)

- Low
- Moderate
- High
- High



Source: American Community Survey, 5 year estimates  
 Note: Families are below 185% Federal Poverty Level with at least one child under age 5.  
 Prepared by: Maternal, Child and Adolescent Health Program, California Department of Public Health.



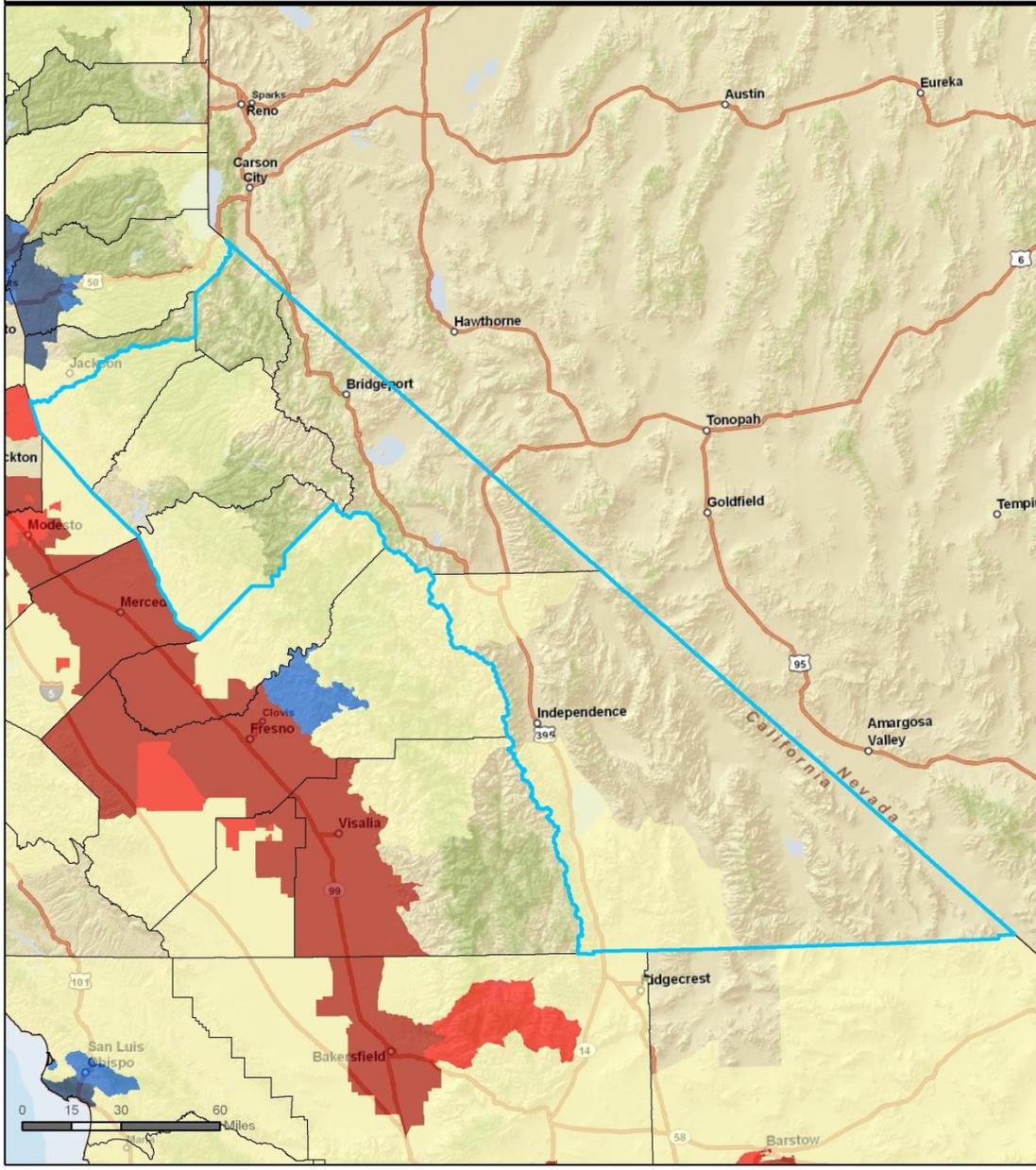
# Hot Spot Analysis: Percent of Families Living in Poverty California Census Tracts, 2005-2009

## Central Sierra

Source: American Community Survey, 5 year estimates  
 Note: Families are below 185% Federal Poverty Level with at least one child under age 5.  
 Prepared by: Maternal, Child and Adolescent Health Program, California Department of Public Health.

Hot-Spots (>26km): Percent of Families <185% FPL (Z-score)

