THE INFORMATION IN THIS BOX IS NOT A PART OF THE CONTRACT AND IS FOR COUNTY USE ONLY

SAN BERNARDINO COUNTY

Contract Number

21-629 A-3

SAP Number

Department of Public Health

Department Contract Representative	Rebecca Saucedo
Telephone Number	(909) 725-5426
Contractor	California Health Collaborative
Contractor Representative	Brandi Muro
Telephone Number	(559) 244-4512
Contract Term	August 24, 2021 through August 23, 2024
Original Contract Amount	$1,346,529
Amendment Amount	$307,261
Total Contract Amount	$1,653,790
Cost Center	9300321000

IT IS HEREBY AGREED AS FOLLOWS:

Amendment NO. 3

It is hereby agreed to amend Contract No. 21-629, effective March 12, 2024, as follows:

Section II. Contractor Service Responsibilities

A. Program Requirements
Contractor shall:

2. Perform the activities and achieve the objectives described in the BIH Program Scope of Work (Attachment A). Contractor shall complete the components of in Attachment A in a manner that represents and promotes the interest of County, as expressed by County, throughout the term of the Contract. This includes in-person group facilitation, case management and community outreach services.

a. Target Number of Participants for Group Model:
- A minimum of nine (9) prenatal groups must be offered per year, serving between 72 and 108 participants.
- A minimum of four (4) postpartum groups must be offered per year, serving between 32 and 48 participants.

b. Target Number of Participants for Case Management Model = 35% of total participants or 56

Section V. Fiscal Provisions, Paragraph A is amended to read as follows:

A. The maximum amount of reimbursement under this Contract shall not exceed $1,653,790 which may consist of state and/or federal funds and shall be subject to availability of said funds to the County. The consideration to be paid to Contractor, as provided herein, shall be in full payment for all Contractor's services and expenses incurred in the performance hereof, including travel and per diem.

Attachment A is amended as attached.

All other terms and conditions of Contract remain in full force and effect.

This Agreement may be executed in any number of counter parts, each of which so executed shall be deemed to be an original, and such counterparts shall together constitute one and the same Contract. The parties shall be entitled to sign and transmit an electronic signature of the Contract (whether by facsimile, PDF, or other email transmission), which signature agrees to promptly execute and deliver to the other party an original signed Contract upon request.

IN WITNESS WHEREOF, the San Bernardino County and the Contractor have each caused this Contract to be subscribed by its respective duly authorized officers, on its behalf.

SAN BERNARDINO COUNTY

► Dawn Rowe

Dawn Rowe, Chair, Board of Supervisors

Dated: MAR 12 2024

SIGNED AND CERTIFIED THAT A COPY OF THIS DOCUMENT HAS BEEN DELIVERED TO THE CHAIRMAN OF THE BOARD

Lynna Monell
Clerk of the Board of Supervisors
San Bernardino County

By _____ Deputy

California Health Collaborative
(Print or type name of corporation, company, contractor, etc.)

By Stephen Ramirez (Feb 28, 2024 06:38 PST)
(Authorized signature - sign in blue ink)

Name Stephen Ramirez
(Print or type name of person signing contract)

Title Chief Executive Officer
(Print or Type)

Dated: 02/28/24

Address 1680 W. Shaw Ave

Fresno, CA 93711

FOR COUNTY USE ONLY

Approved as to Legal Form	Reviewed for Contract Compliance	Reviewed/Approved by Department
►	►	Joshua Dugas (Feb 27, 2024 12:37 PST)
Adam Ebright, County Counsel		Joshua Dugas, Director
Date 02/27/24	Date	Date 02/27/24

Black Infant Health Program

- **Service Delivery Area: Victorville, Adelanto, Hesperia, Apple Valley, Barstow, and surrounding communities**
- **Service Delivery Requirement for BIH Group Model – A minimum of nine (9) prenatal groups must be offered per year, serving between 72 and 108 participants. A minimum of four (4) postpartum groups must be offered per year, serving between 32 and 48 participants.**
- **Service Delivery Requirement for BIH Case Management Model = 35% of total participants or 56.**

