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

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

GAVIN NEWSOM
Governor

MAY 29, 2024

TO: MATERNAL, CHILD, AND ADOLESCENT HEALTH (MCAH) DIRECTORS, MCAH COORDINATORS, BLACK INFANT HEALTH (BIH) COORDINATORS, AND PERINATAL EQUITY INITIATIVE (PEI) COORDINATORS

SUBJECT: STATE FISCAL YEAR (SFY) 2024-2025 AGREEMENT FUNDING APPLICATION (AFA) ANNOUNCEMENT

This letter announces the SFY 2024-2025 AFA process that provides allocation and contract funding updates for the California Department of Public Health, Maternal, Child, and Adolescent Health Division's Local MCAH, California Fetal Infant Mortality Review Plus (CA FIMR+), BIH, and PEI programs.

SFY 2024-2025 funding for Local MCAH, CA FIMR+, BIH, and PEI programs are as follows:

- **Local MCAH** - Title V (TV) funding allocations will remain the same as SFY 2023-2024.

- **CA FIMR+** – Local Health Jurisdictions (LHJs) selected for the CA FIMR+ TV funding will receive the same allocation amount as SFY 2023-2024. The CA FIMR+ funding is included in the Local MCAH TV allocations for Fresno and San Bernardino counties. Each LHJ will be required to track the FIMR funding separately in order to demonstrate the agency's ability to perform the activities and associated costs to implement the CA FIMR+ Scope of Work.

- **BIH** - TV and State General Funds (SGF) allocations have been updated to account for the expansion to the BIH program and to utilize SGF in accordance with prior year's Request for Supplemental Information and individual county contract negotiations to meet the needs of the LHJs. The total allocations for each county remain unchanged, except those with contract negotiations. TV has been calculated utilizing a per-service area approach and each service area will receive $150,627. SGF has been updated to compensate for any shortfall in TV compared to the previous year.

- **PEI** – SGF allocations will remain the same as SFY 2023-2024; however, we will be moving to a quarterly invoicing format. Additionally, Title XIX (TXIX) funding is now available for PEI programs.

TXIX Funding (if applicable) - LHJs can request any amount with the understanding that the agency must have the State General Funds and/or additional agency funds to match TXIX and that their spending plan reflects the agency's ability to spend all their TXIX request. Due to new FI$Cal requirements, budget revisions that are requesting an increase in TXIX funding must be received after your Q2 invoice has been submitted but no later than March 31, 2025.

AFA Timeline/Important Dates:

MAY 29, 2024	**Release of MCAH SFY 2024-2025 AFA Notification.** **The following AFA forms are located at MCAH, FIMR+, BIH, & PEI Agreement Funding Applications** • **AFA Checklist** • **Agency Information Form** • **MCAH Attestation of Compliance with the Sexual Health Education Accountability Act of 2007 Form** • **ICR Certification Form** • **Annual Inventory Form** • **Subcontract Agreement Transmittal Form** • **Use of Certified Public Funds Form** • **Government Agency Taxpayer ID Form** • **TXIX Attestation Form** Note: The Scope of Work templates (MCAH/BIH/PEI), MCAH Director Verification form, MCF Justification example letter, NFR-CRS form, and budget template are attached to this email.

June 7, 2024	**Last Day to Register for your AFA Development Support and Budget Training Meeting** – Optional budget meetings can be provided for technical assistance necessary to complete local agency budgets. Please reach out to your CL and PC via email to request a Budget Training Meeting. If a meeting is requested, Local MCAH/BIH/PEI Programs and Fiscal representatives with decision making authority are required to attend. MCAH/BIH/PEI AFA budget meetings will be offered via TEAMS. Meetings will be scheduled on a first-come, first-served basis between **June 10 - 21, 2024.**
June 10-21, 2024	**MCAH/BIH/PEI AFA Development Support and Budget Training Meetings (Optional)**
June 28, 2024	**AFA Packages Due Back to MCAH**. If needed, please contact your **Contract Liaison** (CL) for any extensions.
June 29, 2024	**Start of MCAH CL/PC AFA Package Review and Approval**

AFA Submission:

Packages are due via email to MCAHFinAct@cdph.ca.gov by June 28, 2024. Please refer to the AFA Checklist instructions for guidance on how to submit your AFA packet. If you have any questions about the AFA process, please contact your CL as soon as possible.

In previous years, LHJs were required to submit budgets for two years. For this AFA cycle and ongoing, instead of requiring two years' worth of budgets, **we are only requesting one budget for the current year.**

Invoice Submission:

All invoices and supporting documentation must be submitted via email to the MCAH invoice inbox: **MCAHInvoices@cdph.ca.gov**. To ensure appropriate processing, please use the following invoice naming protocol for the signed invoice PDF and Excel files as well as the subject line of the email:

Agreement Number, Agency Name, Fiscal Year, and Invoice Quarter and Number - Example: 202401 Alameda FY 24-25 Q1.

Invoice submission must include:

- Signed cover letter noting invoice amount, invoice period, remit to address, and any personnel changes

- Signed invoice
- Excel version of the invoice
- Signed and completed TXIX Cover Sheet (if applicable)
- Signed and completed TXIX Attestation form (if applicable)
- TV and/or TXIX time studies (if applicable)
- Below is the Invoice Submission Timeline for your reference:

Invoice Submission Timeline	Due date
Quarter 1 (July - September 30)	November 15, 2024
Quarter 2 (October - December 31)	February 15, 2025
Quarter 3 (January - March 31)	May 15, 2025
Quarter 4 (April - June 30)	August 15, 2025
Approved Supplemental Final Invoice	September 30, 2025

Thank you for your assistance and timely submission of your AFA package. If you have any questions or concerns, please contact your **Contract Liaison**.

Sincerely,

Angelica Jimenez-Bean

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

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
MATERNAL, CHILD AND ADOLESCENT HEALTH (MCAH) DIVISION

FUNDING AGREEMENT PERIOD
FY 2024-2025

AGENCY INFORMATION FORM

Agencies are required to submit an electronic and signed copy (original signatures only) of this form along with their Annual AFA Package.

Agencies are required to submit updated information when updates occur during the fiscal year. Updated submissions do not require certification signatures.

AGENCY IDENTIFICATION INFORMATION

Any program related information being sent from the CDPH MCAH Division will be directed to all Program Directors.

Please enter the agreement or contract number for each of the applicable programs

MCAH 202410 BIH 202410 AFLP _____ PEI 24-10

Update Effective Date *(only required when submitting updates)* _____

Federal Employer ID#: _____

Complete Official Agency Name: County of Fresno

Business Office Address: 1221 Fulton Street, Fresno, CA 93721

Agency Phone: (559) 600-3330

Agency Fax: (559) 455-4705

Agency Website: www.fcdph.org

AGREEMENT FUNDING APPLICATION
POLICY COMPLIANCE AND CERTIFICATION

Please enter the **agreement or contract** number for each of the applicable programs

MCAH 202410 BIH 202410 AFLP _____ PEI 24-10

The undersigned hereby affirms that the statements contained in the Agreement Funding Application (AFA) are true and complete to the best of the applicant's knowledge.

I certify that these Maternal, Child and Adolescent Health (MCAH) programs will comply with all applicable provisions of Article 1, Chapter 1, Part 2, Division 106 of the Health, and Safety code (commencing with section 123225), Chapters 7 and 8 of the Welfare and Institutions Code (commencing with Sections 14000 and 142), and any applicable rules or regulations promulgated by CDPH pursuant to this article and these Chapters. I further certify that all MCAH related programs will comply with the most current MCAH Policies and Procedures Manual, including but not limited to, Administration, Federal Financial Participation (FFP) Section. I further certify that the MCAH related programs will comply with all federal laws and regulations governing and regulating recipients of funds granted to states for medical assistance pursuant to Title XIX of the Social Security Act (42 U.S.C. section 1396 et seq.) and recipients of funds allotted to states for the Maternal and Child Health Service Block Grant pursuant to Title V of the Social Security Act (42 U.S.C. section 701 et seq.). I further agree that the MCAH related programs may be subject to all sanctions, or other remedies applicable, if the MCAH related programs violate any of the above laws, regulations, and policies with which it has certified it will comply.

Official authorized to commit the Agency to an MCAH Agreement

Name (Print): Nathan Magsig

Title: Chairman of the Board of Supervisors of the County of Fresno

Original Signature: [signature]

Date: December 3, 2024

MCAH/AFLP Director

Name (Print): Ge Vue

Title: MCAH Director

Original Signature: [signature]

Date: 11/12/24

Revised 3/1/2024

ATTEST:
BERNICE E. SEIDEL
Clerk of the Board of Supervisors
County of Fresno, State of California
By Kelly Hancock Deputy

MCAH Program

#	Contact	First Name	Last Name	Title	Address	Phone	Email Address	Program
1	AGENCY EXECUTIVE DIRECTOR	David	Luchini	Public Health Director	1221 Fulton Street, Fresno, CA 93721	(559) 600-3200	dluchini@fresnocountyca.gov	MCAH
2	MCAH DIRECTOR	Ge	Vue	Division Manager	1221 Fulton Street, Fresno, CA 93721	(559) 600-3330	gevue@fresnocountyca.gov	MCAH
3	MCAH COORDINATOR (Only complete if different from #2)	Lillarose	Bangs	Supervising Public Health Nurse	1221 Fulton Street, Fresno, CA 93721	(559) 600-3330	bangsl@fresnocountyca.gov	MCAH
4	MCAH FISCAL CONTACT	Chashua	Lor	Staff Analyst	1221 Fulton Street, Fresno, CA 93721	(559) 600-3330	chlor@fresnocountyca.gov	MCAH
5	FISCAL OFFICER	Irene	Parada	Department of Public Health Business Manager	1221 Fulton Street, Fresno, CA 93721	(559) 600-3200	iparada@fresnocountyca.gov	MCAH
6	CLERK OF THE BOARD or	Bernice	Seidel	Clerk of the Board of Supervisors	2281 Tulare Street, Room 301, Fresno, CA 93721	(559) 600-1601	bseidel@fresnocountyca.gov	MCAH
7	CHAIR BOARD OF SUPERVISORS	Nathan	Magsig	Chairman of the Board of Supervisors of the County of Fresno	2281 Tulare Street, Room 301, Fresno, CA 93721	(559) 600-5000	district5@fresnocountyca.gov	MCAH
8	OFFICIAL AUTHORIZED TO COMMIT AGENCY	Nathan	Magsig	Chairman of the Board of Supervisors of the County of Fresno	2281 Tulare Street, Room 301, Fresno, CA 93721	(559) 600-5000	district5@fresnocountyca.gov	MCAH
9	SUDDEN INFANT DEATH SYNDROME (SIDS) COORDINATOR/CONTACT	Linda	Hicks	Public Health Nurse	1221 Fulton Street, Fresno, CA 93721	(559) 600-3330	lhicks@fresnocountyca.gov	SIDS
10	PERINATAL SERVICES COORDINATOR							CPSP

BIH Program

#	Contact	First Name	Last Name	Title	Address	Phone	Email Address	Program
1	AGENCY EXECUTIVE DIRECTOR	David	Luchini	Public Health Director	1221 Fulton Street, Fresno, CA 93721	(559) 600-3200	dluchini@fresnocountyca.gov	BIH
2	BLACK INFANT HEALTH (BIH) COORDINATOR	Sabrina	Beavers	Health Educator	1221 Fulton Street, Fresno, CA 93721	(559) 600-3330	sbeavers@fresnocountyca.gov	BIH
3	BIH FISCAL CONTACT	Chashua	Lor	Staff Analyst	1221 Fulton Street, Fresno, CA 93721	(559) 600-3330	chlor@fresnocountyca.gov	BIH
4	FISCAL OFFICER	Irene	Parada	Department of Public Health Business Manager	1221 Fulton Street, Fresno, CA 93721	(559) 600-3200	iparada@fresnocountyca.gov	BIH
5	CLERK OF THE BOARD or	Bernice	Seidel	Clerk of the Board of Supervisors	2281 Tulare Street, Room 301, Fresno, CA 93721	(559) 600-1601	bseidel@fresnocountyca.gov	BIH
6	CHAIR BOARD OF SUPERVISORS	Nathan	Magsig	Chairman of the Board of Supervisors of the County of Fresno	2281 Tulare Street, Room 301, Fresno, CA 93721	(559) 600-5000	district5@fresnocountyca.gov	BIH
7	OFFICIAL AUTHORIZED TO COMMIT AGENCY	Nathan	Magsig	Chairman of the Board of Supervisors of the County of Fresno	2281 Tulare Street, Room 301, Fresno, CA 93721	(559) 600-5000	district5@fresnocountyca.gov	BIH

PEI

#	Contact	First Name	Last Name	Title	Address	Phone	Email Address	Program
1	AGENCY EXECUTIVE DIRECTOR	David	Luchini	Public Health Director	1221 Fulton Street, Fresno, CA 93721	(559) 600-3200	dluchini@fresnocountyca.gov	PEI
2	PERINATAL EQUITY INITIATIVE (PEI) COORDINATOR	Gifty	Kwofie	Health Educator	1221 Fulton Street, Fresno, CA 93721	(559) 600-3330	gkwofie@fresnocountyca.gov	PEI
3	PEI FISCAL CONTACT	Chashua	Lor	Staff Analyst	1221 Fulton Street, Fresno, CA 93721	(559) 600-3330	chlor@fresnocountyca.gov	PEI
4	FISCAL OFFICER	Irene	Parada	Department of Public Health Business Manager	1221 Fulton Street, Fresno, CA 93721	(559) 600-3200	iparada@fresnocountyca.gov	PEI
5	CLERK OF THE BOARD or	Bernice	Seidel	Clerk of the Board of Supervisors	2281 Tulare Street, Room 301, Fresno, CA 93721	(559) 600-1601	bseidel@fresnocountyca.gov	PEI
6	CHAIR BOARD OF SUPERVISORS	Nathan	Magsig	Chairman of the Board of Supervisors of the County of Fresno	2281 Tulare Street, Room 301, Fresno, CA 93721	(559) 600-5000	district5@fresnocountyca.gov	PEI
7	OFFICIAL AUTHORIZED TO COMMIT AGENCY	Nathan	Magsig	Chairman of the Board of Supervisors of the County of Fresno	2281 Tulare Street, Room 301, Fresno, CA 93721	(559) 600-5000	district5@fresnocountyca.gov	PEI

AFLP Program

#	Contact	First Name	Last Name	Title	Address	Phone	Email Address	Program
1	AGENCY EXECUTIVE DIRECTOR							AFLP
2	AFLP DIRECTOR							AFLP
3	AFLP COORDINATOR or SUPERVISOR/COORDINATOR							AFLP
4	AFLP FISCAL CONTACT							AFLP
5	FISCAL OFFICER							AFLP
6	CLERK OF THE BOARD or							AFLP
7	CHAIR BOARD OF SUPERVISORS							AFLP
8	OFFICIAL AUTHORIZED TO COMMIT AGENCY							AFLP

ORIGINAL

Public Health | Maternal, Child and Adolescent Health Division

BUDGET SUMMARY

FISCAL YEAR	BUDGET	BUDGET STATUS	BUDGET BALANCE
2024-25	ORIGINAL	ACTIVE	0.00

Version 7.0 - 150 Quarterly 4.20.20

Program:	Maternal, Child and Adolescent Health (MCAH)
Agency:	202410 Fresno
SubK:	

		UNMATCHED FUNDING						NON-ENHANCED MATCHING (50/50)				ENHANCED MATCHING (75/25)			
		MCAH-TV		MCAH-SIDS		AGENCY FUNDS				MCAH-Cnty NE				MCAH-Cnty E	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)
	TOTAL FUNDING	%	MCAH-TV	%	MCAH-SIDS	%	Agency Funds*	%	Combined Fed/State	%	Combined Fed/Agency*	%	Combined Fed/State	%	Combined Fed/Agency*
ALLOCATION(S) →			422,226.00		7,372.00										#VALUE!

EXPENSE CATEGORY															
(I) PERSONNEL	6,420,536.35		422,226.00		7,372.00		1,830,961.50		0.00		2,900,418.08		0.00		1,259,558.76
(II) OPERATING EXPENSES	435,936.00		0.00		0.00		191,530.03		0.00		244,405.97		0.00		0.00
(III) CAPITAL EXPENDITURES	0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00
(IV) OTHER COSTS	1,186,940.00		0.00		0.00		567,839.53		0.00		619,100.47		0.00		0.00
(V) INDIRECT COSTS	1,568,537.03		0.00		0.00		557,458.06		0.00		1,011,078.97		0.00		0.00
BUDGET TOTALS*	9,611,949.38	4.39%	422,226.00	0.06%	7,372.00	32.75%	3,147,789.12	0.00%	0.00	49.68%	4,775,003.49	0.00%	0.00	13.10%	1,259,558.76
BALANCE(S) →			0.00		0.00										

TOTAL MCAH-TV	422,226.00 →	422,226.00							
TOTAL MCAH-SIDS	7,372.00 →		7,372.00						
TOTAL TITLE XIX	3,332,170.83 →			0.00	[50%]	2,387,501.76	0.00	[75%]	944,669.07
TOTAL AGENCY FUNDS	5,850,180.54 →			3,147,789.12	[50%]	2,387,501.73		[25%]	314,889.69

$ 3,761,768.83	Maximum Amount Payable from State and Federal resources

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

MCAH/PROJECT DIRECTOR'S SIGNATURE — DATE: 7/30/24

AGENCY FISCAL AGENT'S SIGNATURE — DATE: 7/30/24

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

STATE USE ONLY - TOTAL STATE AND FEDERAL REIMBURSEMENT		MCAH-TV		MCAH-SIDS		AGENCY FUNDS				MCAH-Cnty NE				MCAH-Cnty E
PCA Codes		53107		53112						53118				53117
(I) PERSONNEL		422,226.00		7,372.00				0.00		1,450,209.04		0.00		944,669.07
(II) OPERATING EXPENSES		0.00		0.00				0.00		122,202.99		0.00		0.00
(III) CAPITAL EXPENSES		0.00		0.00				0.00		0.00		0.00		0.00
(IV) OTHER COSTS		0.00		0.00				0.00		309,550.24		0.00		0.00
(V) INDIRECT COSTS		0.00		0.00				0.00		505,539.49		0.00		0.00
Totals for PCA Codes	3,761,768.83	422,226.00		7,372.00				0.00		2,387,501.76		0.00		944,669.07

Public Health | Maternal, Child and Adolescent Health Division

ORIGINAL

Program:	Maternal, Child and Adolescent Health (MCAH)
Agency:	202410 Fresno
SubK:	

			UNMATCHED FUNDING						NON-ENHANCED MATCHING (50/50)				ENHANCED MATCHING (75/25)				
			MCAH-TV		MCAH-SIDS		AGENCY FUNDS				MCAH-Only NE				MCAH-Only E		
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	
		TOTAL FUNDING	%	MCAH-TV	%	MCAH-SIDS	%	Agency Funds*	%	Combined Fed/State	%	Combined Fed/Agency*	%	Combined Fed/State	%	Combined Fed/Agency*	
(II) OPERATING EXPENSES DETAIL											% TRAVEL NON-ENH MATCH				% TRAVEL ENH MATCH		% PERSONNEL MATCH
											46.47%				14.07%		65.09%
	TOTAL OPERATING EXPENSES	435,936.00		0.00		0.00		191,530.03		0.00		244,405.97		0.00		0.00	Match Available
	TRAVEL	50,326.00	0.00%	0.00		0.00	39.46%	19,859.14		0.00	60.54%	30,466.86		0.00		0.00	0.00%
	TRAINING	48,080.00	0.00%	0.00		0.00	34.91%	16,784.73		0.00	65.09%	31,295.27		0.00		0.00	0.00%
1	Communications	144,585.00	0.00%	0.00		0.00	34.91%	50,474.62		0.00	65.09%	94,110.38					0.00%
2	Office Supplies	11,000.00	0.00%	0.00		0.00	34.91%	3,840.10		0.00	65.09%	7,159.90					0.00%
3	Postage	4,292.00	0.00%	0.00		0.00	34.91%	1,498.34		0.00	65.09%	2,793.66					0.00%
4	Printing (Duplication)	2,205.00	0.00%	0.00		0.00	34.91%	769.77		0.00	65.09%	1,435.23					0.00%
5	Minor Equipment	5,000.00	0.00%	0.00		0.00	34.91%	1,745.50		0.00	65.09%	3,254.50					0.00%
6	Facilities, Utilities, Securities	113,520.00	0.00%	0.00		0.00	34.91%	39,629.83		0.00	65.09%	73,890.17					0.00%
7	Nurse-Family Partnership	56,928.00	0.00%	0.00		0.00	100.00%	56,928.00		0.00		0.00					65.09%
8				0.00		0.00		0.00		0.00		0.00					
9				0.00		0.00		0.00		0.00		0.00					
10				0.00		0.00		0.00		0.00		0.00					
11				0.00		0.00		0.00		0.00		0.00					
12				0.00		0.00		0.00		0.00		0.00					
13				0.00		0.00		0.00		0.00		0.00					
14				0.00		0.00		0.00		0.00		0.00					
15				0.00		0.00		0.00		0.00		0.00					