- Low
- Moderate
- High
- High



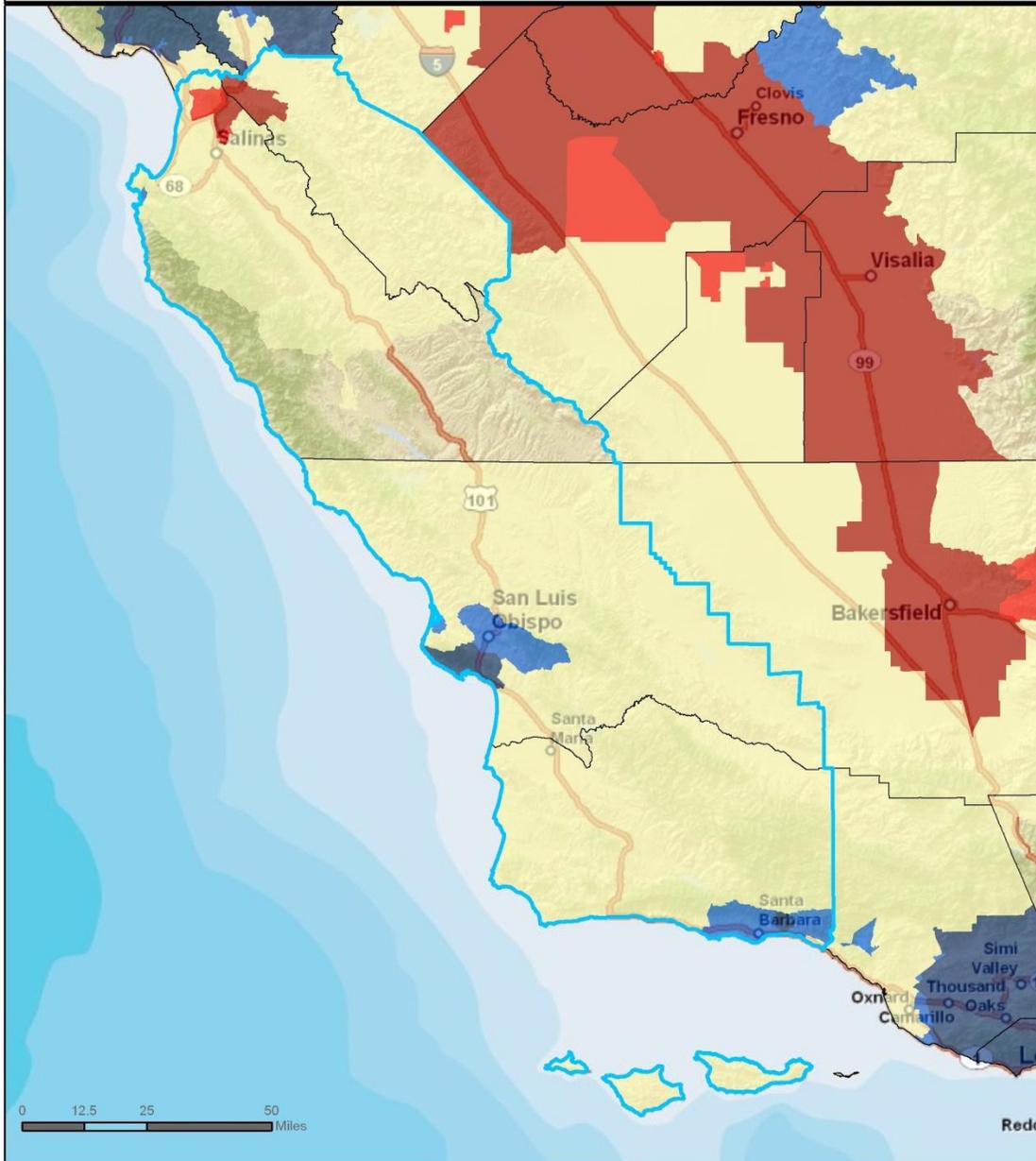
# Hot Spot Analysis: Percent of Families Living in Poverty California Census Tracts, 2005-2009

## Central Coast

Source: American Community Survey, 5 year estimates  
 Note: Families are below 185% Federal Poverty Level with at least one child under age 5.  
 Prepared by: Maternal, Child and Adolescent Health Program, California Department of Public Health.

Hot-Spots (26km): Percent of Families <185% FPL (Z-score)

- Low
- Moderate
- High
- High

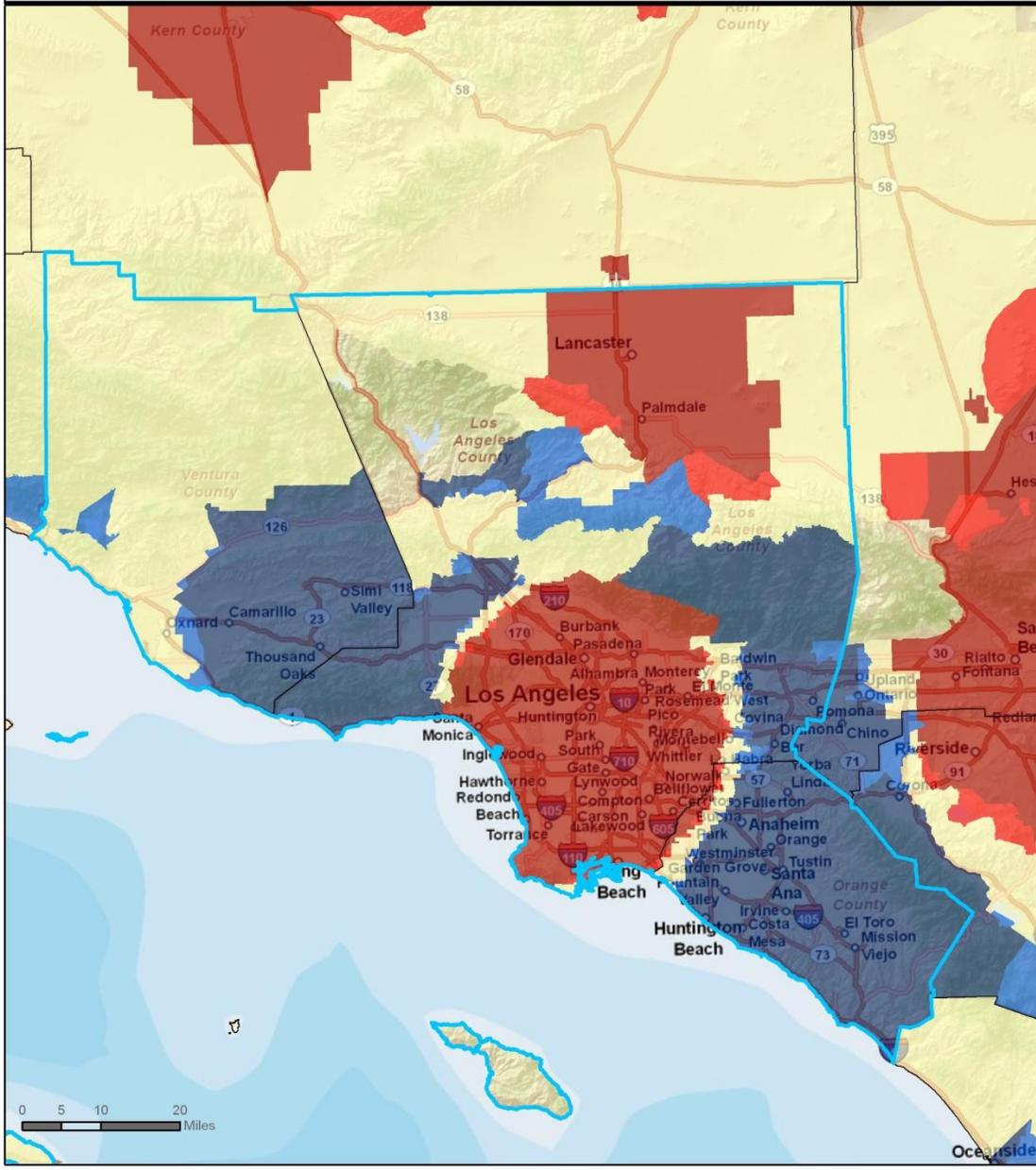


# Hot Spot Analysis: Percent of Families Living in Poverty California Census Tracts, 2005-2009 Greater Los Angeles

Hot-Spots (≥6km): Percent of Families <185% FPL (Z-score)

- Low
- Moderate
- High
- High

Source: American Community Survey, 5 year estimates  
 Note: Families are below 185% Federal Poverty Level with at least one child under age 5.  
 Prepared by: Maternal, Child and Adolescent Health Program, California Department of Public Health.