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)	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)
IMPLEMENTATION 1.1 BIH Coordinator, under the guidance and leadership of the San Bernardino County (SBC) BIH Program Coordinator 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 SBC BIH Program Coordinator to complete, review, and approve the BIH budget prior to submission. • Collaborate with SBC BIH Program Coordinator to submit BIH Annual report to SBC BIH Program Coordinator by July 15. • Collaborate with SBC BIH Program Coordinator to submit BIH Quarterly Reports as directed by MCAH. • Submit Monthly deliverable report to SBC BIH Program Coordinator by the 15th of the following month.	1.1 • Provide organization chart that designates the delineation of responsibilities of BIH Coordinator and additional staff.	1.1 • Submit BIH Annual report to SBC BIH Program Coordinator by July 15. • Submit BIH Quarterly Reports as directed by MCAH. • Submit Monthly deliverable report to SBC BIH Program Coordinator by the 15th of the following month.

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 honor 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 • 3.0 FTE Family Health Advocates (FHA)/Group Facilitators (GF) • 1.0 FTE Community Outreach Liaison (COL) • 1.0 FTE Data Entry • 1.0 FTE Mental Health Professional (MHP) • 1.0 FTE Public Health Nurse • 1.0 FTE Child Watch Utilization of a staff-hiring plan.	**1.2** • Describe process of recruiting and hiring staff at each site that are filled by personnel meeting qualifications in the P&P. • 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.

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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 SBC BIH Program Coordinator of any training needs. • Ensure that all key BIH staff participates in on-going training or educational opportunities designed to enhance cultural sensitivity and responsiveness through webinars, trainings and/or conferences. • 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	**1.3** • List staff training activities in quarterly report. • Describe improved staff performance and confidence in implementing the program model due to participating in staff development activities and/or trainings. • List gaps in staff development and training in quarterly report. • Describe plan to ensure that staff development needs are met in quarterly report. • Describe how cultural sensitivity training has enhanced BIH staff knowledge and how that knowledge is applied. • Describe how staff utilized information from the MCAH SIDS conference with participants. • Document strategies and	**1.3** • Maintain records of staff attendance at trainings. • Number of trainings and conferences (both state and local) attended by staff during fiscal year. • Completion of at least 2 group observation feedback forms by the BIH Coordinator for every group facilitator during fiscal year.

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	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, conference calls, meetings and/or conferences as scheduled by MCAH Division. • Ensure that the BIH Coordinator and all direct service staff attend mandatory MCAH Division-sponsored training(s) prior to implementing the BIH Program. • Ensure the BIH Coordinator perform regular observations of GFs and assessments of FHAs, MHPs and/or PHNs case management activities.	action plans related to SIDS risk reduction strategies developed from SIDS collaborative workgroup meetings. • Recommend training topic suggestions for statewide meetings.	

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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 accuracy and completeness of data input into Efforts to Outcome (ETO) system including establishing a Data Entry Lead. • Ensure that all staff receives updates about changes in ETO and data book forms. • Participate 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 SBC BIH Program Coordinator to ensure proper and continuous operation of the MCAH-BIH- ETO. • Store Participant level Data forms on paper per security guidelines in P&P for a minimum of four years (prior three years plus current FY). • Define a data entry schedule for staff and monitor for adherence.	**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. • 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 and should include all staff collecting data. The audits should verify the data in the paper forms matches the information in ETO for that sample.	**1.4** • Number and percent of forms that were entered within ten (10) days of collection. (E) *BIH PA: Timeliness of data entry* report. • Maintain records of the four (4) chart audits conducted in the fiscal year.

