



Contract Number
21-871

SAP Number
N/A

Department of Public Health

Department Contract Representative	<u>Stewart Hunter</u>
Telephone Number	<u>(909) 383-3044</u>
 Contractor	 <u>California Department of Public Health</u>
Contractor Representative	<u>Jing Yuan, Contract Manager</u>
Telephone Number	<u>916-650-0340</u>
Contract Term	<u>July 1, 2021 through June 30, 2022</u>
Original Contract Amount	<u>\$1,418,738</u>
Amendment Amount	<u></u>
Total Contract Amount	<u>\$1,418,738</u>
Cost Center	<u>9300321000</u>

Briefly describe the general nature of the contract: Grant award (State Agreement No. 202136) from the California Department of Public Health for the Department of Public Health's Black Infant Health Program, in the amount of \$1,418,738, for the period of July 1, 2021 through June 30, 2022.

FOR COUNTY USE ONLY

Approved as to Legal Form

Adam Ebright, Deputy County Counsel

Date 10/28/2021

Reviewed for Contract Compliance

►

Date _____

Reviewed/Approved by Department

Joshua Dugas, Director

Date 11-3-21



TOMÁS J. ARAGÓN, M.D., Dr.P.H
Director and State Public Health Officer

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



GAVIN NEWSOM
Governor

October 11, 2021

Ms. Elizabeth Sneed-Berrie
BIH Coordinator
County of San Bernardino
351 North Mountain View Ave., Third Floor
San Bernardino, CA 92415-0010

Dear Ms. Sneed-Berrie:

**APPROVAL OF AGREEMENT FUNDING APPLICATION (AFA) FOR AGREEMENT
#202136 – FISCAL YEAR 2021-22**

The California Department of Public Health, Maternal, Child and Adolescent Health (CDPH/MCAH) Division approves your Agency's AFA. Attached are the most current Scope(s) of Work (SOW) and Budget(s) that were approved for administration of MCAH related programs.

To carry out the program(s) outlined in the enclosed SOW(s) and Budget(s), during the period of July 1, 2021 through June 30, 2022, the CDPH/MCAH Division will reimburse expenditures up to the following amounts:

Black Infant Health\$1,418,738.34

The availability of Title V funds and State General funds (BIH only) are based upon funds appropriated in the FY 2021-22 Budget Act. The availability of Federal Financial Participation (FFP), also known as Title XIX, are based upon the dissemination of funds from the Department of Healthcare Services that administers the FFP Medicaid Program. Reimbursement of invoices is subject to compliance with all federal and state requirements pertaining to the CDPH/MCAH related programs and adherence to all applicable regulations, policies and procedures. Your Agency agrees to invoice actual and documented expenditures and to follow all the conditions of compliance stated in the current CDPH/MCAH Program and Fiscal Policies and Procedures manuals, including the ability to substantiate all funds claimed.

CDPH Maternal, Child and Adolescent Health Division/Center for Family Health
MS 8300 • P.O. Box 997420 • Sacramento, CA 95899-7420
(916) 650-0300 • (916) 650-0305 FAX
Department Website (www.cdph.ca.gov)



For agencies claiming Title XIX funds, you also agree to maintain secondary documentation that clearly substantiates time study activities as being non-program related, unmatched, non-enhanced or enhanced. You also agree to use either:

1. The web-posted CDPH/MCAH, BIH Base Medi-Cal Factor (MCF), and/or
2. A Variable Base MCF for specific staff who serve a unique client population, and who verify and document 100% of their Medi-Cal enrolled and non-Medi-Cal enrolled clients during each time study period (MCAH Program only).

Please ensure that all necessary individuals within your Agency are notified of this approval and that the enclosed documents are carefully reviewed. This approval letter constitutes a binding agreement. If any of the information contained in the enclosed SOW and Budget is incorrect or different from that negotiated, please contact your contract manager, Jing Yuan, at (916) 650-0340 or by e-mail at Jing.Yuan@cdph.ca.gov within 14 calendar days from the date of this letter. Non-response constitutes acceptance of the enclosed documents.

