

Version 5.0 - 150 Quarterly 06.19.19

390,054.00	→	390,054.00					
821,573.00	→	691,989.97		116,571.96		13,011.07	
176,512.76	→			116,571.96		39,033.22	
149,373.61	→	128,466.02			[50%]	20,907.59	[75%]
					[50%]	20,907.59	[25%]
							0.00
							0.00

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

201936 San Bernardino

Program: Black Infant Health (BIH) Agency: 201936 San Bernardino SubK:		UNMATCHED FUNDING								NON-ENHANCED MATCHING (50/50)				ENHANCED MATCHING (75/25)					
		BIH-TV		BIH-SGF		TBD		AGENCY FUNDS		BIH-SGF-NE		BIH-Only NE		BIH-SGF-E		BIH-Only E			
		(1)	(2)	(3)	(4)	(5)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	
		TOTAL FUNDING	%	BIH-TV	%	BIH-SGF	%	TBD	%	Agency Funds*	%	Combined Fed/State	%	Combined Fed/Agency*	%	Combined Fed/State	%	Combined Fed/Agency*	
(II) OPERATING EXPENSES DETAIL		RECONCILIATION SECTION (Remaining Funds)																	% PERSONNEL MATCH
TOTAL OPERATING EXPENSES		71,200.75	54.27%	22,270.19	100.00%	18,527.71	#DIV/0!	0.00	100.00%	4,711.54	100.00%	4,675.42	4.13%	93.10	#DIV/0!	0.00	#DIV/0!	0.00	24.24%
				41,033.54		18,527.71		0.00		4,711.54		4,675.42		2,252.54		0.00		0.00	Match Available
	TRAVEL	19,950.00	60.00%	11,970.00	40.00%	7,980.00		0.00		0.00		0.00	0.00%	0.00		0.00			19.59%
	TRAINING	2,100.00	73.00%	1,533.00	12.00%	252.00		0.00		0.00	10.00%	210.00	5.00%	105.00		0.00			9.24%
1	Office / Outside Supplies	4,100.00	30.90%	1,266.90	4.12%	168.92		0.00	49.98%	2,049.18	10.00%	410.00	5.00%	205.00					9.24%
2	Furniture / Chairs	300.00	88.58%	265.74	10.09%	30.27		0.00	1.33%	3.99		0.00		0.00					24.24%
3	Administrative Costs	6,652.11	40.04%	2,663.50	5.00%	332.61		0.00	39.96%	2,658.18	10.00%	665.21	5.00%	332.61					9.24%
4	Transportation / Mileage	2,000.00	73.00%	1,460.00	12.00%	240.00		0.00		0.00	10.00%	200.00	5.00%	100.00					9.24%
5	Equipment Maintenance	4,539.20	73.00%	3,313.62	12.00%	544.70		0.00		0.00	10.00%	453.92	5.00%	226.96					9.24%
6	Communications	7,757.84	73.00%	5,663.22	12.00%	930.94		0.00		0.00	10.00%	775.78	5.00%	387.89					9.24%
7	Postage	500.00	68.50%	342.50	12.00%	60.00		0.00		0.00	14.50%	72.50	5.00%	25.00					4.74%
8	Printing	1,600.00	63.76%	1,020.16	12.00%	192.00		0.00		0.00	19.24%	307.84	5.00%	80.00					0.00%
9	e-mail / Internet	13,851.60	73.00%	10,111.67	12.00%	1,662.19		0.00		0.00	10.00%	1,385.16	5.00%	692.58					9.24%
10	Board Approved Costs	500.00	73.00%	365.00	12.00%	60.00		0.00		0.00	10.00%	50.00	5.00%	25.00					9.24%
11	Minor Office Equipment (including automated systems)	100.00	72.73%	72.73	12.08%	12.08		0.00	0.19%	0.19	10.00%	10.00	5.00%	5.00					9.24%
12	County Counsel	250.00	73.00%	182.50	12.00%	30.00		0.00		0.00	10.00%	25.00	5.00%	12.50					9.24%