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OUTREACH **1.5** Increase and expand community awareness of BIH by collaborating with other BIH counties and individually as a county on communication outreach activities, including the use of social media.	**1.5** • 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. • Establish referral mechanisms that will facilitate reciprocity with partner agencies as appropriate. • Collaborate with SBC BIH Program Coordinator to utilize social media campaigns developed by MCAH and/or the County of San Bernardino to increase community awareness while conducting outreach activities.	**1.5** • Describe the types of community partner agencies contacted by BIH staff. • Describe outreach activities performed in order to reach target population. • Describe deviations in outreach activities, noting changes from local recruitment plan. • Document type, frequency and number of social media activities conducted on the BIH Primary Contact Table and submit with Quarterly and Annual Report.	**1.5** • Total number (overall and by type) of outreach activities completed by all staff during the fiscal year.
PARTICIPANT RECRUITMENT **1.6a** Recruit African-American women 18 years of age and older, and	**1.6a** • Develop and implement a Participant Recruitment Plan	**1.6a** • Track and document progress in meeting goals of the	**1.6a** • Number and percent of recruited and referred women

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less than 30 weeks pregnant for group sessions, or up to six (6) months postpartum for postpartum group services.	(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. • Site uses social media strategies (Facebook, Twitter, Instagram) for distribution of BIH materials, community events, engagement of former and current participants. • Staff will complete a recruitment for all people recruited and referred to the Program.	Participant Recruitment Plan, review annually and update as needed.	that were eligible (at least 18 years old and less than 30 weeks pregnant) based on their recruitment date. • List social media addresses.
1.6b For Case Management Only, Recruit African-American teens at least 16 years of age and adult women, pregnant or up to six (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. • Site uses social media strategies (Facebook, Twitter, Instagram) for distribution of BIH materials, community events, engagement of former and current participants. • Staff will complete a recruitment for all people recruited and referred to the Program.	**1.6b** Track and document progress in meeting goals of the Participant Recruitment Plan, review annually and update as needed.	**1.6b** Number and percent of recruited and referred women that were eligible for Case Management (based on age and pregnancy status) based on their recruitment date, in the fiscal year.
PARTICIPANT REFERRAL **1.7** Establish a network of referral partners.	**1.7** • Collaborate with network of established partners (community- based	**1.7** • Describe process for ensuring that referral partner agencies are referring eligible women	**1.7** • Total number of service providers that made referrals to the BIH Program in the

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	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.	to BIH in quarterly reports and during technical assistance calls.	fiscal year.
PARTICIPANT ENROLLMENT **1.8 a** BIH Coordinator 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 group intervention. • All participants will be enrolled during pregnancy or postpartum. • All participants will receive a rights and responsibilities form and provide signed or verbal acknowledgement. • All women will participate in virtual or in-person prenatal and/or postpartum group intervention. • Participants may receive services until infant is 1 year of age.	**1.8a** • Enroll women that are African-American. • 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 participants that agree to enroll among those recruited and eligible. • Number and percent that has a recruitment and a rights and responsibilities (consent) touchpoint in ETO in the fiscal year.

1.8b BIH Coordinator will ensure the following: • All participants enrolled in Case Management-Only intervention will be African-American. • Participants will be enrolled in virtual or in-person Case Management-Only during pregnancy through six (6) months postpartum. • Participants enrolled in Case Management-Only intervention are not required to attend BIH Group sessions. • Participants may receive services until infant is 1 year of age.	**1.8b** • Enroll women that are African-American. • Enroll women during pregnancy up to 6 months postpartum. • Enroll women to participate in the Case Management-Only intervention.	**1.8b** • 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 participants that agree to enroll among those recruited and eligible in the fiscal year. • Number and percent that has a recruitment and a rights and responsibilities (consent) touchpoint in ETO in the fiscal year.

