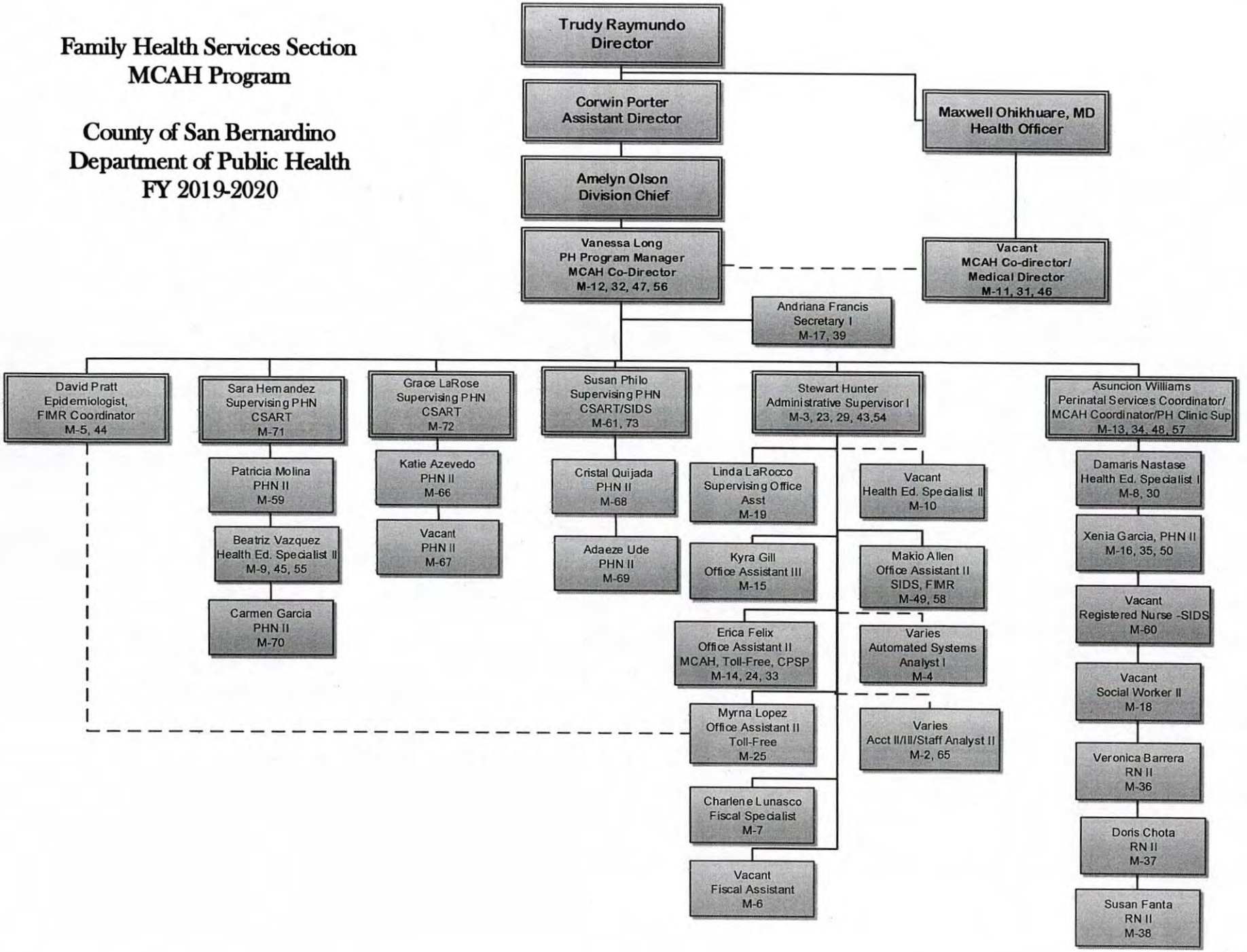
Family Health Services Section
MCAH Program

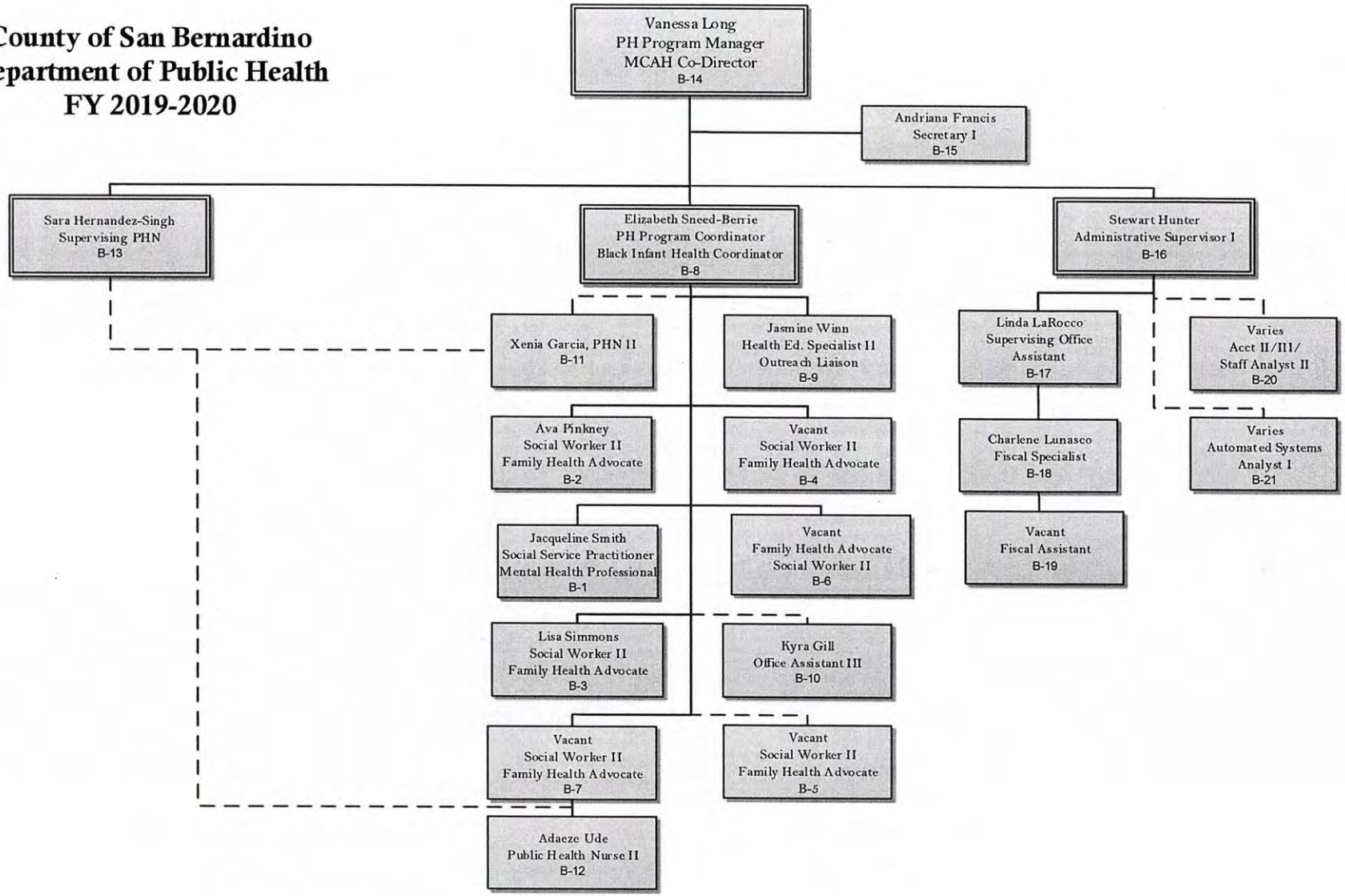
County of San Bernardino
Department of Public Health
FY 2019-2020



Rev. 5.1.19

Family Health Services Section
Black Infant Health Program

County of San Bernardino
Department of Public Health
FY 2019-2020



Rev. 4.29.19

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www.SBCounty.gov

SAN BERNARDINO COUNTY

Public Health
Family Health Services Section

Trudy Raymundo
Director

Corwin Porter
Assistant Director

Maxwell Ohikhuare, M.D.
Health Officer

May 1, 2019

Mary DeSouza, MSW
Chief, LHJ Program Integrity and Operations
Maternal, Child, and Adolescent Health
California Department of Public Health
1615 Capitol Avenue
Sacramento, CA 95814

RE: MCAH ALLOCATION #201936 – REQUEST FOR FTE TIME WAIVER AND APPROVAL FOR MCAH KEY PERSONNEL IN THE COUNTY OF SAN BERNARDINO FOR FY 2019-20

Dear Ms. DeSouza:

The County of San Bernardino Department of Public Health is requesting for a waiver of the FTE time requirements, as stipulated in the MCAH Policies and Procedures Manual, for a full-time physician as the MCAH Director and a waiver for 1.25 FTE as the Perinatal Services Coordinator. This request for a waiver is submitted as part of the FY 2019-20 Agreement Funding Application.

We are requesting approval for the following key MCAH personnel. The MCAH Director requirement will be fulfilled by the following qualified health professionals: 1) MCAH Co-Director/Public Health Physician II at 0.5 FTE; 2) MCAH Co-Director/Public Health Program Manager, Vanessa Long, at 0.4 FTE, and 3) MCAH Coordinator, Asuncion Williams, at 0.7 FTE for a total of 1.6 FTE.

The Public Health Physician II will be responsible for providing medical consultation and will coordinate the Title V Needs Assessment. Ms. Long will provide administrative oversight of various MCAH programs included within the MCAH Scope of Work and ensure the performance of the core public health functions. Ms. Williams will assist in implementing the core public health functions and oversee the implementation of the MCAH Action Plan and the Comprehensive Perinatal Services Program (CPSP).

For the CPSP Program, the County is requesting approval for the following CPSP personnel: 1) CPSP Health Education Specialist, Damaris Nastase, at 0.6 FTE; 2) MCAH Coordinator, Asuncion Williams, and with the CPSP Health Education Specialist (HES) functioning in an assistant PSC capacity, these two personnel will continue to function as a team to complete the CPSP scope of work requirements. Ms. Williams will continue to oversee and promote the CPSP Program as well as direct the activities of Ms. Nastase. Ms. Nastase will recruit and retain providers and perform site reviews.

Enclosed is the organizational chart that includes the aforementioned positions within the Department of Public Health and Family Health Services Section structure.

Thank you for your consideration of this waiver request. If you have any question, please contact Amelyn Olson, Division Chief, or myself at 909-387-9146.

Sincerely,

Trudy Raymundo
Public Health Director

TR/sh

Attachments

cc: Maxwell Ohikhuare, MD, Health Officer
Department of Public Health
County of San Bernardino

Amelyn Olson, DrPH, RN, PHN, CHES, Division Chief
Department of Public Health
County of San Bernardino

Vanessa Long, RN, PHN, MSN, Public Health Program Manager
Family Health Services
Department of Public Health
County of San Bernardino

California Department of Public Health (CDPH)
Maternal, Child and Adolescent Health (MCAH) Program
Scope of Work (SOW)

☐ **IMPORTANT:** By clicking this box, I agree to allow the state MCAH Program to post my Scope of Work on the CDPH/MCAH website.

The Local Health Jurisdiction (LHJ), in collaboration with the State MCAH Program, shall strive to develop systems that protect and improve the health of California's women of reproductive age, infants, children, adolescents and their families. The goals and objectives in this MCAH SOW incorporate local problems identified by LHJs in the 5-Year Needs Assessments and reflect the Title V priorities of the MCAH Division. The local 5-Year Needs Assessment identified problems that LHJs may address in their 5-Year Action Plans. The LHJ 5-Year Action Plans inform the development of the annual MCAH SOW.

All LHJs must perform the activities in the shaded areas in Goals 1-3 and monitor and report on the corresponding evaluation/performance measures. In addition, each LHJ is required to develop at least two local objectives in Goal 1, one to address the health of reproductive age women and one to address the needs of pregnant women and two local objectives for Goal 3, a SIDS/SUID objective and an objective to improve infant health. LHJs that receive FIMR funding will perform the activities in the shaded area in Goal 3.5, including one local objective addressing fetal, neonatal, post-neonatal and infant deaths. In the second shaded column of 3.5a, Intervention Activities to Meet Objectives, insert the number and percent of cases that will be reviewed for the fiscal year. Lastly, if resources allow, LHJs should develop additional objectives, which can be placed under any of the Goals 1-5. All activities in this SOW must take place within the fiscal year. Please see the MCAH Policies and Procedures for further instructions on completing the SOW.

The development of this SOW was guided by several public health frameworks including the ones listed below. Please consider integrating these approaches when conceptualizing and organizing local program, policy, and evaluation efforts.

- The Ten Essential Services of Public Health
- The Spectrum of Prevention
- Life Course Perspective
- The Social-Ecological Model
- Social Determinants of Health
- Strengthening Families

All Title V programs must comply with the MCAH Fiscal Policies and Procedures Manual, which is found on the CDPH/MCAH website

CDPH/MCAH Division expects each LHJ to make progress towards Title V State Performance Measures and Healthy People 2020 goals. These goals involve complex issues and are difficult to achieve, particularly in the short term. As such, in addition to the required activities to address Title V State Priorities and requirements, the MCAH SOW provides LHJs the opportunity to develop locally determined objectives and activities that can be realistically achieved given the scope and resources of local MCAH programs.