Sincerely,



Angelica Jimenez-Bean
Section Chief – Contract Management and Allocations Process
Maternal, Child and Adolescent Health Division
Center for Family Health
California Department of Public Health

Attachment(s)

cc: Mr. Stewart Hunter
Administrative Supervisor I

Ms. Jing Yuan
Contract Manager

Ms. Chioko Grevious
Program Consultant

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 - Women/Maternal Domain: Focus Areas 1-5: Ensure women in California are healthy before, during and after pregnancy. Perinatal/Infant Domain: Ensure all infants are born healthy and thrive in their first year of life. Focus Area 2: Reduce infant mortality with a focus on reducing disparities. 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 outcomes that disproportionately impact the African-American community in California due to systemic racism. 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 life planning and case management that embraces the lifecycle 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 and Fiscal Year (FY) 2019-20 State General Fund expansion funding requirements 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, Los Angeles, Fresno, San Joaquin, Kern	San Diego, Alameda, Riverside, Bernardino	Sacramento, San Bernardino	Los Angeles
BIH Coordinator	1.0 FTE	1.0 FTE	1.0 FTE	1.0 FTE	1.0 FTE
PHA/Group Facilitator	2.0 FTE	2.0 FTE	4.0 FTE	6.0 FTE	8.0 FTE
Mental Health Professional	1.0 FTE	1.0 FTE	1.0 FTE	1.0 FTE	1.0 FTE
Outreach Liaison	1.0 FTE	1.0 FTE	1.0 FTE	1.0 FTE	1.0 FTE
Data Entry PHN	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE
	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 to ensure fidelity and standardization across all sites:

RSI 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, Kern	San Diego, Alameda, Riverside	Sacramento, San Bernardino	Los Angeles
	84	96	128	192	240

All BIH Sites are required to and will be held accountable for complying with the following additional tiered BIH Model or Case Management (CM) enrollment targets per the FY 2019-20 BIH State General Fund expansion-funding requirements:

	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
Additional Enrollment Target for Expansion Funding to be served through BIH Model or Case Management					
Local Health Jurisdiction	San Francisco, Santa Clara	Contra Costa, Long Beach, Fresno, San Joaquin, Kern	San Diego, Alameda, Riverside	Sacramento, San Bernardino	Los Angeles
Enrollment Target	40	50	56	90	208
Local Health Jurisdiction		Solano			
Enrollment Target		8			

Per the BIH P&P, the following criteria applies to participants enrolled in the Case Management-Only intervention:

- African-American
- 16 years of age or older
- Pregnant through 6 months postpartum
- Women 18 years of age and older are offered BIH Group model services before consenting to the BIH CM Intervention
- Has a signed consent, completed Assessment 1, received 1 referral for services
- May receive Case Management services until infant is 1 year of age
- Not required to attend BIH Group sessions

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 or amend the agreement/contract to reflect reduced funding. Continued participation in the BIH program beyond the current fiscal year is also subject to successful performance in meeting caseload requirements and implementing the agreed upon activities.

The development of this SOW is a collaborative process with BIH Program Coordinators and 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 consider integrating these approaches when conceptualizing and organizing local program, policy, and evaluation efforts.

- o The Ten Essential Services of Public Health and Social Determinants of Health:
 - o https://www.cdc.gov/publichealthatwork/publichealthservices/pdf/ten_essential_services_and_sdoH.pdf
- o The Spectrum of Prevention: The Spectrum of Prevention | Prevention Institute
- o Life Course Perspective: <http://www.amche.org/programsandtopics/LifecourseFinal/Pages/default.aspx>
- o Social Determinants of Health: <http://www.cdc.gov/socialdeterminants/>
- o Strengthening Families | Center for the Study of Social Policy (cssp.org)

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, 2021	September 30, 2021	October 15, 2021
Second Report	October 1, 2021	December 31, 2021	January 15, 2022
Third Report	January 1, 2022	March 31, 2022	April 15, 2022
Fourth Report (WAIVED)	April 1, 2022	June 30, 2022	August 15, 2022

Information during this reporting period will be included in the Annual Progress Report

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

Part II: Black Infant Health (BIH) Program

Goal 1: BIH local staff 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. Local staff will also support, as their capacity allows, activities related to the revisions of the BIH model.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Process Description and Measures	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	Short and/or Intermediate Outcome Measure(s)
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, BIH data collection forms, 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 4)	
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: 1.0 FTE BIH Coordinator Family Health Advocates (FHA)/Group Facilitators (GF) based on MCAH-BIH designated tier level.	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)	