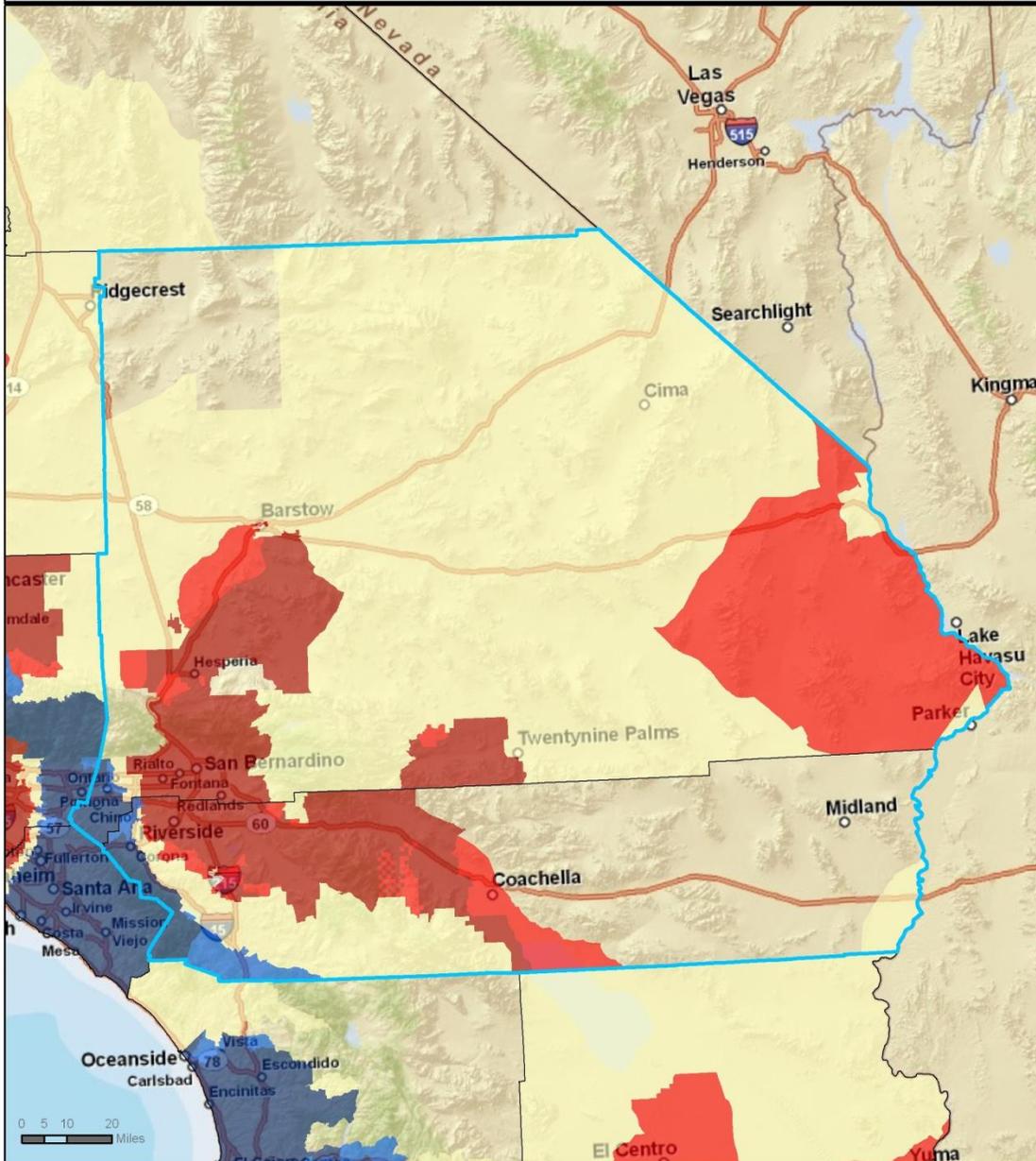
# Hot Spot Analysis: Percent of Families Living in Poverty California Census Tracts, 2005-2009

## Inland Empire

Source: American Community Survey, 5 year estimates  
 Note: Families are below 185% Federal Poverty Level with at least one child under age 5.  
 Prepared by: Maternal, Child and Adolescent Health Program, California Department of Public Health.

Hot-Spots (26km): Percent of Families <185% FPL (Z-score)

