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

FUNDING AGREEMENT PERIOD
FY 2021-2022

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____________________ BIH______________________ AFLP____________________

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

Federal Employer ID#:____________________

Complete Official Agency Name:____________________

Business Office Address:____________________

Agency Phone:____________________

Agency Fax:____________________

Agency Website:____________________

AGREEMENT FUNDING APPLICATION
POLICY COMPLIANCE AND CERTIFICATION

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

MCAH 202110 BIH 202110 AFLP ____________

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)	Title
Steve Brandau	Chairmain of the Board of Supervisors of the County of Fresno

Original Signature

Date: November 16, 2021

MCAH/AFLP Director

Name (Print)	Title
Rose Mary Rahn	MCAH Director

Original Signature: Rose Mary Rahn — Digitally signed by Rose Mary Rahn DN: cn=Rose Mary Rahn, c=US, email=rrahn@fresnocountyca.gov Date: 2021.07.06 17:11:08 -07'00'

Date ____________

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

MCAH Program

#	Contact	First Name	Last Name	Title	Address	Phone	Email Address	Program
1	AGENCY EXECUTIVE DIRECTOR							MCAH
2	MCAH DIRECTOR							MCAH
3	MCAH COORDINATOR (Only complete if different from #2)							MCAH
4	MCAH FISCAL CONTACT							MCAH
5	FISCAL OFFICER							MCAH
6	CLERK OF THE BOARD or							MCAH
7	CHAIR BOARD OF SUPERVISORS							MCAH
8	OFFICIAL AUTHORIZED TO COMMIT AGENCY							MCAH
9	FETAL INFANT MORTALITY REVIEW (FIMR) COORDINATOR							FIMR
10	SUDDEN INFANT DEATH SYNDROME (SIDS) COORDINATOR/CONTACT							SIDS
11	PERINATAL SERVICES COORDINATOR							CPSP

BIH Program

#	Contact	First Name	Last Name	Title	Address	Phone	Email Address	Program
1	AGENCY EXECUTIVE DIRECTOR							BIH
2	BLACK INFANT HEALTH (BIH) COORDINATOR							BIH
3	BIH FISCAL CONTACT							BIH
4	FISCAL OFFICER							BIH
5	CLERK OF THE BOARD or							BIH
6	CHAIR BOARD OF SUPERVISORS							BIH
7	OFFICIAL AUTHORIZED TO COMMIT AGENCY							BIH

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

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

BUDGET SUMMARY

FISCAL YEAR	BUDGET	BUDGET STATUS	BUDGET BALANCE
2021-22	ORIGINAL	ACTIVE	0.00

Version 7.0 - 150 Quarterly 4.20.20

Program: Maternal, Child and Adolescent Health (MCAH)
Agency: 202110 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)
EXPENSE CATEGORY	TOTAL FUNDING	%	MCAH-TV	%	MCAH-SIDS	%	Agency Funds*	%	Combined Fed/State	%	Combined Fed/Agency*	%	Combined Fed/State	%	Combined Fed/Agency*
ALLOCATION(S) →			210,795.00		7,372.00										#VALUE!
(I) PERSONNEL	5,282,923.97		187,660.66		7,372.00		1,505,507.57		0.00		2,121,748.83		0.00		1,460,634.92
(II) OPERATING EXPENSES	140,678.00		0.00		0.00		46,006.36		0.00		94,671.64		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	1,224,096.00		0.00		0.00		468,302.30		0.00		755,793.70		0.00		0.00
(V) INDIRECT COSTS	1,197,850.18		23,134.34		0.00		362,453.63		0.00		812,262.21		0.00		0.00
BUDGET TOTALS*	7,845,548.15	2.69%	210,795.00	0.09%	7,372.00	30.36%	2,382,269.86	0.00%	0.00	48.24%	3,784,476.38	0.00%	0.00	18.62%	1,460,634.92
BALANCE(S) →			0.00		0.00										