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)	Short and/or Intermediate Outcome Measure(s)
	1 FTE Community Outreach Liaison (COL) 0.5 FTE Data Entry 1.0 FTE Mental Health Professional (MHP) 0.5 FTE Public Health Nurse (PHN) Utilization of a staff-hiring plan.		
1.3 TRAINING 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 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 in-person or virtual trainings.	1.3 List staff training activities in quarterly report. (N) Describe improved staff performance and confidence in implementing the program model due to 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 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. Recommend training topic suggestions for statewide meetings. (N)	1.3 Maintain records of staff attendance at trainings. (N) Number of trainings and conferences (both state and local) attended by staff during FY 2021-22. Completion of at least two (2) group observation feedback forms by the BIH Coordinator for every group facilitator during FY 2021-22. (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) Short and/or Intermediate Outcome Measure(s)
	conference calls, meetings and/or conferences as scheduled by MCAH Division. Quarter 1: Annual 2-day Basic Training Annual COL Meeting Quarter 2: Annual 2-day Advanced FHA/GF Meeting Quarter 3: Annual MHP/Public Health Nurse (PHN) Meeting Quarter 4: Annual Coordinator Meeting 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, MHPs and/or PHNs case management activities.	

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Process Description and Measures (Report on these measures in the Annual Report)	Evaluation/Performance Measures (Report on these measures in the Annual Report)
1.4 DATA COLLECTION AND ENTRY 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 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. Ensure that all staff that have ETO access are current in the SharePoint roster by completing	1.4 Review ETO and fidelity reports, discuss during calls with BIH State Team. Review ETO Utilization Reports for all staff at BIH Sites. Enter all data into ETO within ten (10) 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. Read data alerts or other data guidance sent via email or posted on SharePoint. 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 required forms that were entered within ten (10) days of collection. (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)	Short and/or Intermediate Outcome Measure(s)
OUTREACH 1.5 All BIH LHJs will increase and expand community awareness of BIH by collaborating with other BIH counties and individually as a county on communications 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 2021-22. (N) Number of new Memorandum of Understanding (MOUs) established in FY 2021-22. (N) Total number (overall and by type) of outreach activities completed by all staff during FY 2021-22. (N)
PARTICIPANT RECRUITMENT 1.6a For BIH Group Sessions, all BIH LHJs will recruit African-American women 18 years of age and older, and less than 30 weeks pregnant.	1.6a 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.	1.6a 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.	1.6a 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)

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)
1.6b For Case Management Only, all BIH LHJs will recruit African-American teens at least 16 years of age and adult women, pregnant or up to 6 months postpartum.	1.6b 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.	1.6b • Track and document progress in meeting goals of the Participant Recruitment Plan, review annually and update as needed.	1.6b Total number of women enrolled in Case management services only.
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 2021-22. (E)
PARTICIPANT ENROLLMENT 1.8a BIH Coordinator, under the guidance and leadership of the MCAH Director will ensure the following: • All participants enrolled in the BIH group model will be African-American. • All participants will be 18 years or older when enrolled. • All participants will be enrolled during pregnancy or postpartum.	1.8a Enroll women that are African-American. Enroll women at or before 30 weeks of pregnancy or up to 6 months postpartum. Enroll women that will participate in the group intervention.	1.8a Visual inspection of all recruitment eligibility fields on incoming referral forms for completeness. Inclusion of eligibility criteria with materials used for referral and recruitment.	1.8a Number and percent of enrolled women who meet eligibility criteria defined by age and timing of pregnancy. (E) – Fidelity Indicator A1b