- Low
- Moderate
- High
- High



# Hot Spot Analysis: Percent of Families Living in Poverty California Census Tracts, 2005-2009

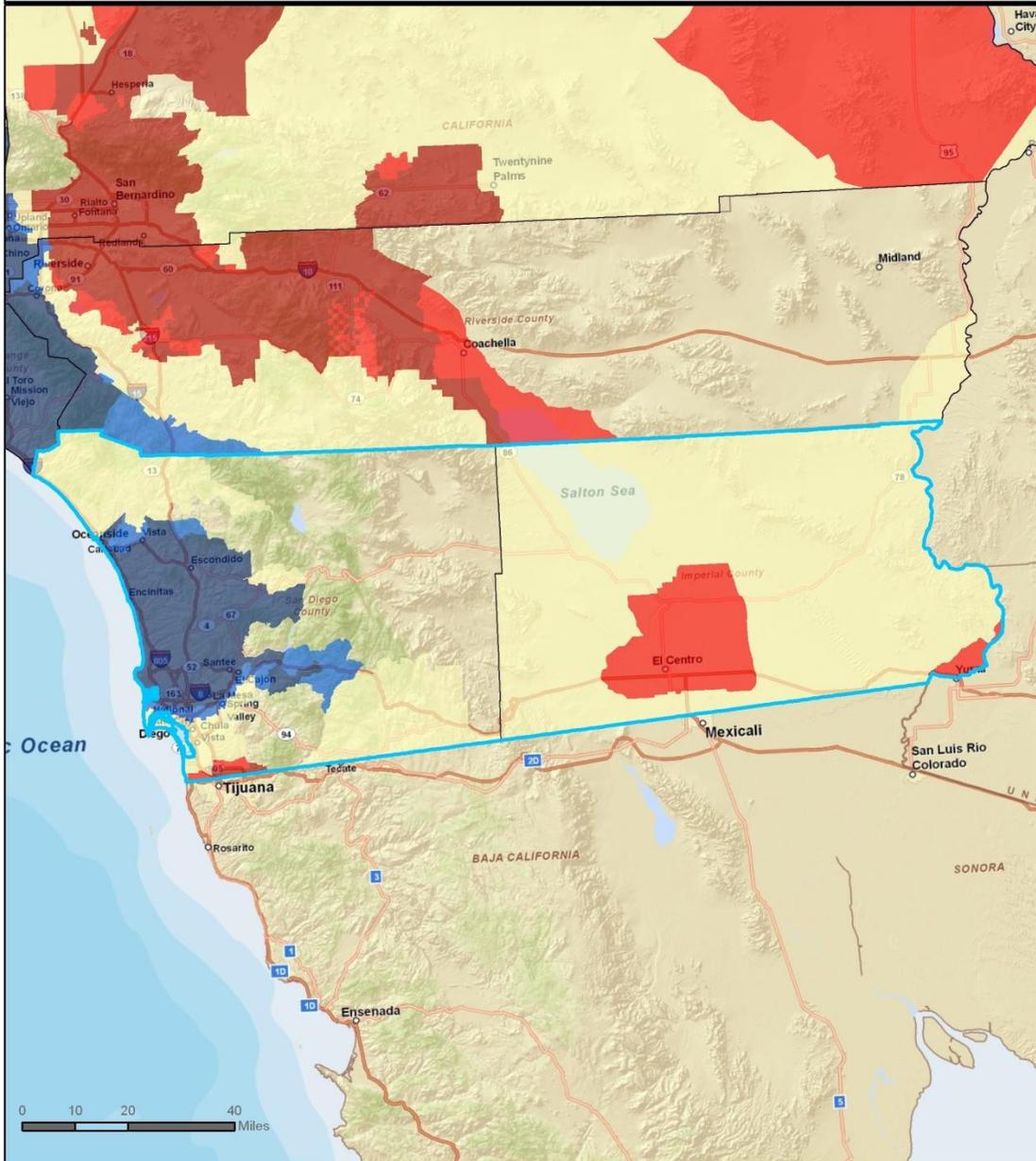
## Southern Border

Hot-Spots (≥26km): Percent of Families <185% FPL (Z-score)