13	Background Checks / Wellness	800.00	73.00%	584.00	12.00%	96.00		0.00		0.00	10.00%	80.00	5.00%	40.00					9.24%
14	Non-inventory Equipment	300.00	73.00%	219.00	12.00%	36.00		0.00		0.00	10.00%	30.00	5.00%	15.00					9.24%
15	Automated systems equipment (e.g., computers, monitors, printers)	5,900.00	0.00%	0.00	100.00%	5,900.00		0.00		0.00		0.00		0.00					24.24%
** Unmatched Operating Expenses are not eligible for Federal matching funds (Title XIX). Expenses may only be charged to Unmatched Title V (Col. 3), State General Funds (Col. 5), and/or Agency (Col. 7) funds.																			
(III) CAPITAL EXPENDITURE DETAIL		RECONCILIATION SECTION (Remaining Funds)																	
TOTAL CAPITAL EXPENDITURES		0.00	#DIV/0!	0.00	#DIV/0!	0.00	#DIV/0!	0.00	#DIV/0!	0.00	#DIV/0!	0.00	#DIV/0!	0.00	#DIV/0!	0.00	#DIV/0!	0.00	
				0.00		0.00		0.00		0.00		0.00		0.00		0.00			
(IV) OTHER COSTS DETAIL		RECONCILIATION SECTION (Remaining Funds)																	% PERSONNEL MATCH
TOTAL OTHER COSTS		243,832.67	37.77%	5,853.15	100.00%	221,294.90	#DIV/0!	0.00	100.00%	904.41	100.00%	6,137.13	#DIV/0!	0.00	#DIV/0!	0.00	#DIV/0!	0.00	Match Available
				15,496.23		221,294.90		0.00		904.41		6,137.13		0.00		0.00		0.00	
SUBCONTRACTS																			
1	Contractor for BIH Group Model and Case Management services	89,462.50	0.00%	0.00	93.14%	83,325.37		0.00		0.00	6.86%	6,137.13		0.00		0.00		0.00	
2	Contract with Uber for participant transportation	6,000.00	0.00%	0.00	100.00%	6,000.00		0.00		0.00		0.00		0.00		0.00		0.00	
3	Contract with Lyft for participant transportation	6,000.00	0.00%	0.00	100.00%	6,000.00		0.00		0.00		0.00		0.00		0.00		0.00	
4	Contract with Child Watch Provider	83,394.41	0.00%	0.00	100.00%	83,394.41		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	
OTHER CHARGES																			Match Available
1	Client Support Materials	23,675.76	63.34%	14,996.23	32.84%	7,775.12		0.00	3.82%	904.41		0.00		0.00		0.00			24.24%
2	Educational Materials	500.00	100.00%	500.00		0.00		0.00		0.00		0.00		0.00		0.00			24.24%
3	Participant Transportation	16,800.00	0.00%	0.00	100.00%	16,800.00		0.00		0.00		0.00		0.00		0.00			24.24%
4	Child Watch Space (County site)	18,000.00	0.00%	0.00	100.00%	18,000.00		0.00		0.00		0.00		0.00		0.00			24.24%
5				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			
7				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			
(V) INDIRECT COSTS DETAIL		RECONCILIATION SECTION (Remaining Funds)																	
TOTAL INDIRECT COSTS		156,004.09	75.16%	54,558.97	100.00%	31,200.82	#DIV/0!	0.00	100.00%	12,651.93	#DIV/0!	0.00	46.94%	18,571.10					
				72,588.70		31,200.82		0.00		12,651.93		0.00		39,562.64					
14.63% of Total Wages + Fringe Benefits		156,004.09	46.53%	72,588.70	20.00%	31,200.82		0.00	8.11%	12,651.93		0.00	25.36%	39,562.64					