** 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																
TOTAL CAPITAL EXPENDITURES			0.00		0.00		0.00		0.00		0.00					

(IV) OTHER COSTS DETAIL																% PERSONNEL MATCH
																65.09%
	TOTAL OTHER COSTS	1,186,940.00		0.00		0.00		567,839.53		0.00		619,100.47		0.00		0.00
	SUBCONTRACTS															
1	Exceptional Parents Unlimited	275,000.00	0.00%	0.00		0.00	52.32%	143,876.23		0.00	47.68%	131,123.77		0.00		0.00
2	Centro La Familia Advocacy Services	261,229.00	0.00%	0.00		0.00	52.94%	138,297.46		0.00	47.06%	122,931.54		0.00		0.00
3	Central Valley Children's Services Network	274,448.00	0.00%	0.00		0.00	45.32%	124,391.13		0.00	54.68%	150,056.87		0.00		0.00
4	Fresno County Economic Opportunities Commission	275,000.00	0.00%	0.00		0.00	45.70%	125,670.30		0.00	54.30%	149,329.70		0.00		0.00
5	TBD (Dr. Linscheid Consulting Services)	65,000.00	0.00%	0.00		0.00	35.30%	22,945.00		0.00	64.70%	42,055.00		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
	OTHER CHARGES															Match Available
1	Books & Publications	4,930.00	0.00%	0.00		0.00	34.91%	1,721.06		0.00	65.09%	3,208.94				0.00%
2	Behavioral Motivational Materials	31,333.00	0.00%	0.00		0.00	34.91%	10,938.35		0.00	65.09%	20,394.65				0.00%
3				0.00		0.00		0.00		0.00		0.00				
4				0.00		0.00		0.00		0.00		0.00				
5				0.00		0.00		0.00		0.00		0.00				
6				0.00		0.00		0.00		0.00		0.00				
7				0.00		0.00		0.00		0.00		0.00				
8				0.00		0.00		0.00		0.00		0.00				

(V) INDIRECT COSTS DETAIL																
	TOTAL INDIRECT COSTS	1,568,537.03		0.00		0.00		557,458.06		0.00		1,011,078.97				
24.43%	of Total Wages + Fringe Benefits	1,568,537.03	0.00%	0.00		0.00	35.54%	557,458.06		0.00	64.46%	1,011,078.97				

Program:	Maternal, Child and Adolescent Health (MCAH)
Agency:	202410 Fresno
SubK:	

(I) PERSONNEL DETAIL

						UNMATCHED FUNDING						NON-ENHANCED MATCHING (50/50)				ENHANCED MATCHING (75/25)					
						MCAH-TV		MCAH-SIDS		AGENCY FUNDS				MCAH-Cnty NE				MCAH-Cnty E			
					(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)		
					TOTAL FUNDING	%	MCAH-TV	%	MCAH-SIDS	%	Agency Funds*	%	Combined Fed/State	%	Combined Fed/Agency*	%	Combined Fed/State	%	Combined Fed/Agency*		
		TOTAL PERSONNEL COSTS			6,420,536.35		422,226.00		7,372.00		1,830,961.50		0.00		2,900,418.08		0.00		1,259,558.76		
		FRINGE BENEFIT RATE	71.54%		2,677,656.35		176,087.49		3,074.46		763,594.41		0.00		1,209,606.56		0.00		525,293.42		
				TOTAL WAGES	3,742,880.00		246,138.51		4,297.54		1,067,367.09		0.00		1,690,811.52		0.00		734,265.34		
	FULL NAME (First Name Last Name)	TITLE OR CLASSIFICATION (No Acronyms)	% FTE	ANNUAL SALARY	TOTAL WAGES															J-Pers MCF Per Staff	Staff Traveling (X)
1	Ge Vue	Division Manager	20.00%	162,140.00	32,428.00	0.00%	0.00		0.00	36.66%	11,888.10		0.00	63.34%	20,539.90		0.00		0.00	64.70%	x
2	Ge Vue	MCAH Director/FIMR Director	50.00%	162,140.00	81,070.00	0.00%	0.00		0.00	36.00%	29,185.20		0.00	54.93%	44,531.75		0.00	9.07%	7,353.05	64.70%	x
3	Melinda Meza	Administrative Assistant	70.00%	53,858.00	37,701.00	0.00%	0.00		0.00	35.30%	13,308.45		0.00	64.70%	24,392.55		0.00		0.00	64.70%	x
4	Chashua Lor	Staff Analyst III	100.00%	75,536.00	75,536.00	0.00%	0.00		0.00	35.30%	26,664.21		0.00	64.70%	48,871.79		0.00		0.00	64.70%	x
5	Dalgit Martinez	Account Clerk I	30.00%	51,922.00	15,577.00	0.00%	0.00		0.00	35.30%	5,498.68		0.00	64.70%	10,078.32		0.00		0.00	64.70%	x
6	Yvonne Lopez	Public Health Nurse II -Perinatal Service	100.00%	120,414.00	120,414.00	0.00%	0.00		0.00	43.10%	51,898.43		0.00	48.65%	58,581.41		0.00	8.25%	9,934.16	64.70%	x
7	Linda Hicks	Public Health Nurse II -Sudden Infant De	50.00%	127,373.00	63,687.00	0.00%	0.00	6.75%	4,297.54	93.25%	59,389.46		0.00	0.00%	0.00		0.00		0.00	64.70%	x
8	Jennifer Pino-Xiong	Medical Social Worker III	75.13%	92,866.00	69,770.00	0.00%	0.00		0.00	33.07%	23,072.94		0.00	66.93%	46,697.06		0.00		0.00	90.90%	x
9	Bee Vang	Epidemiologist	20.00%	99,944.00	19,989.00	0.00%	0.00		0.00	35.30%	7,056.12		0.00	64.70%	12,932.88		0.00		0.00	64.70%	x
10	Quentin Paramo	Health Education Specialist	90.00%	59,284.00	53,356.00	0.00%	0.00		0.00	35.30%	18,834.67		0.00	64.70%	34,521.33		0.00		0.00	64.70%	x
11	Vacant	Health Education Specialist	100.00%	52,323.00	52,323.00	0.00%	0.00		0.00	35.30%	18,470.02		0.00	64.70%	33,852.98		0.00		0.00	64.70%	x
12	Socheata Meas	Program Technician I	100.00%	53,346.00	53,346.00	0.00%	0.00		0.00	35.30%	18,831.14		0.00	64.70%	34,514.86		0.00		0.00	64.70%	x
13	Vacant	Program Technician I	100.00%	42,242.00	42,242.00	0.00%	0.00		0.00	35.30%	14,911.43		0.00	64.70%	27,330.57		0.00		0.00	64.70%	x
14	Christina Wyrick	Program Technician II (1501)	100.00%	60,270.00	60,270.00	0.00%	0.00		0.00	35.30%	21,275.31		0.00	64.70%	38,994.69		0.00		0.00	64.70%	x
15	Madeleine Yakoub	Program Technician II	75.00%	46,350.00	34,763.00	0.00%	0.00		0.00	35.30%	12,271.34		0.00	64.70%	22,491.66		0.00		0.00	64.70%	x
16	Vacant	Office Assistant I	100.00%	37,306.00	37,306.00	0.00%	0.00		0.00	15.40%	5,745.12		0.00	84.60%	31,560.88		0.00		0.00	85.29%	x
17	Linda Willome	Office Assistant II	100.00%	52,423.00	52,423.00	0.00%	0.00		0.00	18.10%	9,488.56		0.00	81.90%	42,934.44		0.00		0.00	85.29%	x
18	Sophia Armenta Q.	Office Assistant II	100.00%	52,423.00	52,423.00	0.00%	0.00		0.00	16.15%	8,466.31		0.00	83.85%	43,956.69		0.00		0.00	85.29%	x
19	Lynette Yamanaka	Office Assistant II	100.00%	52,423.00	52,423.00	0.00%	0.00		0.00	16.35%	8,571.16		0.00	83.65%	43,851.84		0.00		0.00	85.29%	x
20	Vacant	Public Health Nurse I - Fetal Infant Mort	50.00%	88,131.00	44,066.00	100.00%	44,066.00		0.00	0.00%	0.00		0.00	0.00%	0.00		0.00		0.00	64.70%	x
21	Natalie Adolph	Supervising Public Health Nurse (1615)	70.00%	155,469.00	108,828.00	0.00%	0.00		0.00	24.81%	27,000.23		0.00	61.04%	66,428.61		0.00	14.15%	15,399.16	90.90%	x
22	Vacant	Public Health Nurse I (1677)	100.00%	88,131.00	88,131.00	0.00%	0.00		0.00	81.76%	72,055.91		0.00	17.81%	15,696.13		0.00	0.43%	378.96	64.70%	x
23	Fred Toshimitsu	Public Health Nurse II (1677)	100.00%	129,407.00	129,407.00	0.00%	(0.00)		0.00	84.93%	109,905.37		0.00	14.83%	19,191.06		0.00	0.24%	310.58	64.70%	x
24	Gabriel Velazquez	Public Health Nurse I (1615)	100.00%	102,106.00	102,106.00	0.00%	0.00		0.00	41.22%	42,088.09		0.00	26.41%	26,966.19		0.00	32.37%	33,051.71	86.70%	x
25	Tammy Hess	Public Health Nurse I (1615)	100.00%	111,328.00	111,328.00	0.00%			0.00	46.08%	51,299.94		0.00	15.54%	17,300.37		0.00	38.38%	42,727.69	86.70%	x
26	Elisabeth Tobiasen	Public Health Nurse I (1615)	100.00%	93,338.00	93,338.00	0.00%	0.00		0.00	40.00%	37,335.20		0.00	25.00%	23,334.50		0.00	35.00%	32,668.30	86.70%	x
27	Chanell Gray	Public Health Nurse I (1615)	100.00%	94,582.00	94,582.00	0.00%	0.00		0.00	40.00%	37,832.80		0.00	25.00%	23,645.50		0.00	35.00%	33,103.70	86.70%	x
28	Natalie Adolph	Supervising Public Health Nurse (1706)	30.00%	155,469.00	46,641.00	10.00%	4,664.10		0.00	7.10%	3,311.51		0.00	72.23%	33,688.79		0.00	10.67%	4,976.59	85.29%	x
29	Pon Chin	Public Health Nurse II	100.00%	129,407.00	129,407.00	15.00%	19,411.05		0.00	9.03%	11,685.45		0.00	35.03%	45,331.27		0.00	40.94%	52,979.23	85.29%	x
30	Lillarose Bangs	Supervising Public Health Nurse-MCAH	100.00%	155,469.00	155,469.00	10.00%	15,546.90		0.00	6.25%	9,716.81		0.00	65.60%	101,987.66		0.00	18.15%	28,217.62	85.29%	x
31	Deborah Omolayo	Public Health Nurse II	100.00%	129,407.00	129,407.00	5.03%	6,509.31		0.00	11.40%	14,752.26		0.00	47.16%	61,028.34		0.00	36.41%	47,117.09	85.29%	x
32	Erin An	Public Health Nurse II	100.00%	116,599.00	116,599.00	0.00%	0.00		0.00	16.24%	18,935.68		0.00	50.36%	58,719.26		0.00	33.40%	38,944.07	85.29%	x
33	Vacant	Public Health Nurse I	100.00%	88,131.00	88,131.00	0.00%	(0.00)		0.00	16.00%	14,100.96		0.00	50.00%	44,065.50		0.00	34.00%	29,964.54	85.29%	x
34	Latoya Woods	Public Health Nurse II (1720)	100.00%	120,638.00	120,638.00	0.00%	(0.00)		0.00	22.10%	26,661.00		0.00	58.00%	69,970.04		0.00	19.90%	24,006.96	85.29%	x
35	Brienna Harker	Public Health Nurse II (1720)	100.00%	125,271.00	125,271.00	0.00%	0.00		0.00	30.07%	37,668.99		0.00	34.96%	43,794.74		0.00	34.97%	43,807.27	85.29%	x
36	Vacant	Public Health Nurse I (1720)	100.00%	88,131.00	88,131.00	0.00%	0.00		0.00	25.00%	22,032.75		0.00	40.00%	35,252.40		0.00	35.00%	30,845.85	85.29%	x
37	Lorriane Hardy	Supervising Public Health Nurse	55.00%	155,469.00	85,508.00	0.00%	(0.00)		0.00	10.79%	9,226.31		0.00	61.15%	52,288.14		0.00	28.06%	23,993.54	92.10%	x
38	Lorriane Hardy	Supervising Public Health Nurse (1719)	15.00%	155,469.00	23,320.00	0.00%			0.00	10.90%	2,541.88		0.00	44.73%	10,431.04		0.00	44.37%	10,347.08	92.10%	x
39	Kayla Marcinkevicz	Public Health Nurse II (1719)	100.00%	118,152.00	118,152.00	0.00%	(0.00)		0.00	25.19%	29,762.49		0.00	42.57%	50,297.31		0.00	32.24%	38,092.20	92.10%	x
40	Jaynie Ortiz	Public Health Nurse II (1719)	100.00%	112,483.00	112,483.00	0.00%	(0.00)		0.00	20.34%	22,879.04		0.00	42.79%	48,131.48		0.00	36.87%	41,472.48	92.10%	x
41	Melanie Delo	Public Health Nurse II	100.00%	129,407.00	129,407.00	15.00%	19,411.05		0.00	12.06%	15,606.48		0.00	29.65%	38,369.18		0.00	43.29%	56,020.29	85.29%	x
42	Mai Vang	Public Health Nurse II	0.00%	129,407.00	0.00		0.00		0.00	0.00%	0.00		0.00	0.00%	0.00		0.00		0.00	0.00%	x
43	Bridget Ballesteros	Public Health Nurse II	100.00%	129,407.00	129,407.00	15.00%	19,411.05		0.00	16.89%	21,856.84		0.00	38.14%	49,355.83		0.00	29.97%	38,783.28	85.29%	x
44	Rachel Nevarez	Public Health Nurse II	100.00%	129,407.00	129,407.00	15.00%	19,411.05		0.00	11.77%	15,231.20		0.00	34.77%	44,994.81		0.00	38.46%	49,769.93	85.29%	x
45	Lia Vangyi	Public Health Nurse II	40.00%	129,407.00	51,763.00	0.00%	0.00		0.00	35.30%	18,272.34		0.00	64.70%	33,490.66		0.00		0.00	64.70%	x
46	Linda Hicks	Public Health Nurse II -Fetal Infant Mort	50.00%	127,373.00	63,687.00	100.00%	63,687.00		0.00	0.00%	0.00		0.00	0.00%	0.00		0.00		0.00	64.70%	x
47	Jennifer Pino-Xiong	Medical Social Worker III	24.87%	92,866.00	23,096.00	100.00%	23,096.00		0.00	0.00%	0.00		0.00	0.00%	0.00		0.00		0.00	64.70%	x
48	Bee Vang	Epidemiologist	5.00%	99,944.00	4,997.00	100.00%	4,997.00		0.00	0.00%	0.00		0.00	0.00%	0.00		0.00		0.00	64.70%	x
49	Quentin Paramo	Health Education Specialist	10.00%	59,284.00	5,928.00	100.00%	5,928.00		0.00	0.00%	0.00		0.00	0.00%	0.00		0.00		0.00	64.70%	x
50	Vacant	Senior Staff Analyst	100.00%	87,198.00	87,198.00	0.00%	0.00		0.00	35.30%	30,780.89		0.00	64.70%	56,417.11		0.00		0.00	64.70%	x
51					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
52					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
53					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
54					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
55					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	

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

The Local Health Jurisdiction (LHJ), in collaboration with the CDPH/MCAH Division, shall strive to develop systems that protect and improve the health of California's women of reproductive age, infants, children, adolescents and their families.

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

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

All Title V programs must comply with the MCAH Fiscal Policy and Procedures Manual and the Local MCAH Program Policies and Procedures Manual.

Certification by MCAH Director:	Name: Ge Vue Title: MCAH Director/Division Manager Date: 6/28/2024 *I certify that I have reviewed and approved this Scope of Work.*

Note: The Title V Maternal and Child Health Block Grant provides core funding to California to improve the health of mothers and children. The Title V Block Grant is federally administered by the Health Resources and Services Administration.

CDPH/MCAH may post SOWs on the CDPH/MCAH website.

Section A: General requirements and activities for all LHJs				
Aligns With	**General Requirement(s)**	**Required Local Activities**	**Time Frame**	**Deliverable Description**
CDPH/MCAH Requirement	Local MCAH Annual Report	**A1** Complete and submit an Annual Report each fiscal year to report on Scope of Work activities.	Annually, each fiscal year	The Annual Report will report on progress of program activities and the extent to which the LHJ met the SOW goals and deliverables and how funds were expended.
Title V Requirement	Toll-Free Line	**A2** Provide a toll-free telephone number or "no cost to the calling party" number (and other appropriate methods) which provides a current list of culturally and linguistically appropriate information and referrals to community health and human resources for the public regarding access to prenatal care.	Annually, each fiscal year	Include on Local MCAH budget during the AFA cycle. Report in Annual Report: • List toll-free telephone number
Title V Requirement	MCAH Website	**A3** Share link, if available, to the appropriate Local MCAH Title V Program website.	Annually, each fiscal year	Report in the Annual Report: • List the URL for the Local MCAH Title V program website
Title V/ CDPH/MCAH Requirement	Workforce Development and Training	**A4** Attend required trainings/meetings as outlined in the MCAH Program Policies and Procedures.	Annually, each fiscal year	Report attendance in Annual Report: • MCAH Directors' meeting(s) • SIDS Coordinators' meeting
CDPH/MCAH Requirement	MCAH Director	**A5** Maintain required MCAH Director position and recruit and retain qualified Title V program staff by as outlined in the MCAH Policies and Procedures.	Ongoing	The LHJ must submit a Local MCAH Director Verification form annually during the AFA process and resubmit with any changes.
CDPH/MCAH Requirement	Community Resource and Referral Guide	**A6** Develop a comprehensive MCAH resource and referral guide of available health, mental health, emergency resources, and social services.	By end of 2025	Report in Annual Report: • Submit/upload a copy or link to the existing resource and referral guide
CDPH/MCAH Requirement	Protocols	**A7** Develop and adopt protocols to ensure that MCAH clients are enrolled in health insurance, are linked to a provider and access preventive visits.	Annually, each fiscal year	Report on protocols in the Annual Report.

Title V Requirement	Conduct Local Needs Assessment	**A8** Conduct a Local Needs Assessment to acquire an accurate, thorough picture of the strengths and weaknesses of the local public health system.	Once in five-year cycle	Complete Local Needs Assessment deliverable documents provided by CDPH/MCAH.