- Low
- Moderate
- High
- High
- High

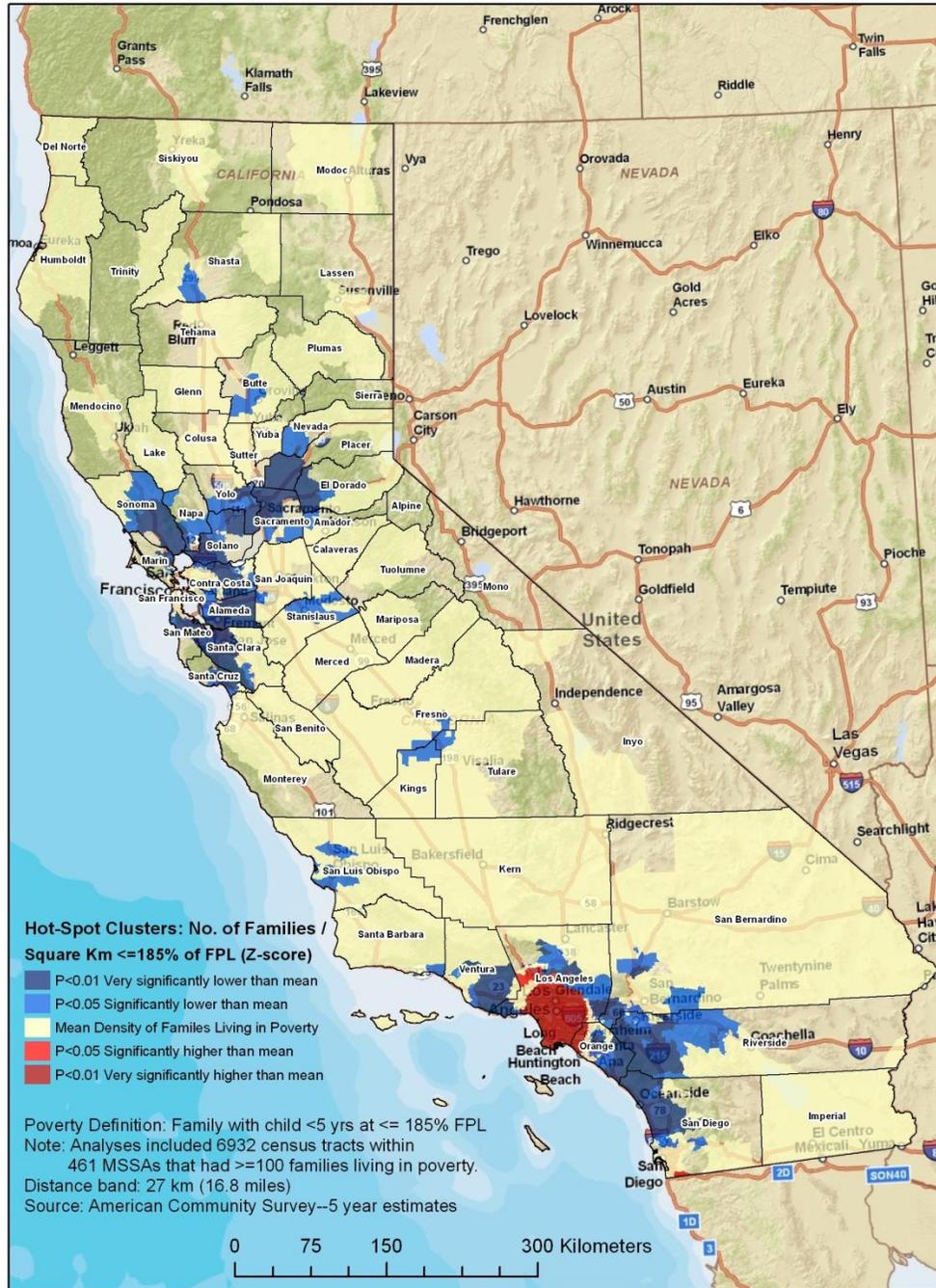


Source: American Community Survey, 5 year estimates  
 Note: Families are below 185% Federal Poverty Level with at least one child under age 5.  
 Prepared by: Maternal, Child and Adolescent Health Program, California Department of Public Health.



# Hot-Spot Analysis: Count Per Square Kilometer of Families Below 185% FPL With Any Children Under Age 5

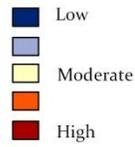
## Hot-Spot Analysis: Density of Families Living in Poverty California Census Tracts, 2005-2009



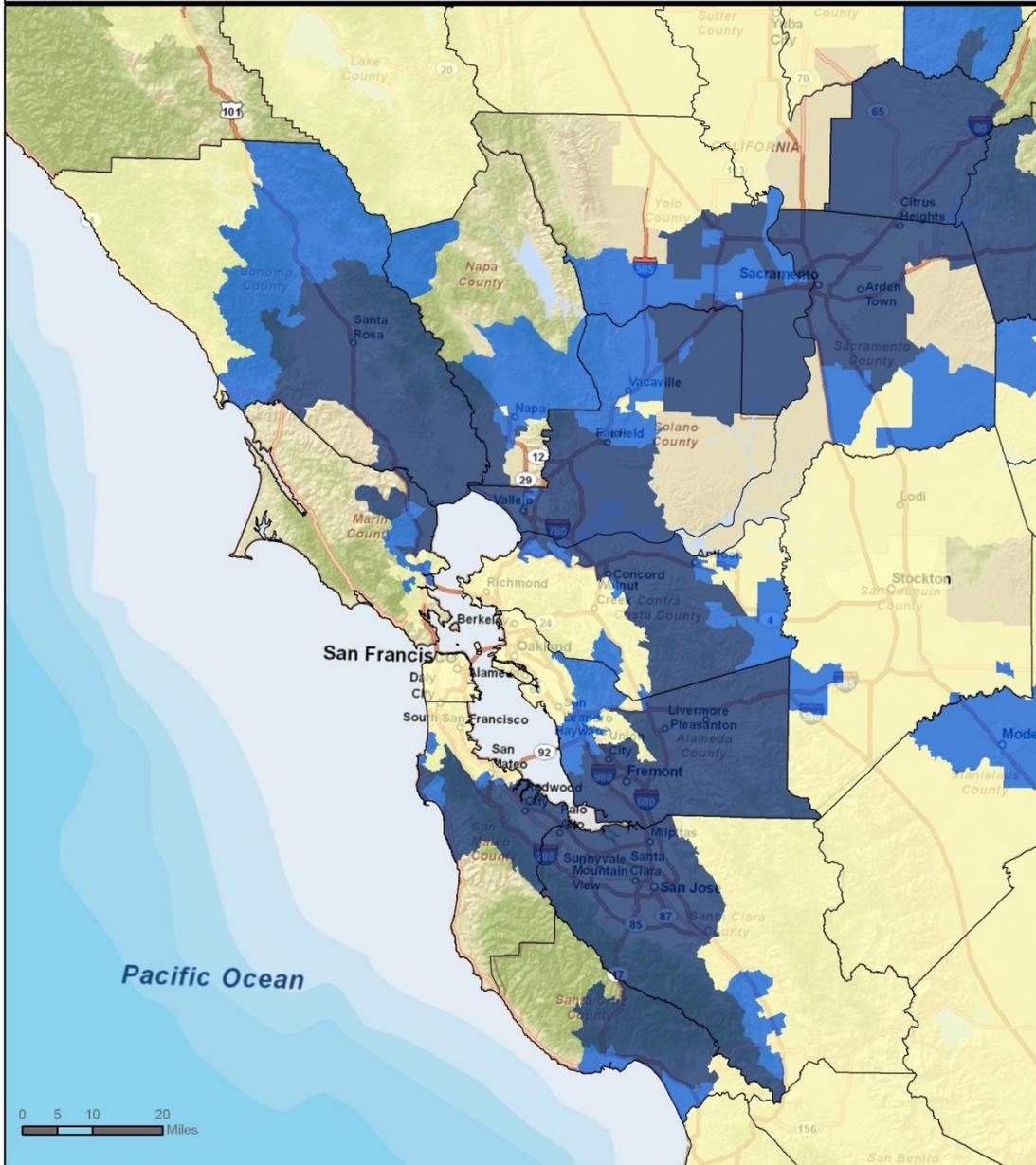
# Hot Spot Analysis: Density of Families Living in Poverty California Census Tracts, 2005-2009

## Bay Area

Hot-Spot Clusters: No. of Families / Square Km  $\leq$ 185% of FPL (Z-score)



Source: American Community Survey, 5 year estimates  
 Note: Families are below 185% Federal Poverty Level with at least one child under age 5.  
 Prepared by: Maternal, Child and Adolescent Health Program, California Department of Public Health.