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Agency:							BIH-TV		BIH-SGF		TBD		AGENCY FUNDS		BIH-SGF-NE		BIH-Cnty NE		BIH-SGF-E		BIH-Cnty E				
SubK:							(1)	(2)	(3)	(4)	(5)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)		
							TOTAL FUNDING	%	BIH-TV	%	BIH-SGF	%	TBD	%	Agency Funds*	%	Combined Fed/State	%	Combined Fed/Agency*	%	Combined Fed/State	%	Combined Fed/Agency*		
63							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
64							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
65							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
66							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
67							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
68							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
69							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
70							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
71							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
72							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
73							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
74							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
75							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
76							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
77							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
78							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
79							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
80							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
81							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
82							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
83							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
84							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
85							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
86							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
87							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
88							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
89							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
90							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
91							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
92							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
93							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
94							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
95							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
96							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
97							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
98							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
99							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
100							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
101							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
102							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
103							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
104							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
105							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
106							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
107							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
108							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
109							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
110							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
111							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
112							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
113							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
114							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
115							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
116							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
117							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
118							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
119							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
120							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
121							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
122							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
123							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
124							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
125							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
126							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
127							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
128							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
129							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
130							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
131							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
132							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	
133							0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%	

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																	BIH-SGF-NE				BIH-Cnty NE		BIH-SGF-E	
					(1)	(2)	(3)	(4)	(5)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)			
					TOTAL FUNDING	%	BIH-TV	%	BIH-SGF	%	TBD	%	Agency Funds*	%	Combined Fed/State	%	Combined Fed/Agency*	%	Combined Fed/State	%	Combined Fed/Agency*			
134					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%		
135					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%		
136					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%		
137					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%		
138					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%		
139					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%		
140					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%		
141					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%		
142					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%		
143					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%		
144					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%		
145					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%		
146					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%		
147					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%		
148					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%		
149					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%		
150					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	82.0%		

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

Black Infant Health Program

The BIH Program is a specialized CDPH MCAH program under the local MCAH system and helps to address MCAH SOW Goal 1 - Women/Maternal Domain: Improve access to and utilization of comprehensive, quality health and social services and Goal 3 - Perinatal/Infant Domain: Reduce infant morbidity and mortality. The goals in this SOW incorporate local problems identified by the Local Health Jurisdiction's (LHJs') 5-Year Needs Assessments and reflect the Title V priorities of the MCAH Division.

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

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

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

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

All BIH Sites are required to comply with the following tiered staffing matrix per the BIH 2015 Request For Supplemental Information (RSI) [BIH RSI Instructions](#) 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, Long Beach, Fresno, San Joaquin, Kern	San Diego, Alameda, Riverside	Sacramento, San Bernardino	Los Angeles
BIH Coordinator	1.0 FTE	1.0 FTE	1.0 FTE	1.0 FTE	1.0 FTE
FHA/Group Facilitator	2.0 FTE	3.0 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	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE
PHN	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
	64	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:

Additional Enrollment Target for Expansion Funding to be served through BIH Model or Case Management	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
Enrollment Target	40	50	66	90	208
Local Health Jurisdiction		Solano			
Enrollment Target		8			

Updated BIH Group Model objectives and intervention activities are documented in **bold** below as applicable.

Updated BIH CM objectives and intervention activities are documented in **bold italics** below in goal 1 as applicable. 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 integrate these approaches when conceptualizing and organizing local program, policy, and evaluation efforts.

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

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

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

Deliverables for each FY

Due Date for each FY

Annual Progress Report

August 15

Coordinator Quarterly Report:

Reporting Period	From	To	Due Date
First Report	July 1, 2019	September 30, 2019	October 15, 2019
Second Report	October 1, 2019	December 31, 2019	January 15, 2020
Third Report	January 1, 2020	March 31, 2020	April 15, 2020
Fourth Report (WAIVED) Information during this reporting period will be included in the Annual Progress Report	April 1, 2020	June 30, 2020	July 31, 2020

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

Part II: Black Infant Health (BIH) Program

Goal 1: BIH 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.