LHJs are required to comply with requirements as stated in the MCAH Program Policies and Procedures Manual, such as attending statewide meetings, conducting a Needs Assessment every five years, submitting Agreement Funding Applications, and completing Annual Progress Reports.

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 1: Women/Maternal Domain: Improve access to and utilization of comprehensive, quality health and social services

The shaded and/or highlighted areas represent required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
Objective 1.1 **All women of reproductive age, pregnant women, infants, children, adolescents and children and youth with special health care needs (CYSHCN) will have access to needed and preventive, medical, dental, and social services by:** • Targeting outreach services to identify pregnant women, women of reproductive age, infants, children and adolescents and their families who are eligible for Medi-Cal assistance or other publicly provided health care programs and assist them in applying for these benefits[2] • Decreasing Medi-Cal eligible women, children, post-partum women without insurance[1]	**Assessment** **1.1a** i. Identify and monitor the health status of women of reproductive age, pregnant women, infants, children, adolescents, and CYSHCN, including the social determinants of health and access/barriers to the provision of: • Preventive, medical, dental, and social services ii. Review data books and monitor trends over time, geographic areas and population group disparities iii. Annually, share your data with key local health department leadership	**1.1a** i. This deliverable will be fulfilled by completing and submitting your Community Profile with your Agreement Funding Application each year ii. Briefly describe process for monitoring and interpreting data iii. Report the date data shared with the key health department leadership. Briefly describe their response, if significant.	**1.1a** Nothing is entered here.

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 1: Women/Maternal Domain: Improve access to and utilization of comprehensive, quality health and social services

The shaded and/or highlighted areas represent required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	1.1b Participate in collaboratives, coalitions, community organizations, etc., to review data and develop policies and products to address social determinants of health and disparities.	**1.1b** Report the total number of collaboratives with MCAH staff participation. Submit online Collaborative Surveys that document participation, objectives, activities and accomplishments of MCAH – related collaboratives.	**1.1b** List policies or products developed to improve infrastructure that address MCAH priorities.
	Policy Development **1.1c** i. Review, revise and enact protocols or policies that facilitate access to Medi-Cal, California Children's Services (CCS), Covered CA, and Women, Infants, and Children (WIC)	**1.1c** i. List types of protocols or policies developed or revised to facilitate access to health care services.	**1.1c** i. List formal and informal agreements in place including Memoranda of Understanding with Medi-Cal Managed Care Plans (MCP) or other organizations that address the needs of mothers and infants

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[3] State Requirements

Goal 1: Women/Maternal Domain: Improve access to and utilization of comprehensive, quality health and social services

The shaded and/or highlighted areas represent required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	ii. Develop and implement protocols to ensure all clients in MCAH programs are enrolled in a health insurance plan, linked to a provider, and complete an annual visit. Protocols include the following key components: • Assist clients to enroll in health insurance • Link clients to a health care provider for a preventive and/or medical visit • Develop a tracking mechanism to verify that the client enrolled in health insurance, completed a preventive or well medical visit	ii. Briefly describe the key components of the protocols developed to ensure all clients in MCAH programs are enrolled in insurance or a health plan, linked to a provider and complete an annual preventative and/or medical visit.	ii. Describe and summarize the impact of protocols or policy and systems changes that facilitate access to Medi-Cal, CCS, Covered CA, and WIC.
	Assurance **1.1d** Develop staff knowledge and public health competencies for MCAH related issues	**1.1d** Summarize staff knowledge and competencies gained	**1.1d** Nothing is entered here

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 1: Women/Maternal Domain: Improve access to and utilization of comprehensive, quality health and social services

The shaded and/or highlighted areas represent required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	1.1e Conduct activities to facilitate referrals to Medi-Cal, Covered CA, CCS, and other low cost/no-cost health insurance programs for health care coverage[2]	**1.1e** Describe activities to ensure referrals to health insurance, programs and preventive visits	**1.1e** Report the number of referrals to Medi-Cal, Covered CA, CCS, or other low/no-cost health insurance or programs.
	1.1f Provide a toll-free or "no-cost to the calling party" telephone information service and other appropriate methods of communication, e.g., local MCAH Program web page to the local community[2] to facilitate linkage of MCAH population to services	**1.1f** Describe the methods of communication, including the, cultural and linguistic challenges and solutions to linking the MCAH population to services	**1.1f** Report the following: • Number of calls to the toll-free or "no-cost to the calling party" telephone information service • The number of web hits to the appropriate local MCAH Program webpage

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 1.2: WOMEN/MATERNAL DOMAIN: Improve access to and utilization of comprehensive, quality health and social services for reproductive age women.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
REQUIRED LOCAL OBJECTIVE: Insert locally developed Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. Each LHJ is required to develop at least one specific short and/or intermediate SMART outcome objective(s) to address access to needed preventive services. ***Number each locally developed objective as follows: 1.2, 1.2a, 1.2b, 1.2c, 1.2d, etc.***			
Objective 1.2 By June 30, 2020, 70% of CHDP program providers (pediatricians, family health physicians, and FQHCs) will be implementing Maternal Depression screening at 1, 2, 4 and 6 months.	**1.2a** 1. List evidence-based or informed activities to meet the Objective(s): Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice" http://pediatrics.aappublications.org/content/126/5/1032 2. Interventions/activities: • Provide technical assistance to CHDP providers to identify and implement the use of validated maternal depression screening tools. • Link CHDP providers to resources related to maternal depression screening and counseling. • Continue providing "Feelings in Motherhood" training to CDHP providers. • Promote maternal depression screening through webinars,	**1.2a** • Describe how maternal depression screening was promoted. • Number of CHDP providers that received maternal mental health referral resources. • Number of CHDP providers that were trained in the use of "Feelings in Motherhood" flipchart. • Number of trainings or community events promoting MMH awareness. • QA process developed, including process to measure implementation and barriers to implementation.	**1.2a** Percentage of CHDP program providers implementing Maternal Depression screening at 1, 2, 4 and 6 months.

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 1.2: WOMEN/MATERNAL DOMAIN: Improve access to and utilization of comprehensive, quality health and social services for <u>reproductive age women.</u>

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
<u>REQUIRED LOCAL OBJECTIVE</u>: Insert locally developed Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. Each LHJ is required to develop at least one specific short and/or intermediate SMART outcome objective(s) to address access to needed preventive services. ***Number each locally developed objective as follows: 1.2, 1.2a, 1.2b, 1.2c, 1.2d, etc.***			
	workshops, and presentations at conferences/professional meetings.		

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 1.3: WOMEN/MATERNAL DOMAIN: <u>All pregnant women</u> will have access to early, adequate, and high quality perinatal care with a special emphasis on low-income and Medi-Cal eligible women.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
Objective 1.3 **All women will have access to quality maternal and early perinatal care, including CPSP services for Medi-Cal eligible women by:** • Increasing first trimester prenatal care initiation[1] • Increasing postpartum visit[1] • Increasing access to providers that can provide the appropriate services and level of care for reproductive age women[1]	**Assurance** **1.3a** i. Develop MCAH staff knowledge of the system of maternal and perinatal care ii. Develop a comprehensive resource and referral guide of available health and social services iii. Attend the yearly CPSP statewide meeting iv. Conduct local activities to facilitate increased access to early and quality perinatal care	**1.3a** Report the following: i. List of trainings received by staff on perinatal care, such as roundtables, regional meetings, collaborative work ii. Submit resource and referral guide iii. Date and attendance at the CPSP yearly meeting iv. List activities implemented to increase access of women to early and quality perinatal care. Identify barriers and opportunities to improve access to early and quality perinatal care	**1.3a** Provide the number and describe the outcomes of: • Roundtable meetings • Regional meetings • Other maternal and perinatal meetings

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 1.3: WOMEN/MATERNAL DOMAIN: All pregnant women will have access to early, adequate, and high quality perinatal care with a special emphasis on low-income and Medi-Cal eligible women.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	1.3b Outreach to perinatal providers, including Medi-Cal Managed Care i. Enroll in CPSP (Fee-for-Service and FQHC/RHC/IHC providers) ii. Identify and work with MCP liaisons to provide CPSP comparable services iii. Assist MCP providers to provide CPSP comparable services	**1.3b** i. Enroll FFS and FQHC/RHC/IHC providers Identify the MCP liaison(s). ii. Work with MCP(s) to provide CPSP comparable services iii. Work with MCP providers to provide CPSP comparable services	**1.3b** Nothing is entered here
	1.3c Coordinate perinatal activities between MCAH and the Regional Perinatal Programs of California (RPPC) to improve maternal and perinatal systems of care, including coordinated post-partum referral systems for high-risk mothers and infants upon hospital discharge	**1.3c** List number of meetings attended to facilitate coordination of activities between RPPC and MCAH and briefly describe outcomes	**1.3c** Nothing is entered here.
	1.3d Conduct technical assistance and face-to-face quality assurance/quality improvement (QA/QI) activities with CPSP providers or managed care providers in collaboration with	**1.3d** Report the number of CPSP provider technical assistance activities conducted by phone or email	**1.3d** Describe the results of technical assistance provided by phone or email

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 1.3: WOMEN/MATERNAL DOMAIN: <u>All pregnant women</u> will have access to early, adequate, and high quality perinatal care with a special emphasis on low-income and Medi-Cal eligible women.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	**Short and/or Intermediate Outcome Measure(s)**
	MCP(s) liaison to ensure that CPSP services are implemented and protocols are in place	Report the number of QA/QI face-to-face site visits conducted with: • Enrolled CPSP providers • MCPs providers (with MCP liaison(s)) • Number of chart reviews List common problems or barriers and successful interventions	Describe the results of QA/QI activities that were conducted with: • Enrolled CPSP providers • MCPs providers (with MCP liaison(s)) • Summary of findings from the chart reviews

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 1.4: WOMEN/MATERNAL DOMAIN: Improve access to and utilization of comprehensive, quality health and social services for pregnant women.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
REQUIRED LOCAL OBJECTIVE: Insert locally developed Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. Each LHJ is required to develop at least one specific short and/or intermediate SMART outcome objective(s) to address access to needed preventive services. ***Number each locally developed objective as follows: 1.4, 1.4a, 1.4b, 1.4c, 1.4d, etc.***			
Objective 1.4 By June 30, 2019, 20% of CPSP providers will adopt Low Dose Aspirin (LDA) protocol to prevent preeclampsia.	**1.4** 1. List evidence-based or informed activities to meet the Objective(s) ACOG Committee Opinion: Low Dose Aspirin during pregnancy. https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Low-Dose-Aspirin-Use-During-Pregnancy?IsMobileSet=false 2. Intervention/ activities and performance measures: • Utilize annual CPSP QA or technical support visits to distribute ACOG recommendations regarding use of LDA to prevent preeclampsia. • Promotion of March of Dimes/CDC webinar: "Saving Lives: Preventing Preeclampsia with low dose aspirin". https://www.cdnetwork.org/library/saving-lives-preventing-preeclampsia-low-dose-aspirin	**1.4** Develop process measures for applicable intervention activities here • Number of CPSP providers that received information and technical support. • Describe how maternal LDA was promoted. • Number of CPSP providers that received LDA sample protocol. • QA process developed, including process to measure knowledge change and intent to implement new practices	**1.4** % of CPSP providers that incorporated the Low Dose Aspirin protocol to prevent preeclampsia into their practices.

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 1.4: WOMEN/MATERNAL DOMAIN: Improve access to and utilization of comprehensive, quality health and social services for <u>pregnant women.</u>

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
<u>REQUIRED LOCAL OBJECTIVE</u>: Insert locally developed Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. Each LHJ is required to develop at least one specific short and/or intermediate SMART outcome objective(s) to address access to needed preventive services. ***Number each locally developed objective as follows: 1.4, 1.4a, 1.4b, 1.4c, 1.4d, etc.***			
	• Provide LDA educational materials for CPSP clinic staff and clients. • Establish a baseline of CPSP Providers that have already incorporated LDA into their practice. • Develop a sample LDA protocol		

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 2: CHILD/CYSHCN DOMAIN: Improve the cognitive, physical, and emotional development of all children, including children and youth with special health care needs.

The shaded and bolded areas represent required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
Objective 2.1 **Provide developmental screening for all children[1] in MCAH programs** • All children, including CYSHCN, receive a yearly preventive medical visit • Increase the rate of developmental screening for children ages 0-5 years according to AAP guidelines – 9 months, 18 months and 30 months	**Child Objective** **2.1a** Promote the American Academy of Pediatrics (AAP) developmental screening guidelines. **The following bolded activities, i, ii, are required:** **i. Promote regular preventive medical visits for all children, including CYSHCN, in MCAH Home Visiting and Case Management programs, per Bright Futures/AAP,** **ii. Adopt protocols/policies, including a QA/QI process, to screen, refer, and link all children in MCAH Home Visiting or Case Management Programs**	**2.1a** **Required** **Describe or report the following for MCAH programs:** **i. Activities to promote the yearly preventive medical visit** **ii. Describe protocols/policies including QA/QI process to screen, refer and link all children in MCAH programs**	**2.1a** **Required** **Describe or report the following for children in MCAH programs** **i. Number of children, including CYSHCN, receiving a yearly preventive medical visit** **ii. Number of children in MCAH programs receiving developmental screening** **• Number of children with positive screens that complete a follow-up visit with their primary care provider** **• Number of children with positive screens linked to services** **• Number of calls received for referrals and linkages to services**

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Goal 2: CHILD/CYSHCN DOMAIN: Improve the cognitive, physical, and emotional development of all children, including children and youth with special health care needs.