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PROGRAM PARTICIPATION **1.9.1** BIH Coordinator will ensure the following: • All women will participate in a prenatal or postpartum group. • All women will participate in a group within 30-45 days of enrollment. • All groups will be implemented according to the 10-group intervention model as specified in the P&P.	**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 -45 days of enrollment. • Enroll participants in a prenatal group within 45 days enrollment. • 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 prenatal group within 30-45 days of first successful contact during technical assistance calls. • Describe barriers, challenges and successes of beginning groups with the minimum required number of participants during technical assistance calls.	**1.9.1** • Number and percent of enrolled women who attended a prenatal group session within 45 days of enrollment. • Percent of group sessions that were conducted in the prescribed sequence and at the prescribed time intervals. • Percent of group sessions in a series that were attended by at least 5 participants.
1.9.2 a BIH Coordinator will ensure the following: • All BIH participants (enrolled	**1.9.2 a** • Assign participants to a FHA as part of enrollment process. • Conduct case management	**1.9.2 a** • Collect and record service delivery activities for enrolled women into ETO.	**1.9.2 a** • Number and percent of enrolled women who complete prenatal and

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in BIH Group) will complete all prenatal and postpartum assessments 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 transportation assistance as needed to attend group sessions and Life Planning meetings. • All BIH locations will include a space dedicated for Child Watch during group sessions.	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. • 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. • Conduct participant dismissal activities. • Conduct participant satisfaction surveys.	• Describe successes and/or challenges in assisting participants with setting short and long-term goals during Life Planning meetings. • Describe program improvements resulting from participant satisfaction survey findings at least quarterly.	postpartum 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. • 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. • Number and percent of enrolled women with a Birth Plan collected before the expected date of delivery (among women past due). • 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). • Number and percent of enrolled women who have been dismissed from BIH with a completed participant satisfaction survey.

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	• Submit complete and accurate reports in the timeframe specified by MCAH and/or SBC BIH Program Coordinator.		
1.9.2b BIH Coordinator will ensure that Case Management participants will receive BIH Case Management support as defined in the P&P.	**1.9.2b** • Assign participants to a FHA and/or MHP 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; 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	**1.9.2b** • Collect and record service delivery activities for enrolled women into ETO. • Describe program improvements resulting from participant satisfaction survey findings at least quarterly.	**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 the MHP.

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	MCAH. • **.fiswl:** BIH Case Management support will be provided until the child turns one year of age.		
1.9.3a BIH Coordinator will ensure that all BIH participants will participate in Group Intervention Sessions.	**1.9.3 a** • Schedule Group Intervention Sessions with guidance from SBC BIH Program Coordinator. • 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 a** • Collect and record Group Intervention Session attendance records for all enrolled women into ETO. • Describe participant successes or challenges with completing seven (7) of ten (10) prenatal and/or postpartum Group Intervention Sessions.	**1.9.3 a** • Number of Group Intervention Sessions entered into ETO that began during fiscal year. • Number and percent of enrolled women who attend at least one (1) prenatal Group Intervention Session. • Number and percent of enrolled women who attended the expected number of Group Intervention Sessions based upon the number of days in program.
1.9.3b BIH Participants enrolled in the Case Management only intervention are not required to attend BIH group sessions.	**1.9.3b** • Schedule case management meetings per guidance in the BIH P&P. • Participants enrolled in the BIH Case Management only intervention may enroll in the BIH Group model on a case-by-case basis.	**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 meetings at the P&P-designated time intervals.

Attachment A

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)	
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PARTICIPANT RETENTION **1.9.4** BIH Coordinator 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. • 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. • Review participant retention strategies quarterly and update as needed. • Document participant retention strategies in ETO and in Quarterly Reports. • Submit participant retention strategy successes and challenges with Annual Report.	**1.9.4** • Submit Participant Retention Strategies with Quarterly and Annual Report.

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 will increase and expand community awareness of African-American birth outcomes and the role of the Black Infant Health Program.	**2.1** • Participation on 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. • 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	**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. • Submit quarterly reports that describe outreach activities electronically using ETO in a timely manner. • Document the local plan for community linkages, including an effective referral process that will be reviewed on an annual basis and updated as needed. • Document successes and barriers to community education activities or events at least once per quarter in the ETO through quarterly reporting. • List and maintain current documentation on the nature of formal and informal partnerships with community and referral agencies at least once a quarter; record Memorandum of Understanding (MOU) and referral relationships in the ETO service provider details form. • 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, and minutes) with BIH quarterly report. • Number, format, and outcomes associated with community outreach activities conducted by BIH Coordinator during fiscal year.