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)
1.1 IMPLEMENTATION BIH Coordinator, under the guidance and leadership of the MCAH Director will provide oversight, maintain program fidelity, fiscal management and demonstrate that BIH activities are conducted as required in the BIH P&Ps, SOW, Data Collection Manual, ETO Data Book, Group Curriculum, and MCAH Fiscal P&Ps.	1.1 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Submit BIH Annual report by August 15. Submit BIH Quarterly Reports as directed by MCAH. (See page 3)
1.2 Hire and maintain culturally competent/relevant personnel and required Full Time Equivalent (FTE) to implement a BIH Program that is relevant to the cultural heritage of African-American women, and the community.	1.2 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	<ul style="list-style-type: none"> 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. 		
TRAINING 1.3 All BIH staff will maintain and increase staff competency.	1.3 <ul style="list-style-type: none"> 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 	1.3 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Maintain records of staff attendance at trainings. (N) Number of trainings and conferences (both state and local) attended by staff during FY 2018-19. Completion of at least 2 group observation feedback forms by the BIH Coordinator for every group facilitator during FY 2018-19. (E)

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)
	<p>service staff) attend mandatory MCAH Division-sponsored trainings, conference calls, meetings and/or conferences as scheduled by MCAH Division.</p> <ul style="list-style-type: none"> 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)	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)
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 <ul style="list-style-type: none"> • Ensure that all direct service staff participate in data collection, data entry, data quality improvement, and use of data collection software determined by MCAH. • Ensure that all subcontractor agencies providing direct service enter data in the ETO as determined by MCAH. • Ensure accuracy and completeness of data input into ETO system. • Ensure that all staff receives updates about changes in ETO and data book forms. • Ensure that a selected staff member with advanced knowledge of the BIH Program, data collection, and ETO is selected as the BIH Site's Data Entry lead and participates in all Data and Evaluation calls. • Accurately and completely collect required participant information, with timely data input into the appropriate data system(s). • Work with MCAH to ensure proper and continuous operation of the MCAH-BIH- ETO. • Store Participant level Data forms on paper per guidelines in P&P. • Define a data entry schedule for staff and monitor for adherence. 	1.4 <ul style="list-style-type: none"> • 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 seven (7) working days of collection. • Review of the BIH Data Collection Manual by all staff. • Completion of ETO training by all staff. • Participation in periodic MCAH-Data calls. • Participation in role-specific trainings by the Data Entry Lead. • Review of ETO data quality reports by the BIH Coordinator and Data Entry staff on at least a monthly basis. • Conduct and report on audits of recruitment, enrollment, and service delivery paper forms against ETO reports; audit sample must include at least 10% of recruitment records and 10% of enrollment records. 	1.4 <ul style="list-style-type: none"> • Number and percent of forms that were entered within seven (7) 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)	
		Process Description and Measures	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 communication outreach activities, including the use of social media.	1.5 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Number of existing MOUs prior to FY 2018-19. (E) Number of new Memorandum of Understanding (MOUs) established in FY 2018-19. (E) Total number (overall and by type) of outreach activities completed by all staff during FY 2018-19. (E)
PARTICIPANT RECRUITMENT 1.6a 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 <ul style="list-style-type: none"> 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. 	1.6a <ul style="list-style-type: none"> 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)
	<ul style="list-style-type: none"> Review Recruitment plan annually and update as needed. 		
1.6b <i>For Case Management Only, all BIH LHJs will recruit African-American women 16 years of age and older, and pregnant or up to 6 months postpartum.</i>	1.6b <ul style="list-style-type: none"> <i>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.</i> 	1.6b <ul style="list-style-type: none"> <i>Track and document progress in meeting goals of the Participant Recruitment Plan, review annually and update as needed.</i> 	1.6b <i>Total number of women served via Case management services only.</i>
PARTICIPANT REFERRAL 1.7 All BIH LHJs will establish a network of referral partners.	1.7 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Total number of service providers that made referrals to the BIH Program in FY 2018-19. (E)
PARTICIPANT ENROLLMENT 1.8a BIH Coordinator, under the guidance and leadership of the MCAH Director will ensure the following: <ul style="list-style-type: none"> All participants enrolled in BIH will be African-American All participants will be 18 years or older when enrolled in BIH. 	1.8a <ul style="list-style-type: none"> Enroll women that are African-American. Enroll women at or before 30 weeks of pregnancy. Enroll women that will participate in the group intervention. 	1.8a <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
<ul style="list-style-type: none"> All participants will be enrolled during pregnancy. All participants will be enrolled at or before 30 weeks of pregnancy. All women will participate in group intervention. 			
1.8b BIH Coordinator, under the guidance and leadership of the MCAH Director will ensure the following: <ul style="list-style-type: none"> 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 Case Management during pregnancy up to 6 months postpartum. Participants enrolled in Case Management only intervention are not 	1.8b <ul style="list-style-type: none"> 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. 	1.8a <ul style="list-style-type: none"> 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.