Section B: Domain specific requirements and activities				
CDPH/MCAH Requirement	Infant – Sudden Infant Death Syndrome/Sudden Unexpected Infant Death (SIDS/SUID)	**B1** **Required for Infant Domain - all LHJs** Provide SIDS/SUID grief and bereavement services and supports through home visits and/or mail resource packets to families suffering an infant loss.	Annually, each fiscal year	Report on SIDS/SUID services and supports in the Annual Report.
CDPH/MCAH Requirement	Infant – Sudden Infant Death Syndrome/Sudden Unexpected Infant Death (SIDS/SUID)	**B1.a.** Submit Public Health Services Report Form of a sudden, unexpected infant death to the CDPH/MCAH.	Annually, each fiscal year	
CDPH/MCAH Requirement	Infant – Safe Sleep	**B2** **Required for Infant Domain - all LHJs** Promote the latest AAP Safe Sleep guidance and implement Infant Safe Sleep Interventions to reduce the number of SUID related deaths.	Annually, each fiscal year	Report on safe sleep activities in the Annual Report.
CDPH/MCAH Requirement	Child Health - Developmental Screening	**B3** **Required for Child Domain - all LHJs** Partner with CDPH/MCAH to identify, review and monitor local developmental screening rates.	Annually, each fiscal year	Report on developmental screening activities in the Annual Report.
CDPH/MCAH Requirement	Child Health – Family Economic Supports	**B4** **Required for Child Domain - all LHJs** Link and refer families in MCAH programs to safety net and public health care programs such as Family Planning, Access, Care, and Treatment (PACT), Medi-Cal, and Denti-Cal.	Annually, each fiscal year	Report on family economic support activities in the Annual Report.
CDPH/MCAH Requirement	Children and Youth with Special Health Care needs (CYSHCN)	**B5** **Required for CYSHCN Domain - all LHJs** Link and refer children in families served by Local MCAH programs to services if results of a developmental or trauma screening indicates that the child needs follow-up.	Annually, each fiscal year	Report on screening and referral activities in the Annual Report.
CDPH/MCAH Requirement	Children and Youth with Special Health Care needs (CYSHCN)	**B6** **Required for CYSHCN Domain - all LHJs** Outreach to and connect with your local or regional family resource center to understand needs of CYSHCN and their families and the resources available to them. Get Connected - Family Resource Centers Network of California (frcnca.org)	Annually, each fiscal year	Report on outreach activities in the Annual Report.

CDPH/MCAH Requirement	Infant – Infant Mortality Reviews	**B7** **Required for funded LHJs only** LHJs funded for infant mortality reviews will implement activities in accordance with Local MCAH Program Policies and Procedures.	Annually, each fiscal year	Report on activities in the Annual Report.
CDPH/MCAH Requirement	Black Infant Health (BIH) Program	**B8** **Required for BIH funded LHJs only** LHJs funded for BIH will implement the BIH Program in accordance with BIH Policies and Procedures.	Annually, each fiscal year	Report on BIH activities in the Annual Report.
CDPH/MCAH Requirement	Adolescent Family Life Program (AFLP)	**B9** **Required for AFLP funded LHJs only** LHJs funded for AFLP will implement the AFLP Program in accordance with AFLP Policies and Procedures.	Annually, each fiscal year	Report on AFLP activities in the Annual Report.

Section C: Local Activities by Domain

At least one activity must be selected or the LHJ must develop at least one activity of their own in the Women/Maternal Health Do

Women/Maternal Health Domain	
Women/Maternal Priority Need: Ensure women in California are healthy before, during and after pregnancy. *Women/Maternal Focus Area 1: Reduce the impact of chronic conditions related to maternal mortality.*	
Performance Measures (National/State Performance Measures and Evidence-Based Strategy Measure)	**NPM 1:** Well-woman visit (Percent of women with a preventive medical visit in the past year). **ESM 1.1**: Percent of local health jurisdictions that have adopted a protocol to ensure that all persons in MCAH Programs are referred for enrollment in health insurance and complete a preventive visit.
Women/Maternal State Objective 1: By 2025, reduce the rate of pregnancy-related deaths (up to 1 year after the end of pregnancy) from 18.6 deaths per 100,000 live births (2020 CA-PMSS) to 12.2 deaths per 100,000 live births.	
Women/Maternal State Objective 1: Strategy 1: Lead surveillance and investigations of pregnancy-related deaths (up to 1 year after the end of pregnancy) in California.	**Women/Maternal State Objective 1: Strategy 2:** Partner to translate findings from pregnancy-related mortality investigations into recommendations for action to improve maternal health and perinatal clinical practices.
Local Activities for Women/Maternal Objective 1: Strategy 1:	**Local Activities for Women/Maternal Objective 1: Strategy 2:**
w 1.1.1 ☐Partner with CDPH/MCAH on dissemination of data findings, guidance, and education to the general public and local partners, including perinatal obstetric providers. **What is your anticipated outcome?**	**w 1.2.1** ☐ Partner with CDPH/MCAH on dissemination and translation of recommendations to improve maternal health and perinatal clinical practices, including quality improvement toolkits to reduce disparities. **What is your anticipated outcome?**
w 1.1.2 ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	**w 1.2.2** ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**

If you have additional local activities, please add a row.

<table>
<tr><th colspan="3">Women/Maternal Health Domain</th></tr>
<tr><td colspan="3">Priority Need: Ensure women in California are healthy before, during and after pregnancy.
Women/Maternal Focus Area 2: Reduce the impact of chronic conditions related to maternal morbidity.</td></tr>
<tr><td colspan="1">Performance Measures
(National/State Performance Measures and Evidence-Based Strategy Measure)</td><td colspan="2">NPM 1: Well-woman visit (Percent of women with a preventive medical visit in the past year).
ESM: The number of Local Health Jurisdictions (LHJs) that report developing or adopting a protocol to link clients (women 22-44) to a provider to access a preventive visit. (Objective 4)</td></tr>
<tr><td colspan="3">Women/Maternal State Objective 2:
By 2025, reduce the rate of severe maternal morbidity from 110.5 per 10,000 delivery hospitalizations (2021 PDD) to 88.8 per 10,000 delivery hospitalizations.</td></tr>
<tr><td><u>Women/Maternal State Objective 2: Strategy 1:</u>
Lead surveillance and research related to maternal morbidity in California.</td><td><u>Women/Maternal State Objective 2: Strategy 2:</u>
Lead statewide regionalization of maternal care to ensure women receive appropriate care for childbirth.</td><td><u>Women/Maternal State Objective 2: Strategy 3:</u>
Partner to strengthen knowledge and skill among health care providers and individuals on chronic conditions exacerbated during pregnancy.</td></tr>
<tr><td>Local Activities for Women/Maternal Objective 2: Strategy 1</td><td>Local Activities for Women/Maternal Objective 2: Strategy 2</td><td>Local Activities for Women/Maternal Objective 2: Strategy 3</td></tr>
</table>

w 2.1.1	w 2.2.1	w 2.3.1
☐Partner with CDPH/MCAH on dissemination of data findings, guidance, and education to the general public and local partners. **What is your anticipated outcome?**	☒Partner with local Regional Perinatal Programs of California (RPPC) Director to understand efforts to establish Perinatal Levels of Care and quality improvement efforts. **Activities:** • Attend and participate in the Central Valley Regional Perinatal Programs of California (RPPC) Leadership Meetings and corresponding workgroups. • Partner with Central Valley RPPC in planning and participation in the Central Valley Perinatal Symposium. • Engage in collaborative quality improvement efforts with Central Valley RPPC to address such issues as Preeclampsia and Gestational Diabetes. • Engage Central Valley RPPC leaders in efforts to eliminate disparities in infant and maternal morbidity and mortality through there participation in the Fetal and Infant Mortality Case Review Team/Community Action Team. **What is your anticipated outcome?** • Increased community awareness, targeted quality improvement actions, and access to the appropriate Perinatal levels of Care to ultimately reduce adverse maternal, fetal, and infant outcomes.	☐Partner with CDPH/MCAH to pilot test educational materials addressing chronic health conditions during pregnancy and disseminate to consumers and providers. **What is your anticipated outcome?**

w 2.1.2 ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	**w 2.2.2** ☐ Perinatal Service Coordinator (PSC) will collaborate with Women Infant Children (WIC), RPPC, CDPH/MCAH, Medi-Cal, and other key partners to ensure integration of resources and a coordinated delivery system for women during and after pregnancy. **What is your anticipated outcome?**	**w 2.3.2** ☐ For Black Infant Health (BIH) funded sites only, disseminate culturally responsive materials to inform Black women on chronic health conditions. **What is your anticipated outcome?**
w 2.1.3 ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	**w 2.2.3** ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	**w 2.3.3** ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**

If you have additional local activities, please add a row.

Woman/Maternal Health Domain		
Priority Need: Ensure women in California are healthy before, during and after pregnancy. *Women/Maternal Focus Area 3: Improve mental health for all mothers in California.*		
Performance Measures (National/State Performance Measures and Evidence-Based Strategy Measure)	**NPM 1:** Well-woman visit (Percent of women with a preventive medical visit in the past year). **ESM:** The number of Local Health Jurisdictions (LHJs) that report developing or adopting a protocol to link clients (women 22-44) to a provider to access a preventive visit. (Objective 4)	
Women/Maternal State Objective 3: By 2025, increase the receipt of mental health services among women who reported needing help for emotional well-being or mental health concerns during the perinatal period from 54.2% (2021 MIHA) to 56.9%.		
Women/Maternal State Objective 3: Strategy 1: Partner with state and local programs to disseminate information and resources to reduce mental health conditions in the perinatal period.	**Women/Maternal State Objective 3: Strategy 2:** Partner to strengthen knowledge and skill among health care providers, individuals, and families to identify signs of maternal mental health-related needs.	**Women/Maternal State Objective 3: Strategy 3:** Partner to ensure pregnant and parenting women are screened and referred to mental health services during the perinatal period.
Local Activities for Women/Maternal Objective 3: Strategy 1	**Local Activities for Women/Maternal Objective 3: Strategy 2**	**Local Activities for Women/Maternal Objective 3: Strategy 3**
w 3.1.1 ☒Partner with local programs responsible for the provision of mental health services and early intervention programs to promote mental health services in the perinatal period. **What is your anticipated outcome?** Provide health education materials and resources during the perinatal period for better birth outcomes.	**w 3.2.1** ☐ Perinatal Service Coordinators (PSCs) will ensure providers, local health plans, and other partners in their communities are aware of mental health requirements at roundtable discussions or through other communications. **What is your anticipated outcome?**	**w 3.3.1** ☐Implement and utilize standardized and validated mental health screening tools for pregnant and parenting women in MCAH programs. **What is your anticipated outcome?**
w 3.1.2	**w 3.2.2**	**w 3.3.2** ☐Lead the development of a county maternal mental health algorithm that outlines a referral

☐Partner with local mental health service providers to improve referral and linkages to mental health services. **What is your anticipated outcome?**	☐Partner with local Mental Health Services Act (MHSA)/Prop. 63 funded programs to increase available services to women during perinatal period. **What is your anticipated outcome?**	system and the services available to address maternal mental health and identify systems gaps. **What is your anticipated outcome?**
w 3.1.3 ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	**w 3.2.3** ☐Partner with CDPH/MCAH to disseminate mental health promotional messages that educate women and families to recognize early signs and symptoms of mental health disorders. **What is your anticipated outcome?**	**w 3.3.3** ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**
w 3.1.4 ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	**w 3.2.4** ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	**w 3.3.4** ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**

If you have additional local activities, please add a row.

Woman/Maternal Health Domain			
Priority Need: Ensure women in California are healthy before, during and after pregnancy. *Women/Maternal Focus Area 4: Ensure optimal health before pregnancy and improve pregnancy planning and birth spacing.*			
Performance Measures (National/State Performance Measures and Evidence-Based Strategy Measure)	**NPM 1:** Well-woman visit (Percent of women with a preventive medical visit in the past year). **ESM:** The number of Local Health Jurisdictions (LHJs) that report developing or adopting a protocc provider to access a preventive visit. (Objective 4)		
Women/Maternal State Objective 4: By 2025, increase the percent of women who had an optimal interpregnancy interval of at least 18 months from 73.1% (2021 CCMB			
Women/Maternal State Objective 4: Strategy 1: Partner to increase provider and individual knowledge and skill to improve health and health care before and between pregnancies.	**Women/Maternal State Objective 4: Strategy 2:** Lead a population-based assessment of mothers in California, the Maternal and Infant Health Assessment Survey (MIHA), to provide data to guide programs and services.	**Women/Maternal State Objective 4: Strategy 3:** Lead efforts to improve local perinatal health systems utilizing morbidity and mortality data and implement evidence-based interventions to improve the health of pregnant individuals and their infants.	**Women/M** Fund the administer Services (A home vis Indian
Local Activities for Women/Maternal Objective 4: Strategy 1	**Local Activities for Women/Maternal Objective 4: Strategy 2**	**Local Activities for Women/Maternal Objective 4: Strategy 3**	
w 4.1.1 ☐Partner with CDPH/MCAH to disseminate and promote best practices and resources from key preconception initiatives. **What is your anticipated outcome?**		**w 4.3.1** ☐Partner with Perinatal Service Coordinators (PSCs) to identify barriers in access to care in medically underserved areas and collaborate with local health plans to reduce barriers. **What is your anticipated outcome?**	
w 4.1.2 ☐Coordinate with CDPH/MCAH to identify uninsured populations and conduct outreach and awareness of health insurance options. **What is your anticipated outcome?**	**w 4.2.2** ☐Partner with CDPH/MCAH to disseminate MIHA data findings and guidance to the public and local partners. **What is your anticipated outcome?**	**w 4.3.2** ☐ Outreach coordination to underserved populations and provide information and education on topics to improve health outcomes for parents, infants, and their families (e.g., social media, resource fairs). **What is your anticipated outcome?**	

w 4.1.3 ☐Partner with CDPH/MCAH to promote preconception/inter-conception health programs. **What is your anticipated outcome?**	**w 4.2.3** ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	**w 4.3.3** ☐ Monitor the health status of the MCAH population including disparities and social determinants of health and work with local leadership to address identified issues. **What is your anticipated outcome?**	
w 4.1.4 ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	**w 4.2.4** ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	**w 4.3.4** ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	

If you have additional local activities, please add a row.

Woman/Maternal Health Domain	
Priority Need: Ensure women in California are healthy before, during and after pregnancy. *Women/Maternal Focus Area 5: Reduce maternal substance use.*	
Performance Measures (National/State Performance Measures and Evidence-Based Strategy Measure)	**NPM 1:** Well-woman visit (Percent of women with preventive medical visit in the a past year). **ESM:** The number of Local Health Jurisdictions (LHJs) that report developing or adopting a protocol to link clients (women 22-44) to a provider to access a preventive visit. (Objective 4)
Women/Maternal State Objective 5: By 2025, reduce the rate of maternal substance use from 20.8 per 1,000 delivery hospitalizations (2021 PDD) to 19.7 per 1,000 delivery hospitalizations.	
Women/Maternal State Objective 5: Strategy 1: Lead research and surveillance on maternal substance use in California.	**Women/Maternal State Objective 5: Strategy 2:** Partner at the state and local level to increase prevention and treatment of maternal opioid and other substance use.
Local Activities for Women/Maternal Objective 5: Strategy 1	**Local Activities for Women/Maternal Objective 5: Strategy 2**
w 5.1.1 ☐Coordinate with CDPH/MCAH to disseminate data findings, guidance, and education to the general public and local partners. **What is your anticipated outcome?**	**w 5.2.1** ☒Identify county specific resources on treatment and best practices to address substance use and collaborate to improve referral and linkages to services. Dr. Linscheid has connections with the CA Bridge Navigator Program. Two Substance Abuse Navigators (SAN) at Community Regional Medical Center (CRMC) emergency department are point persons to assist patients in accessing medical assisted treatment and mental health services. Dr. Linscheid will assist in distributing the Perinatal Substance Use Disorder (SUD) brochures to OB and Family Practice colleagues. **What is your anticipated outcome?** Every local hospital will encourage their perinatal staff to utilize California Maternal Quality Care Collaborative (CMQCC's) interactive online *Mother & Baby Substance Exposure Initiative Toolkit* to learn the best practices for improving outcomes for substance exposed mothers and babies. Regional Perinatal Programs of California (RPPC) will assist in distribution of the Perinatal SUD brochures to local hospitals and as needed, review the following information with staff: a) reporting guidelines, referral process, and plan of safe care; b) local treatment options; and c) linkage to community resources.

w 5.1.2 ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	**w 5.2.2** ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**

If you have additional local activities, please add a row.

Section C: Local Activities by Domain

At least one activity must be selected or the LHJ must develop at least one activity of their own in the Perinatal/Infant Health Dom

Perinatal/Infant Health Domain			
Perinatal/Infant Priority Need: Ensure all infants are born healthy and thrive in their first year of life. *Perinatal/Infant Focus Area 1: Improve healthy infant development through breastfeeding.* *Perinatal/Infant Focus Area 2: Improve healthy infant development through caregiver/infant bonding.*			
Performance Measures (National/State Performance Measures and Evidence-Based Strategy Measure)	**NPM 4a**: Percent of infants who are ever breastfed. **NPM 4b:** Percent of infants breastfed exclusively through 6 months. **ESM 4.1:** Number of online views/hits to the "Lactation Support for Low-Wage Workers". **SPM 1:** Preterm birth rate among infants born to non-Hispanic Black women.		
Perinatal/Infant State Objective 1: By 2025, increase the percent of women who report exclusive in-hospital breastfeeding from 69.2% (2021 GDSP) to 72.5%.			
Perinatal/Infant State Objective 1: Strategy 1: Lead surveillance of breastfeeding practices and assessment of initiation and duration trends.	**Perinatal/Infant State Objective 1: Strategy 2:** Lead technical assistance and training to support breastfeeding initiation, including the implementation of the Model Hospital Policy or Baby Friendly in all California birthing hospitals by 2025.	**Perinatal/Infant State Objective 1: Strategy 3:** Partner to develop and disseminate information and resources about policies and best practices to promote breastfeeding duration, including lactation accommodation within all MCAH programs.	**Perinatal/Infant State Objective 1: Strategy 4:** Partner with birthing hospitals to support caregiver/infant bonding.
Local Activities for Perinatal/Infant Objective 1: Strategy 1	**Local Activities for Perinatal/Infant Objective 1: Strategy 2**	**Local Activities for Perinatal/Infant Objective 1: Strategy 3**	**Local Activities for Perinatal/Infant Objective 1: Strategy 4**
p 1.1.1 ☐Monitor and track breastfeeding initiation and duration rates and disseminate data to community and local partners. **What is your anticipated outcome?**	**p 1.2.1** ☐Promote breastfeeding education to prenatal women in local MCAH programs. **What is your anticipated outcome?**	**p 1.3.1** ☒Partner to develop and disseminate information and resources about policies and best practices to promote extending breastfeeding duration, including lactation accommodation within local MCAH programs. **Activities:** • Partner and participate in Fresno County Breastfeeding Collaborative.	**p 1.4.1** ☐Partner with Regional Perinatal Program of California (RPPC) Directors to work with local birthing hospitals on messaging related to infant bonding with an emphasis on a client-centered approach. **What is your anticipated outcome?**

		• Plan and participate in the Annual Breastfeeding Conference. • Plan and attend annual Breastfeeding Walk. • Link and send appropriate home visiting staff through Certified Lactation Counselor Training. • Partner with WIC Regional Breastfeeding Liaison to develop and disseminate educational materials on breastfeeding and lactation accommodations. • Distribute information and resources through home visiting programs, at outreach events, and community-based organizations. **What is your anticipated outcome?** • Increased provider and public awareness and understanding on the benefits of breastfeeding and lactation accommodations. • Greater reach and engagement of the target population, including expectant mothers, families, and communities, through multiple channels of communication and in-person interactions.	

p 1.1.2 ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	**p 1.2.2** ☐Partner to disseminate information to the community regarding evidence-based breastfeeding initiation guidance. **What is your anticipated outcome?**	**p 1.3.2** ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	**p 1.4.2** ☐Partner with community leaders to promote infant bonding, skin to skin training and outreach activities to dads, partners, and caretakers. **What is your anticipated outcome?**
p 1.1.3 ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	**p 1.2.3** ☐Partner with Regional Perinatal Programs of California (RPPC) Directors to track and assess implementation and technical assistance needs of birthing hospitals related to the implementation of Model Hospital Policy or Baby Friendly. **What is your anticipated outcome?**	**p 1.3.3** ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	**p 1.4.3** ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**
p 1.1.4 ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	**p 1.2.4** ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	**p 1.3.4** ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	**p 1.4.4** ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**

If you have additional local activities, please add a row.