	Total	MCAH-TV	MCAH-SIDS	Agency Funds	Combined Fed/State (NE)	%	Combined Fed/Agency (NE)	Combined Fed/State (E)	%	Combined Fed/Agency (E)
TOTAL MCAH-TV	210,795.00	210,795.00								
TOTAL MCAH-SIDS	7,372.00		7,372.00							
TOTAL TITLE XIX	2,987,714.39				0.00	[50%]	1,892,238.20	0.00	[75%]	1,095,476.19
TOTAL AGENCY FUNDS	4,639,666.77			2,382,269.86		[50%]	1,892,238.18		[25%]	365,158.73

$ 3,205,881.39 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.

Rose Mary Rahn — Digitally signed by Rose Mary Rahn DN: cn=Rose Mary Rahn, c=US, email=rrahn@fresnocountyca.gov Date: 2021.09.02 11:50:11 -07'00'

MCAH/PROJECT DIRECTOR'S SIGNATURE DATE

Bruna Chavez — Digitally signed by Bruna Chavez DN: cn=Bruna Chavez, c=US, o=County Of Fresno, Dept of Public Hlth, ou=Finance, email=blchavez@fresnocountyca.gov Reason: Reviewed and approved Date: 2021.09.13 09:34:57 -07'00'

AGENCY FISCAL AGENT'S SIGNATURE DATE

* 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		187,660.66	7,372.00		0.00	1,060,874.42	0.00	1,095,476.19
(II) OPERATING EXPENSES		0.00	0.00		0.00	47,335.82	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	377,896.85	0.00	0.00
(V) INDIRECT COSTS		23,134.34	0.00		0.00	406,131.11	0.00	0.00
Totals for PCA Codes	3,205,881.39	210,795.00	7,372.00		0.00	1,892,238.20	0.00	1,095,476.19

Program:	Maternal, Child and Adolescent Health (MCAH)		UNMATCHED FUNDING						NON-ENHANCED MATCHING (50/50)				ENHANCED MATCHING (75/25)				
Agency:	202110 Fresno																
SubK:			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*	
(II) OPERATING EXPENSES DETAIL											% TRAVEL NON-ENH MATCH 45.45%				% TRAVEL ENH MATCH 23.26%		% PERSONNEL MATCH 67.73%
	TOTAL OPERATING EXPENSES	140,678.00		0.00		0.00		46,006.36		0.00		94,671.64		0.00		0.00	Match Available
	TRAVEL	52,073.00	0.00%	0.00		0.00	32.27%	16,803.96		0.00	67.73%	35,269.04		0.00		0.00	0.98%
	TRAINING	37,110.00	0.00%	0.00		0.00	32.27%	11,975.40		0.00	67.73%	25,134.60		0.00		0.00	0.00%
1	Communications	38,045.00	0.00%	0.00		0.00	32.27%	12,277.12		0.00	67.73%	25,767.88					0.00%
2	Office Supplies	6,646.00	0.00%	0.00		0.00	32.27%	2,144.66		0.00	67.73%	4,501.34					0.00%
3	Postage	1,161.00	0.00%	0.00		0.00	32.27%	374.65		0.00	67.73%	786.35					0.00%
4	Duplication	443.00	0.00%	0.00		0.00	32.27%	142.96		0.00	67.73%	300.04					0.00%
5	Conference Charges	1,900.00	0.00%	0.00		0.00	32.27%	613.13		0.00	67.73%	1,286.87					0.00%
6	Toll-Free Hotline	900.00	0.00%	0.00		0.00	100.00%	900.00		0.00		0.00					67.73%
7	Software	2,400.00	0.00%	0.00		0.00	32.27%	774.48		0.00	67.73%	1,625.52					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 67.73%
	TOTAL OTHER COSTS	1,224,096.00		0.00		0.00		468,302.30		0.00		755,793.70		0.00		0.00	
	SUBCONTRACTS																
1	West Fresno Health Care Coalition	138,419.00	0.00%	0.00		0.00	43.37%	60,025.60		0.00	56.63%	78,393.40		0.00		0.00	
2	Exceptional Parents Unlimited	275,000.00	0.00%	0.00		0.00	41.05%	112,889.36		0.00	58.95%	162,110.64		0.00		0.00	
3	Centro La Familia Advocacy Services	261,229.00	0.00%	0.00		0.00	38.53%	100,643.00		0.00	61.47%	160,586.00		0.00		0.00	
4	Central Valley Children's Services Network	274,448.00	0.00%	0.00		0.00	33.80%	92,764.00		0.00	66.20%	181,684.00		0.00		0.00	
5	Fresno County Economic Opportunities Commission	275,000.00	0.00%	0.00		0.00	37.08%	101,980.34		0.00	62.92%	173,019.66		0.00		0.00	
	OTHER CHARGES																Match Available
1				0.00		0.00		0.00		0.00		0.00					
2				0.00		0.00		0.00		0.00		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	1,197,850.18		23,134.34		0.00		362,453.63		0.00		812,262.21				
22.67%	of Total Wages + Fringe Benefits	1,197,850.18	1.93%	23,134.34		0.00	30.26%	362,453.63		0.00	67.81%	812,262.21				