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)
<i>required to attend BIH Group sessions.</i>			
PROGRAM PARTICIPATION			
1.9.1 BIH Coordinator, under the guidance and leadership of the MCAH Director will ensure the following: <ul style="list-style-type: none"> All women will participate in a prenatal group. All women will participate in a group within 45 days of enrollment. All groups will be implemented according to the 20-group intervention model as specified in the P&P. (see 1.9.3) 	1.9.1 <ul style="list-style-type: none"> Assign participants to a prenatal group as part of enrollment process. Schedule prenatal groups to allow participants to attend within 30 days of enrollment. Enroll participants in a prenatal group within 45 days of first successful contact. Begin groups with the minimum required number of participants per the BIH P&P. 	1.9.1 <ul style="list-style-type: none"> Describe barriers, challenges and successes of enrolling women in a prenatal 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 <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> All BIH participants (enrolled 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. 	1.9.2a <ul style="list-style-type: none"> Assign participants to a FHA as part of enrollment process. Conduct case management services that align with Life Plan activities (goal setting). Collect completed self-assessment administered scaled questions as described in P&P. Collect the required number of assessments per timeframe outlined in P&P. Develop and implement a Life Plan based on goal setting during Life Planning meetings for each BIH participant; complete all prenatal and postpartum assessments; provide ongoing identification of her specific concerns/needs and referral to services outside of BIH as 	1.9.2a <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Number and percent of enrolled women who complete prenatal and postpartum assessments at the P&P-designated time intervals. (E) Number and percent of enrolled women who received at least one (1) case conference attended by a FHA or GF, and either the MHP or PHN. (E) – Fidelity Indicator A2a Percent of enrolled women who have (a) a long-term goal and (b) one (1) or more short-term goals documented in one (1) of the three (3) focus areas (health, relationship, and finances) (among women enrolled 30 days or longer) during Life Planning

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)
<ul style="list-style-type: none"> All BIH locations will include a space dedicated for Child Watch during group sessions. 	<p>needed based on Life Planning meetings.</p> <ul style="list-style-type: none"> 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. Submit complete and accurate reports in the timeframe specified by MCAH. 		<p>meetings. (E) – Fidelity Indicator P1a</p> <ul style="list-style-type: none"> 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. 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)
<p>1.9.2b BIH Coordinator, under the guidance and leadership of the MCAH Director will ensure the following:</p> <ul style="list-style-type: none"> Case Management participants will receive BIH Case Management support as defined in the P&P. 	<p>1.9.2b</p> <ul style="list-style-type: none"> 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; provide ongoing 	<p>1.9.2b</p> <ul style="list-style-type: none"> 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) 	<p>1.9.2b</p> <ul style="list-style-type: none"> 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 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)
	<p>identification of her specific concerns/needs and referral to services outside of BIH as needed based on case management meetings.</p> <ul style="list-style-type: none"> • 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. 		
<p>1.9.3a BIH Coordinator, under the guidance and leadership of the MCAH Director will ensure that all BIH participants will participate in Group Intervention Sessions.</p>	<p>1.9.3a</p> <ul style="list-style-type: none"> • 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. 	<p>1.9.3a</p> <ul style="list-style-type: none"> • Collect and record Group Intervention Session attendance records for all enrolled women into ETO. • Submit FY 2019-20 Group Intervention Sessions Calendar to MCAH-BIH Program with submission of AFA and upon request. • Describe participant successes or challenges with completing seven (7) of ten (10) prenatal and/or postpartum Group Intervention Sessions. (N) 	<p>1.9.3a</p> <ul style="list-style-type: none"> • Number of Group Intervention Sessions entered into ETO that began during FY 2018-19. (E) • Number and percent of enrolled women who attend at least one (1) prenatal Group Intervention Session. (E) • Number and percent of enrolled women who attended the expected number of Group Intervention Sessions based upon the number of days in program (E) – Fidelity Indicators D1a and D1b.
<p>1.9.3b BIH Participants enrolled in the Case Management only intervention are not required to attend BIH group sessions.</p>	<p>1.9.3b</p> <ul style="list-style-type: none"> • Schedule case management meetings per guidance in the BIH P&P. 	<p>1.9.3b</p> <ul style="list-style-type: none"> • Describe participant successes or challenges with completing case management services. 	<p>1.9.3b</p> <ul style="list-style-type: none"> • Number and percent of enrolled women who complete case management meetings at