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)	Short and/or Intermediate Outcome Measure(s)
- All participants will be enrolled at or before 30 weeks of pregnancy to attend prenatal groups, or up to 6 months postpartum to attend postpartum groups. - All women will participate in virtual or in-person prenatal and/or postpartum group intervention.			
1.8b BIH Coordinator, under the guidance and leadership of the MCAH Director will ensure the following: - All participants enrolled in Case Management-Only intervention will be African-American. - All participants will be 16 years or older when enrolled in Case Management-Only intervention. - All participants 18 years of age and older will be given the opportunity to enroll in the BIH Group Model first and if not able to enroll will then be offered the Case Management-Only intervention. - Participants will be enrolled in virtual or in-person Case Management-Only during pregnancy through 6 months postpartum.	1.8b - Enroll women that are African-American. - Enroll women during pregnancy through 6 months postpartum. - Enroll women to participate in the Case Management-Only intervention.	1.8a Visual inspection of all recruitment eligibility fields on incoming referral forms for completeness. Inclusion of eligibility criteria with materials used for referral and recruitment.	1.8b Number and percent of enrolled women who meet eligibility criteria for Case Management-Only.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Process Description and Measures	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report) Short and/or Intermediate Outcome Measure(s)
Participants enrolled in Case Management-Only intervention are not required to attend BIH Group sessions.			
PROGRAM PARTICIPATION 1.9.1 BIH Coordinator, under the guidance and leadership of the MCAH Director will ensure the following: All women will participate in a prenatal or postpartum 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)	1.9.1 Assign participants to a prenatal or postpartum group as part of enrollment process. Schedule groups to allow participants to attend within 30 days of enrollment. Enroll participants in a group within 45 days of first successful contact. Begin groups with the minimum required number of participants per the BIH P&P.	1.9.1 Describe barriers, challenges and successes of enrolling women in a group within 30-45 days of first successful contact 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)	1.9.1 Number and percent of enrolled women who attended a prenatal group session within 45 days of 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.
1.9.2a BIH Coordinator, under the guidance and leadership of the MCAH Director will ensure the following: All BIH participants (enrolled in BIH Group) will complete all prenatal and postpartum assessments, as applicable within the recommended time intervals. All BIH participants (enrolled in BIH Group) will receive referrals to services outside of BIH based on Life Planning meetings. All BIH participants (enrolled in BIH Group) will receive door-to-door transportation assistance as	1.9.2a Assign participants to a FHA as part of enrollment process. Conduct 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	1.9.2a 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)	1.9.2a Number and percent of enrolled women who complete prenatal and/or 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 Number and percent of enrolled women with a Birth Plan collected before the expected date of delivery (among women past due). (E) – Fidelity Indicator (supplemental) 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)
needed to attend group sessions and Life Planning meetings. All BIH locations will include a space dedicated for Child Watch during group sessions. All BIH Participants will be provided with necessary tools for participation in virtual services as necessary.	as needed based on Life Planning meetings. Ensure participant referrals are generated and completed for all services identified. Ensure participants have access to transportation assistance via Uber/Lyft or other door-to-door services in order to attend group sessions and Life Planning meetings. Ensure location of group services have dedicated child watch staff and space when group sessions are conducted. Ensure participants have access to necessary tools in order to participate in virtual services. Conduct participant dismissal activities. Conduct participant satisfaction surveys. Submit complete and accurate reports in the timeframe specified by MCAH.		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)
1.9.2b BIH Coordinator, under the guidance and leadership of the MCAH Director will ensure the following: Case Management participants will receive BIH Case Management support as defined in the P&P.	1.9.2b Assign participants to a FHA, MHP and/or PHN as part of enrollment process. Conduct case management services that align with identified needs of each participant. Collect required assessments per timeframe outlined in P&P. Develop and implement a Care Plan based on participant needs during case management meetings for each BIH participant; complete all prenatal and postpartum assessments.	1.9.2b Collect and record service delivery activities for enrolled women into ETO. (E) Describe program improvements resulting from participant satisfaction survey findings at least quarterly. (N)	1.9.2b • Number and percent of enrolled women who complete assessments at the P&P-designated time intervals. • 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.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	provide ongoing identification of her specific concerns/needs and referral to services outside of BIH as needed based on case management meetings. Ensure participant referrals are generated and completed for all services identified. Conduct participant dismissal activities. Conduct participant satisfaction surveys. Submit complete and accurate reports in the timeframe specified by MCAH. BIH Case Management support will be provided until the child turns one year of age.		
1.9.3a BIH Coordinator, under the guidance and leadership of the MCAH Director will ensure that all BIH participants will participate in virtual or in-person Group Intervention Sessions.	1.9.3a 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.	1.9.3a Collect and record Group Intervention Session attendance records for all enrolled women into ETO. Submit FY 2021-22 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)	1.9.3a Number of Group Intervention Sessions entered into ETO that began during FY 2021-22. (E) Number and percent of enrolled women who attend at least one (1) prenatal or postpartum 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.
1.9.3b BIH Participants enrolled in the Case Management only intervention are not required	1.9.3b Schedule case management meetings per guidance in the BIH P&P.	1.9.3b Describe participant successes or challenges with completing case management services.	1.9.3b Number and percent of enrolled women who complete case management