The shaded and bolded areas represent required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	CYSHCN Objective(s) At least one activity is required. Choose from activities 2.1.b-2.1. (highlight your choices in yellow):	***Report the following based on the activities you chose to implement in the second column (highlight your choices in yellow):***	***Describe the following based on the activities you chose to implement in the second column (highlight your choices in yellow):***
	2.1b Promote the use of Birth to 5; Watch Me Thrive, Learn the Signs, Act Early or other screening materials consistent with AAP guidelines	**2.1b** Number of providers or provider systems receiving information about Birth to 5, Learn the Signs, Act Early or other screening materials	**2.1b** Nothing is entered here
	2.1c Participate in Help Me Grow (HMG) or programs that promote the core components of HMG	**2.1c** Describe participation in HMG or HMG like programs	**2.1c** Outcomes of participation in HMG or HMG like programs. Describe results of work to implement HMG core components
	2.1d Increase understanding of the specific barriers to referral and evaluation by early intervention or pediatric specialists (including mental/behavioral health)	**2.1d** Describe barriers to referral and evaluation by early intervention or pediatric specialists	**2.1d** Nothing is entered here
	2.1e Plan and implement a family engagement project to improve local efforts to serve children and youth with special health care needs (e.g., convene a family	**2.1e** Describe project activities, goals, and outcomes such as number of family members engaged, number of community meetings, and other	**2.1e** Nothing is entered here

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[3] State Requirements

Goal 2: CHILD/CYSHCN DOMAIN: Improve the cognitive, physical, and emotional development of all children, including children and youth with special health care needs.

The shaded and bolded areas represent required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	advisory group to assess how CYSHCN are served in local home visiting or case management programs)	process measures specific to the planned project	
	2.1f Work with health plans (HPs), including MCPs, to identify and address barriers to screening, referral, linkage and to assist the HPs in increasing developmental screenings for their members, per AAP guidelines, through education, provider feedback, incentives, quality improvement, or other methods	**2.1f** Describe barriers and strategies to increase screening, referral and linkage • Number of HPs requiring screenings per AAP guidelines	**2.1f** Nothing is entered here
	2.1g Identify methods to measure and monitor rates of developmental and other types of childhood screening, referrals, and successful linkages to care in your jurisdiction	**2.1g** If applicable, provide data on developmental and other screening rates, referrals, and successful linkages to care for the target population	**2.1g** Nothing is entered here
	2.1h Based on local needs, develop strategies to promote awareness of and address childhood adversity and trauma, including Adverse Childhood Experiences	**2.1h** Provide a description, and data if applicable, on process measures and outcomes relevant to the planned activities	**2.1h** Nothing is entered here

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[3] State Requirements

Goal 2: CHILD/CYSHCN DOMAIN: Improve the cognitive, physical, and emotional development of all children, including children and youth with special health care needs.

The shaded and bolded areas represent required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	(ACEs), and build family and community resilience		
	2.1i Outreach and education to providers to promote developmental screening, referral and linkages	**2.1i** Describe type of outreach/education performed and results of outreach to providers	**2.1i** Nothing is entered here
	2.1j Provide care coordination for CYSHCN, especially non-CCS eligible children or children enrolled in CCS in need of services not covered by CCS	**2.1j** Describe activities for care coordination provided	**2.1j** List the number of children receiving care coordination

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 2: CHILD/CYSHCN DOMAIN: Improve the cognitive, physical, and emotional development of all children, including children and youth with special health care needs.

The shaded and bolded areas represent required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
OPTIONAL LOCAL OBJECTIVE: Insert locally developed Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. ***Number each locally developed objective as follows: 2.2, 2.2a, 2.2b, 2.2c, etc.***			
Objective 2.2 Provide a local objective that improves the, cognitive, physical, and emotional development of all children, including children and youth with special health care needs. **CSART Objective** Examples of focus areas can include but are not limited to: • Reducing unintentional injuries[1] • Reducing child abuse and neglect[1] **By June 30, 2020, children under the age of 6 at risk for developmental and behavioral delays will be referred and linked to medical, dental, and behavioral health services.**	**2.2** List evidence-based or informed activities to meet the objective(s) here. Organize intervention activities and performance measures using the three core functions of public health: Assessment, Policy Development and Assurance 2.2a ASQ screening results will be reviewed and assessed by the PHN within 30 days of receipt and referred for behavioral and developmental screening, assessment, referral and treatment, as needed.	**2.2** Develop process measures for applicable intervention activities here **2.2a** Develop monthly tracking log of ASQ screenings received and reviewed by the PHN.	**2.2** Develop short and/or intermediate outcome related performance measures for the objectives and activities here **2.2a** Number of children referred to PHN with a completed ASQ screening.

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 2: CHILD/CYSHCN DOMAIN: Improve the cognitive, physical, and emotional development of all children, including children and youth with special health care needs.

The shaded and bolded areas represent required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
OPTIONAL LOCAL OBJECTIVE: Insert locally developed Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. ***Number each locally developed objective as follows: 2.2, 2.2a, 2.2b, 2.2c, etc.***			
	2.2b PHN will provide care coordination and nursing consultation to CSART agencies, Children and Family Services and /or to foster care parent/ caregiver to determine service plan that includes referrals and treatment for medical, dental, behavioral and developmental needs.	2.2b PHN to collaborate with CSART, Children and Family Services and /or foster care parent/caregiver to ensure medical and behavioral health referrals and linkages are completed.	2.2b Number of children linked to medical, dental, behavioral, and other services.
	2.2c Intra/Inter-agency collaboration will be maintained to ensure children are linked Medi-Cal covered services available at the CSART program and other community agencies.	2.2c PHN will participate in multidisciplinary team meetings with professional staff and families to discuss and interpret assessments results and treatments.	2.2c Number of multidisciplinary team meetings attended by PHN for each foster care child.
	2.2d Promote with caregivers of children, the use of Birth to 5; Watch Me Thrive, Learn the Signs, Act Early or other screening materials consistent with AAP guidelines.	2.2d PHN will monitor the number of caregivers children who receive information about Birth to 5, Learn the Signs, Act Early or other screening materials.	2.2d Number of caregivers o children receiving information about Birth to 5, Learn the Signs, Act Early or other screening materials.

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 3: PERINATAL/INFANT DOMAIN: Reduce infant morbidity and mortality by reducing the rate of SIDS/SUID deaths

The shaded area represents required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	**Short and/or Intermediate Outcome Measure(s)**
Objective 3.1 **All parents/caregivers experiencing a sudden and unexpected death will be offered grief and bereavement support services**	**Assurance** **3.1a** Establish contact with parents/caregivers of infants with presumed SIDS death to provide grief and bereavement support services[3] Provide grief and support materials to parents	**3.1a** (Insert number) of parents/caregivers who experience a presumed SIDS death and the number who are contacted for grief and bereavement support services.	**3.1a** Nothing is entered here
	3.1b Contact local coroner office to ensure timely reporting and referral of parents of all babies who die suddenly and unexpectedly regardless of circumstances of death	**3.1b** Report the coroner's notifications received Briefly describe barriers and opportunities for success	**3.1b** Nothing is entered here
Objective 3.2 **All professionals, para-professionals, staff, and community members will receive information and education on SIDS risk reduction practices and infant safe sleep**	**3.2a** Disseminate AAP guidelines on infant safe sleep and SIDS risk reduction to providers, pediatricians, CPSP providers, parents, community members and other caregivers of infants	**3.2a** Numbers receiving AAP guidelines on infant safe sleep: • Providers • Pediatricians • CPSP providers • Child care providers • Other – list	**3.2a** Nothing is entered here

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 3: PERINATAL/INFANT DOMAIN: Reduce infant morbidity and mortality by reducing the rate of SIDS/SUID deaths

The shaded area represents required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	3.2b Attend the SIDS Annual Conference/SIDS training(s), SIDS Coordinators' meeting and other conferences/trainings related to infant health[3].	**3.2b** Provide staff member name and date of attendance at SIDS Annual Conference/SIDS training(s) and other conference/trainings related to infant health.	**3.2b** Describe results of staff trainings related to infant health.

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 3: PERINATAL/INFANT DOMAIN: Reduce infant morbidity and mortality by reducing the rate of SIDS/SUID deaths

The shaded area represents required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
REQUIRED LOCAL OBJECTIVE: Insert Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. Each LHJ must provide at least one specific short and/or intermediate SMART outcome objective(s) to address SIDS/SUID. ***Number each locally developed objective as follows: 3.3, 3.3a, 3.3b, 3.3c., etc.***			
Objective 3.3 Provide objective(s) that reduce the risk of SIDS/SUIDS. Examples of focus areas can include but are not limited to: • Child care providers, i.e. babysitters, grandparents, formal day care • Hospitals • Clinics, FQHC, RCH, IHC	**3.3** List evidence-based or informed activities to meet outcome objectives here. Organize intervention activities and performance measures using the three core functions of public health: Assessment, Policy Development and Assurance	**3.3** Develop process measures for applicable intervention activities here	**3.3** Develop short and/or intermediate outcome related performance measures for the objectives and activities here
3.3c **By June 30, 2019, HES will continue to promote best practice tools developed for Safe Sleep education, so that that at least 2 foster care agencies will consult with SBCDPH to offer SIDS risk reduction and safe sleep education within agency trainings.**	**3.3c** • Health Education Specialist (HES) will identify at least 5 liaisons in government agencies, other health programs and community groups in the Local Health Jurisdiction (LHJ) to facilitate information-sharing and potential development of joint outreach and education programs • HES will contact the identified liaisons and meet with those contacts to discuss collaboration plans	**3.3c** • Contact file, including names of liaisons for government agencies, CBOs, or other health programs • List of meetings/presentations with collaborative agencies / 5 • List and description of collaborative strategies developed with each of the agencies named above • Describe process to measure knowledge and behavior change • Number and type of materials distributed	**3.3c** • Number of government agencies, CBOs, or other health programs participating / 5 • Number of foster care agencies that consult with SBCDPH to offer SIDS risk reduction and safe sleep education within agency/2 • Number of attendees at presentations on SIDS that state increased knowledge and intent to change behavior/ all attendees

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 3: PERINATAL/INFANT DOMAIN: Reduce infant morbidity and mortality by reducing the rate of SIDS/SUID deaths

The shaded area represents required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	• HES will review and compile a list of free materials on SIDS. • HES will prepare a presentation that incorporates the most recent recommendations from the American Academy of Pediatrics on a safe sleep environment that can reduce the risk of all sleep-related infant deaths, including SIDS and statistics for San Bernardino County • HES will prepare post-test for presentations • HES will create and update as needed a log of liaisons in government agencies, other health programs and community groups to be contacted • HES will order and distribute SIDS materials to be displayed or distributed by other government agencies, CBOs, or health programs • Develop a process to measure knowledge change and intent to implement what was learned Develop a QA process to monitor implementation of policies/processes and evaluate impact. • The SBCDPH HES will continue coordination with foster care agencies to promote activities on	• Describe QA process developed • Promote the display of SIDS educational materials at 5 different sites, and/or distribute materials to the community they serve • Sign-in sheets for presentations and summary of post-test results Sign-in sheets for presentations	• Describe outcomes of collaborative activities, including barriers and successes • Describe outcomes of post-test results and any lessons learned • and summary of post-test results • Describe outcomes of QA process developed • Number of foster care agencies that adopt infant safe sleep practice policies and offer SIDS risk reduction and safe sleep education in agency trainings. Goal is two foster care agencies • The SIDS and Safe Sleep QI process will be evaluated utilizing data from the SIDS and Safe Sleep Trainings database to include the number and type of agencies trained, number of staff trained, percentage of agencies with knowledge improvement, and number of agencies with intent to implement SIDS and Safe Sleep practices.

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[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 3: PERINATAL/INFANT DOMAIN: Reduce infant morbidity and mortality by reducing the rate of SIDS/SUID deaths

The shaded area represents required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	infant safe sleep education and SIDS risk reduction. • The HES will continue coordination with foster care agencies to collect infant safe sleep practice information. • HES will utilize an annual SIDS and Safe Sleep survey to evaluate public/private agency adoption of SIDS and Safe Sleep policy implementation for Quality Improvement.		

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 3: PERINATAL/INFANT DOMAIN: Reduce infant morbidity and mortality

The shaded area represents required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
REQUIRED LOCAL OBJECTIVE: Insert Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. Each LHJ must provide at least one specific short and/or intermediate SMART outcome objective(s) to address perinatal/infant health. ***Number each locally developed objective as follows: 3.4, 3.4a, 3.4b, 3.4c., etc.***			
Objective 3.4 By June 30, 2020, 80% of African-American mothers participating in BIH will express their intention to breastfeed before birth, and 73% will breastfeed 1 month after delivery.	**3.4** 1. Evidenced bas-based or informed activities to meet objective(s): "Confident Commitment" https://onlinelibrary.wiley.com/doi/full/10.1111/j.1523-536X.2009.00312.x 2. List evidence-based or informed activities to meet outcome objective: • In collaboration with WIC provide BIH participants with: 1. Text messages with linkage to WIC online education: "Explore the Stages of Breastfeeding" series: https://wicbreastfeeding.fns.usda.gov/#explore_stages And WIC YouTube breastfeeding videos https://www.youtube.com/playlist?list=PL9-	**3.4** • Describe collaboration between San Bernardino County WIC, BIH and MCAH to promote and support breastfeeding decision of BIH participants. • Describe professional breastfeeding training received by BIH staff. • Describe how BIH program staff provides breastfeeding support.	**3.4** % of African-American mothers participating in BIH that: • Will express their intention to breastfeed before birth. • Will breastfeed 1 month after delivery.