<table>
<tr><th colspan="3">Perinatal/Infant Health Domain</th></tr>
<tr><td colspan="3">Perinatal/Infant Priority Need: Reduce infant mortality with a focus on eliminating disparities.
Perinatal/Infant Focus Area 3: Reduce Black Infant Mortality.</td></tr>
<tr><td colspan="2">Performance Measures
(National/State Performance Measures and Evidence-Based Strategy Measure)</td><td>NPM 4a: Percent of infants who are ever breastfed
NPM 4b: Percent of infants breastfed exclusively through 6 months
ESM 4.1: Number of online views to the "Lactation Support for Low-Wage Workers Report"
SPM 1: Preterm birth rate among infants born to non-Hispanic Black women.</td></tr>
<tr><td colspan="3">Perinatal/Infant State Objective 2:
By 2025, reduce the rate of infant deaths from 4.1 per 1,000 live births (2021 BSMF/DSMF) to 4.0.
*Note: Even though the objective has been surpassed, California has chosen to keep the target at the same level (4.0) for now because this might have been a statistical fluctuation and we want to ascertain if it is an actual stable trend.</td></tr>
<tr><td><u>Perinatal/Infant State Objective 2: Strategy 1:</u>
Lead research and surveillance related to fetal and infant mortality in California.</td><td><u>Perinatal/Infant State Objective 2: Strategy 2:</u>
Lead planning and development of evidence-based practices and lesson learned for reducing infant mortality rates.</td><td><u>Perinatal/Infant State Objective 2: Strategy 3:</u>
Lead the California SIDS Program to provide grief and bereavement support to parents, technical assistance, resources, and training on infant safe sleep to reduce infant mortality.</td></tr>
<tr><td>Local Activities for Perinatal/Infant Objective 2: Strategy 1</td><td>No Local Activities</td><td>Local Activities for Perinatal/Infant Objective 2: Strategy 3</td></tr>
<tr><td>p 2.1.1

☒ Monitor and track fetal and infant mortality utilizing the National Fatality Review-Case Reporting System (NFR-CRS) and disseminate data to community and local partners.

What is your anticipated outcome?
Shared with community partners and stakeholders such as Babies First (Healthy Start) Community Advisory Network, County Medical Providers, CPSP Providers, PEI/BIH Community Advisory Board, sub-contracted MCAH providers.</td><td>p 2.2.1

☐Other local activity (Please Specify/Optional):

What is your anticipated outcome?</td><td>p 2.3.1

☒Promote and disseminate information and resources related to SIDS/SUID risk factors and reduction strategies.

What is your anticipated outcome?
New staff will receive training on safe sleep to increase understanding of SIDs and other sleep related infant deaths. Staff will use teaching materials to promote safe sleep and share resources to promote safer sleep in the community.

New MCAH home visiting staff will receive training on Cribette distribution and distribute cribettes to clients as needed.

Provide MCAH home visitors Safe Sleep flipbooks with updated 2022</td></tr>
</table>

		AAP Guidelines.
p 2.1.2 ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**		**p 2.3.2** ☒Disseminate Safe to Sleep® campaign and Safe Sleep strategies that address SIDS and other sleep-related causes of infant death. **What is your anticipated outcome?** Wide-spread community awareness and knowledge of safe sleep strategies and dissemination of safe sleep materials in the community Provide updated Safe Sleep flipbooks to CBO's who teach Safe Sleep.
p 2.1.3 ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**		**p 2.3.3** ☐Partner with Regional Perinatal Programs of California (RPPC) to work with birthing hospitals to disseminate Sudden Infant Death Syndrome/Sudden Unexpected Infant Death (SIDS/SUID) risk reduction information to parents or guardians of newborns upon discharge. **What is your anticipated outcome?**
p 2.1.4 ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**		**p 2.3.4** ☒Partner with local childcare licensing, birthing facilities, clinics, Women Infant Children (WIC) sites, and medical providers to provide SIDS/SUID and Safe Sleep education.

		What is your anticipated outcome? Promotion of best practices for Safe Sleep education beginning in the prenatal period. SIDs coordinator will participate in the Central Valley Safe Sleep Coalition meetings whose goal is to standardize and promote Safe Sleep education in the Central Valley. Continued collaboration with SIDS Coordinators throughout the valley to promote safe sleep.
p 2.1.5 ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**		**p 2.3.5** ☒ Provide SIDS/SUID grief and bereavement services and supports through home visits and/or mail resource packets to families suffering an infant loss. **What is your anticipated outcome?** Families will report feeling supported and having a better understanding of their grief. Conduct annual reviews of grief materials, adding new resources as needed.
		p 2.3.6 X Other local activity (Please Specify/Optional): Improve Grief and Loss support for families who have experienced an infant loss by: • Participate in trainings on Grief/Loss and support for families. • Attend CA SIDS council meetings and trainings, Northern Regional CA SIDS meetings and National SIDS meetings.

		• Work closely with Fresno Angel Babies to link families for grief support. **What is your anticipated outcome?** Collaboration with other state and national SIDS coordinators. Increased access to latest SIDS research and education materials. Improved grief support for parents.

If you have additional local activities, please add a row.

Perinatal/Infant Health Domain			
Perinatal/Infant Priority Need: Reduce infant mortality with a focus on eliminating disparities. *Perinatal/Infant Focus Area 4: Reduce preterm births.*			
Performance Measures (National/State Performance Measures and Evidence-Based Strategy Measure)		**NPM 4a:** Percent of infants who are ever breastfed **NPM 4b:** Percent of infants breastfed exclusively through 6 months **ESM 4.1:** Number of online views to the "Lactation Support for Low-Wage Workers Report" **SPM 1:** Preterm birth rate among infants born to non-Hispanic Black women.	
Perinatal/Infant State Objective 3: By 2025, reduce the percentage of preterm births from 9.1% (2021 BSMF) to 8.4%.			
Perinatal/Infant State Objective 3: Strategy 1: Lead research and surveillance on disparities in preterm birth rates in California.	**Perinatal/Infant State Objective 3: Strategy 2:** Lead the implementation of the Black Infant Health (BIH) Program to reduce the impact of stress due to structural racism to improve Black birth outcomes.	**Perinatal/Infant State Objective 3: Strategy 3:** Lead the implementation of the state general fund effort, Perinatal Equity Initiative (PEI), to support local initiatives to support birthing populations of color.	**Perinatal/Infant State Objective 3: Strategy 4:** Lead the development and dissemination of preterm birth reduction strategies across California.
Local Activities for Perinatal/Infant Objective 3: Strategy 1	**Local Activities for Perinatal/Infant Objective 3: Strategy 2**	**Local Activities for Perinatal/Infant Objective 3: Strategy 3**	**Local Activities for Perinatal/Infant Objective 3: Strategy 4**
p 3.1.1 ☐Monitor and track local preterm birth rates and disseminate data to community and local partners. **What is your anticipated outcome?**	**p 3.2.1** ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	**p 3.3.1** ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	**p 3.4.1** ☐Partner with local birthing hospitals, and community stakeholders to disseminate social media campaigns about preterm birth reduction strategies. **What is your anticipated outcome?**

p 3.1.2	p 3.2.2	p 3.3.2	p 3.4.2
☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	☒Develop and disseminate preterm birth reduction materials and resources to the community and agencies providing services to moms and babies. Anticipated Activities: • Collaborate with local media outlets, such as newspapers, radio stations, and television channels, to feature stories or public service announcements related to preterm birth reduction. • Organize/Participate in community outreach events such as health fairs, workshops and presentations to disseminate preterm birth reduction materials and engage directly with the target population. **What is your anticipated outcome?** • Increased public awareness and understanding of preterm birth, its risk factors, and prevention strategies through the dissemination of information via local media outlets and community outreach events. • Greater reach and engagement of the target population, including expectant mothers, families, and communities, through multiple channels of communication and in-person interactions.

p 3.1.3	p 3.2.3	p 3.3.3	p 3.4.3
☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**

If you have additional local activities, please add a row.

Section C: Local Activities by Domain

At least one activity must be selected or the LHJ must develop at least one activity of their own in the Child Health Domain

Child Health Domain			
Child Priority Need: Optimize the healthy development of all children so they can flourish and reach their full potential. *Child Focus Area 1: Expand and support developmental screening.*			
(National/State Performance Measures and Evidence-Based Strategy Measure)	**NPM 6:** Percentage of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year. **ESM 6.1**: Percent of children enrolled in CHVP with at least one developmental screen using a validated instrument within AAP-defined age range (10 months, 18 months, or 24 months' time points) during the reporting period.		
Child State Objective 1: By 2025, increase the percentage of children (ages 9 through 35 months) who received a developmental screening from a health care provider using a parent-completed screening tool in the past year from 25.2% (NSCH 2022) to 32.4%. *Please note: We are waiting for the incoming NSCH oversample before updating this target.			
Child State Objective 1: Strategy 1: Partner to build data capacity for public health surveillance and program monitoring and evaluation related to developmental screening in California.	**Child State Objective 1: Strategy 2:** Partner to improve early childhood systems to support early developmental health and family well-being.	**Child State Objective 1: Strategy 3:** Partner to educate and build capacity among providers and families to understand developmental milestones and implement best practices in developmental screening and monitoring within MCAH programs.	**Child State Objective 1: Strategy 4:** Support implementation of Department of Health Care Services (DHCS) policies regarding child health and well-being, including developmental screening.
No Local Activities	**Local Activities for Child Objective 1: Strategy 2**	**Local Activities for Child Objective 1: Strategy 3**	**Local Activities for Child Objective 1: Strategy 4**
	ch 1.2.1 ☐ Partner with local stakeholders and partners, such as the local First 5 program, Help Me Grow system (if available in your jurisdiction), or Home Visiting Community Advisory Board to identify key local resources for developmental screening/linkage.	**ch 1.3.1** ☒ Partner with early childhood and family-serving programs (including CHVP, AFLP, BIH) to assess current policies and practices on developmental screening and monitoring developmental milestones and determine whether additional monitoring or screening should be incorporated into the programs. **Activities:**	**ch 1.4.1** ☐Build capacity by partnering with local Medi-Cal managed care health plans to educate and share information with providers about Medi-Cal developmental screening reimbursement and quality measures.

	What is your anticipated outcome?	• Partner with home visiting community-based organizations (CBO) and Department of Public Health (DPH) Partners serving families and assess current policies and practices on developmental screening and monitoring developmental milestones to be incorporated into programs. • Provide training and education to CBO, DPHN partners and providers in the community. • Initiate implementation plan to increase the percentage of children who receive developmental screenings and referred to appropriate services. **What is your anticipated outcome?** • Assessment report on current developmental screenings policies and practices. • Tracking of training and education provided on developmental screenings. • Increased partner and public awareness on the importance of developmental screenings. • Enhanced skills in assessing for developmental delays, early intervention, and referring appropriately amongst all home visiting programs.	**What is your anticipated outcome?**
	ch 1.2.2	**ch 1.3.2**	**ch 1.4.2**

	☐Lead the development of a community resource map that links referrals to services. **What is your anticipated outcome?**	☐Partner with providers to educate families in MCAH programs about specific milestones and developmental screening needs. **What is your anticipated outcome?**	☐Track County Medi-Cal managed care health plan developmental screening data. **What is your anticipated outcome?**
	ch 1.2.3 ☐ Implement a social media campaign or other outreach to educate families on the importance of well-child and other preventive health visits. **What is your anticipated outcome?**	**ch 1.3.3** ☐Partner with Help Me Grow (HMG) and other key partners to educate providers and families about developmental screening recommendations and tools. **What is your anticipated outcome?**	**ch 1.4.3** ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**
	ch 1.2.4 ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	**ch 1.3.4** ☐Partner with Women Infant Children (WIC) to disseminate developmental milestone information, educational resources, and tools. **What is your anticipated outcome?**	**ch 1.4.4** ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**
	ch 1.2.5	**ch 1.3.5**	**ch 1.4.5**

	☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**

If you have additional local activities, please add a row.

<table>
<tr><th colspan="3">Child Health Domain</th></tr>
<tr><td colspan="3">Child Priority Need: Optimize the healthy development of all children so they can flourish and reach their full potential.
Child Focus Area 2: Raise awareness of adverse childhood experiences and prevent toxic stress through building resilience.</td></tr>
<tr><td>Performance Measures
(National/State Performance Measures and Evidence-Based Strategy Measure)</td><td colspan="2">NPM 6: Percentage of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year.
ESM 6.1: Percent of children enrolled in CHVP with at least one developmental screen using a validated instrument within AAP-defined age range (10 months, 18 months, or 24 months' time points) during the reporting period.</td></tr>
<tr><td colspan="3">Child State Objective 2:
By 2025, increase the percentage of children (ages 0 - 17 years) who live in a home where the family demonstrated qualities of resilience (i.e., met all four resilience items as identified in the NSCH survey) during difficult times from 85.1% (NSCH 2022) to 84.5%.</td></tr>
<tr><td><u>Child State Objective 2: Strategy 1:</u>
Partner with CDPH Essentials for Childhood and other stakeholders to build data capacity to track and understand experiences of adversity and resilience among children and families.</td><td><u>Child State Objective 2: Strategy 2:</u>
Partner to build capacity and expand programs and practices to build family resiliency by optimizing the parent-child relationship, enhancing parenting skills, and addressing child poverty through increasing access to safety net programs within MCAH-funded programs.</td><td><u>Child State Objective 2: Strategy 3:</u>
Support the California Office of the Surgeon General and DHCS' ACEs Aware initiative to build capacity among communities, providers, and families to understand the impact of childhood adversity and the importance of trauma-informed care.</td></tr>
<tr><td>Local Activities for Child Objective 2: Strategy 1</td><td>Local Activities for Child Objective 2: Strategy 2</td><td>Local Activities for Child Objective 2: Strategy 3</td></tr>
<tr><td>ch 2.1.1

☐Identify and examine local county data sources for childhood adversity, childhood poverty, and social determinants of health affecting child health and family resilience.

What is your anticipated outcome?</td><td>ch 2.2.1

☐ Assess current MCAH program practices to promote healthy, safe, stable, and nurturing parent-child relationships within MCAH programs.

What is your anticipated outcome?</td><td>ch 2.3.1
☒ Participate and promote within local county agencies the Surgeon General's ACEs trainings.

Trainers will train home visiting staff.
Train new staff when onboarding to PHN
Will follow up with Network of Care and Maternal Wellness Collision (MWC) or train the trainer course.

Activities:
• Organize a trauma-Informed Care Training for parents and caregivers that utilizes a comprehensive training curriculum that covers the basics of Adverse Childhood Experiences (ACEs), the science of the mind, and the importance of trauma-informed care.
• Provide parents and caregivers educational materials with practical tips and strategies to boost</td></tr>
</table>

		their child's growing brain, recognize signs of stress, and address their child's emotional needs. • Conduct pre- and post-training surveys to assess parents and caregivers knowledge, skills, and confidence in applying trauma-informed care principles and use result on survey to improve future curriculums **What is your anticipated outcome?** • Increased awareness and understanding among parents and caregivers about the impact of Adverse Childhood Experience and the importance of trauma-informed care. • Enhanced knowledge and skills among parents and caregivers to create supportive and loving home environments that promote children's emotional well-being and resilience. • Greater confidence among parents and caregivers in recognizing signs of stress in their children and addressing their emotional needs using trauma-informed approaches. FCDPH MCAH program staff and Home Visitors will increase their knowledge of ACES and impacts on families being served by MCAH programs. Recertify home visiting staff to ACEs.
ch 2.1.2 ☐ Identify opportunities to expand data collection on key child adversity and family resilience measures. **What is your anticipated outcome?**	**ch 2.2.2** ☐ Research and share information on statewide initiatives that address social determinants of health and strengthen economic supports for families. **What is your anticipated outcome?**	**ch 2.3.2** ☐ Share information to support the Surgeon General and DHCS' efforts on trauma screening and training for health care providers. **What is your anticipated outcome?**

ch 2.1.3 ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	**ch 2.2.3** ☐Incorporate policies and practices to strengthen economic supports, including improving access to safety net programs, for families within MCAH programs. **What is your anticipated outcome?**	**ch 2.3.3** ☐ Identify resources and training opportunities locally on ACEs and trauma-informed care for local programs. **What is your anticipated outcome?**

If you have additional local activities, please add a row.

Child Health Domain	
Child Priority Need: Optimize the healthy development of all children so they can flourish and reach their full potential. *Child Focus Area 3: Support and build partnerships to improve the physical health of all children.*	
Performance Measures (National/State Performance Measures and Evidence-Based Strategy Measure)	**NPM 6:** Percentage of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year. **ESM 6.1**: Percent of children enrolled in CHVP with at least one developmental screen using a validated instrument within AAP-defined age range (10 months, 18 months, or 24 months' time points) during the reporting period.
Child State Objective 3: By 2025, increase the percentage of children (ages 1 - 17 years) who had a preventive dental visit in the past year from 81.1% (NSCH 2022) to 82.6%.	
Child State Objective 3: Strategy 1: Support the CDPH Office of Oral Health in their efforts to increase access to regular preventive dental visits for children by sharing information with MCAH programs.	
Local Activities for Child Objective 3: Strategy 1	
ch 3.1.1 ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	

If you have additional local activities, please add a row.

Child Health Domain	
Child Priority Need: Optimize the healthy development of all children so they can flourish and reach their full potential. *Child Focus Area 3: Support and build partnerships to improve the physical health of all children.*	
Performance Measures (National/State Performance Measures and Evidence-Based Strategy Measure)	**NPM 6:** Percentage of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year. **ESM 6.1**: Percent of children enrolled in CHVP with at least one developmental screen using a validated instrument within AAP-defined age range (10 months, 18 months, or 24 months' time points) during the reporting period.
Child State Objective 4: By 2025, decrease the percentage of fifth grade students who are overweight or obese from 41.3% (2019) to 39.3%.	
Child State Objective 4: Strategy 1: Partner to enable the reporting of data on childhood overweight and obesity in California.	**Child State Objective 4: Strategy 2:** Partner with WIC and others to provide technical assistance to local MCAH programs to support healthy eating and physically active lifestyles for families.
Local Activities for Child Objective 4: Strategy 1	**Local Activities for Child Objective 4: Strategy 2**
ch 4.1.1 ☐ Contingent upon CDPH/MCAH procuring sub-State-level data on child overweight and obesity, utilize guidance to inform local-level prevention initiatives. **What is your anticipated outcome?**	**ch 4.2.1** ☐ Partner with local WIC, local Center for Healthy Communities Programs and Initiatives, local Education initiatives, and local CDPH/MCAH programs and initiatives, stakeholders, and partners to identify resources and best practices and tools on healthy eating and share with families in MCAH programs. **What is your anticipated outcome?**
ch 4.1.2 ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	**ch 4.2.2** ☐Partner with Women Infant Children (WIC), and other local programs to refer and link eligible families to WIC and other healthy food resources. **What is your anticipated outcome?**

ch 4.1.3 ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	**ch 4.2.3** ☐Partner with CDPH/MCAH to utilize the Policies, Systems, and Environmental Change Toolkit to improve physical activity, nutrition, and breastfeeding within the local health jurisdiction. **What is your anticipated outcome?**
ch 4.1.4 ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	**ch 4.2.4** ☐ Share the child MyPlates and related messaging with families and providers to promote healthy eating in children. **What is your anticipated outcome?**
ch 4.1.5 ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	**ch 4.2.5** ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**

If you have additional local activities, please add a row.