Program:	**Maternal, Child and Adolescent Health (MCAH)**
Agency:	**202110 Fresno**
SubK:	

(I) PERSONNEL DETAIL

#	FULL NAME (First Name Last Name)	TITLE OR CLASSIFICATION (No Acronyms)	% FTE	ANNUAL SALARY	(1) TOTAL FUNDING / TOTAL WAGES	UNMATCHED FUNDING: MCAH-TV (2) %	(3) MCAH-TV	MCAH-SIDS (4) %	(5) MCAH-SIDS	AGENCY FUNDS (6) %	(7) Agency Funds*	NON-ENHANCED MATCHING (50/50) (8) %	(9) Combined Fed/State	MCAH-Cnty NE (10) %	(11) Combined Fed/Agency*	ENHANCED MATCHING (75/25) (12) %	(13) Combined Fed/State	MCAH-Cnty E (14) %	(15) Combined Fed/Agency*	J-Pers MCF Per Staff	Staff Traveling (X)
		TOTAL PERSONNEL COSTS			5,282,923.97		187,660.66		7,372.00		1,505,507.57		0.00		2,121,748.83		0.00		1,460,634.92		
		FRINGE BENEFIT RATE	79.21%		2,334,945.97		82,942.23		3,258.27		665,404.02		0.00		937,770.24		0.00		645,571.21		
		TOTAL WAGES			2,947,978.00		104,718.43		4,113.72		840,103.55		0.00		1,183,978.59		0.00		815,063.71		
1	Rose Mary Rahn	Division Manager	20.00%	132,640.00	26,528.00	0.00%	0.00		0.00	33.84%	8,977.74		0.00	55.36%	14,685.24		0.00	10.80%	2,865.02	66.2%	x
2	Rose Mary Rahn	MCAH Director	50.00%	132,640.00	66,320.00	0.00%	0.00		0.00	33.84%	22,444.35		0.00	55.36%	36,713.09		0.00	10.80%	7,162.56	66.2%	x
3	VACANT	Administrative Assistant	70.00%	32,209.00	22,546.00	0.00%	0.00		0.00	33.80%	7,620.55		0.00	66.20%	14,925.45		0.00	0.00%	0.00	66.2%	x
4	Aphivanh Xayavath	Staff Analyst III	100.00%	76,234.00	76,234.00	0.00%	0.00		0.00	48.86%	37,249.84		0.00	51.14%	38,984.16		0.00	0.00%	0.00	66.2%	x
5	Dalgit Martinez	Account Clerk I	30.00%	41,693.00	12,508.00	0.00%	0.00		0.00	33.80%	4,227.70		0.00	66.20%	8,280.30		0.00	0.00%	0.00	66.2%	x
6	Linda Griffith	Public Health Nurse II -Perinatal Services Coordinator	100.00%	102,264.00	102,264.00	0.00%	(0.00)		0.00	33.81%	34,575.46		0.00	47.79%	48,871.97		0.00	18.40%	18,816.58	66.2%	x
7	Eilene Browne	Public Health Nurse II -Sudden Infant Death Syndrome/Fetal Infant Mortality Review Coordinator	100.00%	73,549.00	73,549.00	19.41%	14,273.53	5.59%	4,113.72	75.00%	55,161.75		0.00	0.00%	0.00		0.00	0.00%	0.00	66.2%	x
8	Jennifer Pino	Medical Social Worker III	85.00%	74,493.00	63,319.00	0.00%	0.00		0.00	14.98%	9,482.02		0.00	85.03%	53,836.98		0.00	0.00%	0.00	89.3%	x
9	Bee Vang	Epidemiologist	25.00%	86,574.00	21,644.00	0.00%	0.00		0.00	33.80%	7,315.67		0.00	66.20%	14,328.33		0.00	0.00%	0.00	66.2%	x
10	Ana Carbajal	Health Education Assistant	50.00%	44,761	22,381.00	0.00%	0.00		0.00	42.97%	9,617.68		0.00	57.03%	12,763.32		0.00	0.00%	0.00	66.2%	x