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 3: PERINATAL/INFANT DOMAIN: Reduce infant morbidity and mortality

The shaded area represents required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	MtG_B0MzlMxEP9mvSWvgvHUD5cH4pY 2. Breastfeeding decision making class provided by WIC breastfeeding Coordinator during prenatal group session. 3. "Inland Empire Breastfeeding, Childbirth & Community Resources Guide" 4. "Breastfeeding Clinics and Support Groups in San Bernardino County" 5. Breast pumps. 6. Training for BIH staff • Identify a participant champion within each prenatal and postpartum group for breastfeeding support. • Breastfeeding incentives.		

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 3: PERINATAL/INFANT DOMAIN: Reduce infant morbidity and mortality

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	**Short and/or Intermediate Outcome Measure(s)**
For FIMR LHJs only complete **Objective 3.5** **Reduce preventable fetal, neonatal and post-neonatal and infant deaths.**	**For FIMR LHJs only complete Assessment** **3.5a** Complete the review of at least 15 cases, which is approximately 4% of all fetal, neonatal, and post-neonatal deaths.	**For FIMR LHJs only complete Assessment** **3.5a** Develop a process for sample. Submit number of cases reviewed as specified in the Annual Report table.	**For FIMR LHJs only complete Assessment** **3.5a** Submit annual local summary report of findings and recommendations (periodicity to be determined by consulting with MCAH).
	Assurance **3.5b** Establish, facilitate, and maintain a Case Review Team (CRT) to review selected cases, identify contributing factors to fetal, neonatal, and post-neonatal deaths, and make recommendations to address these factors.	**3.5b** Submit FIMR Tracking Log and FIMR Committee Membership forms for CRT and CAT with the Annual Report.	**3.5b and c** Nothing is entered here
	3.5c Establish, facilitate, and maintain a Community Action Team (CAT) to recommend and implement community, policy, and/or systems changes that address review findings.		

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 3: PERINATAL/INFANT DOMAIN: Reduce infant morbidity and mortality

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
REQUIRED LOCAL OBJECTIVE for FIMR LHJs Only: Insert Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. Each LHJ must provide at least one specific short and/or intermediate SMART outcome objective(s) to address perinatal/infant health. ***Number each locally developed objective as follows: 3.6, 3.6a, 3.6b, 3.6c, etc.***			
Objective 3.6 **By June 30, 2020, the SBCDPH FIMR Coordinator will develop and begin implementation of FIMR Case Review Team (CRT) recommendations through collaboration with at least three public and/or private agencies to provide epidemiology consultation for policy development and program planning in order to develop strategies to reduce fetal and infant mortality and improve MCAH healthcare services.**	**3.6** • The SBCDPH FIMR Coordinator will develop a comprehensive FIMR Gap Analysis Report (2019-20) for use by SBCDPH officials and the FIMR CRT to analyze gaps in MCAH healthcare services and make recommendations to improve MCAH healthcare services for the San Bernardino County MCAH population. • The SBCDPH FIMR Coordinator will partner with the March of Dimes 'Healthy Babies are Worth the Wait' campaign to provide Regional and local-level statistical analysis of the San Bernardino County MCAH population. The SBCDPH FIMR Coordinator will partner with the Perinatal Advisory Council: Leadership, Advocacy, and Consultation (PACLAC) to provide Regional and local-level statistical analysis of San Bernardino County MCAH population.	**3.6** • The FIMR Gap Analysis Report (2019-20) will include documentation for public/private agency consultation summaries, consultation topic analysis, and strategic recommendations. • SBCDPH FIMR Coordinator will continue to maintain FIMR CRT/CAT agendas and sign-in sheets documenting the number of attendees and agency representatives.	**3.6** • Number of agencies receiving epidemiology consultation for policy development and program planning. • Type of epidemiology consultation provided to each agency. • The FIMR Gap Analysis Report (2019-20) will include summary statistics from cases reviewed during FIMR CRT meetings in addition to FIMR CRT key findings and recommendations.

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 4: CROSSCUTTING DOMAIN: Increase the proportion of children, adolescents and women of reproductive age who maintain a healthy weight.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
OPTIONAL LOCAL OBJECTIVE: Insert locally developed Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. ***Number each locally developed objective as follows: 4.1, 4.1a, 4.1b, 4.1c, etc.***			
Objective 4.1 Insert a local objective that addresses the proportions of children, adolescents and women of reproductive age who maintain a healthy weigh by: • Increasing consumption of a healthy diet[1] • Increasing physical activity[1] Examples of focus areas can include but are not limited to: • Overweight/obesity in children • Physical activity • Recommended weight gain during pregnancy • Recommended intake of folic acid • Food security • Access to WIC services	**4.1** List evidence-based or informed activities to meet the objective(s) here. Organize intervention activities and performance measures using the three core functions of public health: Assessment, Policy Development and Assurance	**4.1** Develop process measures for applicable intervention activities here	**4.1** Develop short and/or intermediate outcome related performance measures for the objectives and activities here

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 5: ADOLESCENT DOMAIN: Promote and enhance adolescent strengths, skills, and supports to improve adolescent health.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
OPTIONAL LOCAL OBJECTIVE: Insert locally developed Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. ***Number each locally developed objective as follows: 5.1, 5.1a, 5.1b, 5.1c, etc.***			
Objective 5.1 By June 30, 2020, 50% of the CHDP providers attending the CHDP Overview training will demonstrate knowledge increase related to screening adolescents for e-cigarette use and providing preventive counseling and referrals in their practice.	**5.1** List evidence-based or informed activities to meet the objective(s) : AAP E-cigarettes and similar devices https://pediatrics.aappublications.org/content/pediatrics/143/2/e20183652.full.pdf Activities: • Update CHDP provider Overview training content adding screening, counseling and referral of adolescents for e-cigarette use. • Create a pre and post-test to measure knowledge increase.. • Dissemination of fact-sheet: "E-Cigarette Use Among Youth and Young Adult, a Report of the Surgeon General". https://e-cigarettes.surgeongeneral.gov/documents/2016_SGR_Fact_Sheet_508.pdf	**5.1** Develop process measures for applicable intervention activities here • Number of CHDP providers participating in the CHDP Overview Training. • Material distributed during the training. • Explain how knowledge change was measured. • Number of CHDP providers that received additional e-cigarette education and follow up during CHDP technical support visits.	**5.1** % of the CHDP providers attending the CHDP Overview training that demonstrated knowledge increase related to screening adolescents for e-cigarette use and providing preventive counseling and referrals in their practice.

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 5: ADOLESCENT DOMAIN: Promote and enhance adolescent strengths, skills, and supports to improve adolescent health.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	• Provide e-cigarette handouts for youth. • Continue support and follow up during CHDP technical support visits.		

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

California Department of Public Health (CDPH)
Maternal, Child and Adolescent Health (MCAH)
Black Infant Health (BIH) Scope of Work (SOW)

Black Infant Health Program

The BIH Program is a specialized CDPH MCAH program under the local MCAH system and helps to address MCAH SOW Goal 2 – Improve Maternal and Women's Health. The goals in this SOW incorporate local problems identified by the Local Health Jurisdiction's (LHJs') 5-Year Needs Assessments and reflect the Title V priorities of the MCAH Division.

All BIH sites are required to comply with BIH Policy and Procedures (P&P) and the Fiscal Policies and Procedures https://www.cdph.ca.gov/Programs/CFH/DMCAH/Pages/Fiscal-Documents.aspx in their entirety. In addition, all BIH Sites shall work towards maximizing fidelity in the following four domains (*adherence*, *dose*, *participant engagement* and *quality of service delivery*) by implementing Program services, fulfilling all deliverables associated with benchmarks, attending required meetings and trainings and completing other MCAH-BIH reports as required. A list of the fidelity indicators for each domain is located in table 1: BIH Fidelity Indicator Listing (rev. 7/1/2017),

The CDPH Maternal, Child and Adolescent Health (MCAH) Division places a high priority on the poor outcomes that disproportionately impact the African-American community in California. The BIH site agrees to implement all activities in this Scope of Work (SOW). Central to the efforts in reducing these disparities, listed below are the four (4) goals that are the hallmark of the program:

1. Improve African-American (AA) infant and maternal health.
2. Increase the ability of African-American women to manage chronic stress.
3. Decrease Black-White health disparities and social inequities for women and infants.
4. Engage the community to support African-American families' health and well-being with education and outreach efforts.

To achieve these goals, the BIH Program is a client-centered, strength-based group intervention with complementary case management that embraces the lifecourse perspective and promotes skill building, stress reduction and life goal setting. Each BIH Site shall also assure program fidelity, collect and enter participant and program data into the electronic Efforts to Outcomes (ETO) data system and engage community partner agencies.

All BIH Sites are required to comply with the following tiered staffing matrix per the BIH 2015 Request For Supplemental Information (RSI) BIH RSI Instructions to ensure fidelity and standardization across all sites:

Staffing Requirements	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
Local Health Jurisdiction	San Francisco, Santa Clara,	Contra Costa, Long Beach, Fresno, San Joaquin, Solano, Kern	San Diego, Alameda, Riverside	Sacramento, San Bernardino	Los Angeles
BIH Coordinator	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE
FHA/Group Facilitator	2.0 FTE	3.0 FTE	4.0 FTE	6.0 FTE	8.0 FTE
Mental Health Professional	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE
Outreach Liaison	1.0 FTE	1.0 FTE	1.0 FTE	1.0 FTE	1.0 FTE
Data Entry	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE
PHN (Optional)	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE

All BIH Sites are required to and will be held accountable for complying with the following tiered enrollment target per the BIH 2015 Request For Supplemental Information (RSI) BIH RSI Instructions:

Enrollment Target	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
Local Health Jurisdiction	San Francisco, Santa Clara,	Contra Costa, Long Beach, Fresno, San Joaquin, Solano, Kern	San Diego, Alameda, Riverside	Sacramento, San Bernardino	Los Angeles
	64	96	128	192	240

Contained within the BIH SOW, under the Measures (Process and Outcome) cells, there are Source Keys that are designed to provide a reference for reporting purposes. The "E" Source Key refers to information that is based on participant-level program data included and maintained in ETO. The "N" "Source Key refers to narrative information provided in quarterly reports or site surveys.

It is the responsibility of the LHJ to meet the goals and objectives of this SOW. The LHJ shall strive to develop systems that protect and improve the health of California's women of reproductive age, infants, children, adolescents, and their families. It is the responsibility of an LHJ to solicit technical assistance and guidance from MCAH if performance issues arise. If a program does not meet the goals and objectives outlined in this SOW, the LHJ may be placed on a corrective action plan (CAP) status. **After implementation of the CAP, if the LHJ does not demonstrate substantial growth or fails to successfully meet the goals and objectives of this SOW, MCAH will either cancel the Agreement or amend it to reflect reduced funding.** Continued participation in the BIH program beyond the current fiscal year is also subject to successful performance of agreed upon activities.

The development of this SOW was guided by several public health frameworks including the Ten Essential Services of Public Health and the three (3) core functions of assessment, policy development, and assurance; the Spectrum of Prevention; the Life Course Perspective; the Social-Ecological Model, and the Social Determinants of Health. Please integrate these approaches when conceptualizing and organizing local program, policy, and evaluation efforts.

- The Ten Essential Services of Public Health: https://www.cdc.gov/stltpublichealth/publichealthservices/essentialhealthservices.html
- The Spectrum of Prevention: The Spectrum of Prevention | Prevention Institute
- Life Course Perspective: Life Course Approach in MCH
- The Social-Ecological Model: http://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html
- Social Determinants of Health: http://www.cdc.gov/socialdeterminants/
- Strengthening Families: Center for the Study of Social Policy / Young Children & Their Families / Strengthening Families

All activities in this SOW shall take place within the fiscal year.

For each fiscal year of the contract period, the LHJ shall submit the deliverables identified below. All deliverables shall be submitted to the MCAH Division to your designated Program Consultant in accordance with the BIH P&P Manual and postmarked or emailed no later than the due date.

Deliverables for each FY	Due Date for each FY
Annual Progress Report	August 15

Coordinator Quarterly Report:

Reporting Period	From	To	Due Date
First Report	July 1, 2019	September 30, 2019	October 31, 2019
Second Report	October 1, 2019	December 31, 2019	January 31, 2020
Third Report	January 1, 2020	March 31, 2020	April 30, 2020
Fourth Report (WAIVED) Information during this reporting period will be included in the Annual Progress Report	April 1, 2020	June 30, 2020	July 31, 2020

See the following pages for a detailed description of the services to be performed.

Part II: Black Infant Health (BIH) Program

Goal 1: BIH will assure program implementation, staff competency, data management, and maintain program fidelity and fiscal management to administer the program as required by the Program's Policy and Procedures (P&P's) and Scope of Work (SOW) guidelines.