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Process Description and Measures	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	Short and/or Intermediate Outcome Measure(s)
to attend BIH group sessions.	Participants enrolled in the BIH Case Management only intervention may enroll in the BIH Group model on a case-by-case basis.			meetings at the P&P designated time intervals.
1.9.4 PARTICIPANT RETENTION 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). Ensure participants have access to transportation assistance via Uber/Lyft or other door-to-door services in order to attend group sessions and Life Planning meetings. Ensure location of group services have dedicated child watch staff and space when group sessions are conducted. Ensure participants have access to necessary tools in order to participate in virtual services. 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

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Process Description and Measures	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	Short and/or Intermediate Outcome Measure(s)
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. • Document collaborative efforts with local MCAH programs and Regional Perinatal Programs	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 2021-22. (E/N)	

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)	Short and/or Intermediate Outcome Measure(s)
	- o Increase utilization of well-woman and postpartum visits - o Identify Preterm Birth (PTB) reduction strategies - o 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.	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 participants and for referrals of active participants.	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 2021-22. (N)

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)	Short and/or Intermediate Outcome Measure(s)
	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

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Process Description and Measures (Report on these measures in the Annual Report)	Evaluation/Performance Measures (Report on these measures in the Annual Report)	Short and/or Intermediate Outcome Measure(s)
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 2021-22 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 P3a	3.1 Number and percent of enrolled participants who have both a baseline and follow-up measurement. (E) – Fidelity Indicator P3a
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-setting skills and create their Life Plans. Teach participants about the importance of stress reduction	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 P3a	3.2 Number and percent of enrolled participants who have both a baseline and follow-up measurement. (E) – Fidelity Indicator P3a

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)
	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

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Process Description and Measures	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)
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: Stress management Sexual health Healthy relationships Nutrition 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 psychosocial 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. Assist participants with completion of the birth plan that outlines specific labor/delivery and birthing requests to be conveyed to their prenatal care provider.	4.1 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

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)
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.	Provide information on the benefits and importance of delivering a full term baby. Provide information related to the risks associated with delivering via cesarean section in order to make an informed decision related to their delivery.		
	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 ensure that all BIH participants will be screened	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

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)	Short and/or Intermediate Outcome Measure(s)
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 conveyed to their prenatal care provider. Provide participants with health education materials addressing the benefits of breastfeeding.	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 practices/SIDS/SUID risk reduction. (N) Provide anecdotes/participant success stories about infant safe	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)	Short and/or Intermediate Outcome Measure(s)
	Assist participants with identifying and using bonding strategies, including breastfeeding, with their newborns.	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)
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 Short and/or Intermediate Outcome Measure(s) 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)	Process Description and Measures	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	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 and breastfeeding including those from MCAH-BIH and MOD. LHJ staff will distribute any customized preterm birth resources to local medical providers. LHJ staff will support, promote, and attend preterm birth educational webinars for medical providers. Increase knowledge of infant safe sleep practices, SIDS, SUID risk reduction by participating in local SIDS collaborative meetings and trainings.	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) - Reducing Preterm Birth: What Black Women Need to Know Tip Sheet - Reducing Premature Birth: What Providers Need to Know Tip Sheet - Reducing Premature Birth Discussion Points – guidance to encourage conversation with women about preterm birth reduction strategies Provide participants with health education materials related to safe sleep practices and SIDS reduction. (N) Conduct and 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)	6.1 Maintain records of staff attendance at trainings. (N) Maintain attendee records of trainings/Webinars hosted by LHJ. (N) Maintain a list of local medical providers LHJ staff distribute preterm birth resources to. (N) Number and percent of participants who complete the safety checklist prior to delivery. (E) – Fidelity Indicator A4ail Number and percent of postpartum participants who initiate breastfeeding. (E)	

Table 1 - Black Infant Health Selected Fidelity Dimensions, Measures and Indicators¹ (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

DIMENSION	MEASURE	INDICATOR																		
DOSE	D1. Completeness of group sessions attended	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>	To date, number of days since women enrolled...	Minimum Expected Number of Group Sessions Attended	0 to 44 days	Not measured	45 to 60 days	1	61 to 67 days	2	68 to 74 days	3	75 to 81 days	4	82 to 88 days	5	89 to 95 days	6	96 days or more	7
		To date, number of days since women enrolled...	Minimum Expected Number of Group Sessions Attended																	
		0 to 44 days	Not measured																	
		45 to 60 days	1																	
		61 to 67 days	2																	
		68 to 74 days	3																	
		75 to 81 days	4																	
		82 to 88 days	5																	
		89 to 95 days	6																	
		96 days or more	7																	
[FINAL] ² – Percent of enrolled women who have attended 7 or more prenatal group sessions																				