11	Tong Thao	Health Education Assistant	50.00%	48,173	24,087.00	0.00%	0.00		0.00	35.46%	8,541.25		0.00	64.54%	15,545.75		0.00	0.00%	0.00	66.2%	x
12	Christine Vang	Health Education Specialist	80.00%	53,648	42,918.00	0.00%	0.00		0.00	63.81%	27,383.83		0.00	36.20%	15,534.17		0.00	0.00%	0.00	66.2%	x
13	Quentin Paramo	Health Education Specialist	100.00%	48,173	48,173.00	0.00%	(0.00)		0.00	66.68%	32,119.35		0.00	33.33%	16,053.65		0.00	0.00%	0.00	66.2%	x
14	Ah Vang	Health Educator	75.00%	67,071	50,303.00	0.00%	(0.00)		0.00	53.89%	27,107.03		0.00	46.11%	23,195.97		0.00	0.00%	0.00	66.2%	x
15	Valerie Wells	Supervising Office Assistant	100.00%	54,117	54,117.00	0.00%	(0.00)		0.00	43.60%	23,592.31		0.00	56.41%	30,524.69		0.00	0.00%	0.00	66.2%	x
16	VACANT	Office Assistant I	100.00%	25,688	25,688.00	0.00%	(0.00)		0.00	20.80%	5,343.75		0.00	79.20%	20,344.25		0.00	0.00%	0.00	89.3%	x
17	Diana Colin	Office Assistant III	100.00%	40,563	40,563.00	0.00%	0.00		0.00	11.83%	4,796.57		0.00	88.18%	35,766.43		0.00	0.00%	0.00	89.3%	x
18	Linda Willome	Office Assistant III	100.00%	40,045	40,045.00	0.00%	0.00		0.00	13.19%	5,280.93		0.00	86.81%	34,764.07		0.00	0.00%	0.00	89.3%	x
19	Sophia Rodriguez	Office Assistant III	100.00%	41,863	41,863.00	0.00%	0.00		0.00	14.47%	6,057.58		0.00	85.53%	35,805.42		0.00	0.00%	0.00	89.3%	x
20	Martha Garcia	Office Assistant III	100.00%	41,863	41,863.00	0.00%	0.00		0.00	25.49%	10,670.88		0.00	74.51%	31,192.12		0.00	0.00%	0.00	89.3%	x
21	VACANT	Office Assistant I	100.00%	25,688	25,688.00	0.00%	0.00		0.00	15.26%	3,919.35		0.00	84.74%	21,768.65		0.00	0.00%	0.00	89.3%	x
22	Christina Wyrick	Program Technician I	100.00%	52,853	52,853.00	0.00%	0.00		0.00	10.70%	5,655.27		0.00	89.30%	47,197.73		0.00	0.00%	0.00	89.3%	x
23	Yvonne Lopez	Public Health Nurse II (1677)	100.00%	73,549	73,549.00	0.00%			0.00	82.90%	60,972.12		0.00	7.27%	5,348.85		0.00	9.83%	7,228.03	66.2%	x
24	Fred Toshimitsu	Public Health Nurse II (1677)	100.00%	100,314	100,314.00	0.00%	0.00		0.00	70.36%	70,580.93		0.00	19.65%	19,711.70		0.00	9.99%	10,021.37	66.2%	x
25	Megan Gunn	Supervising Public Health Nurse (1615)	70.00%	118,504	82,953.00	0.00%			0.00	14.08%	11,681.86		0.00	44.82%	37,177.46		0.00	41.10%	34,093.68	91.7%	x
26	Barbara Besmer	Public Health Nurse II (1615)	100.00%	100,314	100,314.00	0.00%			0.00	20.29%	20,348.69		0.00	13.77%	13,815.75		0.00	65.94%	66,149.56	91.7%	x