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		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
IMPLEMENTATION **1.1** BIH Coordinator, under the guidance and leadership of the MCAH Director will provide oversight, maintain program fidelity, fiscal management and demonstrate that BIH activities are conducted as required in the BIH P&Ps, SOW, Data Collection Manual, ETO Data Book, Group Curriculum, and MCAH Fiscal P&Ps.	**1.1** • Implement the program activities as defined in the SOW. • Annually review and revise internal local policies and procedures for delivering services to eligible BIH participants. • BIH Coordinator will coordinate and collaborate with MCAH Director to complete, review, and approve the BIH budget prior to submission. • Submit Agreement Funding Application (AFA) timely. • Submit BIH Annual report by August 15. • Submit BIH Quarterly Reports as directed by MCAH.	**1.1** • Define and describe MCAH Director and BIH Coordinator responsibilities as they relate to BIH. (N) • Provide organization chart that designates the delineation of responsibilities of MCAH Director and BIH Coordinator from MCAH to the BIH Program in AFA packet. • Describe collaborative process between MCAH Director and BIH Coordinator related to BIH budget prior to AFA submission. (N)	**1.1** • Submit BIH Annual report by August 15. • Submit BIH Quarterly Reports as directed by MCAH. (See page 3)
1.2 Hire and maintain culturally competent/relevant personnel and required Full Time Equivalent (FTE) to implement a BIH Program that is relevant to the cultural heritage of African-American women, and the community.	**1.2** • Maintain culturally competent staff to perform program services that honors the unique history/traditions of people of African-American descent as outlined in the P& P. • At a minimum, the following key staffing roles are required: o 0.5 FTE BIH Coordinator o Family Health Advocates (FHA)/Group Facilitators (GF)	**1.2** • Describe process of recruiting and hiring staff at each site that are filled by personnel meeting qualifications in the P&P. • Include duty statements of all staff with submission of AFA packet. • Submission of all staff changes per guidelines outlined in BIH P&P.	**1.2** • Percent of key staffing roles at site filled by personnel who meet qualifications in the P&P. (N)

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	based on MCAH-BIH designated tier level. o 1 FTE Community Outreach Liaison (COL) o 0.5 FTE Data Entry o 0.5 FTE Mental Health Professional (MHP) o 0.5 FTE PHN (Optional) • Utilization of a staff hiring plan.		
TRAINING **1.3** All BIH staff will maintain and increase staff competency.	**1.3** • Develop a plan to assess the ability of staff to effectively perform their assigned tasks, including regular observations of group facilitators. • Identify staff training needs and ensure those needs are met, notifying MCAH of any training needs. • Ensure that all key BIH staff participates in on-going training or educational opportunities designed to enhance cultural sensitivity. • Ensure that all new and key BIH staff attend the Annual MCAH Sudden Infant Death Syndrome (SIDS) Conference to receive the latest AAP guidelines on infant safe sleep practices and SIDS risk reduction strategies. • Establish local SIDS. collaborative workgroups with community partners in order to enhance awareness of AA SIDS	**1.3** • List staff training activities in quarterly report. (N) • Describe improved staff performance and confidence in implementing the program model as a result of participating in staff development activities and/or trainings. (N) • List gaps in staff development and training in quarterly report. (N) • Describe plan to ensure that staff development needs are met in quarterly report. (N) • Describe how cultural sensitivity training has enhanced LHJ staff knowledge and how that knowledge is being applied. (N) • Describe how staff utilized information from the MCAH SIDS conference with participants. • Document strategies and action plans related to SIDS risk reduction strategies developed from SIDS collaborative workgroup meetings.	**1.3** • Maintain records of staff attendance at trainings. (N) • Number of trainings and conferences (both state and local) attended by staff during FY 2018-19. • Completion of at least 2 group observation feedback forms by the BIH Coordinator for every group facilitator during FY 2018-19. (E)

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	rates and to develop SIDS risk reduction strategies. • Require that all key BIH staff (i.e. BIH Coordinator, and ALL direct service staff) attend mandatory MCAH Division-sponsored trainings, conference calls, meetings and/or conferences as scheduled by MCAH Division. • Quarter 1: o Annual 2-day Basic Training o Annual COL Meeting • Quarter 2: o Annual 2-day Advanced FHA/GF Meeting • Quarter 3: o Annual MHP/Public Health Nurse (PHN) Meeting • Quarter 4: o Annual Coordinator Meeting o Annual 2-day Statewide Meeting • Ensure that the BIH Coordinator and all direct service staff attend mandatory MCAH Division-sponsored training(s) prior to implementing the BIH Program. • 2-day Abbreviated Training – scheduled by MCAH based on LHJ needs. • 2-day Basic Training Quarter 1 • Ensure that the BIH Coordinator and/or MCAH Director perform regular observations of GFs and assessments of FHAs' case management activities.	• Recommend training topic suggestions for statewide meetings. (N)	

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DATA COLLECTION AND ENTRY **1.4** All BIH participant program information and outcome data will be collected and entered timely and accurately using BIH required forms at required intervals.	**1.4** • Ensure that all direct service staff participate in data collection, data entry, data quality improvement, and use of data collection software determined by MCAH. • Ensure that all subcontractor agencies providing direct service enter data in the ETO as determined by MCAH. • Ensure accuracy and completeness of data input into ETO system. • Ensure that all staff receives updates about changes in ETO and data book forms. • Ensure that a selected staff member with advanced knowledge of the BIH Program, data collection, and ETO is selected as the BIH Site's Data Entry lead and participates in all Data and Evaluation calls. • Accurately and completely collect required participant information, with timely data input into the appropriate data system(s). • Work with MCAH to ensure proper and continuous operation of the MCAH-BIH- ETO. • Store Participant level Data forms on paper per guidelines in P&P. • Define a data entry schedule for staff and monitor for adherence.	**1.4** • Review ETO and fidelity reports and discuss during calls with BIH State Team. • Review ETO Utilization Reports for all staff at BIH Sites. • Enter all data into ETO within seven (7) working days of collection. • Review of the BIH Data Collection Manual by all staff. • Completion of ETO training by all staff. • Participation in periodic MCAH-Data calls. • Participation in role-specific trainings by the Data Entry Lead. • Review of ETO data quality reports by the BIH Coordinator and Data Entry staff on at least a monthly basis. • Conduct and report on audits of recruitment, enrollment, and service delivery paper forms against ETO reports; audit sample must include at least 10% of recruitment records and 10% of enrollment records.	**1.4** • Number and percent of forms that were entered within seven (7) days of collection. (E)

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OUTREACH **1.5** All BIH LHJs will increase and expand community awareness of BIH by conducting outreach activities, including the use of social media.	**1.5** • All BIH LHJs will conduct outreach activities and build collaborative relationships with local Women, Infants, and Children (WIC) providers, Comprehensive Perinatal Services Program (CPSP) Perinatal Service Coordinators, social service providers, health care providers, the Faith-based community, and other community-based partners and individuals to increase and maximize awareness opportunities to ensure that eligible women are referred to BIH. • All BIH LHJs will establish referral mechanisms that will facilitate reciprocity with partner agencies as appropriate. • At a minimum, all BIH LHJs will utilize social media campaigns developed by MCAH to increase community awareness while conducting outreach activities.	**1.5** • Describe the types of community partner agencies contacted by LHJ staff. (N) • Describe outreach activities performed in order to reach target population. (N) • Describe deviations in outreach activities, noting changes from local recruitment plan. (N) • Document type, frequency and number of social media activities conducted on the BIH Primary Contact Table and submit with Quarterly and Annual Report. (N)	**1.5** • Number of existing MOUs prior to FY 2018-19. (E) • Number of new Memorandum of Understanding (MOUs) established in FY 2018-19. (E) • Total number (overall and by type) of outreach activities completed by all staff during FY 2018-19. (E)
PARTICIPANT RECRUITMENT **1.6** All BIH LHJs will recruit African- American women 18 years of age, less than 30 weeks pregnant.	**1.6** • Develop and implement a Participant Recruitment Plan (standardized intake process) according to the target population and eligibility guidelines in MCAH-BIH P&P and submit upon request. • Review Recruitment plan annually and update as needed.	**1.6** • Submit participant triage algorithm with submission of AFA packet. • Track and document progress in meeting goals of the Participant Recruitment Plan, review annually and update as needed.	**1.6** • Number and percent of recruited and referred women that were eligible (at least 18 years old and less than 30 weeks pregnant) based on their recruitment date. (E)

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PARTICIPANT REFERRAL **1.7** All BIH LHJs will establish a network of referral partners.	**1.7** • Collaborate with network of established partners (community-based organizations, traditional and non-traditional partners, etc.) to develop a network of referral partners who will refer eligible women to BIH. • Provide referrals to other MCAH programs for women who cannot participate in group intervention sessions.	**1.7** • Describe process for ensuring that referral partner agencies are referring eligible women to BIH in quarterly reports and during technical assistance calls. (N)	**1.7** • Total number of service providers that made referrals to the BIH Program in FY 2018-19. (E)
PARTICIPANT ENROLLMENT **1.8** BIH Coordinator, under the guidance and leadership of the MCAH Director will ensure the following: • All participants enrolled • In BIH will be African-American. • All participants will be 18 years or older when enrolled in BIH. • All participants will be enrolled during pregnancy. o All participants will be enrolled at or before 30 weeks of pregnancy. • All women will participate in group intervention.	**1.8** • Enroll women that are African-American. • Enroll women at or before 30 weeks of pregnancy. • Enroll women that will participate in the group intervention.	**1.8** • Visual inspection of all recruitment eligibility fields on incoming referral forms for completeness. • Inclusion of eligibility criteria with materials used for referral and recruitment.	**1.8** • Number and percent of enrolled women who meet eligibility criteria defined by age and timing of pregnancy. (E) – *Fidelity Indicator A1b*
PROGRAM PARTICIPATION **1.9.1** BIH Coordinator, under the guidance and leadership of the MCAH Director will ensure the following:	**1.9.1** • Assign participants to a prenatal group as part of enrollment process.	**1.9.1** • Describe barriers, challenges and successes of enrolling women in a prenatal group within 30-45 days of first successful contact	**1.9.1** • Number and percent of enrolled women who attended a prenatal group session within 45 days of

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• All women will participate in a prenatal group. • All women will participate in a group within 45 days of enrollment. • All groups will be implemented according to the 20-group intervention model as specified in the P&P. (see 1.9.3)	• Schedule prenatal groups to allow participants to attend within 30 days of enrollment. • Enroll participants in a prenatal group within 45 days of first successful contact. • Begin groups with the minimum required number of participants per the BIH P&P.	during technical assistance calls. (N) • Describe barriers, challenges and successes of beginning groups with the minimum required number of participants during technical assistance calls. (N)	enrollment. (E) – *Fidelity Indicator A3a* • Percent of group sessions that were conducted in the prescribed sequence and at the prescribed time intervals. (E) – *Fidelity Indicator A3c* • Percent of group sessions in a series that were attended by at least 5 participants. (E) - *Fidelity Indicator* A3b.
1.9.2 BIH Coordinator, under the guidance and leadership of the MCAH Director will ensure the following: • All BIH participants will receive case management support as defined in the P&P. • All BIH participants will complete all prenatal and postpartum assessments within the recommended time intervals. • All BIH participants will receive referrals to services outside of BIH based on Life Planning meetings.	**1.9.2** • Assign participants to a FHA as part of enrollment process. • Conduct case management services that align with Life Plan activities (goal setting). • Collect completed self-assessment administered scaled questions as described in P&P. • Collect the required number of assessments per timeframe outlined in P&P. • Develop and implement a Life Plan based on goal setting during Life Planning meetings for each BIH participant; complete all prenatal and postpartum assessments; provide ongoing identification of her specific concerns/needs and referral to services outside of BIH as needed based on Life Planning meetings. • Ensure participant referrals are generated and completed for all services identified.	**1.9.2** • Collect and record service delivery activities for enrolled women into ETO. (E) • Describe successes and/or challenges in assisting participants with setting short and long-term goals during Life Planning meetings. (N) • Describe program improvements resulting from participant satisfaction survey findings at least quarterly. (N)	**1.9.2** • Number and percent of enrolled women who complete prenatal and postpartum assessments at the P&P-designated time intervals. (E) • Number and percent of enrolled women who received at least one (1) case conference attended by a FHA or GF, and either the MHP or PHN. (E) – *Fidelity Indicator A2a* • Percent of enrolled women who have (a) a long-term goal and (b) one (1) or more short-term goals documented in one (1) of the three (3) focus areas (health, relationship, and finances) (among women enrolled 30 days or longer) during Life Planning meetings. (E) – *Fidelity Indicator P1a* • Number and percent of enrolled women with a Birth Plan collected before the expected date of delivery (among women past

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	• Conduct participant dismissal activities. • Conduct participant satisfaction surveys. • Submit complete and accurate reports in the timeframe specified by MCAH.		due). (E) – *Fidelity Indicator (supplemental) A4ai.* • Number and percent of enrolled women who have a known referral status for every documented referral at time of exit from the program (among women dismissed from BIH).(E) – *Fidelity Indicator Q4a* • Number and percent of enrolled women who have been dismissed from BIH with a completed participant satisfaction survey. (E)
1.9.3 BIH Coordinator, under the guidance and leadership of the MCAH Director will ensure that all BIH participants will participate in Group Intervention Sessions.	**1.9.3** • Schedule Group Intervention Sessions with guidance from State BIH Team. • All participants will have the opportunity to enroll in Group Intervention Sessions within 30-45 days of the first successful contact. • Conduct and adhere to the 20-group intervention model as specified in the P&P.	**1.9.3** • Collect and record Group Intervention Session attendance records for all enrolled women into ETO. • Submit FY 2019-20 Group Intervention Sessions Calendar to MCAH-BIH Program with submission of AFA and upon request. • Describe participant successes or challenges with completing seven (7) of ten (10) prenatal and/or postpartum Group Intervention Sessions. (N)	**1.9.3** • Number of Group Intervention Sessions entered into ETO that began during FY 2018-19. (E) • Number and percent of enrolled women who attend at least one (1) prenatal Group Intervention Session. (E) • Number and percent of enrolled women who attended the expected number of Group Intervention Sessions based upon the number of days in program (E) – *Fidelity Indicators D1a and D1b.*