Child Health Domain
Child Priority Need: Optimize the healthy development of all children so they can flourish and reach their full potential. *Child Focus Area 3: Support and build partnerships to improve the physical health of all children.*

Performance Measures (National/State Performance Measures and Evidence-Based Strategy Measure)	**NPM 17:** Medical home. **ESM 17.1**: Percent of children enrolled in home visiting who received the last recommended visit based on the American Academy of Pediatrics (AAP) schedule.
Child State Objective 5: By 2025, increase the percentage of children (ages 1 – 17 years) who had a preventive medical visit in the past year from 70.0% (NSCH 2022) to TBD%	
Child State Objective 5: Strategy 1: Support local MCAH programs in ensuring children and their families have access to preventive and primary medical care.	**Child State Objective 5: Strategy 2:** Partner to build data capacity and program monitoring and evaluation to evaluate availability and access of regular, routine medical care for children and families in California.
Local Activities for Child Objective 4: Strategy 1	**Local Activities for Child Objective 4: Strategy 2**
ch 5.1.1 ☐ Link and refer families in MCAH programs to safety net and public health care programs such as Family Planning, Access, Care, and Treatment (PACT), Medi-Cal, and Denti-Cal. **What is your anticipated outcome?**	No Local Activities
ch 5.1.2 ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	

Section C: Local Activities by Domain

At least one activity must be selected or the LHJ must develop at least one activity of their own in the CYSHCN Health Domain

Children and Youth with Special Health Care Needs (CYSHCN) Domain		
CYSHCN Priority Need 1: Make systems of care easier to navigate for CYSHCN and their families. *CYSHCN Focus Area 1: Build capacity at the state and local levels to improve systems that serve CYSHCN and their families.*		
Performance Measures (National/State Performance Measures and Evidence-Based Strategy Measure)	**NPM 12:** Percent of adolescents with and without special health care needs who receive services necessary to make transitions to adult health care. **ESM 12.1:** Number of Local MCAH programs that implement a Scope of Work objective focused on CYSHCN public health systems.	
CYSHCN State Objective 1: By 2025, maintain the number of Local MCAH programs (44) that chose to implement a Scope of Work objective focused on CYSHCN public health systems and services.		
CYSHCN State Objective 1: Strategy 1: Lead state and local MCAH capacity-building efforts to improve and expand public health systems and services for CYSHCN.	**CYSHCN State Objective 1: Strategy 2:** Lead program outreach and assessment within State MCAH to ensure best practices for serving CYSHCN are integrated into all MCAH programs.	**CYSHCN State Objective 1: Strategy 3:** Partner to build data capacity to understand needs and health disparities in the CYSHCN population.
Local Activities for CYSHCN Objective 1: Strategy 1	**Local Activities for CYSHCN Objective 1: Strategy 2**	**No Local Activities**
cy 1.1.1 ☐ Conduct an environmental scan focused on CYSHCN and their families, which could include strengths, opportunities, needs, gaps, and resources available in your county or region. **What is your anticipated outcome?**	**cy 1.2.1** ☐ Create or update a resource guide or diagram to help families, providers, and organizations understand the landscape of available local resources for CYSHCN. **What is your anticipated outcome?**	
cy 1.1.2	**cy 1.2.2** ☐Other local activity (Please Specify/Optional):	

☐Improve coordination of emergency preparedness and disaster relief support for CYSHCN and their families. **What is your anticipated outcome?**	**What is your anticipated outcome?** Increased number of children in MCAH FCDPH children's home visitation programs who are enrolled in CCS will receive a joint consultation with CCS staff and MCAH PHN case manager.	
cy 1.1.3 ☐Conduct a local data/evaluation project focused on CYSHCN. **What is your anticipated outcome?**	**cy 1.2.3** ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	
cy 1.1.4 ☐Create or join a public health taskforce focused on the needs of CYSHCN in your county or region. **What is your anticipated outcome?**	**cy 1.2.4** ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	
cy 1.1.5 ☒Partner with your county CCS program to improve connections and referrals between CCS and Local MCAH. **Activities:**	**cy 1.2.5** ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	

• Collaboration between Fresno County MCAH and CCS on mutual clients including data sharing, plan of care, and case management. • Increase staff resources dedicated to partnership and referral process. **What is your anticipated outcome?** • Improved quality of data and, case management services, and care coordination between local MCAH and CCS. • Improved navigation and access to systems of care for CYSHCN and their families.		

If you have additional local activities, please add a row.

Children and Youth with Special Health Care Needs (CYSHCN) Domain		
CYSHCN Priority Need 1: Make systems of care easier to navigate for CYSHCN and their families. CYSHCN Focus Area 2: Increase access to coordinated primary and specialty care for CYSHCN.		
Performance Measures (National/State Performance Measures and Evidence-Based Strategy Measure)	**NPM 12:** Percent of adolescents with and without special health care needs who receive services necessary to make transitions to adult health care **ESM 12.1:** Number of Local MCAH programs that implement a Scope of Work objective focused on CYSHCN public health systems	
CYSHCN State Objective 2: By 2025, increase the percent of adolescents with special health care needs (ages 12 – 17) who received services necessary to make transitions to adult health care from 18.4% to 20.2%. (NSCH 2016-20)		
CYSHCN State Objective 2: Strategy 1: Partner on identifying and incorporating best practices to ensure that CYSHCN and their families receive support for a successful transition to adult health care.	**CYSHCN State Objective 2: Strategy 2:** Fund DHCS/ISCD to assist CCS counties in providing necessary care coordination and case management to CCS clients to facilitate timely and effective access to care and appropriate community resources.	**CYSHCN State Objective 2: Strategy 3:** Fund DHCS/ISCD to increase timely access to qualified providers for CCS clients to facilitate coordinated care.
Local Activities for CYSHCN Objective 2: Strategy 1	**No Local Activities**	**No Local Activities**
cy 2.1.1 ☐Conduct an environmental scan in your county and/or region to understand needs, strengths, barriers, and opportunities in the transition to adult health care, supports, and services for youth with special health care needs. **What is your anticipated outcome?**		
cy 2.1.2 ☐Develop a communication and/or outreach campaign focused on transition from pediatric care to adult health care, including supports and services for youth with special health care needs. **What is your anticipated outcome?**		

cy 2.1.3 ☐Create/join a local learning collaborative or workgroup focused on the transition to adult health care and supports and services for youth with special health care needs. **What is your anticipated outcome?**		
cy 2.1.4 ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**		

If you have additional local activities, please add a row.

Children and Youth with Special Health Care Needs (CYSHCN) Domain		
CYSHCN Priority Need 2: Increase engagement and build resilience among CYSHCN and their families. *CYSHCN Focus Area 3: Empower and support CYSHCN, families, and family-serving organizations to participate in health program planning and implementation.*		
Performance Measures (National/State Performance Measures and Evidence-Based Strategy Measure)	**NPM 12:** Percent of adolescents with and without special health care needs who receive services necessary to make transitions to adult health care. **ESM 12.1:** Number of Local MCAH programs that implement a Scope of Work objective focused on CYSHCN public health systems.	
CYSHCN State Objective 3: By 2025, maintain the number of local MCAH programs (17) that chose to implement a Scope of Work objective focused on family engagement, social/community inclusion, and/or family strengthening for CYSHCN.		
CYSHCN State Objective 3: Strategy 1: Partner to train and engage CYSHCN and families to improve CYSHCN-serving systems through input and involvement in state and local MCAH program design, implementation, and evaluation.	**CYSHCN State Objective 3: Strategy 2:** Fund DHCS/ISCD to support continued family engagement in CCS program improvement, including the Whole Child Model, to assist families of CYSHCN in navigating services.	**CYSHCN State Objective 3: Strategy 3:** Support statewide and local efforts to increase resilience among CYSHCN and their families.
Local Activities for CYSHCN Objective 3: Strategy 1	**No Local Activities**	**Local Activities for CYSHCN Objective 3: Strategy 3**
cy 3.1.1 ☐ Collaborate with a local Family Resource Center or other CYSHCN-serving community organization to develop a training for LHJ staff on best practices for working with families of CYSHCN. **What is your anticipated outcome?**		**cy 3.3.1** ☐ Implement a project focused on mental health for parents/caregivers of CYSHCN (examples: connecting families in the NICU to home visiting or other Local MCAH programs, provider outreach to integrate maternal mental health screening into NICU follow-up visits or other pediatric specialty visits). **What is your anticipated outcome?**

cy 3.1.2 ☐ Provide training to a local Family Resource Center or other CYSHCN-serving community organization on how to access Local MCAH programs and resources. **What is your anticipated outcome?**		**cy 3.3.2** ☐ Implement a project focused on social and community inclusion for CYSHCN and their families (examples: creating a youth with special health care needs advisory group to improve community inclusion, partner with Parks and Rec or other non-traditional partners to make public spaces and events more inclusive). **What is your anticipated outcome?**
cy 3.1.3 ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**		**cy 3.3.3** ☐ Partner with child welfare to address health needs (including mental health) of children and youth in foster care. **What is your anticipated outcome?**
cy 3.1.4 ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**		**cy 3.3.4** ☐ Integrate trauma-informed and resilience-building practices specific to CYSHCN and their families into local MCAH programs. **What is your anticipated outcome?**

cy 3.1.5 ☐Other (Please Specify/Optional): **What is your anticipated outcome?**		**cy 3.3.5** ☐Other (Please Specify/Optional): **What is your anticipated outcome?**

If you have additional local activities, please add a row.

Section C: Local Activities by Domain

At least one activity must be selected or the LHJ must develop at least one activity of their own in the Adolescent Health Domain

Adolescent Domain		
Adolescent Priority Need 1: Enhance strengths, skills and supports to promote positive development and ensure youth are healthy and thrive. *Adolescent Focus Area 1: Improve sexual and reproductive health and well-being for all adolescents in California.*		
Performance Measures (National/State Performance Measures and Evidence-Based Strategy Measure)	**NPM 10:** Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year. **ESM 10.1:** Percent of AFLP participants who received a referral for preventive services.	
Adolescent State Objective 1: By 2025, increase the proportion of sexually active adolescents who use condoms and/or hormonal or intrauterine contraception to prevent pregnancy and provide barrier protection against sexually transmitted diseases as measured by: • percent of sexually active adolescents who used a condom at last sexual intercourse from 55% to 58% • percent of sexually active adolescents who used the most effective or moderately effective methods of FDA-approved contraception from 23% to 25%.		
Adolescent State Objective 1: Strategy 1: Lead surveillance and program monitoring and evaluation related to adolescent sexual and reproductive health.	**Adolescent State Objective 1: Strategy 2:** Lead to strengthen knowledge and skills to increase use of protective sexual health practices within CDPH/MCAH-funded programs.	**Adolescent State Objective 1: Strategy 3:** Partner across state and local health and education systems to implement effective comprehensive sexual health education in California.
Local Activities for Adolescent Objective 1: Strategy 1	**Local Activities for Adolescent Objective 1: Strategy 2**	**Local Activities for Adolescent Objective 1: Strategy 3**
a 1.1.1 ☐Utilize California Adolescent Sexual Health Needs Index (CASHNI) to target adolescent sexual health programs and efforts to youth facing the greatest inequities in health and social outcomes. **What is your anticipated outcome?**	**a 1.2.1** ☐For non-AFLP funded county agencies, partner with local AFLP agencies and/or other community partners to promote healthy sexual behaviors and healthy relationships among expectant and parenting youth. **What is your anticipated outcome?**	**a 1.3.1** ☐ For non- ASH Ed funded county agencies, partner with local ASH Ed funded agencies and/or other community partners to ensure local implementation of sexual health education that is aligned with the California Healthy Youth Act (CHYA) to young people facing the greatest inequities in health and social outcomes. **What is your anticipated outcome?**

a 1.1.2 ☐Utilize and disseminate California's Adolescent Birth Rate (ABR) data report to the public and local partners. **What is your anticipated outcome?**	**a 1.2.2** ☒ Build capacity of local MCAH workforce to promote protective adolescent sexual health practices by disseminating information, resources, and training opportunities. Activities: • Collaborate with Local Health Department STD program on education, outreach, and targets projects such as increased access to contraception (vending machine project). • Public health nursing, health education, and Comprehensive Perinatal Service Program staff to attend adolescent and sexual health training. **What is your anticipated outcome?** • Trained MCAH Work force in protective adolescent and sexual health practices. • Increased understanding of protective sexual and reproductive health for adolescents • Utilization of appropriate teaching materials that promote protective sexual and reproductive health in the community. • Increased public awareness and access to contraception.	**a 1.3.2** ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**

a 1.1.3 ☐Other (Please Specify/Optional): **What is your anticipated outcome?**	**a 1.2.3** ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	**a 1.3.3** ☐Other (Please Specify/Optional): **What is your anticipated outcome?**

If you have additional local activities, please add a row.

Adolescent Domain	
Adolescent Priority Need: Enhance strengths, skills and supports to promote positive development and ensure youth are healthy and thrive. *Adolescent Focus Area 2: Improve awareness of and access to youth-friendly services for all adolescents in California.*	
Performance Measures (National/State Performance Measures and Evidence-Based Strategy Measure)	**NPM 10:** Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year. **ESM 10.1:** Percent of AFLP participants who received a referral for preventive services.
Adolescent State Objective 2: By 2025, increase the percent of adolescents 12 -17 with a preventive medical visit in the past year from 59.8% (NSCH 2020-2021) to 83.8%.	
Adolescent State Objective 2: Strategy 1: Lead to develop and implement best practices in CDPH/MCAH funded programs to support youth with accessing youth-friendly preventative care, sexual and reproductive health care, and mental health care.	**Adolescent State Objective 2: Strategy 2:** Partner to increase the quality of preventive care for adolescents in California.
Local Activities for Adolescent Objective 2: Strategy 1	**Local Activities for Adolescent Objective 2: Strategy 2**
a 2.1.1 ☐Implement evidence-based screening tools or evidence-informed assessments to connect adolescents in Local MCAH programs to needed services. **What is your anticipated outcome?**	**a 2.2.1** ☐ Partner with CDPH/MCAH to disseminate tools and resources to improve the quality and accessibility of adolescent health care in their communities. **What is your anticipated outcome?**
a 2.1.2 ☐Lead the development of a community resources map that links referrals to services for young people. **What is your anticipated outcome?**	**a 2.2.2** ☐Other (Please Specify/Optional): **What is your anticipated outcome?**
a 2.1.3	**a 2.2.3**

☐Partner to disseminate adolescent preventive care recommendations to improve the quality of adolescent health services. **What is your anticipated outcome?**	☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**
a 2.1.4 ☐Implement referrals to youth-friendly preventive care, mental health care, and sexual and reproductive health care, including the California's Family Planning, Access, Care and Treatment program. **What is your anticipated outcome?**	**a 2.2.4** ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**

If you have additional local activities, please add a row.

Adolescent Domain		
Priority Need: Enhance strengths, skills and supports to promote positive development and ensure youth are healthy and thrive. *Adolescent Focus Area 3: Improve social, emotional, and mental health and build resilience among all adolescents in California.*		
Performance Measures (National/State Performance Measures and Evidence-Based Strategy Measure)	**NPM 10:** Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year. **ESM 10.1:** Percent of AFLP participants who received a referral for preventive services.	
Adolescent State Objective 3: By 2025, increase the percent of adolescents aged 12-17 who have an adult in their lives with whom they can talk to about serious problems from 76.7% (NSDUH 2018-2019) to 79.7%.		
Adolescent State Objective 3: Strategy 1: Lead to strengthen resilience among expectant and parenting adolescents to improve health, social, and educational outcomes.	**Adolescent State Objective 3: Strategy 2:** Partner to identify opportunities to build protective factors for adolescents at the individual, community, and systems levels.	**Adolescent State Objective 3: Strategy 3:** Partner to strengthen knowledge and skills among providers, individuals, and families to identify signs of distress and mental health related needs among adolescents.
Local Activities for Adolescent Objective 3: Strategy 1	**Local Activities for Adolescent Objective 3: Strategy 2**	**Local Activities for Adolescent Objective 3: Strategy 3**
a 3.1.1 ☐Partner with CDPH/MCAH to utilize evidence-based tools and resources, such as the Positive Youth Development (PYD) Model, to build youth resiliency to improve health, social, and educational outcomes among expectant and parenting youth. **What is your anticipated outcome?**	**a 3.2.1** ☐ Conduct a Positive Youth Development (PYD) Organizational Assessment to build agency capacity to engage and promote youth leadership and youth development. **What is your anticipated outcome?**	**a 3.3.1** ☐Identify local needs and assets relating to adolescent mental health. **What is your anticipated outcome?**

a 3.1.2 ☐Lead or participate on an Adolescent Family Life Program's (AFLP) Local Stakeholder Coalition (if AFLP exists in the county). **What is your anticipated outcome?**	**a 3.2.2** ☐Establish or join a local youth advisory board to incorporate youth voice and feedback into local MCAH health programs and initiatives. **What is your anticipated outcome?**	**a 3.3.2** ☐Partner with or join local adolescent health coalitions and co-develop a plan to improve adolescent mental health and well-being. **What is your anticipated outcome?**
a 3.1.3 ☐Other local activity (Please Specify/Optional): **What is your anticipated outcome?**	**a 3.2.3** ☐Partner with local community agencies to understand and promote efforts to improve youth engagement and leadership opportunities. **What is your anticipated outcome?**	**a 3.3.3** ☐ Partner to disseminate training opportunities and resources related to adolescent mental health and well-being. **What is your anticipated outcome?**
a 3.1.4 ☐Other (Please Specify/Optional): **What is your anticipated outcome?**	**a 3.2.4** ☐Other (Please Specify/Optional): **What is your anticipated outcome?**	**a 3.3.4** ☐Other (Please Specify/Optional): **What is your anticipated outcome?**

If you have additional local activities, please add a row.

California Department of Public Health | Maternal, Child and Adolescent Health Division

BUDGET SUMMARY

FISCAL YEAR	BUDGET	BUDGET STATUS	BUDGET BALANCE
2024-25	ORIGINAL	ACTIVE	0.00

Version 7.0 - 150 Quarterly 4.20.20

Program:	Black Infant Health (BIH)
Agency:	202410 Fresno
SubK:	

		UNMATCHED FUNDING					NON-ENHANCED MATCHING (50/50)				ENHANCED MATCHING (75/25)			
		BIH-TV		BIH-SGF		AGENCY FUNDS	BIH-SGF-NE		BIH-Cnty NE		BIH-SGF-E		BIH-Cnty E	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)
	TOTAL FUNDING	%	BIH-TV	%	BIH-SGF	%	Agency Funds*	%	Combined Fed/State	%	Combined Fed/Agency*	%	Combined Fed/State	%	Combined Fed/Agency*
ALLOCATION(S) →			150,627.00		753,373.00										#VALUE!
EXPENSE CATEGORY															
(I) PERSONNEL	1,080,533.62		84,633.41		171,885.63		170,930.93		576,868.10		0.00		76,215.55		0.00
(II) OPERATING EXPENSES	60,813.53		0.00		60,813.53		0.00		0.00		0.00		0.00		0.00
(III) CAPITAL EXPENDITURES	0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00
(IV) OTHER COSTS	68,000.00		0.00		68,000.00		0.00		0.00		0.00		0.00		0.00
(V) INDIRECT COSTS	263,974.36		65,993.59		92,391.03		0.00		105,589.75		0.00		0.00		0.00
BUDGET TOTALS*	1,473,321.51	10.22%	150,627.00	26.66%	393,090.19	11.60%	170,930.93	46.32%	682,457.85	0.00%	0.00	5.17%	76,215.55	0.00%	0.00
BALANCE(S) →			0.00		0.00										

TOTAL BIH-TV	150,627.00 →	150,627.00								
TOTAL BIH-SGF	753,373.00 →		393,090.19		[50%] 341,228.92		[25%] 19,053.89			
TOTAL TITLE XIX	398,390.59 →				[50%] 341,228.93	[50%] 0.00	[75%] 57,161.66	[75%] 0.00		
TOTAL AGENCY FUNDS	170,930.93 →			170,930.93		[50%] 0.00		[25%] 0.00		

$ 1,302,390.59 — **Maximum Amount Payable from State and Federal resources**

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

MCAH PROJECT DIRECTOR'S SIGNATURE — DATE: 9/24/24

AGENCY FISCAL AGENT'S SIGNATURE — DATE: 9/24/24

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

STATE USE ONLY - TOTAL STATE AND FEDERAL REIMBURSEMENT		BIH-TV		BIH-SGF		AGENCY FUNDS		BIH-SGF-NE		BIH-Cnty NE		BIH-SGF-E		BIH-Cnty E
PCA Codes		53113		53127				53124		53100		53125		53102
(I) PERSONNEL		84,633.41		171,885.63				576,868.10		0.00		76,215.55		0.00
(II) OPERATING EXPENSES		0.00		60,813.53				0.00		0.00		0.00		0.00
(III) CAPITAL EXPENSES		0.00		0.00				0.00		0.00		0.00		0.00
(IV) OTHER COSTS		0.00		68,000.00				0.00		0.00		0.00		0.00
(V) INDIRECT COSTS		65,993.59		92,391.03				105,589.75		0.00		0.00		0.00
Totals for PCA Codes	1,302,390.59	150,627.00		393,090.19				682,457.85		0.00		76,215.55		0.00

Program:	Black Infant Health (BIH)
Agency:	202410 Fresno
SubK:	