27	Eileen Murry	Public Health Nurse I (1615)	100.00%	87,211	87,211.00	0.00%	(0.00)		0.00	15.38%	13,410.87		0.00	7.98%	6,959.44		0.00	76.64%	66,840.69	91.7%	x
28	Kayla Marcinkevicz	Public Health Nurse I (1615)	100.00%	75,928	75,928.00	0.00%			0.00	31.50%	23,919.22		0.00	21.28%	16,153.68		0.00	47.22%	35,855.10	91.7%	x
29	VACANT	Public Health Nurse I (1615)	100.00%	73,549	73,549.00	0.00%	(0.00)		0.00	22.91%	16,851.91		0.00	17.67%	12,992.43		0.00	59.42%	43,704.65	91.7%	x
30	Megan Gunn	Supervising Public Health Nurse (1670)	30.00%	118,504	35,551.00	13.00%	4,621.63		0.00		0.00		0.00	54.00%	19,197.54		0.00	33.00%	11,731.83	87.0%	x
31	VACANT	Public Health Nurse I (1670)	100.00%	73,549	73,549.00	0.00%	0.00		0.00	25.43%	18,701.67		0.00	34.71%	25,530.70		0.00	39.86%	29,316.63	87.0%	x
32	Pon Chin	Public Health Nurse II (1670)	100.00%	103,371	103,371.00	0.00%			0.00	23.20%	23,984.66		0.00	39.42%	40,743.68		0.00	37.38%	38,642.66	87.0%	x
33	Lillarose Bangs	Supervising Public Health Nurse-MCAH Coordinator	85.00%	115,736	98,376.00	0.00%	0.00		0.00	10.78%	10,604.93		0.00	66.33%	65,252.80		0.00	22.89%	22,518.27	89.3%	x
34	Deborah Omolayo	Public Health Nurse II	70.00%	98,850	69,195.00	10.71%	7,409.05		0.00		0.00		0.00	40.37%	27,935.75		0.00	48.92%	33,850.19	89.3%	x
35	Erin An	Public Health Nurse I	70.00%	75,495	52,847.00	10.71%	5,658.59		0.00		0.00		0.00	44.61%	23,576.37		0.00	44.68%	23,612.04	89.3%	x
36	Janel Claybon	Public Health Nurse II	25.00%	98,667	24,667.00	25.07%	6,182.78		0.00		0.00		0.00	12.13%	2,990.87		0.00	62.81%	15,493.34	89.3%	x
37	VACANT	Public Health Nurse I	70.00%	73,549	51,484.00	0.00%	(0.00)		0.00	10.70%	5,508.79		0.00	21.30%	10,966.09		0.00	68.00%	35,009.12	89.3%	x
38	VACANT	Public Health Nurse I (1720)	100.00%	73,549	73,549.00	0.00%	0.00		0.00	23.18%	17,050.50		0.00	39.36%	28,950.73		0.00	37.46%	27,547.78	89.3%	x
39	VACANT	Public Health Nurse I (1720)	100.00%	73,549	73,549.00	0.00%	0.00		0.00	25.00%	18,387.25		0.00	45.00%	33,097.05		0.00	30.00%	22,064.70	89.3%	x
40	Brienna Harker	Public Health Nurse I (1720)	100.00%	80,482	80,482.00	0.00%			0.00	18.60%	14,969.65		0.00	48.50%	39,033.77		0.00	32.90%	26,478.58	89.3%	x
41	Lorraine Hardy	Supervising Public Health Nurse	40.00%	121,755	48,702.00	0.00%	0.00		0.00	13.74%	6,691.65		0.00	51.14%	24,907.42		0.00	35.12%	17,102.92	92.3%	x
42	Lorraine Hardy	Supervising Public Health Nurse (1719)	15.00%	121,755	18,263.00	0.00%	(0.00)		0.00	15.66%	2,859.99		0.00	65.12%	11,892.87		0.00	19.22%	3,510.15	92.3%	x