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PARTICIPANT RETENTION **1.9.4** BIH Coordinator, under the guidance and leadership of the MCAH Director will ensure that participant retention strategies are in place.	**1.9.4** • Discuss and develop participant retention strategies during team meetings. • Plan participant retention strategies as they relate to program implementation components (outreach/recruitment, enrollment, Life Planning, group sessions, program completion). • Designated staff will conduct participant satisfaction surveys after group sessions and at program completion to obtain feedback related to improvement of retention strategies.	**1.9.4** • Discuss participant retention strategies during technical assistance calls. (N) • Review participant retention strategies quarterly and update as needed. (N) • Document participant retention strategies in ETO and in Quarterly Reports. (E/N) • Submit participant retention strategy successes and challenges with Annual Report. (N)	**1.9.4** • Submit Participant Retention Strategies with Quarterly and Annual Report. (N)

Goal 2: Engage the African American community to support African-American families' health and well-being with education and outreach efforts

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2.1 BIH Coordinator under the guidance and leadership of the MCAH Director will increase and expand community awareness of African-American birth outcomes and the role of the Black Infant Health Program.	**2.1** • Implementation of a Community Advisory Board (CAB) in order to: • Inform the community about disparate birth outcomes among African-American women by delivering standardized messages describing how the BIH Program addresses these issues. • Create partnerships with community and referral agencies that support the broad goals of the BIH Program, through formal and informal agreements. • Develop and implement a community awareness plan that outlines how community engagement activities will be conducted. • Develop and implement activities related to multi-level community engagement and awareness with referral partners to identify service gaps in the LHJ target area. • Develop performance strategies with local organizations that provide services to AA women and infants to improve referrals and linkage to BIH services. • Collaborate with local MCAH programs and other partners such as Medi-Cal to identify strategies, activities and provide technical assistance to: o Improve access to health care services	**2.1** • Document efforts of Community Advisory Board, collaborations or other similar formal or informal partnerships to address maternal and infant health disparities, social determinants of health, well-woman visits and postpartum visits at least once per quarter. (N) • Submit quarterly reports that describe outreach activities electronically using ETO in a timely manner. (N) • Document the local plan for community linkages, including an effective referral process that will be reviewed on an annual basis and updated as needed. (N) • Document successes and barriers to community education activities or events at least once per quarter in the ETO through quarterly reporting. (E/N) • List and maintain current documentation on the nature of formal and informal partnerships with community and referral agencies at least once a quarter; record MOUs and referral relationships in the ETO service provider details form. (E/N) • Enter all outreach activities in the Community Contacts Log in ETO.	**2.1** • Submit CAB meeting materials (roster, agenda, minutes) with BIH quarterly report. (N) • Number, format, and outcomes associated with community outreach activities conducted by BIH Coordinator and/or MCAH Director during FY 2018-19. (E/N)

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	○ Increase utilization of well-woman and postpartum visits ○ Identify Preterm Birth (PTB) reduction strategies ○ Increase the utilization of preconception health services. • Collaborate with local MCAH programs and Regional Perinatal Programs to improve maternal and perinatal systems of care. • Participate in collaboratives with community partners to review data and develop strategies and policies to address social determinants of health and disparities. • Collaborate with agencies providing services to AA moms to develop and disseminate tangible Reproductive Life Planning training materials (e.g. power point presentation, webinars, toolkits, etc.) to focus on Before, During, and Beyond Pregnancy for dissemination and integration in their service delivery protocols.	• Document collaborative efforts with local MCAH programs and Regional Perinatal Programs describing strategies to improve maternal and perinatal systems of care at least quarterly. (N) • Maintain current lists of community providers and Service Provider details in ETO.	
2.2 BIH COL will increase information sharing with other local agencies providing services to African-American women and children in the community and establish a clear point of contact.	**2.2** • Develop collaborative relationships with local Medi-Cal Managed Care, Commercial Health Plans, WIC and local agencies in the community that provide services to African-American women and children, to establish strong resource linkages for recruitment of potential	**2.2** • Enter all outreach activities in the Community Contacts Log in ETO. • Maintain current lists of community providers and Service Provider details in ETO. • Describe materials used to inform community partners about BIH. (N)	**2.2** • Number of agencies where the COL has a documented point(s) of contact and with whom information is regularly exchanged. (N) • Total number of agencies with outreach records during FY 2018-19. (E)

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	participants and for referrals of active participants. • Develop a clear point(s) of contact with collaborating community agencies on a regular basis as it relates to outreach, enrollment, referrals, care coordination, etc. • Assess referrals from partner agencies to determine enrollment points of entry quarterly.	• List and describe barriers, challenges and/or successes related to establishing community partnerships and point(s) of contact at least quarterly. (N)	

Goal 3: Increase the ability of African-American women to manage chronic stress

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3.1 BIH Coordinator under the guidance and leadership of the MCAH Director will ensure that all BIH participants will have their social support measured at baseline and after attending the prenatal and/or postpartum group intervention and completing Life Planning activities using the Social Provisions Scale – Short (SPS-S).	**3.1** • Implement the prenatal and postpartum group intervention with fidelity to the P&P. • Encourage participants to attend and participate in group sessions. • Support clients in fostering healthy interpersonal and familial relationships. • Report results from group session information form, including description of participant engagement in group activities for each group session.	**3.1** • Provide FY 2018-19 group intervention schedules upon request. (N) • Percent of participants who meet expected prenatal life planning session attendance (prenatal dose). (E) – *Fidelity Indicator D2a* • Percent of participants who meet expected prenatal group session attendance (prenatal dose). (E) – *Fidelity Indicator D1a and D1b.*	**3.1** • Number and percent of enrolled participants who have both a baseline and follow-up measurement. (E) – *Fidelity Indicator P3aii*
3.2 BIH Coordinator under the guidance and leadership of the MCAH Director will ensure that all BIH participants will have their self-esteem, mastery, coping and resiliency measured at baseline and after attending prenatal and/or postpartum group intervention and completing Life Planning activities using the Rosenberg Self-Esteem, Pearlin Mastery and the Brief Resilience Scales.	**3.2** • LHJ staff will facilitate the administration of the self-esteem, mastery, coping, and resiliency tools and their frequency as outlined in the P&P focused on the participant's ability to be resilient and manage chronic stressors presenting during pregnancy. • All activities are delivered with an understanding of African-American culture and history. • Assist participants in identifying and utilizing their personal strengths. • Develop and implement a Life Plan with each participant. • Teach and provide support to participants as they develop goal-	**3.2** • Describe challenges/barriers why participants did not have their self-esteem, mastery, coping and resiliency measured after attending prenatal and/or postpartum group intervention and completing Life Planning activities. (N)	**3.2** • Number and percent of enrolled participants who have both a baseline and follow-up measurement. (E) – *Fidelity Indicator P3aii*

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	setting skills and create their Life Plans. • Teach participants about the importance of stress reduction and guide them in applying stress reduction techniques. • Support participants as they become empowered to take actions toward meeting their needs. • Teach participants how to express their feelings in constructive ways. • Help participants to understand societal influences and their impact on African-American health and wellness.		

Goal 4: Improve the health of pregnant and parenting African American women and their infants

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4.1 BIH Coordinator under the guidance and leadership of the MCAH Director will ensure that all BIH participants will be linked to services that support health and wellness while enrolled in the BIH Program.	**4.1** • Assist participants in understanding behaviors that contribute to overall good health, including: o Stress management o Sexual health o Healthy relationships o Nutrition o Physical activity • Ensure that participants are enrolled in health insurance and are receiving risk-appropriate perinatal care. • Ensure that healthy nutritious food is available during group sessions. • Provide participants with health information that supports a healthy pregnancy. • Provide participants with health education materials that address preterm birth reduction strategies, such as the MCAH-BIH prematurity awareness and Provider sheet tip sheet. • Identify participants' health, dental and psycho-social needs and provide referrals and follow-up as needed to health and community services. • Provide information and health education to participants who report drug, alcohol and/or tobacco use.	**4.1** • List and document additional activities (e.g., Champions for Change cooking demonstrations) conducted that promote health and wellness of BIH participants and their infants at least once per quarter. (N/E) • Describe collaborative efforts with March of Dimes, MotherToBaby and other agencies that provide health education, preterm birth reduction materials and resources.	**4.1** • Number and percent of participants uninsured at enrollment who received referral and follow-up for health insurance before delivery. (E) • Number and percent of participants who complete a birth plan. (E) – *Fidelity Indicator A4ai*

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	• Assist participants with completion of the birth plan that outlines specific labor/delivery and birthing requests to be conveyed to their prenatal care provider.		
4.2 BIH LHJ staff will coordinate with State MCAH and BIH staff to assist BIH Participants with increased knowledge and understanding of a Reproductive Life Plan and Family Planning services by providing culturally and linguistically appropriate tools for integration into existing program materials.	**4.2** • Promote and support family planning by providing information and education on birth spacing and interconception health during group sessions and Life Planning Meetings. • Help participants understand and value the concept of reproductive life planning as Life Plans are completed and discussed with Family Health Advocates during Life Planning Meetings and Group Facilitators during group sessions. • Provide referrals and promote linkages to family planning providers including Family Planning, Access, Care, and Treatment (Family PACT). • Help participants understand the characteristics of healthy relationships and provide resources that can help participants deal with abuse, reproductive coercion or birth control sabotage.	**4.2** • Summarize challenges/barriers of birth control usage among enrolled women who have delivered. (N) • Document collaborative activities with local MCAH programs and other partners such as Medi-Cal Managed Care and CPSP Provider networks to identify strategies, activities and provide technical assistance to improve access to health care services and increase utilization of the postpartum visit. (N) • Describe collaborative efforts with Violence Prevention Organizations such as Futures without Violence to determine service capacity to adequately meet needs identified by participants and LHJ staff providing case management services. (N)	**4.2** • Number and percent of participants who use any method of birth control to prevent pregnancy after their babies are born. (E) • Number and percent of participants who attend a 4-6 week postpartum checkup with a medical provider. (E)
4.3 BIH Coordinator under the guidance and leadership of the MCAH Director will	**4.3** • Local staff will work with or support participants to:	**4.3** • Summarize successes and challenges in addressing mental health issues, including mental	**4.3** • Number and percent of enrolled participants who completed the EPDS 6-8 weeks postpartum. (E) *– Fidelity Indicators A5a*

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		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
ensure that all BIH participants will be screened for Perinatal Mood and Anxiety Disorders (PMAD) and those with positive screens will be given a referral to mental health services.	○ Understand how mental health contributes to overall health and wellness, ○ Recognize the connection between stress and mental health and practice stress reduction techniques, ○ Help participants understand the connection between physical activity and mental health, ○ Understand the symptoms of postpartum depression. • Local staff will administer the Edinburgh Postpartum Depression Screen (EPDS) to every participant 6-8 weeks after she gives birth; and • Provide referrals and follow-up to mental health services when appropriate.	health referrals at least once per quarter. (N)	• Number and percent of participants with "positive" EPDS screens with a recorded referral to a community mental health provider within two (2) weeks after the EPDS collection date. (E)
4.4 All BIH participants will report an increase in parenting skills and bonding with their infants and other family members.	**4.4** • Assist participants in understanding and applying effective parenting techniques. • Assist participants with completing home safety checklist. • Assist participants with increasing knowledge of infant safe sleep practices, SIDS, Sudden Unexplained Infant Death (SUID) risk reduction. • Assist participants with completion of the birth plan that outlines specific labor/delivery and birthing requests to be	**4.4** • List and describe additional activities that enhance parenting and bonding. (N) • Provide anecdotes/participant success stories about improved parenting/bonding with submission of BIH Quarterly Reports. • Provide participants with health education materials related to safe sleep practices and SIDS reduction. • List and describe additional activities on infant safe sleep	**4.4** • Number and percent of participants who complete the safety checklist. (E) – *Fidelity Indicators A4aii* • Number and percent of postpartum participants who initiate breastfeeding. (E) • Number and percent of prenatal participants who complete a birth plan prior to delivery. (E) – *Fidelity Indicator A4ai*

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	conveyed to their prenatal care provider. • Provide participants with health education materials addressing the benefits of breastfeeding. • Assist participants with identifying and using bonding strategies, including breastfeeding, with their newborns.	practices/SIDS/SUID risk reduction. (N) • Provide anecdotes/participant success stories about infant safe sleep practices and SIDS/SUID risk reduction with submission of BIH Quarterly Reports. (N) • Document collaborative activities with State MCAH Programs used to identify strategies, provide technical assistance and disseminate resource materials that address the benefits of breastfeeding. (N) • Provide anecdotes/participant success stories about breastfeeding practices with submission of BIH Quarterly Reports.	