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)
	<ul style="list-style-type: none"> <i>Participants enrolled in the BIH Case Management only intervention may enroll in the BIH Group model on a case-by-case basis.</i> 		<i>the P&P- designated time intervals.</i>
PARTICIPANT RETENTION 1.9.4 BIH Coordinator, under the guidance and leadership of the MCAH Director will ensure that participant retention strategies are in place.	1.9.4 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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)	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)
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 <ul style="list-style-type: none"> • 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: 	2.1 <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • Submit CAB meeting materials (roster, agenda, minutes) with BIH quarterly report. (N) • Number, format, and outcomes associated with community outreach activities conducted by BIH Coordinator and/or MCAH Director during FY 2018-19. (E/N)

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)
	<ul style="list-style-type: none"> ○ 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, etc.) to focus on Before, During, and Beyond Pregnancy for dissemination and integration in their service delivery protocols. 	<p>describing strategies to improve maternal and perinatal systems of care at least quarterly. (N)</p> <ul style="list-style-type: none"> ● 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 <ul style="list-style-type: none"> ● Develop collaborative relationships with local Medi-Cal Managed Care, Commercial Health Plans, WIC and local agencies in the community that provide services to African- 	2.2 <ul style="list-style-type: none"> ● 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 <ul style="list-style-type: none"> ● Number of agencies where the COL has a documented point(s) of contact and with whom information is regularly exchanged. (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)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	<p>American women and children, to establish strong resource linkages for recruitment of potential participants and for referrals of active participants.</p> <ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Describe materials used to inform community partners about BIH. (N) • List and describe barriers, challenges and/or successes related to establishing community partnerships and point(s) of contact at least quarterly. (N) 	<ul style="list-style-type: none"> • Total number of agencies with outreach records during FY 2018-19. (E)

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 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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Provide FY 2018-19 group intervention schedules upon request. (N) Percent of participants who meet expected prenatal life planning session attendance (prenatal dose). (E) – Fidelity Indicator D2a Percent of participants who meet expected prenatal group session attendance (prenatal dose). (E) – Fidelity Indicator D1a and D1b. 	3.1 <ul style="list-style-type: none"> Number and percent of enrolled participants who have both a baseline and follow-up measurement. (E) – Fidelity Indicator P3aai
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 <ul style="list-style-type: none"> 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. 	3.2 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Number and percent of enrolled participants who have both a baseline and follow-up measurement. (E) – Fidelity Indicator P3aai

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)
	<ul style="list-style-type: none"> • 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 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 <ul style="list-style-type: none"> Assist participants in understanding behaviors that contribute to overall good health, including: <ul style="list-style-type: none"> 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 	4.1 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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)
	<p>outlines specific labor/delivery and birthing requests to be conveyed to their prenatal care provider.</p> <ul style="list-style-type: none"> • 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. 		
<p>4.2</p> <p>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.</p>	<p>4.2</p> <ul style="list-style-type: none"> • 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, 	<p>4.2</p> <ul style="list-style-type: none"> • 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) 	<p>4.2</p> <ul style="list-style-type: none"> • 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)