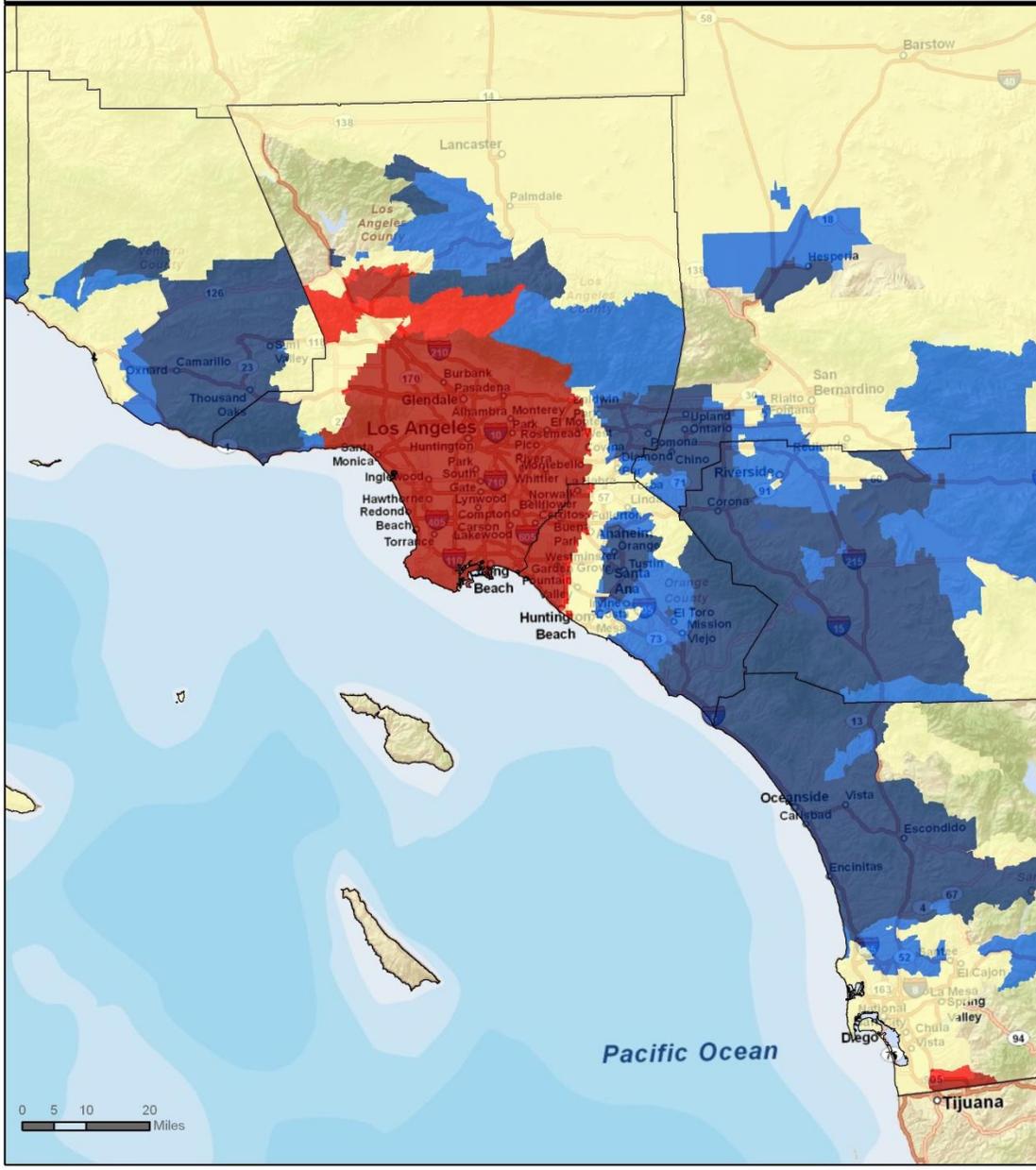
# Hot Spot Analysis: Density of Families Living in Poverty California Census Tracts, 2005-2009 Southern California/Southern Border

Hot-Spot Clusters: No. of Families / Square Km <=185% of FPL (Z-score)