Goal 5: Improve interconception health by decreasing risk factors for adverse life course events among African American women of reproductive age.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
5.1 BIH Coordinator under the guidance and leadership of the MCAH Director will ensure that all BIH participants are linked to services that support timely prenatal care, postpartum visits and well-woman check-ups while enrolled in the BIH Program.	**5.1** • Ensure that participants are enrolled in prenatal care and are receiving risk-appropriate perinatal care. • Provide participants with health education materials and messages including but not limited to: the importance of attending prenatal care visits; recognizing the signs and symptoms of preterm labor; safe sleeping practices. • Provide participants with health information that supports a healthy pregnancy. • Ensure that participants are attending postpartum visits and well-woman check-ups as scheduled. • Increase knowledge of and facilitate collaboration with local MCAH programs to improve perinatal and post-partum referral systems for high-risk participants.	**5.1** • Describe collaborative activities with Text 4 Baby to deliver health education messages to pregnant women about the importance of postpartum visits. (N/E) • Document collaborative activities with March of Dimes (MOD), MotherToBaby and other agencies that provide preterm birth reduction and health education resources and messaging. (N) • Describe collaborative efforts with local MCAH programs and other partners such as Medi-Cal Managed Care and CPSP to identify strategies, activities and provide technical assistance to improve access to health care services and increase utilization of the postpartum visit. (N)	**5.1** Number and percent of participants who attend a 4-6 week postpartum checkup with a medical provider. (E)

Goal 6: Assist in reducing Infant Morbidity and Mortality by decreasing the percentage of preterm births.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
6.1 BIH Participants will have an increased knowledge of strategies and interventions they can utilize to reduce the occurrence of preterm births.	**6.1** • Provide participants with health education materials that address preterm birth reduction strategies; from MCAH-BIH and MOD. • LHJ staff will distribute any customized preterm birth resources to local medical providers and monitor/track how providers utilize and/or incorporate resources to engage clients in service delivery. • LHJ staff will support, promote, and attend preterm birth educational webinars for medical providers. • Assist participants with increasing knowledge of infant safe sleep practices, SIDS, SUID risk reduction by participating in local SIDS collaborative meetings and trainings. • Provide participants with health education materials addressing the benefits of breastfeeding.	**6.1** • Participate in MOD webinars and trainings that provide LHJ staff with opportunities to increase their knowledge of preterm birth reduction strategies and other approaches for having a healthy pregnancy. (N) • Distribute and encourage MCAH programs to integrate the following preterm birth resources to educate women and providers on preventing preterm births: (N) o Reducing Preterm Birth: What Black Women Need to Know Tip Sheet o Reducing Premature Birth: What Providers Need to Know Tip Sheet o Reducing Premature Birth Discussion Points – guidance to encourage conversation with women about • Facilitate one – two educational webinars for medical providers on topics such as: (N) o Roles and Responsibilities: Steps to Prevent Preterm Birth o The use of 17P to prevent preterm birth o Reducing Preterm Birth: Evidence-Based Strategies to Improve Outcomes	**6.1** • Maintain records of staff attendance at trainings. (N) • Maintain attendee records of trainings/Webinars hosted by LHJ. (N) • Number and percent of participants who complete the safety checklist prior to delivery. (E) – *Fidelity Indicator A4aii* • Number and percent of postpartum participants who initiate breastfeeding. (E)

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
		• Provide participants with health education materials related to safe sleep practices and SIDS reduction. (N) • Document collaborative activities with State MCAH Programs used to identify strategies, provide technical assistance and disseminate resource materials that address the benefits of breastfeeding. (N)	

Table 1 - Black Infant Health Selected Fidelity Dimensions, Measures and Indicators[1] (Revised 7/1/2017)

DIMENSION	MEASURE	INDICATOR
ADHERENCE	A1. Adherence to orientation and enrollment standards	A.1.a. Percent of recruited women that either a) enroll within 2 working days or b) receive a documented contact within two working days of the recruitment date
		A.1.b. Percent of enrolled women who meet eligibility criteria defined by age and timing of pregnancy
		A.1.c. Percent of recruited women who enroll within 14 days of their first in-person or phone contact
		A.1.d. Percent of enrolled women whose Rights, Responsibilities and Consent form was administered by either the Mental Health Professional, the BIH Coordinator, or the Public Health Nurse
	A2. Coordination of service provision	A.2.a. Percent of enrolled women who receive at least one case conference attended by the Family Health Advocate or Group Facilitator and either the Mental Health Professional or Public Health Nurse
	A3. Adherence of group program delivery to standards	A.3.a. Percent of enrolled women who attend a group session within 45 days of enrollment.
		A.3.b. Percent of group sessions attended by at least 5 participants
		A.3.c. Percent of group sessions that were conducted in the prescribed sequence and at the prescribed time intervals
		A.3.d. Percent of group sessions that were led by two trained facilitators
		A.3.e. Percent of participants attending a prenatal group series who attend session 1, 2, or 3

<table>
<tr><th>DIMENSION</th><th>MEASURE</th><th>INDICATOR</th></tr>
<tr><td>DOSE</td><td>D1. Completeness of group sessions attended</td><td>D.1.a.

[PRELIMINARY][2] – Percent of women enrolled at least 45 days that have attended the expected number of prenatal group sessions in the prescribed P&P timeframes.

<table>
<tr><th>To date, number of days since women enrolled…</th><th>Minimum Expected Number of Group Sessions Attended</th></tr>
<tr><td>0 to 44 days</td><td>Not measured</td></tr>
<tr><td>45 to 60 days</td><td>1</td></tr>
<tr><td>61 to 67 days</td><td>2</td></tr>
<tr><td>68 to 74 days</td><td>3</td></tr>
<tr><td>75 to 81 days</td><td>4</td></tr>
<tr><td>82 to 88 days</td><td>5</td></tr>
<tr><td>89 to 95 days</td><td>6</td></tr>
<tr><td>96 days or more</td><td>7</td></tr>
</table>
[FINAL][2] – Percent of enrolled women who have attended 7 or more prenatal group sessions</td></tr>
</table>

<table>
<tr><th>DIMENSION</th><th>MEASURE</th><th>INDICATOR</th></tr>
<tr><td></td><td>D2. Completeness of life planning meetings attended</td><td>D.2.a.

[PRELIMINARY][2] – Percent of women enrolled for at least 30 days who have attended the expected number of life planning meetings
<table>
<tr><th>To date, number of days since women enrolled…</th><th>Minimum Expected Number of Life Planning Meetings Attended</th></tr>
<tr><td>0 to 29 days</td><td>Not measured</td></tr>
<tr><td>30 to 44 days</td><td>1</td></tr>
<tr><td>45 to 59 days</td><td>2</td></tr>
<tr><td>60 to 85 days</td><td>3</td></tr>
<tr><td>86 days or more</td><td>4</td></tr>
</table>
[FINAL][2] – Percent of enrolled women who have attended 4 or more prenatal life planning meetings.</td></tr>
</table>

1. Source: BIH Fidelity Methods Presentation (January 2016)
2. Preliminary dose indicators are used when there is less than 6 months between recruitment cohort end date and data extraction date. Final dose scores are only when a minimum of 6 months lag exists between the end date and the data extraction date.

Exhibit _____

INVENTORY/DISPOSITION OF CDPH-FUNDED EQUIPMENT

Current Contract Number: 201936

Previous Contract Number (if applicable): _____

Contractor's Name: County of San Bernardino

Contractor's Complete Address: 606 East Mill Street, Second Floor
San Bernardino, CA 92415-0011

Contractor's Contact Person: Stewart Hunter

Contact's Telephone Number: 909-383-3044

Date Current Contract Expires: June 30, 2020

CDPH Program Name: Maternal, Child and Adolescent Health (MCAH)

CDPH Program Contract Manager: Diana Clements

CDPH Program Address: 1615 Capitol Avenue, Fifth Floor, Suite 73.560
P. O. Box 997420, MS Code 8305, Sacramento, CA 95899-7420

CDPH Program Contract Manager's Telephone Number: 916-445-8542

Date of this Report: April 30, 2019

(THIS IS NOT A BUDGET FORM)

STATE/ CDPH PROPERTY TAG (If motor vehicle, list license number.)	QUANTITY	ITEM DESCRIPTION 1. Include manufacturer's name, model number, type, size, and/or capacity. 2. If motor vehicle, list year, make, model number, type of vehicle (van, sedan, pick-up, etc.) 3. If van, include passenger capacity.	UNIT COST PER ITEM (Before Tax)	CDPH ASSET MGMT. USE ONLY CDPH Document (DISPOSAL) Number	ORIGINAL PURCHASE DATE	MAJOR/MINOR EQUIPMENT SERIAL NUMBER (If motor vehicle, list VIN number.)	*OPTIONAL— PROGRAM USE ONLY*
		No items in inventory.	$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				

Exhibit _____

INVENTORY/DISPOSITION OF CDPH-FUNDED EQUIPMENT

Current Contract Number: 201936

Previous Contract Number (if applicable): _____

Contractor's Name: County of San Bernardino

Contractor's Complete Address: 606 East Mill Street, Second Floor
San Bernardino, CA 92415-0011

Contractor's Contact Person: Stewart Hunter

Contact's Telephone Number: 909-383-3044

Date Current Contract Expires: June 30, 2020

CDPH Program Name: Black Infant Health Program (BIH)

CDPH Program Contract Manager: Diana Clements

CDPH Program Address: 1615 Capitol Avenue, Fifth Floor, Suite 73.560
P. O. Box 997420, MS Code 8305, Sacramento, CA 95899-7420

CDPH Program Contract Manager's Telephone Number: 916-445-8542

Date of this Report: April 30, 2019 (Page 1 of 2)

(THIS IS NOT A BUDGET FORM)

STATE/ CDPH PROPERTY TAG (If motor vehicle, list license number.)	QUANTITY	ITEM DESCRIPTION 1. Include manufacturer's name, model number, type, size, and/or capacity. 2. If motor vehicle, list year, make, model number, type of vehicle (van, sedan, pick-up, etc.) 3. If van, include passenger capacity.	UNIT COST PER ITEM (Before Tax)	CDPH ASSET MGMT. USE ONLY CDPH Document (DISPOSAL) Number	ORIGINAL PURCHASE DATE	MAJOR/MINOR EQUIPMENT SERIAL NUMBER (If motor vehicle, list VIN number.)	*OPTIONAL— PROGRAM USE ONLY*
	11	HP-EO800G1-CTO	$ 1,143.87		4/27/2015	MXL517233J	
		HP ELITEONE 83.2GHZ 8GB DDR3 1280GB SATA SSD	$			MXL517233K	
		INTEL 3.2GHZ 8GB DDR3 1280GB SATA SSD INTEL	$			MXL517233L	
		HD GRAPHICS 4600 WIN 7 PRO 23.5" DISPLAY	$			MXL517233M	
			$			MXL517233N	
			$			MXL517233P	
			$			MXL517233Q	
			$			MXL517233R	
			$			MXL517233S	
			$			MXL517233T	
			$			MXL517233V	
	2	HP Elite One 800 G2 i5-6500 Desktop Computer	$ 1,026.97		12/22/2016	MXL6231MCL	
			$			MXL6231M7K	
	1	Epson Powerlite 1284 LCD projector, 3200-lumen	$ 775.07		10/24/2016	WEVK6200093	
	1	Sanyo Model FWZV475F DVD Player	$ 203.99		11/22/2016	J12658935	
			$				

Exhibit _____

INVENTORY/DISPOSITION OF CDPH-FUNDED EQUIPMENT

Current Contract Number: 201936

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Contractor's Name: County of San Bernardino

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P. O. Box 997420, MS Code 8305, Sacramento, CA 95899-7420

CDPH Program Contract Manager's Telephone Number: 916-445-8542

Date of this Report: April 30, 2019 (Page 2 of 2)

(THIS IS NOT A BUDGET FORM)

STATE/ CDPH PROPERTY TAG (If motor vehicle, list license number.)	QUANTITY	ITEM DESCRIPTION 1. Include manufacturer's name, model number, type, size, and/or capacity. 2. If motor vehicle, list year, make, model number, type of vehicle (van, sedan, pick-up, etc.) 3. If van, include passenger capacity.	UNIT COST PER ITEM (Before Tax)	CDPH ASSET MGMT. USE ONLY CDPH Document (DISPOSAL) Number	ORIGINAL PURCHASE DATE	MAJOR/MINOR EQUIPMENT SERIAL NUMBER (If motor vehicle, list VIN number.)	*OPTIONAL— PROGRAM USE ONLY*
	4	Printer, HP Color Laser Jet Enterprise M553,	626.77		6/10/2016	JPBCJ6110C	
		Model BOISB-1406-02	$			JPBCJ611OP	
			$			JPBCJ110V	
			$			JPBCJ6110D	
	1	Printer, HP Laser Jet Pro 400 M401dne,	$ 239.24		6/10/2016	PHGFF51786	
		Model SHNGC-1100-00	$				
	1	Printer, HP Color Laser Jet Pro M452dn	$ 239.24		6/10/2016	VNB3B10691	
		Model BOISB-1407-00	$				
	2	Laptop, HP EliteBook Folio 1040 G3 Notebook PC	$ 1,050.03		6/10/2016	5CD6237MB8	
		Model 8260NGW	$			5CD6237MDQ	
	1	Vizio Plasma Television D60 D3	$ 600.35		11/22/2016	LFTRUPBS3301202	
			$				
			$				
			$				
			$				
			$				

INSTRUCTIONS FOR CDPH 1204
(Please read carefully.)