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)
	reproductive coercion or birth control sabotage.		
4.3 BIH Coordinator under the guidance and leadership of the MCAH Director 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 <ul style="list-style-type: none"> Local staff will work with or support participants to: <ul style="list-style-type: none"> 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. 	4.3 <ul style="list-style-type: none"> Summarize successes and challenges in addressing mental health issues, including mental health referrals at least once per quarter. (N) 	4.3 <ul style="list-style-type: none"> Number and percent of enrolled participants who completed the EPDS 6-8 weeks postpartum. (E) – Fidelity Indicators A5a 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 <ul style="list-style-type: none"> 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. 	4.4 <ul style="list-style-type: none"> 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. 	4.4 <ul style="list-style-type: none"> Number and percent of participants who complete the safety checklist. (E) – Fidelity Indicators A4aii Number and percent of postpartum participants who initiate breastfeeding. (E) Number and percent of prenatal participants who complete a birth plan prior to delivery. (E) – Fidelity Indicator A4ai

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	<ul style="list-style-type: none"> 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 newborns. 	<ul style="list-style-type: none"> List and describe additional activities on infant safe sleep practices/SIDS/SUID risk reduction. (N) Provide anecdotes/participant success stories about infant safe sleep practices and SIDS/SUID risk reduction with submission of BIH Quarterly Reports. (N) Document collaborative activities with State MCAH Programs used to identify strategies, provide technical assistance and disseminate resource materials that address the benefits of breastfeeding. (N) Provide anecdotes/participant success stories about breastfeeding practices with submission of BIH Quarterly Reports. 	

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

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
5.1 BIH Coordinator under the guidance and leadership of the MCAH Director will ensure that all BIH participants are linked to services that support timely prenatal care, postpartum visits and well-woman check-ups while enrolled in the BIH Program.	5.1 <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • Describe collaborative activities with Text 4 Baby to deliver health education messages to pregnant women about the importance of postpartum visits. (N/E) • Document collaborative activities with March of Dimes (MOD), MotherToBaby and other agencies that provide preterm birth reduction and health education resources and messaging. (N) • Describe collaborative efforts with local MCAH programs and other partners such as Medi-Cal Managed Care and CPSP to identify strategies, activities and provide technical assistance to improve access to health care services and increase utilization of the postpartum visit. (N) 	5.1 <ul style="list-style-type: none"> • Number and percent of participants who attend a 4-6 week postpartum checkup with a medical provider. (E)

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

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
6.1 BIH Participants will have an increased knowledge of strategies and interventions they can utilize to reduce the occurrence of preterm births.	6.1 <ul style="list-style-type: none"> • Provide participants with health education materials that address preterm birth reduction strategies from MCAH-BIH and MOD. • LHJ staff will distribute any customized preterm birth resources to local medical providers and monitor/track how providers utilize and/or incorporate resources to engage clients in service delivery. • LHJ staff will support, promote, and attend preterm birth educational webinars for medical providers. • Assist participants with increasing knowledge of infant safe sleep practices, SIDS, SUID risk reduction by participating in local SIDS collaborative meetings and trainings. • Provide participants with health education materials addressing the benefits of breastfeeding. 	6.1 <ul style="list-style-type: none"> • 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) <ul style="list-style-type: none"> ○ 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 • Facilitate one – two educational webinars for medical providers on topics such as: (N) <ul style="list-style-type: none"> ○ Roles and Responsibilities: Steps to Prevent Preterm Birth ○ The use of 17P to prevent preterm birth ○ Reducing Preterm Birth: Evidence-Based Strategies to Improve Outcomes • Provide participants with health education materials related to 	6.1 <ul style="list-style-type: none"> • Maintain records of staff attendance at trainings. (N) • Maintain attendee records of trainings/Webinars hosted by LHJ. (N) • Number and percent of participants who complete the safety checklist prior to delivery. (E) – Fidelity Indicator A4aii • Number and percent of postpartum participants who initiate breastfeeding. (E)

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
		<p>safe sleep practices and SIDS reduction. (N)</p> <ul style="list-style-type: none"> • Document collaborative activities with State MCAH Programs used to identify strategies, provide technical assistance and disseminate resource materials that address the benefits of breastfeeding. (N) 	

Table 1 - Black Infant Health Selected Fidelity Dimensions, Measures and 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	
	D2. Completeness of life planning meetings attended	D.2.a.	
		[PRELIMINARY] ² – Percent of women enrolled for at least 30 days who have attended the expected number of life planning meetings	
		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.