			UNMATCHED FUNDING						NON-ENHANCED MATCHING (50/50)				ENHANCED MATCHING (75/25)			
			BIH-TV		BIH-SGF		AGENCY FUNDS		BIH-SGF-NE		BIH-Cnty NE		BIH-SGF-E		BIH-Cnty E	
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)
		TOTAL FUNDING	%	BIH-TV	%	BIH-SGF	%	Agency Funds*	%	Combined Fed/State	%	Combined Fed/Agency*	%	Combined Fed/State	%	Combined Fed/Agency*
(II) OPERATING EXPENSES DETAIL											% TRAVEL NON-ENH MATCH				% TRAVEL ENH MATCH		% PERSONNEL MATCH
	TOTAL OPERATING EXPENSES	**60,813.53**		**0.00**		**60,813.53**		**0.00**		**0.00**		**0.00**		**0.00**		**0.00**	**60.24%**
	TRAVEL	11,500.00	0.00%	0.00	100.00%	11,500.00		0.00		0.00		0.00		0.00		0.00	60.23%
	TRAINING	17,500.00	0.00%	0.00	100.00%	17,500.00		0.00		0.00		0.00		0.00		0.00	60.24%
1	Office Supplies	5,000.00	0.00%	0.00	100.00%	5,000.00		0.00		0.00		0.00					60.24%
2	Postage	56.53	0.00%	0.00	100.00%	56.53		0.00		0.00		0.00					60.24%
3	Duplication	757.00	0.00%	0.00	100.00%	757.00		0.00		0.00		0.00					60.24%
4	Communications	10,000.00	0.00%	0.00	100.00%	10,000.00		0.00		0.00		0.00					60.24%
5	Minor Equipment	5,500.00	0.00%	0.00	100.00%	5,500.00		0.00		0.00		0.00					60.24%
6	Public Awareness Campaigns	10,500.00	0.00%	0.00	100.00%	10,500.00		0.00		0.00		0.00					60.24%
7				0.00		0.00		0.00		0.00		0.00					
8				0.00		0.00		0.00		0.00		0.00					
9				0.00		0.00		0.00		0.00		0.00					
10				0.00		0.00		0.00		0.00		0.00					
11				0.00		0.00		0.00		0.00		0.00					
12				0.00		0.00		0.00		0.00		0.00					
13				0.00		0.00		0.00		0.00		0.00					
14				0.00		0.00		0.00		0.00		0.00					
15				0.00		0.00		0.00		0.00		0.00					

** 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														
TOTAL CAPITAL EXPENDITURES			**0.00**		**0.00**		**0.00**		**0.00**		**0.00**			

(IV) OTHER COSTS DETAIL															% PERSONNEL MATCH
TOTAL OTHER COSTS	**68,000.00**		**0.00**		**68,000.00**		**0.00**		**0.00**		**0.00**		**0.00**		**0.00**	**60.24%**
SUBCONTRACTS																
1 TBD (Child Watch)	10,000.00	0.00%	0.00	100.00%	10,000.00		0.00		0.00		0.00		0.00		0.00	
2			0.00	100.00%	0.00		0.00		0.00		0.00		0.00		0.00	
3			0.00		0.00		0.00		0.00		0.00		0.00		0.00	
4			0.00		0.00		0.00		0.00		0.00		0.00		0.00	
5			0.00		0.00		0.00		0.00		0.00		0.00		0.00	
OTHER CHARGES																Match Available
1 Client Support Materials	42,000.00	0.00%	0.00	100.00%	42,000.00		0.00		0.00		0.00					60.24%
2 Participant Transportation	8,500.00	0.00%	0.00	100.00%	8,500.00		0.00		0.00		0.00					60.24%
3 Client Refreshments	7,500.00	0.00%	0.00	100.00%	7,500.00		0.00		0.00		0.00					60.24%
4			0.00		0.00		0.00		0.00		0.00					
5			0.00		0.00		0.00		0.00		0.00					
6			0.00		0.00		0.00		0.00		0.00					
7			0.00		0.00		0.00		0.00		0.00					
8			0.00		0.00		0.00		0.00		0.00					

(V) INDIRECT COSTS DETAIL													
TOTAL INDIRECT COSTS		**263,974.36**		**65,993.59**		**92,391.03**		**0.00**		**105,589.75**		**0.00**		
24.43%	of Total Wages + Fringe Benefits	263,974.36	25.00%	65,993.59	35.00%	92,391.03		0.00	40.00%	105,589.75		0.00		

Program:	Black Infant Health (BIH)
Agency:	202410 Fresno
SubK:	

		UNMATCHED FUNDING						NON-ENHANCED MATCHING (50/50)				ENHANCED MATCHING (75/25)			
		BIH-TV		BIH-SGF		AGENCY FUNDS		BIH-SGF-NE		BIH-Cnty NE		BIH-SGF-E		BIH-Cnty E	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)
	TOTAL FUNDING	%	BIH-TV	%	BIH-SGF	%	Agency Funds*	%	Combined Fed/State	%	Combined Fed/Agency*	%	Combined Fed/State	%	Combined Fed/Agency*
(I) PERSONNEL DETAIL															
TOTAL PERSONNEL COSTS	1,080,533.62		84,633.41		171,885.63		170,930.93		576,868.10		0.00		76,215.55		0.00
FRINGE BENEFIT RATE 84.05%	493,446.62		38,649.49		78,494.91		78,058.92		263,438.00		0.00		34,805.31		0.00
TOTAL WAGES	587,087.00		45,983.92		93,390.73		92,872.01		313,430.10		0.00		41,410.24		0.00

	FULL NAME (First Name Last Name)	TITLE OR CLASSIFICATION (No Acronyms)	% FTE	ANNUAL SALARY	TOTAL WAGES												J-Pers MCF Per Staff	Staff Traveling (X)
1	Janel Claybon	Public Health Nurse II	100.00%	129,407.00	129,407.00	3.02%	3,912.92	16.26%	21,041.73	18.72%	24,220.01	30.00%	38,822.10		0.00	32.00%	41,410.24		0.00	79.50%	X
2	Sabrina Beavers	BIH Coordinator - Health Educator	100.00%	73,940.00	73,940.00	5.00%	3,697.00	20.00%	14,788.00	15.00%	11,091.00	60.00%	44,364.00		0.00		0.00		0.00	79.50%	X
3	Denise Simon	Family Health Advocate Group Facilitato	100.00%	66,752.00	66,752.00	10.00%	6,675.20	15.00%	10,012.80	15.00%	10,012.80	60.00%	40,051.20		0.00		0.00		0.00	79.50%	X
4	Cherika Gamble	Family Health Advocate Community Out	100.00%	55,093.00	55,093.00	10.00%	5,509.30	15.00%	8,263.95	15.00%	8,263.95	60.00%	33,055.80		0.00		0.00		0.00	79.50%	X
5	Arturo Perez	Community Outreach Liaison - Health E	100.00%	64,627.00	64,627.00	10.00%	6,462.70	15.00%	9,694.05	15.00%	9,694.05	60.00%	38,776.20		0.00		0.00		0.00	79.50%	X
6	Kimberly Murphy	Family Health Advocate Group Facilitato	100.00%	54,359.00	54,359.00	10.00%	5,435.90	15.00%	8,153.85	15.00%	8,153.85	60.00%	32,615.40		0.00		0.00		0.00	79.50%	X
7	Martha Garcia	Data Entry - Office Assistant III	100.00%	52,423.00	52,423.00	10.00%	5,242.30	15.00%	7,863.45	15.00%	7,863.45	60.00%	31,453.80		0.00		0.00		0.00	79.50%	X
8	Sheryl Brown-Bowden	Mental Health Professional - Medical So	100.00%	78,898.00	78,898.00	10.00%	7,889.80	15.00%	11,834.70	15.00%	11,834.70	60.00%	47,338.80		0.00		0.00		0.00	79.50%	X
9	Madeleine Yakoub	Program Tech II	25.00%	46,350.00	11,588.00	10.00%	1,158.80	15.00%	1,738.20	15.00%	1,738.20	60.00%	6,952.80		0.00		0.00		0.00	79.50%	X
10					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
11					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
12					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
13					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
14					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
15					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
16					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
17					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
18					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
19					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
20					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
21					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
22					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
23					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
24					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
25					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
26					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
27					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
28					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
29					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
30					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
31					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
32					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
33					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
34					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
35					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
36					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
37					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
38					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
39					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
40					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
41					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
42					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
43					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
44					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
45					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
46					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
47					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
48					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
49					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
50					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
51					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
52					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
53					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
54					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
55					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
56					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
57					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	

Exhibit A
Scope of Work

1. Black Infant Health Program Service Overview

The Contractor agrees to provide to the California Department of Public Health (CDPH) the services described herein.

The BIH Program is a specialized CDPH MCAH program under the local MCAH system and helps to address MCAH SOW - Women/Maternal Domain: Focus Areas 1-5: Ensure women in California are healthy before, during and after pregnancy. Perinatal/Infant Domain: Ensure all infants are born healthy and thrive in their first year of life. Focus Area 2: Reduce infant mortality with a focus on reducing disparities. The goals in this SOW incorporate local problems identified by the Local Health Jurisdiction's (Agency's') 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 MCAH Fiscal Policy and Procedures Manual https://www.cdph.ca.gov/Programs/CFH/DMCAH/Pages/Fiscal-Documents.aspx in their entirety. In addition, all BIH Sites shall work towards maintaining group model fidelity by adhering to the policies and procedures, delivering services as intended, implementing strategies to maximize participant retention, fulfilling all deliverables, attending required meetings and trainings, and completing other MCAH-BIH reports as required.

Certification by MCAH Director:	Name: Ge Vue, RN, PHN Title: MCAH Director Date: 7/1/2024 *I certify that I have reviewed and approved this Scope of Work*

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

1. Improve infant and maternal health of Black Women and/or Birthing People by promoting health knowledge and healthy behaviors
2. Increase the ability of Black Women and/or Birthing People to develop effective stress reduction strategies
3. Increase awareness of the Black-White health disparities and social inequities for Black Women and/or Birthing People and infants
4. Empower Black Women and/or Birthing People and build resiliency
5. Promote social support and healthy relationships
6. Connect Black Women and/or Birthing People with services
7. Engage the community to support Black Birthing families' health and well-being with education and outreach efforts

Exhibit A
Scope of Work

2. Service Location (s)

The services shall be performed at [Enter Contractor address or description of the service area]. West Fresno Regional Center (142 E. California Ave, Fresno, CA 93706)

3. Service Hours

The services shall be provided during normal Contractor working hours, Monday through Friday, and evenings or weekends as needed to meet the needs of participants except for official holidays.

4. Services to be Performed

The Contractor agrees to provide the services presented in this Scope of Work (SOW) from the California Department of Public Health, Maternal, Child and Adolescent Health Division (CDPH/MCAH) for implementation of the BIH Program. The funded Contractor is referred to as "Agency" in this SOW.

To achieve its goals, the BIH Program is a client-centered, strength-based group intervention with complementary 1:1 support that embraces the life course perspective and promotes social support, empowerment, skill building, stress reduction and goal setting. Each BIH Site shall also make all efforts to implement the program with fidelity, collect, and enter participant and program data into the electronic Efforts to Outcomes (ETO) data system and engage community partner agencies.

Black Infant Health Program 2023 Model Components

The Black Infant Health (BIH) Program will provide services in designated sub-county service areas throughout the 14 counties with the greatest number of Black women and/or birthing people in California. A **service area** is defined as a contiguous geographical area with a minimum of 440 eligible Black women and/or birthing people. MCAH will fund up to 26 service areas. Each service area will be required to provide a minimum of 9 in-person prenatal group series and 4 in-person postpartum group series per fiscal year. No virtual groups should be conducted without utilizing the virtual guidance in the policies and procedures. Agencies may also serve participants through 1:1 support. Each service area is required to provide services to a minimum of 160 participants, with a maximum of 35% in 1:1 support.

Model Components

- **Minimum Required Groups per Fiscal Year** (nine prenatal and four postpartum per service area)
- **Minimum Participant Reach** (160 participants served; 72 prenatal, 32 postpartum, and 56 1:1 support per service area)
- **Minimum Population Size** (440 Black women and/or birthing persons per service area)

All BIH Sites are required to comply with the following staffing matrix per service area according to the BIH 2023 Request For Supplemental Information (RSI) BIH RSI Instructions to ensure fidelity and standardization across all sites:

Staffing Requirements	
BIH Coordinator/Program Manager	1.0 FTE
FHA/Group Facilitator	3.0 FTE
Mental Health Professional	1.0 FTE
Outreach Liaison	1.0 FTE
Data Entry	1.0 FTE
Public Health Nurse	1.0 FTE
Child Watch	1.0 FTE

Per the BIH P&P, the following criteria applies to participants enrolled in the 1:1 support intervention:

Eligibility:

- African-American
- 16 years of age or older
- Pregnant through 6 months postpartum

Services:

- For those 18 years of age and older, they are offered BIH Group model services before consenting to the BIH 1:1 support Intervention.
- Has been provided with her rights and responsibilities for program participation, completed Assessment 1 or postpartum entry assessment, documentation of a case management interaction/1:1 support intervention, received 1 referral for services.
- May receive services until infant is 1 year of age.

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 Agency to meet the goals and objectives of this SOW. Agencies that enter into agreement with the Division to provide MCAH-related services, and accept the Division funding, are legally required to provide the full level of services, outlined in the program SOW, regardless of the proportion of funding provided by the Division. The Agency shall strive to develop systems that protect and improve the health of California's women of reproductive age, infants, children, adolescents, and their families. All sites should have policies that facilitate the promotion of health equity.

It is the responsibility of an Agency 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 Policies and Procedures (P&P) and the implementation measures for accountability*, and if the compliance standards are not met in a timely manner, the Agency may be placed on a Performance Improvement Plan (PIP). After implementation of the PIP, if the Agency does not demonstrate substantial growth, or fails to successfully meet the goals and objectives of this SOW, MCAH may temporarily withhold cash payment pending correction of the deficiency; disallowing all or part of the cost of the activity or action out of compliance; wholly or partly suspending or terminating the award; or withholding further awards." Continued participation in the BIH program beyond the current fiscal year is also subject to successful performance in meeting participant reach requirements and implementing the agreed upon activities.

*BIH Implementation Accountability Measures:

- Minimum staffing pattern is not adhered to
- Number of prenatal groups started is less than the required number in a four-month interval
- Number of prenatal group series started with less than 8-12 participants
- Average number of days to enter data (all forms) is greater than 10-12 business days or 90% percent of all forms are not entered on time
- LHJs that fall below the 80% number served by the end of a fiscal year

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

- The Ten Essential Services of Public Health and Toolkit
- The Spectrum of Prevention
- Life Course Perspective AMCHP
- Social Determinants of Health
- The Social-Ecological Modelhttp://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html
- Strengthening Families

All activities in this SOW shall take place from receipt of funding beginning July 1, 2023, to June 30, 2026, contingent on availability of funds and spending authority.

For each fiscal year of the contract period, the Agency 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, 2024	September 30, 2024	October 30, 2023
Second Report	October 1, 2024	December 31, 2024	January 30, 2025
Third Report	January 1, 2025	March 31, 2025	April 30, 2025
Fourth Report (this will serve as annual report)	April 1, 2024	June 30, 2024	August 29, 2024

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

Exhibit A

Scope of Work

Goal 1: Effectively administer and oversee the BIH Program.

1.1 Meet BIH implementation activities and reporting requirements by completing and submitting required reports.

Major Functions, Tasks, and Activities	Time Line	Staff Responsibility	Performance Measure and/or Deliverables
1.1.1. Implement program activities as defined in the BIH P&Ps, SOW, Data Collection Manual (DCM), data collection forms, Group Curriculum and MCAH Fiscal P&Ps.	Annually, each fiscal year	Director, Coordinator/ Program Manager	1.1.1. Submit Agreement Funding Application (AFA) timely. (N)
1.1.2. Complete a Quarterly Report that complies with MCAH/ BIH guidance. The fourth quarter report will serve as the annual report.	Quarterly	Coordinator/ Program Manager	1.1.2. Submit as directed by MCAH/BIH (N)
1.1.3. Coordinate to complete, review and approve the BIH budget prior to submission.	Annually, each fiscal year	Director, Coordinator/ Program Manager	1.1.3. Submit Agreement Funding Application (AFA) withini 45 days of release. (N)

Exhibit A
Scope of Work

1.2. Establish Agency infrastructure and capacity to meet BIH requirements by meeting hiring needs and timelines.

Major Functions, Tasks, and Activities	Time Line	Staff Responsibility	Performance Measure and/or Deliverables
1.2.1. Meet staffing pattern and minimum qualification requirements for all staff roles.	Ongoing, Annually, each fiscal year Quarterly	Director, Coordinator/ Program Manager	1.2.1. Submit organization chart and duty statements with AFA and as requested by MCAH/BIH to BlackInfantHealth@cdph.ca.gov. Complete required staff profiles on SharePoint and keep up to date. (N)
1.2.2. Recruit, hire and maintain culturally competent staff that reflect the community being served to implement a BIH Program that is relevant to the unique traditions/heritage of Black Birthing People, and the community.	Ongoing	Director, Coordinator/ Program Manager	1.2.2. Percent of direct contact staff that reflect the population being served. (N)
1.2.3. Report all BIH staff changes.	Within five (5) business days of staffing change	Director, Coordinator/ Program Manager	1.2.3. Notify MCAH/BIH within five (5) business day of any staff vacancy and five (5) days before hire of Coordinator/Program Manager by submitting an email to BlackInfantHealth@cdph.ca.gov.
1.2.4. Develop, implement, and update, as requested by MCAH/BIH, a Professional Development Plan to support and build the capacity of all staff through assessment, supervision, and professional development	Ongoing, Annually	Director, Coordinator/ Program Manager	1.2.4. Submit Professional Development Plan to MCAH/BIH upon request. (N)

Exhibit A
Scope of Work

1.3 Ensure staff capacity to implement the BIH Program by facilitating and tracking attendance at all required trainings.

Major Functions, Tasks, and Activities	Time Line	Staff Responsibility	Performance Measure and/or Deliverables
1.3.1. Ensure all required staff complete refreshed curriculum training.	By end of year 1	Director, Coordinator/ Program Manager	1.3.1 Maintain records of staff attendance at trainings and submit to MCAH/BIH upon request. (N)
1.3.2. Attend mandatory MCAH/BIH sponsored in-person or virtual trainings, conference calls, meetings and/or conferences as scheduled by MCAH Division.	Ongoing, Monthly, Quarterly, Annually	Staff as required by MCAH/BIH	1.3.2. Maintain records of staff attendance at trainings and submit to MCAH/BIH upon request. (N)
1.3.3. Attend non-mandatory trainings that support the goals of BIH.	As needed	Staff as directed by Coordinator or Program Manager	1.3.3. Maintain staff attendance records of all trainings and submit to MCAH/BIH upon request. (N)
1.3.4. Develop plan to assess the ability of staff to effectively perform their assigned tasks, including regular observations of group facilitators	At least twice per fiscal year	Coordinator/ Program Manager	1.3.4. Maintain completion records of at least of at least two (2) group observation feedback forms by BIH Coordinator for every pair of group facilitators. (N)
1.3.5. Perform regular observations of assessments conducted by FHAs, MHPs and/or PHNs.	Quarterly	Coordinator/ Program Manager	1.3.5. Maintain completion records of observations conducted for FHAs, MHPs and PHNs. (N)
1.3.6. Identify staff training needs and ensure those needs are met	Quarterly	Coordinator/ Program Manager	1.3.6. Describe plan to ensure that staff development needs are met in quarterly report. (N)

Exhibit A
Scope of Work

1.3.7. 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.	Ongoing, Annually	Coordinator/ Program Manager	1.3.7. Describe how cultural sensitivity training has enhanced Agency staff knowledge and how that knowledge is applied in Annual report. (N)
1.3.8. Ensure that all new and key BIH staff attend the Annual MCAH Sudden Infant Death Syndrome (SIDS) Conference to receive the latest American Academy of Pediatrics (AAP) guidelines on infant safe sleep practices and SIDS risk reduction strategies.	Ongoing, Annually	Coordinator/ Program Manager	1.3.8. Describe how staff utilized information from the MCAH SIDS conference with participants in Annual report. (N)
1.3.9. Attend local SIDS collaborative workgroups with community partners to enhance awareness of Black SIDS rates and to develop SIDS risk reduction strategies.	Ongoing, Annually	Coordinator/ Program Manager Core staff	1.3.9. Document strategies and action plans related to SIDS risk reduction strategies developed from SIDS collaborative workgroup meetings in Annual report. (N)

Exhibit A
Scope of Work

1.4 Meet BIH data collection requirements by facilitating access to data collection system, SharePoint, software, security, and proper oversight of data entry and core personnel.