The information on this form will be used by the California Department of Public Health (CDPH) Asset Management (AM) to; (a) conduct an inventory of CDPH equipment and/or property (see definitions A, and B) in the possession of the Contractor and/or Subcontractors, and (b) dispose of these same items. Report all items, regardless of the items' ages, per number 1 below, purchased with CDPH funds and used to conduct state business under this contract. (See *Public Health Administrative Manual (PHAM),* Section 1-1000 and Section 3-1320.)

The CDPH Program Contract Manager is responsible for obtaining information from the Contractor for this form. The CDPH Program Contract Manager is responsible for the accuracy and completeness of the information and for submitting it to AM.

Inventory: List all CDPH tagged equipment and/or property on this form and submit it within 30 days prior to the three-year anniversary of the contract's effective date, if applicable. **The inventory should be based on previously submitted CDPH 1203s**, "Contractor Equipment Purchased with CDPH Funds." AM will contact the CDPH Program Contract Manager if there are any discrepancies. (See PHAM, Section 1-1020.)

Disposal: *(Definition: Trade in, sell, junk, salvage, donate, or transfer; also, items lost, stolen, or destroyed (as by fire).)* The CDPH 1204 should be completed, along with a "Property Survey Report" (STD. 152) or a "Property Transfer Report" (STD. 158), whenever items need to be disposed of; (a) during the term of this contract and (b) 30 calendar days before the termination of this contract. After receipt of this form, the AM will contact the CDPH Program Contract Manager to arrange for the appropriate disposal/transfer of the items. (See PHAM, Section 1-1050.)

1. List the state/ CDPH property tag, quantity, description, purchase date, base unit cost, and serial number (if applicable) for each item of;

   A. Major Equipment: **(These items were issued green numbered state/ CDPH property tags.)**
   - Tangible item having a base unit cost of $5,000 or more and a life expectancy of one (1) year or more.
   - Intangible item having a base unit cost of $5,000 or more and a life expectancy of one (1) year or more (e.g., software, video.)

   B. Minor Equipment/Property: **(These items were issued green state/ CDPH property tags.)**

   Specific tangible items with a life expectancy of one (1) year or more that have a base unit cost less than $5,000. The minor equipment and/or property items were issued green unnumbered "BLANK" state/ CDPH property tags with the exception of the following, which are issued numbered tags: Personal Digital Assistant (PDA), PDA/cell phone combination (Blackberries), laptops, desktop personal computers, LAN servers, routers and switches.

2. If a vehicle is being reported, provide the Vehicle Identification Number (VIN) and the vehicle license number to CDPH Vehicle Services. (See PHAM, Section 17-4000.)

3. If all items being reported do not fit on one page, make copies and write the number of pages being sent in the upper right-hand corner (e.g. "Page 1 of 3.")

4. The CDPH Program Contract Manager should retain one copy and send the original to: California Department of Public Health, Asset Management, MS1801, P.O. Box 997377, Sacramento, CA 95899-7377.

5. Use the version on the CDPH Intranet forms site. The CDPH 1204 consists of one page for completion and one page with information and instructions.

For more information on completing this form, call AM at (916) 341-6168.

606 East Mill Street, San Bernardino, CA 92415 | Phone: 909.383.3022 Fax: 909.383.3023
www.SBCounty.gov

SAN BERNARDINO COUNTY

Public Health
Family Health Services

Trudy Raymundo
Director

Corwin Porter
Assistant Director

Maxwell Ohikhuare, M.D.
Health Officer

DATE: March 19, 2019

TO: Whom It May Concern

FROM: Maxwell Ohikhuare, M.D.
Health Officer
351 North Mountain View Avenue
San Bernardino, CA 92415-0010

SUBJECT: AUTHORITY TO CONDUCT FETAL AND INFANT MORTALITY REVIEW (FIMR) RECORDS ABSTRACTION

The Department of Public Health has been charged by the State of California with funding the Fetal and Infant Mortality Review (FIMR) Project for San Bernardino County. The purpose is to study fetal, neonatal and post-neonatal deaths in order to identify system factors associated with them. A primary objective is to pinpoint possible gaps in services, which may be amenable to community and governmental action.

Under the provisions of California Health and Safety Code §131051 (General Powers of the Department of Public Health), the local health officer may obtain access to medical records for the purpose of public health investigation of fetal and infant deaths. I have assigned this authority to implement the FIMR Project to staff in the Family Health Services Section. This letter provides authorization for David Pratt, Public Health Epidemiologist, to review relevant health and medical records pertaining to the mother and infant from your institution for this purpose. I certify that the records being requested pertain to a fetal or infant death.

Please extend Mr. Pratt the same privileges you would extend to me as Health Officer of San Bernardino County.

Respectfully,

Maxwell Ohikhuare, M.D.
Health Officer

State of California-Health and Human Services Agency

California Department of Public Health
1616 Capitol Ave., Suite 74.262
P.O. Box 997377, MS 1800
Sacramento, CA 95899-7377
www.cdph.ca.gov

Submit

GOVERNMENT AGENCY TAXPAYER ID FORM

The principal purpose of the information provided is to establish the unique identification of the government entity.

Instructions: You may submit one form for the principal government agency and all subsidiaries sharing the same TIN. Subsidiaries with a different TIN must submit a separate form. Fields bordered in red are required. Please print the form to sign prior to submittal. You may email the form to: GovSuppliers@cdph.ca.gov or fax it to (916) 650-0100, or mail it to the address above.

Principal Government Agency Name: County of San Bernardino

Remit-To Address (Street or PO Box): 351 North Mountain View Avenue

City: San Bernardino State: CA Zip Code+4: 92415-001

Government Type:
- ☐ City
- ☐ Special District
- ☐ Other (Specify)
- ■ County
- ☐ Federal

Federal Employer Identification Number (FEIN): 95-6002748

List other subsidiary Departments, Divisions or Units under your principal agency's jurisdiction who share the same FEIN and receives payment from the State of California.

FI$Cal ID# (if known)	Dept/Division/Unit Name	Complete Address
	Public Health	351 N. Mountain View Ave., San Bernardino, CA 92415-0003

Contact Person: Paul Chapman Title: Administrative Manager

Phone number: 909-387-6630 E-mail address: Paul.Chapman@dph.sbcounty.gov

Signature: [signature] Date: 4/30/19

State of California—Health and Human Services Agency
California Department of Public Health

KAREN L. SMITH, MD, MPH
Director and State Public Health Officer

GAVIN NEWSOM
Governor

Attestation of Compliance with the Requirements for Enhanced Title XIX Federal Financial Participation (FFP) Rate Reimbursement for Skilled Professional Medical Personnel (SPMP) and their Direct Clerical Support Staff

In compliance with the Social Security Act (SSA) section 1903(a)(2), Title 42 Code of Federal Regulations (CFR) part 432.2 and 432.50, and the Federal and State guidelines provided, the County of San Bernardino has determined that the list of individuals in the attached Exhibit A are eligible for the enhanced SPMP reimbursement rate, for the State Fiscal Year 2019-2020, based on our review of all the criteria below:

☒ Professional Education and Training

☒ Job Classification

☒ Job Duties /Duty Statement

☒ Specific Tasks (if only a portion will be claimed as SPMP enhanced functions)

☒ Organizational Chart

☒ Accurate, complete, and signed SPMP Questionnaire

☒ Active California License/Certification

The undersigned hereby attests that he/she:

- Has personally reviewed the criteria above and its supporting documentation, and determined that the individuals meet the federal requirements for the enhanced SPMP reimbursement rate.
- Will maintain all the aforementioned records and supporting documentation for audit purposes for a minimum of 3 years.
- Certifies that SPMP expenditures are from eligible non-federal sources and are in accordance with 42 CFR Section 433.51
- Understands that if SPMP requirements are not met, the agency will be financially responsible for repaying the costs to the California Department of Public Health (CDPH).
- Understands that CDPH may request additional information to substantiate the SPMP claims and such information must be provided in a timely manner.

County of San Bernardino Department of Public Health
Agency Name/ Local Health Jurisdiction

Trudy Raymundo, Director
Name and Title

Signature

9/12/19
Date

CDPH MCAH, MS 8306 • P.O. Box 997420 • 1615 Capitol Ave
Sacramento, CA 95899-7420
(916) 650-0374 • (916) 650-0304 FAX
Internet Address: www.cdph.ca.gov

Exhibit A

	Agency Employee	Classification/Position	Professional Education/Training	Type of Licence	Active CA License No./ Certification No.
1	**Azevedo, Katie**	Public Health Nurse II	Bachelor of Science in Nursing	Registered Nurse and California Public Health Nurse Certification	812512 (RN) 82703 (PHN)
2	**Williams, Asuncion**	PH Clinic Supervisor	Nursing Diploma (3 years)	Registered Nurse	474434 (RN)
3	**Garcia, Xenia**	Public Health Nurse II	Bachelor of Science in Nursing	Registered Nurse and California Public Health Nurse Certification	95121724 (RN) 552685 (PH)
4	**Barrera, Veronica**	Registered Nurse II	Bachelor of Science in Nursing	Registered Nurse	757789 (RN)
5	**Chota, Gilma Doris**	Registered Nurse II	Bachelor of Science in Nursing	Registered Nurse	519985 (RN)
6	**Fanta, Susan**	Registered Nurse II	Bachelor of Science in Nursing	Registered Nurse	777280(RN)
7	**Molina, Patricia**	Public Health Nurse II	Bachelor of Science in Nursing	Registered Nurse and California Public Health Nurse Certification	513847 (RN) 67069 (PHN)
8	**Philo, Susan**	Supervising Public Health Nurse	Bachelor of Science in Nursing	Registered Nurse and California Public Health Nurse Certification	327668 (RN) 83019 (PHN)
9	**Garcia, Carmen**	Public Health Nurse II	Masters of Science in Nursing	Registered Nurse and California Public Health Nurse Certification	760041 (RN) 544937 (PHN)

	Agency Employee	Classification/Position	Professional Education/Training	Type of Licence	Active CA License No./ Certification No.
10	**Quijada, Cristal**	Public Health Nurse II	Bachelor of Science in Nursing	Registered Nurse and California Public Health Nurse Certification	95133113 (RN) 553626 (PHN)
11	**Hernandez-Singh, Sara**	Supervising Public Health Nurse	Bachelor of Science in Nursing	Registered Nurse and California Public Health Nurse Certification	522427 (RN) 55972 (PHN)
12	**Ude, Adaeze**	Public Health Nurse II	Bachelor of Science in Nursing	Registered Nurse and California Public Health Nurse Certification	712018 (RN) 544334 (PHN)
13	**LaRose, Grace**	Supervising Public Health Nurse	Bachelor of Science in Nursing	Registered Nurse and California Public Health Nurse Certification	802585 (RN) 550383 (PHN)
14					
15					
16					
17					
18					
19					
20					

State of California—Health and Human Services Agency
California Department of Public Health

KAREN L. SMITH, MD, MPH
Director and State Public Health Officer

GAVIN NEWSOM
Governor

Attestation of Compliance with the Requirements for Enhanced Title XIX Federal Financial Participation (FFP) Rate Reimbursement for Skilled Professional Medical Personnel (SPMP) and their Direct Clerical Support Staff

In compliance with the Social Security Act (SSA) section 1903(a)(2), Title 42 Code of Federal Regulations (CFR) part 432.2 and 432.50, and the Federal and State guidelines provided, the County of San Bernardino has determined that the list of individuals in the attached Exhibit A are eligible for the enhanced SPMP reimbursement rate, for the State Fiscal Year 2019-2020, based on our review of all the criteria below:

☒ Professional Education and Training
☒ Job Classification
☒ Job Duties /Duty Statement
☒ Specific Tasks (if only a portion will be claimed as SPMP enhanced functions)
☒ Organizational Chart
☒ Accurate, complete, and signed SPMP Questionnaire
☒ Active California License/Certification

The undersigned hereby attests that he/she:

- Has personally reviewed the criteria above and its supporting documentation, and determined that the individuals meet the federal requirements for the enhanced SPMP reimbursement rate.
- Will maintain all the aforementioned records and supporting documentation for audit purposes for a minimum of 3 years.
- Certifies that SPMP expenditures are from eligible non-federal sources and are in accordance with 42 CFR Section 433.51
- Understands that if SPMP requirements are not met, the agency will be financially responsible for repaying the costs to the California Department of Public Health (CDPH).
- Understands that CDPH may request additional information to substantiate the SPMP claims and such information must be provided in a timely manner.

County of San Bernardino Department of Public Health
Agency Name/ Local Health Jurisdiction

Trudy Raymundo, Director
Name and Title

Signature

9/12/19
Date

CDPH MCAH, MS 8306 • P.O. Box 997420 • 1615 Capitol Ave
Sacramento, CA 95899-7420
(916) 650-0374 • (916) 650-0304 FAX
Internet Address: www.cdph.ca.gov

Exhibit A

	Agency Employee	Classification/Position	Professional Education/Training	Type of Licence	Active CA License No./ Certification No.
1	**Hernandez-Singh, Sara**	Supervising Public Health Nurse	Bachelor of Science in Nursing	Registered Nurse and California Public Health Nurse Certification	522427 (RN) 55972 (PH)
2	**Garcia, Xenia**	Public Health Nurse II	Bachelor of Science in Nursing	Registered Nurse and California Public Health Nurse Certification	95121724 (RN) 552685 (PH)
3	**Ude, Adaeze**	Public Health Nurse II	Bachelor of Science in Nursing	Registered Nurse and California Public Health Nurse Certification	712018 (RN) 544334 (PH)
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