DIMENSION	MEASURE	INDICATOR												
		D.2.a.												
		[PRELIMINARY] ² – Percent of women enrolled for at least 30 days who have attended the expected number of life planning meetings												
	D2. Completeness of life planning meetings attended	<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>	To date, number of days since women enrolled...	Minimum Expected Number of Life Planning Meetings Attended	0 to 29 days	Not measured	30 to 44 days	1	45 to 59 days	2	60 to 85 days	3	86 days or more	4
To date, number of days since women enrolled...	Minimum Expected Number of Life Planning Meetings Attended													
0 to 29 days	Not measured													
30 to 44 days	1													
45 to 59 days	2													
60 to 85 days	3													
86 days or more	4													
		[FINAL] ² – Percent of enrolled women who have attended 4 or more prenatal life planning meetings.												

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.

BUDGET SUMMARY

FISCAL YEAR
2021-22

BUDGET
ORIGINAL

BUDGET STATUS
ACTIVE

BUDGET BALANCE
0.01

Version 7.0 - 150 Quarts (1/20/20)

Program: Black Infant Health (BIH)

Agency: 202136 San Bernardino

SubK:

UNMATCHED FUNDING									
		BIH-TV		BIH-SGF		AGENCY FUNDS		NON-ENHANCED MATCHING (6050)	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
TOTAL FUNDING	%	BIH-TV	%	BIH-SGF	%	Agency Funds*	%	Combined Fed/State	%
ALLOCATION(S)		390,054.00		821,573.00					

EXPENSE CATEGORY	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)
(I) PERSONNEL	834,340.81		250,980.05		103,448.71		158,571.33		245,834.70		6,954.74		58,843.28		0.00
(II) OPERATING EXPENSES	70,764.05		44,748.80		1,694.30		34.65		0.00		24,296.28		0.00		0.00
(III) CAPITAL EXPENDITURES	0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00
(IV) OTHER COSTS	580,416.57		1,552.75		578,863.82		0.00		0.00		0.00		0.00		0.00
(V) INDIRECT COSTS	132,034.43		82,772.39		0.00		0.00		0.00		45,262.05		0.00		0.00
BUDGET TOTALS*	1,617,555.86	24.11%	390,053.99	42.29%	683,994.83	9.81%	158,605.99	15.20%	245,834.70	4.97%	80,423.07	3.53%	58,843.28	0.00%	0.00
BALANCE(S)			0.01		0.00										

TOTAL BIH-TV
TOTAL BIH-SGF
TOTAL TITLE XIX
TOTAL AGENCY FUNDS

390,053.99
821,573.00
207,111.35
188,817.52

683,994.83
122,917.35
122,917.35

40,211.54
40,211.53
14,860.82
43,982.46

\$ 1,418,738.34

Maximum Amount Payable from State and Federal resources

WE CERTIFY THAT THIS BUDGET HAS BEEN CONSTRUCTED IN COMPLIANCE WITH ALL INCH ADMINISTRATIVE AND PROGRAM POLICIES.

MCAP/PROJECT DIRECTOR'S SIGNATURE

AGENCY FISCAL AGENT'S SIGNATURE

DATE

* These amounts contain local revenue submitted for information and matching purposes. MCAP does not reimburse Agency contributions.

STATE USE ONLY - TOTAL STATE AND FEDERAL REIMBURSEMENT									
		BIH-TV		BIH-SGF		AGENCY FUNDS		BIH-SGF-NE	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
TOTAL FUNDING	%	BIH-TV	%	BIH-SGF	%	Agency Funds	%	Combined Fed/State	%
ALLOCATION(S)		390,054.00		821,573.00					

Totals for PCA Codes

1,418,738.34

245,834.70

40,211.54

58,843.28

Program:
Agency:
Sub:

Black Infant Health (BIH)
202136 San Bernardino

202136 San Bernardino BIH Budget Template

(III) OPERATING EXPENSES DETAIL

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	UNMATCHED FUNDING			NON-ENHANCED MATCHING (60/60)			ENHANCED MATCHING (75/25)			% PERSONNEL MATCH
								BIH-TV	BIH-SGF	AGENCY FUNDS	BIH-SGF-NE	BIH-City NE	BIH-SGF-E	BIH-City E	Combined	Combined	
	TOTAL FUNDING	%	BIH-TV	%	BIH-SGF	%	AGENCY FUNDS				Combined	Combined	Combined	Combined	%	%	
TOTAL OPERATING EXPENSES	70,784.05		44,748.80		1,684.30		34.66				0.00	24,296.28	0.00	0.00	0.00	0.00	
TRAVEL	17,250.00	65.80%	11,503.40		0.00		0.00				0.00	5,727.00	0.00	0.00	0.00	0.00	
TRAINING	2,000.00	65.17%	1,303.40		0.00		0.00				0.00	886.60	0.00	0.00	0.00	0.00	
1 Office / Outside Supplies	7,500.00	60.17%	4,512.75	5.00%	375.00		0.00				0.00	34.83%	0.00	0.00	0.00	0.00	
2 Facilities Costs	6,169.69	60.17%	3,712.30	5.00%	308.48		0.00				0.00	34.83%	0.00	0.00	0.00	0.00	
3 Local BIH Travel	3,200.00	60.17%	1,925.44	5.00%	160.00		0.00				0.00	34.83%	0.00	0.00	0.00	0.00	
4 Minor Office Equipment Maintenance	4,862.40	60.17%	2,937.74	5.00%	244.12		0.00				0.00	34.83%	0.00	0.00	0.00	0.00	
5 Communications	18,621.96	62.17%	11,577.27	3.00%	558.66		0.00				0.00	34.83%	0.00	0.00	0.00	0.00	
6 Postage	500.00	65.17%	325.85		0.00		0.00				0.00	34.83%	0.00	0.00	0.00	0.00	
7 Duplicating	2,400.00	65.17%	1,564.08		0.00		0.00				0.00	34.83%	0.00	0.00	0.00	0.00	
8 Center for Employee Health and Wellness / Background Checks	400.00	65.17%	260.68		0.00		0.00				0.00	34.83%	0.00	0.00	0.00	0.00	
9 Toll-free Communications	200.00	63.65%	127.30	18.02%	38.04		0.00				0.00	34.83%	0.00	0.00	0.00	0.00	
10 County Counsel/Contracts Unit	1,940.00	65.17%	1,284.30		0.00		0.00				0.00	34.83%	0.00	0.00	0.00	0.00	
11 Audit Expense	150.00	65.17%	97.76		0.00		0.00				0.00	34.83%	0.00	0.00	0.00	0.00	
12 Minor Office Equipment/Furniture	300.00	65.17%	195.51		0.00		0.00				0.00	34.83%	0.00	0.00	0.00	0.00	
13 Computer Equipment	5,250.00	65.17%	3,421.43		0.00		0.00				0.00	34.83%	0.00	0.00	0.00	0.00	
14			0.00		0.00		0.00				0.00	0.00	0.00	0.00	0.00	0.00	
15			0.00		0.00		0.00				0.00	0.00	0.00	0.00	0.00	0.00	

* Unmatched Operating Expenses are not eligible for Federal matching funds (Title XX), State General Funds (Col. 8), and/or Agency (Col. 7) funds.