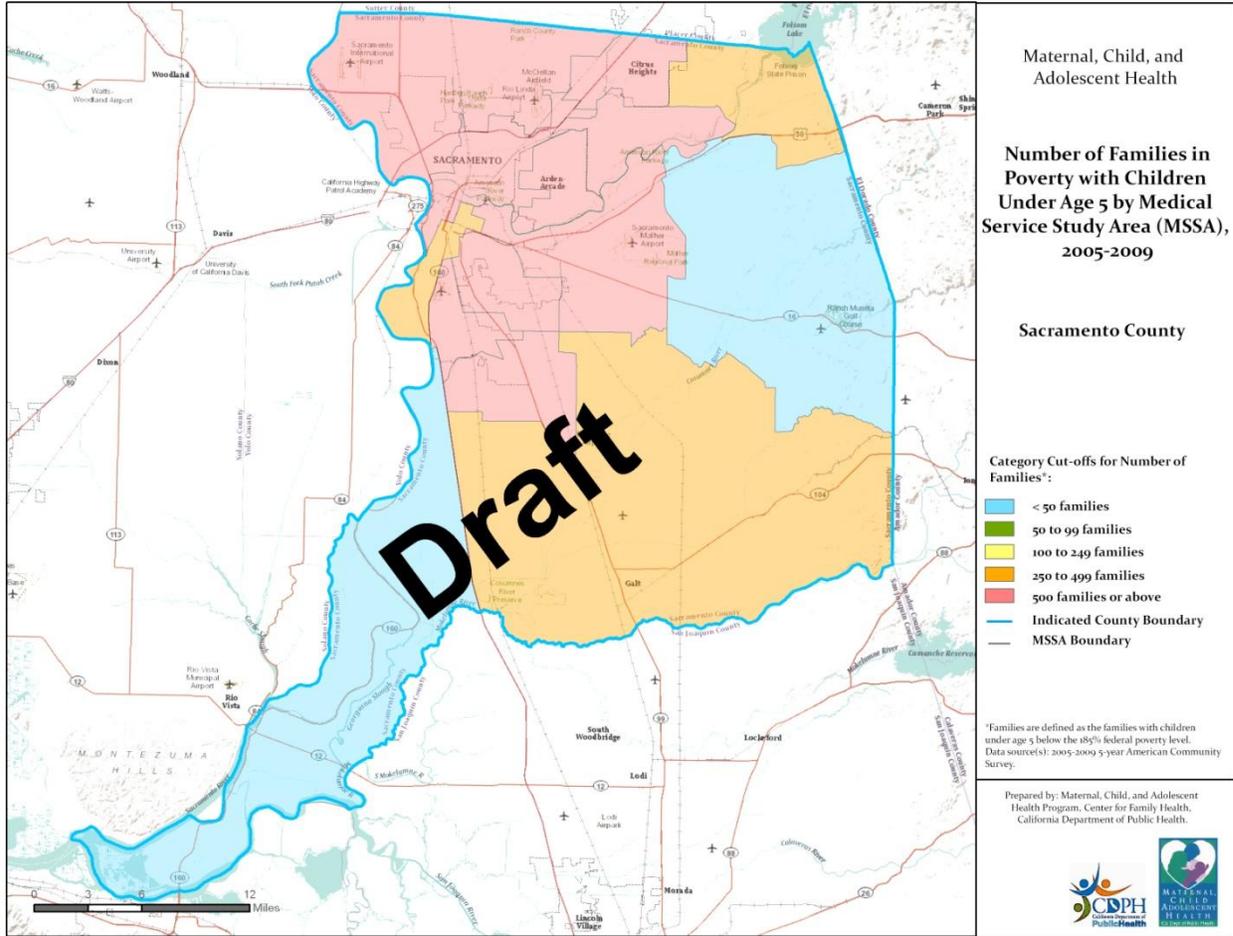
- Low
- Moderate
- High



Source: American Community Survey, 5 year estimates  
 Note: Families are below 185% Federal Poverty Level with at least one child under age 5.  
 Prepared by: Maternal, Child and Adolescent Health Program, California Department of Public Health.



# Example County Level Choropleth (Thematic) Map



## Appendix E

# Reviewing and Categorizing High Risk Communities

### Introduction

To identify the “High Risk Communities” in California where Home Visiting programs, when implemented, will have the greatest impact, the Maternal, Child and Adolescent Health Division of the California Department of Public Health (CDPH/MCAH) has requested information from each Local Health Jurisdiction (LHJ) to incorporate local expertise in the Community selection process. Qualitative information from the California Home Visiting Program Request for Supplemental Information (HVP-RSI) will be combined with quantitative data already available to CDPH/MCAH to identify communities in California with a high need for Home Visiting services and a high likelihood of success in improving the health outcomes of families in those communities.

### Step 1: Need and Enrollment Minimum within the Community

All communities will be categorized into higher and lower need categories based on geospatial analysis of need and if they are likely to meet minimum enrollment for a Home Visiting program. Using the LHJs description of the geographic area targeted for a Home Visiting program (from PART A of the HV RSI: Question 8), CDPH/MCAH staff will determine if the target community aligns with one of the “hot-spots” identified as having statistically significantly higher percentages or counts per square kilometer of poverty than the state average. Poverty is based on data from the 2005-2009 U.S. Census American Community Survey for families below 185% Federal Poverty Level with any children under age 5. In addition, each Community will be assessed on the likelihood of meeting the minimum requirement of 100 families per Home Visiting program using methods provided by HFA and NFP. Based on this review of Community level information regarding need and minimum enrollment, communities will be categorized into four groups, as shown in Table 1.

Table 1: Need and Enrollment Minimum

		Community is a “Hot-Spot”	
		Yes	No
Meet Minimum Enrollment	Yes	High Need <sup>1a</sup>	Moderate Need <sup>1b</sup>
	No	Lower Need <sup>1c</sup>	Lowest Need <sup>1d</sup>

## Step 2: Readiness and Timeline to Implement

The ACA of 2010 federal legislation requires States to demonstrate improvement in four out of the six benchmark areas by year three of the Home Visiting Program. Therefore, community readiness to quickly and efficiently implement a Home Visiting program is of paramount importance in the initial round of funding. Community readiness that enables communities to implement a program on a short timeline will be assessed on the existence of an infrastructure to support expansion or implementation of NFP/HFA, length of time to hire staff and reach minimum client volume, access to target populations for referrals and established community resource connections within the community.

As part of the CDPH/MCAH categorization process, all communities will be placed into higher and lower readiness categories based on the existing community readiness to implement a program on a short timeline. Proposed timelines will be evaluated relative to realistic timelines provided by Healthy Families America (HFA) and Nurse Family Partnership (NFP). Readiness to implement a Home Visiting program will be determined by a community's current infrastructure and its ability to hire and train both program staff and supervisors. Another component of readiness is the existence of systems and/or frameworks for collaboration and referrals, and a strong plan to identify and recruit potential participants that will contribute to both a short timeline to implementation and a short timeline to minimum enrollment requirements. Based on the review of community readiness and timeline, communities will be categorized into the four groups shown in Table 2.

Table 2: Readiness and Timeline to Implement

		Timeline to Required Caseload	
		Short	Long
Readiness to Implement HV	More	More Readiness/ Short Timeline <span style="color: red;">2a</span>	More Readiness/ Long Timeline <span style="color: red;">2b</span>
	Less	Less Readiness/ Short Timeline <span style="color: red;">2c</span>	Less Readiness/ Long Timeline <span style="color: red;">2d</span>

## Step 3: Potential Impact

Information from the Need and Enrollment Minimum Assessment (Step 1) and the Readiness and Timeline to Implement Assessment (Step 2) will be combined to identify communities in which the proposed Home Visiting programs have the greatest potential for impact and to meet requirements stated in the ACA of 2010 Federal Legislation. Table 3 demonstrates how the four categories with the greatest potential for impact would be determined. For example, the cell labeled "Greatest Impact" represents communities that were identified in Step 1 as High Need (in cell 1a) AND also identified in Step 2 as High Readiness to implement (in cell 2a).

Table 3: Categories for Potential for Impact Based on Need and Readiness

	High Readiness	Moderate Readiness
High Need	Greatest Impact (cells 1a and 2a)	Significant Impact (cells 1a and 2b)
Moderate Need	Potential Impact (cells 1b and 2a)	Less Potential for Impact (cells 1b and 2b)

Note: This step uses only the high and moderate need groups from Table 1 and the high and moderate readiness groups from Table 2. If funding permitted, more Categories for Potential Impact could be created using the Lower Need and Lower Readiness groups.