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	provide technical assistance to: • Improve access to health care services • 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) 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. • 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	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.	2.2 • Number of agencies where the COL has a documented point(s) of contact and with whom information is regularly exchanged. • Total number of agencies with outreach records during

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	establish strong resource linkages for recruitment of potential 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.	• Describe materials used to inform community partners about BIH. • List and describe barriers, challenges and/or successes related to establishing community partnerships and point(s) of contact at least quarterly.	fiscal year.

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)	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)
3.1 BIH Coordinator 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.	**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 fiscal year group intervention schedules upon request. • Percent of participants who meet expected prenatal life planning session attendance (prenatal dose). • Percent of participants who meet expected prenatal group session attendance (prenatal dose).	**3.1** • Number and percent of enrolled participants who have both a baseline and follow-up measurement.
3.2 BIH Coordinator 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** • BIH 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.	**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.	**3.2** • Number and percent of enrolled participants who have both a baseline and follow-up measurement.

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)
	• 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 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)	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)

4.1
BIH Coordinator 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.
		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.
		• 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.
			• Number and percent of participants who complete a birth plan.

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 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. • 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 BIH staff will coordinate with SBC 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 interoception 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	4.2 • Summarize challenges/barriers of birth control usage among enrolled women who have delivered. • 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	4.2 • Number and percent of participants who use any method of birth control to prevent pregnancy after their babies are born. • Number and percent of participants who attend a 4-6 week postpartum checkup with a medical provider.

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)
	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.	visit. • 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.	
4.3 BIH Coordinator will 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.	4.3 • Local staff will work with or support participants to: • 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	4.3 • Summarize successes and challenges in addressing mental health issues, including mental health referrals at least once per quarter.	4.3 • Number and percent of enrolled participants who completed the EPDS 6-8 weeks postpartum. • 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.

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)
	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.		
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. • Assist participants with identifying and using bonding strategies, including breastfeeding, with their	4.4 • List and describe additional activities that enhance parenting and bonding. • 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. • Provide anecdotes/participant success stories about infant safe sleep practices and SIDS/SUID risk reduction with submission of BIH Quarterly Reports. • Document collaborative activities with State MCAH Programs used to identify strategies, provide technical assistance and disseminate	4.4 • Number and percent of participants who complete the safety checklist. • Number and percent of postpartum participants who initiate breastfeeding. • Number and percent of prenatal participants who complete a birth plan prior to delivery.

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)
	newborns.	resource materials that address the benefits of breastfeeding. • 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 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	**5.1** • Describe collaborative activities with Text 4 Baby to deliver health education messages to pregnant women about the importance of postpartum visits. • Document collaborative activities with March of Dimes (MOD), Mother To Baby and	**5.1** • Number and percent of participants who attend a 4-6 week postpartum checkup with a medical provider.

	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.	other agencies that provide preterm birth reduction and health education resources and messaging. • 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.	

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. • BIH staff will distribute any customized preterm birth	**6.1** • Participate in MOD webinars and trainings that provide BIH staff with opportunities to increase their knowledge of preterm birth reduction strategies and other approaches for having a	**6.1** • Maintain records of staff attendance at trainings. • Maintain attendee records of trainings/Webinars hosted by BIH. • Number and percent of

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)
	resources to local medical providers and monitor/track how providers utilize and/or incorporate resources to engage clients in service delivery. • BIH 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.	healthy pregnancy. • Distribute and encourage MCAH programs to integrate the following preterm birth resources to educate women and providers on preventing preterm births: 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 preterm birth reduction strategies • Facilitate one to two educational webinars for medical providers on topics such as: 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 • Provide participants with hec;1lth education materials related to safe sleep practices	participants who complete the safety checklist prior to delivery. • Number and percent of postpartum participants who initiate breastfeeding.

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 SIDS reduction. • Document collaborative activities with State MCAH Programs used to identify strategies, provide technical assistance and disseminate resource materials that address the benefits of breastfeeding.	