(III) CAPITAL EXPENDITURE DETAIL

TOTAL CAPITAL EXPENDITURES			0.00		0.00		0.00		0.00		0.00		0.00		0.00		

(IV) OTHER COSTS DETAIL

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	UNMATCHED FUNDING			NON-ENHANCED MATCHING (60/60)			ENHANCED MATCHING (75/25)			% PERSONNEL MATCH
								BIH-TV	BIH-SGF	AGENCY FUNDS	BIH-SGF-NE	BIH-City NE	BIH-SGF-E	BIH-City E	Combined	Combined	
	TOTAL FUNDING	%	BIH-TV	%	BIH-SGF	%	AGENCY FUNDS				Combined	Combined	Combined	Combined	%	%	
TOTAL OTHER COSTS	580,416.57		1,552.75		578,863.82		0.00				0.00	0.00	0.00	0.00	0.00	0.00	
SUBCONTRACTS																	
1 Contractor for BIH Group Model and Case Management services	446,843.00	0.00%	0.00	100.00%	446,843.00		0.00				0.00	0.00	0.00	0.00	0.00	0.00	
2 Contract with Uber for participant transportation	3,000.00	0.00%	0.00	100.00%	3,000.00		0.00				0.00	0.00	0.00	0.00	0.00	0.00	
3 Contract with Lyft for participant transportation	4,157.01	0.00%	0.00	100.00%	4,157.01		0.00				0.00	0.00	0.00	0.00	0.00	0.00	
4 Contract with Child Watch Provider	65,151.00	0.00%	0.00	100.00%	65,151.00		0.00				0.00	0.00	0.00	0.00	0.00	0.00	
5			0.00		0.00		0.00				0.00	0.00	0.00	0.00	0.00	0.00	
OTHER CHARGES																	
1 Client Support Materials	37,620.56	0.00%	0.00	100.00%	37,620.56		0.00				0.00	0.00	0.00	0.00	0.00	0.00	
2 Educational Materials	500.00	96.10%	495.50	0.90%	4.50		0.00				0.00	0.00	0.00	0.00	0.00	0.00	
3 Participant Transportation	21,145.00	5.00%	1,057.25	5.00%	20,087.75		0.00				0.00	0.00	0.00	0.00	0.00	0.00	
4			0.00		0.00		0.00				0.00	0.00	0.00	0.00	0.00	0.00	
5			0.00		0.00		0.00				0.00	0.00	0.00	0.00	0.00	0.00	
6			0.00		0.00		0.00				0.00	0.00	0.00	0.00	0.00	0.00	
7			0.00		0.00		0.00				0.00	0.00	0.00	0.00	0.00	0.00	
8			0.00		0.00		0.00				0.00	0.00	0.00	0.00	0.00	0.00	

(V) INDIRECT COSTS DETAIL

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	UNMATCHED FUNDING			NON-ENHANCED MATCHING (60/60)			ENHANCED MATCHING (75/25)			% PERSONNEL MATCH
								BIH-TV	BIH-SGF	AGENCY FUNDS	BIH-SGF-NE	BIH-City NE	BIH-SGF-E	BIH-City E	Combined	Combined	
	TOTAL FUNDING	%	BIH-TV	%	BIH-SGF	%	AGENCY FUNDS				Combined	Combined	Combined	Combined	%	%	
TOTAL INDIRECT COSTS	132,034.43		82,772.39		0.00		0.00				0.00	49,262.05	0.00	0.00	0.00	0.00	
15.33% of Total Wages + Fringe Benefits	132,034.43	62.65%	82,772.39		0.00		0.00				0.00	37.31%	0.00	0.00	0.00	0.00	

Time-Study Data Report for Summary of FFP (v3.1)

AGENCY:

LAST NAME:

FIRST NAME:

JOB TITLE:

SPMP:

TIME BASE:

TIME STUDY PERIOD:

October-December (Q2)

TIME STUDY MONTH:

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The percentages below are based on the program activities performed by this staff member and can only be used to invoice for the Fiscal Year and Time Study Period entered above.

Percentage Distribution of Staff Time by Program

Program Reference	Budget Line #	Program	Not Matchable	Non-Enhanced	Enhanced	% of time in Program*	Medi-Cal Factor %
A							
B							
C							
D							
E							
F							
G							
H							
I							
J							
K							
L							
Total							

*This information is to be used by agencies to determine the percentage of staff salary that is billable to MCAH Programs. It can be used by agencies that do not maintain a daily record of program time.

Data Entry for Monthly Summary of FFP Time Study Information (v3.1)

AGENCY: _____
 LAST NAME: _____
 FIRST NAME: _____
 JOB TITLE: _____
 SPMP: _____
 TIME BASE: _____

TIME STUDY PERIOD: October-December (Q2)
 TIME STUDY MONTH: _____

Enter time-study information below:

Function Code	Week 1	Week 2	Week 3	Week 4	Week 5	Manual Entry of Totals	Total
Totals							

Allocated Functions

Function Code	Week 1	Week 2	Week 3	Week 4	Week 5	Manual Entry of Totals	Total
10							
12							

Program A:

Function Code	Week 1	Week 2	Week 3	Week 4	Week 5	Manual Entry of Totals	Total
A1							
A2							
A3							
A4							
A5							
A6							
A7							
A8							
A9							
A11							

Program B:

Function Code	Week 1	Week 2	Week 3	Week 4	Week 5	Manual Entry of Totals	Total
B1							
B2							
B3							
B4							
B5							
B6							
B7							
B8							
B11							

Program C:

Function Code	Week 1	Week 2	Week 3	Week 4	Week 5	Manual Entry of Totals	Total
C1							
C2							
C3							
C4							
C5							
C6							
C7							
C8							
C9							
C11							