Major Functions, Tasks, and Activities	Time Line	Staff Responsibility	Performance Measure and/or Deliverables
1.4.1. Ensure all direct Agency and subcontractor service staff have access to BIH Efforts to Outcomes (ETO) Data Management System and SharePoint site by submitting request to MCAH/BIH.	Ongoing, Within five (5) business days of any staffing change	Director, Coordinator/ Program Manager	1.4.1. Submit request for access to ETO and SharePoint for *direct* staff to BlackInfantHealth@cdph.ca.gov
1.4.2. Collect and enter all BIH participant program information and outcome data timely and accurately per guidance in the Data Collection Manual (DCM) using BIH required forms at required intervals.	Enter data within ten (10) business days of collection	Staff as required by MCAH/BIH	1.4.2. BIH PA: Timeliness of data entry report (E)
1.4.3. Ensure all staff receive updates related to ETO changes and forms.	Ongoing	Coordinator/ Program Manager, Data Entry Lead	1.4.3. Maintain attendance records of BIH data calls, receipt of data alerts and other guidance via email or posted on SharePoint.

Exhibit A
Scope of Work

1.4.4. Ensure that a 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 and works to ensure timeliness of data entry and data quality.	Ongoing	Coordinator/ Program Manager	1.4.4. Maintain attendance records of participation in role-specific calls/trainings for the Data Entry Lead.
1.4.5. Store participant level data forms on paper or scanned copies per security guidelines in P&P for a minimum of four years (prior three years plus current FY).	Ongoing	Coordinator/ Program Manager	1.4.5. Maintain Participant level Data forms for a minimum of four years (prior three years plus current FY).
1.4.6. Conduct and report on audits of recruitment, enrollment, and service delivery paper forms against ETO records. Audit sample must include at least 10% of recruitment records and 10% of enrollment records and should include all staff collecting data.	Quarterly	Coordinator and Data Entry Lead	1.4.6. Maintain verification of data in paper forms matches information in ETO for all samples.
1.4.7. Ensure that all staff that collect and enter data into the BIH data system have completed the ETO training video series available in the BIH SharePoint site.	Ongoing	Coordinator/ Program Manager	1.4.7. Maintain attendance records of participation in ETO training video series for all staff.

Exhibit A
Scope of Work

1.4.8. Ensure that all staff that have ETO access are currently in the SharePoint roster by completing the Quarterly Roster Assessment (QRA).	Quarterly	Coordinator/ Program Manager	1.4.8. Completion of QRA on SharePoint.
1.4.9. Ensure all data collection and reporting processes comply with CDPH information privacy and security policies as directed in the BIH Policies and Procedures (P&Ps) before installing and using ETO.	Ongoing Daily	Director, Coordinator/ Program Manager	1.4.9. Maintain record of information privacy and security policies from CDPH.

Exhibit A
Scope of Work

Goal 2: Establish and maintain a structure to support recruitment, outreach, referrals and enrollment in designated service areas of Black women and Birthing People.

Eligibility for Group Services:

- **Black, 18 years of age and older, and less than 30 weeks pregnant for prenatal group services, or up to six months postpartum for postpartum group services.**

Eligibility for Case Management/1:1 Support Services:

- **Black, 16 years of age, pregnant or up to 6 months postpartum.**
- **Group attendance is not required.**

All Participants will attend in-person group or 1:1 support services

All Participants may receive services up to 1 year postpartum

2.1. Target services to areas where there is demonstrated need and Agency capacity to implement BIH.

Major Functions, Tasks, and Activities	Time Line	Staff Responsibility	Performance Measure and/or Deliverables
2.1.1. Define geographical service area for program recruitment for in-person services.	06/19/23	Director, Coordinator/ Program Manager	2.1.1. Submit the defined geographical service area and justification to MCAH/BIH for approval.
2.1.2. 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.	Ongoing, Annually	Coordinator/ Program Manager	2.1.2. Number and percent of recruited and referred women that were *eligible for Group* (based on age and pregnancy status) based on their recruitment date, in FY 2023-24. € *Quarterly Implementation Dashboard*
2.1.3. 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	Ongoing, Annually	Coordinator/ Program Manager	2.1.3. 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 FY 2023-24. €

Exhibit A
Scope of Work

request.			*Quarterly Implementation Dashboard*
2.1.4. Identify and establish formal and informal collaborative relationships with local Medi-Cal Managed Care, Commercial Health Plans, WIC, and local agencies in the community to support recruitment and referral processes.	Ongoing, Annually	Coordinator/ Program Manager	2.1.4. Total number of service providers that made referrals to the BIH Program in FY 2023-24. € *BIH PA: Recruitment during a specified time period report*.
2.1.5. Obtain rights and responsibilities form and provide signed or verbal acknowledgement for all participants.	Ongoing, Annually	Coordinator/ Program Manager	2.1.5. Number and percent that has a recruitment and a rights and responsibilities (consent) touchpoint in ETO in FY 2023-24. € *Quarterly Implementation Dashboard*
2.1.6. Conduct outreach activities and build collaborative relationships with local WIC providers, CPSP 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 eligible women are referred to BIH.	Ongoing, Quarterly, Annually	Coordinator/ Program Manager, COL	2.1.6. Total number (overall and by type) of outreach activities completed by all staff during FY 2023-24. (N)
2.1.7. All BIH Agencies will establish referral mechanisms that will facilitate reciprocity with partner agencies as appropriate.	Ongoing, Annually	Coordinator/ Program Manager	2.1.7. Maintain list of partner agencies and submit with Annual Report. (N)

Exhibit A
Scope of Work

2.1.8. All BIH Agencies will utilize social media campaigns developed by local agencies and/or MCAH to increase community awareness while conducting outreach activities during community events and participant engagement activities.	Ongoing, Annually	Coordinator/ Program Manager	2.1.8. Maintain list of social media platforms and submit with Annual Report. (N)
2.1.9. For BIH Group Sessions, all BIH agencies will recruit Black women 18 years of age and older, and less than 30 weeks pregnant for in-person prenatal group services, or up to six months postpartum for in-person postpartum group services.	Ongoing, Annually	Coordinator/ Program Manager	2.1.9. Number and percent of recruited and referred women that were eligible for Group (based on age and pregnancy status) based on their recruitment date, in FY 2023-24. (E) *Quarterly Implementation Dashboard*
2.2.0. Enroll participants in a group within 45 days of enrollment.	Ongoing	Coordinator/ Program Manager, BIH Staff	2.2.0. Number and percent of enrolled women who attended a prenatal group session within 30- 45 days of enrollment. (E) – *BIH PP: Prenatal Group Dose Report; BIH PP: Postpartum Group Dose Report*
2.2.1. Begin groups with the minimum required number of participants per the BIH P&P.	Ongoing	Coordinator/ Program Manager, BIH Staff	2.2.1. Percent of prenatal group sessions in a series that were attended by at least 5 participants, ideally 8-12. (E) - *BIH PP: Group Attendance by Session.*
2.2.2. All BIH participants (enrolled in BIH Group) will receive services outlined in the BIH P&P to be considered served.	Ongoing	Coordinator/ Program Manager, BIH Staff	2.2.2. Number and percent of active participants that are served during the FY 23-24(E). *Quarterly Implementation Dashboard*
2.2.3. For 1:1 support, all BIH Agencies will recruit Black teens at least 16 years of age and adult women, pregnant or up to 6 months postpartum.	Ongoing, Annually	Coordinator/ Program Manager	2.2.3. Number and percent of recruited and referred women that were eligible for 1:1 support (based on age and pregnancy status) based on their recruitment date, in FY 2023-24. (E)

Exhibit A
Scope of Work

			Quarterly Implementation Dashboard
2.2.4. All BIH participants (enrolled in the BIH 1:1 support intervention) will receive services outlined in the BIH P&P to be considered served.	Ongoing, Annually	Coordinator/ Program Manager	2.2.4. Number and percent of active Participants that are served during the FY (E). Quarterly Implementation Dashboard

Exhibit A
Scope of Work

Goal 3: All BIH Agencies will ensure participant retention strategies are in place.

3.1 Develop participant retention strategies as they relate to program implementation components.

Major Functions, Tasks, and Activities	Time Line	Staff Responsibility	Performance Measure and/or Deliverables
3.1.1. All BIH Agencies will develop participant retention strategies in the areas of outreach/recruitment, enrollment, 1:1 support, group sessions and program completion.	Ongoing	BIH Staff	3.1.1. Submit Participant Retention Strategies with Quarterly and Annual Report. (N) BIH PP: Prenatal Group Dose Report; BIH PP: Postpartum Group Dose Report (E)
3.1.2. Ensure location of group services is within the designated service area, safe, accessible, culturally affirming, and have dedicated child watch staff and space when group sessions are conducted.	Ongoing	BIH Staff	3.1.2. Describe process to ensure that location for group services meet MCAH/BIH guidelines and submit with Annual Report. (N)
3.1.3. Ensure participants have access to transportation assistance via Uber/Lyft or other door-to-door services.	Ongoing	BIH Staff	3.1.3. Number and percent of enrolled women who have been dismissed from BIH with a completed participant satisfaction survey during the FY. (E) BIH PP: Participant Satisfaction Report
3.1.4. Ensure all group sessions include full meals for participants.	Ongoing	BIH Staff	3.1.4. Number and percent of enrolled women who have been dismissed from BIH with a completed participant satisfaction survey during the FY. (E*)* BIH PP: Participant Satisfaction Report

Exhibit A
Scope of Work

3.1.5. Ensure group motivators including but not limited to gift cards, pack and plays, items to support fitness, infant feeding supplies, breastfeeding supplies, diapers, etc. are provided to program participants.	Ongoing	BIH Staff	3.1.5. Submit participant retention strategy successes and challenges with Annual Report. (N)
3.1.6. Designated staff will conduct participant satisfaction surveys after group sessions and at program completion to obtain feedback related to improvement of retention strategies.	Ongoing	BIH Staff	3.1.6. Number and percent of enrolled women who have been dismissed from BIH with a completed participant satisfaction survey during the FY. (E) *BIH PP: Participant Satisfaction Report*

Exhibit A
Scope of Work

Goal 4: All BIH Agencies will increase and expand community awareness of BIH.

4.1 Collaborate with other BIH Agencies regarding outreach activities including the use of social media.

Major Functions, Tasks, and Activities	Time Line	Staff Responsibility	Performance Measure and/or Deliverables
4.1.1. All BIH Agencies will increase and expand community awareness of BIH by collaborating with other BIH agencies and individually as an agency on communication outreach activities, including the use of social media.	Ongoing	BIH Staff	4.1.1. Total number (overall and by type) of outreach activities completed by all staff during FY 2023-24. (N)
4.1.2. Conduct outreach activities and build collaborative relationships with local WIC providers, CPSP 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 eligible women are referred to BIH.	Ongoing	BIH Staff	4.1.2. Describe the types of community partner agencies contacted by Agency staff. (N)
4.1.3. All BIH Agencies will establish referral mechanisms that will facilitate reciprocity with partner agencies as appropriate.	Ongoing	BIH Staff	4.1.3. Describe outreach activities performed to reach target population. (N)
4.1.4. All BIH Agencies will utilize social media campaigns developed by MCAH to increase community awareness while conducting outreach activities.	Ongoing	BIH Staff	4.1.4. Document type, frequency and number of social media activities conducted and submit with Quarterly and Annual Report. (N)

Exhibit A
Scope of Work

4.1.5. Develop and update, as needed, a local service referral and resource directory.	Ongoing	Coordinator/ Program Manager, BIH Staff	4.1.5. Maintain service referral and resource directory and submit to MCAH/BIH upon request. Ensure referral sources are up to date in ETO.
4.1.6. Increase information sharing with other local agencies providing services to Black Birthing People and children in the community and establish a clear point of contact.	Ongoing	COL	4.1.6. Number of agencies where the COL has a documented point(s) of contact and with whom information is regularly exchanged. Submit with Annual Report. (N)

Exhibit A
Scope of Work

Goal 5: Engage the Black community to support Black Birthing families' health and well-being with education and outreach efforts.

5.1 Increase and expand community awareness of Black Birth outcomes and the role of the Black Infant Health Program.

Major Functions, Tasks, and Activities	Time Line	Staff Responsibility	Performance Measure and/or Deliverables
5.1.1. All BIH Agencies will coordinate with the Perinatal Equity Initiative (PEI) (where applicable) to implement a Community Advisory Board (CAB) to Inform the community about disparate birth outcomes among Black Birthing People by delivering standardized messages describing how the BIH Program addresses these issues.	Ongoing	Coordinator/ Program Manager, BIH Staff	5.1.1. Submit CAB meeting materials (roster, stakeholder types, attendance, agenda, minutes) with BIH quarterly report. (N)
5.1.2. Create partnerships with community and referral agencies that support the broad goals of the BIH Program, through formal and informal agreements. Ensure efforts are focused on Black birthing people and families in the community in need of services and are confronting disparities caused by systematic oppression and marginalization, implicit bias, and discrimination.	Ongoing	Director, Coordinator/ Program Manager	5.1.2. Number, format, and outcomes associated with community outreach activities conducted by BIH Coordinator and/or MCAH Director during FY 2023-24 (E/N)
5.1.3. Develop and implement a community awareness plan that outlines how community engagement activities will be conducted.	Ongoing	BIH Staff	5.1.3. Document type, frequency and number of social media activities conducted and submit with Quarterly and Annual Report. (N)

Exhibit A
Scope of Work

5.1.4. Develop and implement activities related to multi-level community engagement and awareness with referral partners to identify service gaps in the Agency target area.	Ongoing	Coordinator/ Program Manager, BIH Staff	5.1.4. Maintain service referral and resource directory and submit to MCAH/BIH upon request.
5.1.5. Collaborate with local MCAH programs and other partners such as Medi-Cal to identify strategies, activities and 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.	Ongoing	Coordinator/ Program Manager, BIH Staff	5.1.5. Document collaborative activities with local MCAH programs and other partners and submit with Annual Report. (N)
5.1.6. Collaborate with local MCAH programs and Regional Perinatal Programs to improve maternal and perinatal systems of care.	Ongoing	Coordinator/ Program Manager, BIH Staff	5.1.6. Document collaborative activities with local MCAH programs and Regional Perinatal Programs and submit with Annual Report. (N)
5.1.7. Participate in collaboratives with community partners to review data and develop strategies and policies to address social determinants of health and disparities.	Ongoing	Coordinator/ Program Manager, BIH Staff	5.1.7. Document collaborative activities that address social determinants of health and disparities and submit with Annual Report. (N)

Exhibit A
Scope of Work

5.1.8. Produce flyers or educational materials as needed using BIH funds to support community awareness efforts, ensuring materials are properly branded with the State BIH log and funding tagline "Funded by the California Department of Public Health."	Ongoing	Coordinator/ Program Manager, BIH Staff	5.1.8. Maintain MCAH/BIH approval on file for all flyers, education, and outreach materials, including community awareness efforts developed.

Exhibit A
Scope of Work

Goal 6: All BIH Agencies will provide resources to assist in improving the health of pregnant and parenting Black Women and/or birthing people and their infants, including the management of chronic stress.

6.1 Provide all participants with additional services that support health and wellness while enrolled in the BIH Program.

Major Functions, Tasks, and Activities	Time Line	Staff Responsibility	Performance Measure and/or Deliverables
6.1.1. Assist participants in understanding behaviors that contribute to overall good health, including: • Stress management • Sexual health • Healthy relationships • Nutrition • Physical activity	Ongoing, Quarterly	BIH Staff	6.1.1. 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)
6.1.2. Ensure that participants are enrolled in health insurance and are receiving risk-appropriate perinatal care.	Ongoing	BIH Staff	6.1.2. Number and percent of enrolled participants that have received a referral for health insurance. (E) *BIH* PA: Referral Status Report (New)
6.1.3. Provide participants with health information that supports a healthy pregnancy.	Ongoing	BIH Staff	6.1.3. Describe collaborative efforts with March of Dimes, MotherToBaby and other agencies that provide health education, preterm birth reduction materials and resources. (N)
6.1.4. Provide participants with health education materials that address preterm birth reduction strategies, such as the MCAH-BIH prematurity awareness and Provider sheet tip sheet.	Ongoing	BIH Staff	6.1.4. Describe collaborative efforts with March of Dimes, MotherToBaby and other agencies that provide health education, preterm birth reduction materials and resources. (N)

Exhibit A
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6.1.5. Identify participants' health, dental and psychosocial needs and provide referrals and follow-up as needed to health and community services.	Ongoing	BIH Staff	6.1.5. 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) *BIH PA: Referral Status Report NEW*
6.1.6. Provide information and health education to participants who report drug, alcohol and/or tobacco use.	Ongoing	BIH Staff	6.1.6. Number and percent of enrolled participants that have received a referral for drug, alcohol and/or tobacco use. (E)
6.1.7. Assist participants with completion of the birth preference form that outlines specific labor/delivery and birthing requests to be conveyed to their prenatal care provider.	Prior to delivery	BIH PHN	6.1.7. Number and percent of active participants with a birth preference form (relative to number of days enrolled in the program). (E) *Quarterly* Implementation Dashboard
6.1.8. Promote and support a reproductive life plan and family planning by providing information and education on birth spacing and interconception health during group sessions and 1:1 support Meetings.	Ongoing	BIH Staff	6.1.8. Number and percent of enrolled participants that have discussed reproductive life planning during 1:1 support meetings. (E)
6.1.9. Ensure that participants are attending postpartum visits and well-woman check-ups as scheduled.	Ongoing	BIH Staff	6.1.9. Number and percent of participants who attend a 4-6 week postpartum checkup with a medical provider. (E)

Exhibit A
Scope of Work

6.2.0. Help participants understand the characteristics of healthy relationships and provide resources that can help participants deal with abuse, reproductive coercion, or birth control sabotage.	Ongoing	BIH Staff	6.2.0. Describe collaborative efforts with Violence Prevention Organizations such as Futures without Violence to determine service capacity to adequately meet needs identified by participants and Agency staff providing case management services. (N)
6.2.1. 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.	6-8 weeks postpartum and as necessary.	BIH MHP	6.2.1. Number and percent of active participants with an EPDS (relative to number of days enrolled in the program). (E) *Quarterly* Implementation Dashboard
6.2.2. Assist participants with increasing knowledge of infant safe sleep practices, SIDS, Sudden Unexplained Infant Death (SUID) risk reduction.	Ongoing	BIH Staff	6.2.2. List and describe health education materials provided to participants related to safe sleep practices and SIDS reduction. (N)
6.2.3. Provide participants with health education materials addressing the benefits of breastfeeding.	Ongoing	BIH Staff	6.2.3. Number and percent of enrolled participants that have discussed breastfeeding/infant feeding during 1:1 support meetings. (E) Number and percent of enrolled participants that have received a referral for breastfeeding or lactation. (E) *BIH PA: Referral Status Report (New)*
6.2.4. Assist participants with completing home safety checklist.	Prior to delivery	BIH PHN	6.2.4. Number and percent of active participants with a safety checklist (relative to number of days enrolled in the program). (E) *Quarterly* Implementation Dashboard

Exhibit A
Scope of Work

6.2.5. Teach participants about the importance of stress reduction and guide them in applying stress reduction techniques (yoga, deep breathing, or meditation).	Ongoing	BIH Staff	6.2.5. Summarize participant successes and challenges in utilizing stress reduction techniques. (N)
6.2.6. Facilitate the administration of the stress scale and ask questions about stress management focused on the participant's ability to be resilient and manage chronic stressors presenting during pregnancy.	Ongoing	BIH Staff	6.2.6. Number and percent of active participants with a baseline and follow-up assessment (relative to number of days enrolled in the program). (E)

Exhibit A
Scope of Work

Goal 7: Educate the public about the factors leading to the disparities in Black maternal and infant birth outcomes by providing consistent and culturally responsive information and promoting enrollment in the California Department of Public Health - Black Infant Health Program (CDPH-BIH).