#### Step 4: Community and LHJ Capacity

Once communities have been categorized by need and readiness, CDPH/MCAH staff will form review panels and will further review responses from the HVP-RSI to assess likelihood to implement a Home Visiting program successfully.

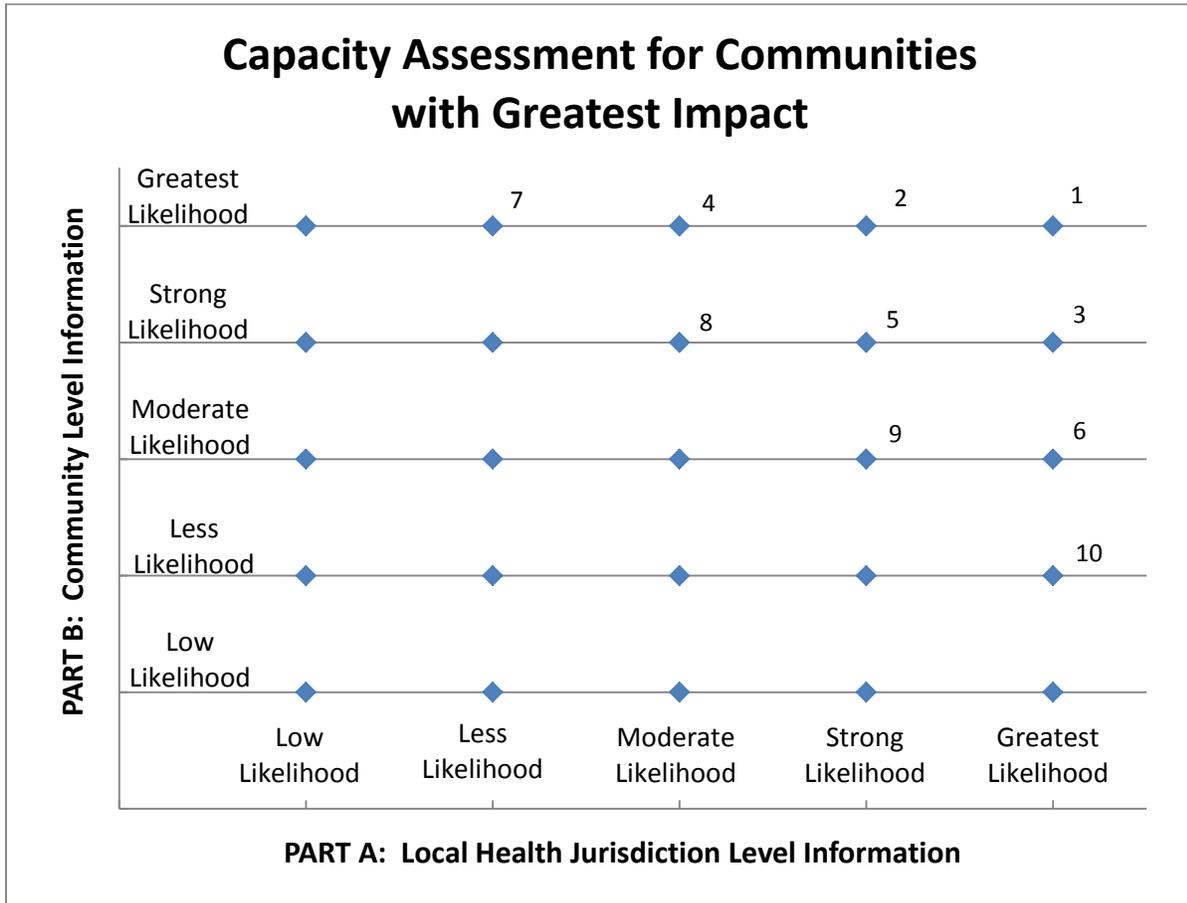
The Federal Supplemental Information Request 2 (SIR-2) requires that the State and funded local Home Visiting programs collect and use high quality data, complete rigorous program evaluation, implement continuous quality improvement, and LHJs maintain high level coordination and collaboration with partner agencies. Therefore, CDPH/MCAH will be reviewing the HVP-RSI responses at the LHJ level for the LHJs previous experience with data collection and use, and current examples of coordination and collaboration with other local agencies.

In addition to the review focusing on the LHJ, responses will be reviewed regarding the identified Community. Federal SIR-2 refers to the importance of community strengths and needs complementing current Home Visiting services, and other aspects of a strong timeline and implementation plan. Therefore, CDPH/MCAH will also be reviewing the HVP-RSI responses at the Community level to categorize likelihood of success with these things in mind.

The two review panels will use a Likert scale to independently categorize communities and corresponding LHJs as having either ‘Greatest Likelihood’, ‘Strong Likelihood’, ‘Moderate Likelihood’, ‘Less Likelihood’ or ‘Low Likelihood’ to Succeed when implementing a Home Visiting program. The categorizations assigned by the review panels will be reconciled to assure objectivity. Once this is complete, each Community will be plotted on an x and y axis with the x-axis representing the likelihood to succeed based on responses to PART A (LHJ Level Information) and the y-axis representing the responses to PART B (Community Level Information). An example of this plot for the category of ‘Greatest Impact’ is shown in Figure 1. This process will be repeated combining the categories ‘Significant Impact’ and ‘Potential Impact’ and creating a

separate plot for these combined groups. Communities graphed at point 1 represent those communities with the greatest likelihood for success at both the LHJ and Community levels. Communities at point 2 have the greatest likelihood for success on the Community level and a strong likelihood of success on the LHJ level.

Figure 1: Greatest Impact: Community and LHJ Capacity Assessment



### Step 5: Programs to Fund

Communities from the 'Greatest Impact' group will be funded first starting at point 1 in Figure 1. If funding remains after all communities at point 1 have been funded, communities will then be funded sequentially at point 2, then point 3, and so on as funding levels permit. In order to ensure funding to some communities without an existing Home Visiting program, one community from the 'Significant Impact' or 'Potential Impact' categories will be funded for every three communities from the 'Greatest Impact' category. This practice will allow CDPH/MCAH to establish best practices and lessons learned for implementing Home Visiting programs in areas with less existing infrastructure. These lessons and best practices will be essential in future years as funding allows for greater numbers of communities with less experience and/or infrastructure for Home Visiting.