7.1 Create and/or maintain a statewide public awareness campaign to inform the State about Black birth outcome inequities and/or the root causes of these inequities.

Major Functions, Tasks, and Activities	Time Line	Staff Responsibility	Performance Measure and/or Deliverables
7.1.1. Develop public awareness materials that are focus tested with targeted community.	Ongoing	BIH Staff, Coordinator/ Program Manager	7.1.1. Provide a report that describes outreach engagement plan in the community. Share ongoing progress in developing/maintaining the campaign during quarterly BIH Statewide Media Campaign meetings/reports. Agency Program Coordinator to review all staff/contractor/subcontractor deliverables and methodologies to ensure materials: • honor the unique history/traditions of people of Black descent • reflect/include the targeted community • are culturally responsive and engaging applicable to all Black birthing people, regardless of enrollment status in the CDPH-

Exhibit A
Scope of Work

			BIH program • Agency to share final campaign deliverables and methodologies with the State for final review and approval. (N)
7.1.2. Hire and maintain culturally competent staff/contractors/subcontractors to develop campaign materials that are relevant and respectful to the cultural heritage of Black women and the community.	Ongoing	Coordinator/ Program Manager	7.1.2. Describe process of recruiting and hiring staff/contractors/subcontractors. (N) Include resumes of staff/contractors/subcontractors with submission of AFA packet. (N) Submit all staff/contractor/subcontractor changes to the State for review (N)

California Department of Public Health — Maternal, Child and Adolescent Health Division

ORIGINAL

BUDGET SUMMARY

FISCAL YEAR	BUDGET	BUDGET STATUS	BUDGET BALANCE
2024-25	ORIGINAL	ACTIVE	0.00

Version 7.0 - 150 Quarterly 4 20 20

Program:	Perinatal Equity Initiative (PEI)
Agency:	24-10 Fresno
SubK:	

	UNMATCHED FUNDING				NON-ENHANCED MATCHING (50/50)				ENHANCED MATCHING (75/25)			
	PEI - SGF		AGENCY FUNDS		PEI-SGF-NE		PEI-Cnty NE		PEI-SGF-E		PEI-Cnty E	
	(1)	(2)	(3)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)
	TOTAL FUNDING	%	PEI - SGF	%	Agency Funds*	%	Combined Fed/State	%	Combined Fed/Agency*	%	Combined Fed/State	%	Combined Fed/Agency*
ALLOCATION(S) →			595,644.00										

#VALUE!

EXPENSE CATEGORY													
(I) PERSONNEL	129,450.92		129,450.92		0.00		0.00		0.00		0.00		0.00
(II) OPERATING EXPENSES	9,368.22		9,368.22		0.00		0.00		0.00		0.00		0.00
(III) CAPITAL EXPENDITURES	0.00		0.00		0.00		0.00		0.00		0.00		0.00
(IV) OTHER COSTS	425,200.00		425,200.00		0.00		0.00		0.00		0.00		0.00
(V) INDIRECT COSTS	31,624.86		31,624.86		0.00		0.00		0.00		0.00		0.00
BUDGET TOTALS*	595,644.00	100.00%	595,644.00	0.00%	0.00	0.00%	0.00	0.00%	0.00	0.00%	0.00	0.00%	0.00
BALANCE(S) →			0.00										

TOTAL PEI - SGF	595,644.00	→	595,644.00			[50%]	0.00			[25%]	0.00		
TOTAL TITLE XIX	0.00	→				[50%]	0.00	[50%]	0.00	[75%]	0.00	[75%]	0.00
TOTAL AGENCY FUNDS	0.00	→			0.00			[50%]	0.00			[25%]	0.00

$ 595,644.00	Maximum Amount Payable from State and Federal resources

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

MCAH PROJECT DIRECTOR'S SIGNATURE — DATE: 7/12/24

AGENCY FISCAL AGENT'S SIGNATURE — DATE: 7/12/24

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

STATE USE ONLY - TOTAL STATE AND FEDERAL REIMBURSEMENT		PEI - SGF		AGENCY FUNDS		PEI-SGF-NE		PEI-Cnty NE		PEI-SGF-E		PEI-Cnty E
PCA Codes		53115				TBD		TBD		TBD		TBD
(I) PERSONNEL		129,450.92				0.00		0.00		0.00		0.00
(II) OPERATING EXPENSES		9,368.22				0.00		0.00		0.00		0.00
(III) CAPITAL EXPENSES		0.00				0.00		0.00		0.00		0.00
(IV) OTHER COSTS		425,200.00				0.00		0.00		0.00		0.00
(V) INDIRECT COSTS		31,624.86				0.00		0.00		0.00		0.00
Totals for PCA Codes	595,644.00	595,644.00				0.00		0.00		0.00		0.00

California Department of Public Health — Maternal, Child and Adolescent Health Division

ORIGINAL

Program:	Perinatal Equity Initiative (PEI)
Agency:	24-10 Fresno
SubK:	

		UNMATCHED FUNDING				NON-ENHANCED MATCHING (50/50)				ENHANCED MATCHING (75/25)				
		PEI - SGF		AGENCY FUNDS		PEI-SGF-NE		PEI-Cnty NE		PEI-SGF-E		PEI-Cnty E		
	(1)	(2)	(3)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	
(II) OPERATING EXPENSES DETAIL	TOTAL FUNDING	%	PEI - SGF	%	Agency Funds*	%	Combined Fed/State	%	Combined Fed/Agency*	%	Combined Fed/State	%	Combined Fed/Agency*	
						% TRAVEL NON-ENH MATCH				% TRAVEL ENH MATCH				% PERSONNEL MATCH
TOTAL OPERATING EXPENSES	9,368.22		9,368.22		0.00	0.00%	0.00		0.00	0.00%	0.00		0.00	0.00%
TRAVEL	5,000.00	100.00%	5,000.00		0.00		0.00		0.00		0.00		0.00	Match Available
TRAINING	500.00	100.00%	500.00		0.00	0.00%	0.00		0.00		0.00		0.00	0.00%
1 Office Supplies	3,718.22	100.00%	3,718.22		0.00	0.00%	0.00		0.00					0.00%
2 Postage	50.00	100.00%	50.00		0.00	0.00%	0.00		0.00					0.00%
3 Duplication	100.00	100.00%	100.00		0.00	0.00%	0.00		0.00					0.00%
4			0.00		0.00		0.00		0.00					
5			0.00		0.00		0.00		0.00					
6			0.00		0.00		0.00		0.00					
7			0.00		0.00		0.00		0.00					
8			0.00		0.00		0.00		0.00					
9			0.00		0.00		0.00		0.00					
10			0.00		0.00		0.00		0.00					
11			0.00		0.00		0.00		0.00					
12			0.00		0.00		0.00		0.00					
13			0.00		0.00		0.00		0.00					
14			0.00		0.00		0.00		0.00					
15			0.00		0.00		0.00		0.00					

** 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														
TOTAL CAPITAL EXPENDITURES			0.00		0.00		0.00		0.00					

(IV) OTHER COSTS DETAIL														% PERSONNEL MATCH
TOTAL OTHER COSTS	425,200.00		425,200.00		0.00		0.00		0.00		0.00		0.00	0.00%
SUBCONTRACTS														
1 TBD (Doula Services)	189,000.00	100.00%	189,000.00		0.00	0.00%	0.00		0.00		0.00		0.00	
2 TBD (Fatherhood)	183,000.00	100.00%	183,000.00		0.00	0.00%	0.00		0.00		0.00		0.00	
3 Two Q, Inc	31,000.00	100.00%	31,000.00		0.00	0.00%	0.00		0.00		0.00		0.00	
4			0.00		0.00		0.00		0.00		0.00		0.00	
5			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	
7			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	
OTHER CHARGES														Match Available
1 Program Materials	12,000.00	100.00%	12,000.00		0.00	0.00%	0.00		0.00					0.00%
2 Community Advisory Board	10,200.00	100.00%	10,200.00		0.00	0.00%	0.00		0.00					0.00%
3			0.00		0.00		0.00		0.00					
4			0.00		0.00		0.00		0.00					
5			0.00		0.00		0.00		0.00					
6			0.00		0.00		0.00		0.00					
7			0.00		0.00		0.00		0.00					
8			0.00		0.00		0.00		0.00					

(V) INDIRECT COSTS DETAIL													
TOTAL INDIRECT COSTS	31,624.86		31,624.86		0.00		0.00		0.00				
24.43% of Total Wages + Fringe Benefits	31,624.86	100.00%	31,624.86		0.00	0.00%	0.00		0.00				

Program:	Perinatal Equity Initiative (PEI)
Agency:	24-10 Fresno
SubK:	

(I) PERSONNEL DETAIL

						UNMATCHED FUNDING				NON-ENHANCED MATCHING (50/50)				ENHANCED MATCHING (75/25)					
						PEI - SGF		AGENCY FUNDS		PEI-SGF-NE		PEI-Cnty NE		PEI-SGF-E		PEI-Cnty E			
					(1)	(2)	(3)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)		
					TOTAL FUNDING	%	PEI - SGF	%	Agency Funds*	%	Combined Fed/State	%	Combined Fed/Agency*	%	Combined Fed/State	%	Combined Fed/Agency*		
				TOTAL PERSONNEL COSTS	129,450.92		129,450.92		0.00		0.00		0.00		0.00		0.00		
			FRINGE BENEFIT RATE	79.28%	57,244.92		57,244.92		0.00		0.00		0.00		0.00		0.00		
				TOTAL WAGES	72,206.00		72,206.00		0.00		0.00		0.00		0.00		0.00		
	FULL NAME (First Name Last Name)	TITLE OR CLASSIFICATION (No Acronyms)	% FTE	ANNUAL SALARY	TOTAL WAGES													J-Pers NCF Per Staff	Staff Traveling (K)
1	Gifty Kwafie	Health Educator	100.00%	72,206.00	72,206.00	100.00%	72,206.00		0.00		0.00		0.00		0.00		0.00	79.50%	
2					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
3					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
4					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
5					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
6					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
7					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
8					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
9					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
10					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
11					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
12					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
13					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
14					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
15					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
16					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
17					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
18					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
19					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
20					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
21					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
22					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
23					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
24					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
25					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
26					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
27					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
28					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
29					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
30					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
31					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
32					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
33					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
34					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
35					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
36					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
37					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
38					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
39					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
40					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
41					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
42					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
43					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
44					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
45					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
46					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
47					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
48					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
49					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
50					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
51					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
52					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
53					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
54					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
55					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
56					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	
57					0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.00%	

For each fiscal year (FY) of the contract period, the Local Health Jurisdictions (LHJ) shall submit the deliverables identified below. All deliverables shall be submitted to the Maternal, Child and Adolescent Health (MCAH) Division to your designated Program Consultant in accordance with Perinatal Equity Initiative (PEI) guidelines and emailed or uploaded to SharePoint no later than the due date.

Reporting Period	From	To	Due Date
1) First Implementation Report[a]	January 1, 2023	June 30, 2023	July 31, 2024
2) Second Implementation Report	July 1, 2023	June 30, 2024	July 31, 2025
3) Third Implementation Report	July 1, 2024	June 30, 2025	July 31, 2025
4) Fourth Implementation Report	July 1, 2025	June 30, 2026	July 31, 2026

a) We are aligning implementation reports with fiscal year funding cycles. As a result, the first implementation period is from the previous grant cycle.

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

7/12/24

Goal 1: To align services with the Black Infant Health Program, oversee administration of the PEI and ensure program implementation, planning evaluation, program oversight, accurate completion of data entry activities and fiscal management is completed in compliance with CDPH-MCAH Guidelines.

Objectives	Activity	Evaluation Measures/Deliverables (Report on these measures in the Annual Report)
1.1 LHJs will provide oversight, maintain program fidelity, fiscal management and demonstrate that PEI activities are conducted as required in the PEI Scope of Work (SOW), CDPH-MCAH Fiscal Policies and Procedures (P&Ps), and PEI P&Ps. cdph.ca.gov/Programs/CFH/DMCAH/Pages/Fiscal-Documents.aspx	1. Implement the program activities as defined in the SOW. 2. Local PEI Coordinator will coordinate and collaborate with MCAH Director to complete, review, and approve the PEI budget prior to submission. 3. Local PEI Coordinator will coordinate and collaborate with the MCAH Director to ensure that accurate intervention data is submitted quarterly and as directed by CDPH MCAH-PEI. 4.Ensure the following key staffing roles are filled: • 1.0 Full-time (FTE) PEI Coordinator 5. Notify MCAH-PEI within five (5) business days of any hire (include start date) or staff vacancy (indicate last day in program).	1. Submit PEI Reports according to the reporting schedule established by CDPH-MCAH-PEI.
1.2 All local PEI staff will maintain and increase staff competency.	1. Ensure that all key local PEI staff participates in training or educational	1. Submit number of activities, trainings, and conferences (both state and local) attended by local PEI staff and/or subcontractors during each FY according to the reporting schedule.

	opportunities designed to enhance cultural sensitivity. 2. Ensure that the local PEI Coordinator and all direct service staff attend mandatory MCAH Division-sponsored training(s) and make best efforts to attend optional activities or trainings. 3. Ensure all key local PEI staff and/or their subcontractors participate in available trainings pertinent to the interventions selected in their jurisdiction.	
1.3 Complete annual Turn the Curve (TTC) thinking process.	1. Complete TTC process with PEI learning cohorts and with county partners for each implemented intervention based on guidance provided by CDPH-MCAH.	1. Submit annual TTC report by July 31st of each state fiscal year. 2. Complete annual TTC process with learning collaborative cohort for each implemented intervention. 3. Complete TTC process as needed with county partners.

Goal 2: Fund county health departments to develop local community grants to reduce Black Maternal and Infant Mortality/Morbidity by expanding the scope of interventions to compliment current Black Infant Health (BIH) Programming.

Objectives	Activity	Evaluation Measures/Deliverables (Report on these measures in the Annual Report)
2.1 To reduce Black Maternal and Infant Mortality/Morbidity, fund/contract with community-based organizations (CBOs) to implement at least two (2) of five (5) legislated PEI interventions: • Evidence-based or evidence-informed group prenatal care program • Pregnancy intentionality, preconception and/or interconception care program • Fatherhood or partnership initiative that supports engagement of partners in pregnancy and childbearing • Evidence-based or evidence-informed home visitation program • A strategy not described above that is justified based on local needs and	1. Attend all learning collaborative cohorts: • Monthly calls or meetings for Community Advisory Board and Public Awareness Campaign updates. • Monthly or Bi-monthly calls/meetings for legislated PEI interventions. 2. Ensure Results-Based Accountability activities are completed. 3. Ensure there is plan in place to meet the needs of your populations in the event of an emergency that may disrupt services. 4. Maintain records and other documentation for auditing purposes. See Audit and Record Retention Section in the CDPH-MCAH Fiscal P&Ps. 5) Develop and implement unique strategies, activities, and services for each	1. Provide intervention progress and share successes and challenges on monthly or bi-monthly learning collaborative calls. 2. See Goal 3 outcomes. 3. Share your plan for meeting the needs of your populations in the event of an emergency that may disrupt services.

resources, that combines social interventions with medical interventions including but not limited to: a) Assessment b) Increase patient empowerment c) Doulas d) Patient navigator services	intervention that address racial health disparities in birth outcomes among Black women as approved by CDPH-MCAH-PEI.	
2.2 Conduct site visits (either virtually or in-person) to ensure culturally affirming site for implementation of services.	1. Develop a schedule for visiting each CBO.	1. Submit schedule to CDPH-MCAH-PEI according to the reporting schedule.

Goal 3: Incorporate Results-Based Accountability (RBA) to monitor program performance.

Objectives	Activity	Evaluation Measures/Deliverables (Report on these measures in the Annual Report)
3.1 LHJs and their subcontractors will attend RBA training(s).	1. County and community-based organizations will utilize the RBA framework to monitor the performance of their interventions. 2. Ensure that local key county personnel and CBOs participate in and/or review CDPH approved RBA training(s). 3. Learn when and how to implement the TTC process to review and analyze data to measure program performance.	1. Submit a list of staff that have attended RBA training (either virtually or in-person). 2. Complete quarterly TTC meetings as needed for each implemented intervention.
3.2 Maintain and/or establish data collection and management methods for CBOs and Local Health Jurisdictions to submit data to CDPH-MCAH.	1. Develop, identify, or utilize existing software to collect and manage data that will later be summarized for submission to CDPH-MCAH PEI according to the reporting schedule. 2. Where applicable, ensure CBOs are submitting data to CDPH-MCAH based on current guidance.	1. Submit name of software used to collect/manage data for each of your interventions (i.e., evidenced-based, evidenced-informed, promising practice, public awareness campaign, community-advisory board). 2. Share plan for CBOs to submit data, including frequency of data submission to

	3. Provide technical assistance to CBOs to ensure data submission is accurate and adheres to CDPH-MCAH guidelines.	CDPH-MCAH according to the reporting schedule. 3. Share your plan for LHJ review of the data entered by the CBO prior to submission to MCAH according to the reporting schedule. 4. Submit performance data according to CDPH-MCAH reporting schedule.
3.3 Work with CDPH-MCAH to develop and/or refine performance measures.	1. Attend learning collaborative cohort meeting for performance measures. 2. Work with Community Advisory Board (CAB) and CBOs to ensure measures continue to meet the community needs.	1. Incorporate performance measures based on LHJ priorities and guidance provided by CDPH-MCAH. 2. Submit County data summary to MCAH by July with each annual report.
3.4 Participate in technical assistance (TA) calls with CDPH-MCAH.	1. Attend and participate in quarterly TA calls to provide program updates and ensure accuracy of data.	1. Update performance measure data based on feedback provided by CDPH-MCAH.

Goal 4: Conduct local public awareness efforts that address birth outcome inequalities to improve prenatal health and birth outcomes for Black women and babies.

Objectives	Activity	Evaluation Measures/Deliverables (Report on these measures in the Annual Report)
4.1 Maintain a local Public Awareness Campaign to inform the community about African-American birth outcome inequities and/or the root causes of these inequities.	1. Maintain a Public Awareness Campaign that is focus-tested with targeted community Members. 2. Incorporate key dates into public awareness efforts. For example: • National Prematurity Day • Black Infant Mortality Week • Black Breastfeeding Week 3. Track outreach and impact of the awareness campaign via RBA PMs.	1. Share ongoing progress in maintaining campaign in learning collaborative cohort. 2. Share final and/or updated campaign components once complete according to the reporting schedule.

Goal 5: Conduct local CAB efforts around birth outcome inequalities to improve prenatal health and birth outcomes.

Objectives	Activity	Evaluation Measures/Deliverables (Report on these measures in the Annual Report)

5.1 Maintain a local collaborative that focuses on Black Maternal and Infant mortality/morbidity.	1. Reach out to local partners (i.e., hospitals, health centers, county clinics, CBOs, etc.) to create a network of partnerships. 2. Ensure coordination/collaboration between PEI and BIH programs, including representation of BIH staff on PEI CAB, PAC and intervention Learning Collaborative calls. 3. Ensure representation of target population for selected interventions is on CAB. 4. Ensure that CAB members participate in training or educational opportunities designed to enhance cultural sensitivity to advocate for efforts to address racial health disparities.	1. Provide a list of CAB members and role/affiliated agency according to the reporting schedule. 2.Submit number of trainings, activities, and conferences attended by CAB members and role/affiliated agency during each FY according to the reporting schedule.
5.2 Ensure community partners are engaged during the implementation of the interventions and are invited to TTC meetings.	1. Hold regularly scheduled CAB meetings.	1. Provide a schedule of CAB meetings according to the reporting schedule. 2. Document quarterly TTC meetings as needed via the TTC view in your RBA scorecard.

Funding Allocation from the California Department of Public Health

Allocation Name: CHDP Maternal, Child and Adolescent Health, Black Infant Health, and Perinatal Equity Initiative Fiscal Year 2024-25 Allocation

Fund/Subclass: 0001/10000
Organization: 56201615, 56201670, 56201677, 56201700, 56201706, 56201715, 56201719, 56201720
Revenue Account #: 4380, 3530