43	VACANT	Public Health Nurse I (1719)	100.00%	73,549	73,549.00	0.00%	(0.00)		0.00	34.49%	25,365.21		0.00	21.99%	16,175.26		0.00	43.52%	32,008.52	92.3%	x
44	Jaynie Ortiz	Public Health Nurse I (1719)	100.00%	81,240	81,240.00	0.00%	0.00		0.00	26.80%	21,774.35		0.00	39.69%	32,244.16		0.00	33.51%	27,221.49	92.3%	x
45	Melanie Deto	Public Health Nurse II	70.00%	93,967	65,777.00	21.81%	14,345.96		0.00	10.00%	6,577.70		0.00	30.27%	19,912.34		0.00	37.92%	24,940.99	92.3%	x
46	Mai Vang	Public Health Nurse II	70.00%	100,314	70,220.00	27.60%	19,377.21		0.00	10.00%	7,022.00		0.00	21.36%	15,000.75		0.00	41.04%	28,820.04	92.3%	x
47	Bridget Ballesteros	Public Health Nurse II	70.00%	100,314	70,220.00	27.29%	19,164.79		0.00	10.00%	7,022.00		0.00	35.20%	24,713.93		0.00	27.51%	19,319.28	92.3%	x
48	Rachel Nevarez	Public Health Nurse II	70.00%	95,738	67,017.00	20.42%	13,684.87		0.00	10.00%	6,701.70		0.00	22.80%	15,276.53		0.00	46.79%	31,353.90	92.3%	x
49	VACANT	Public Health Nurse I (1501)	100.00%	73,549	73,549.00	0.00%	0.00		0.00	58.86%	43,290.94		0.00	9.73%	7,158.16		0.00	31.41%	23,099.90	91.7%	x
50	VACANT	Public Health Nurse	100.00%	73,549	73,549.00	0.00%	(0.00)		0.00	39.00%	28,684.11		0.00	22.00%	16,180.78		0.00	39.00%	28,684.11	66.2%	x
51					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
52					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
53					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
54					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
55					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
56					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
57					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
58					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
59					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
60					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
61					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
62					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
63					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
64					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
65					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
66					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
67					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
68					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	

Program: Maternal, Child and Adolescent Health (MCAH)
Agency: 202110 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) TOTAL FUNDING	(2) %	(3) MCAH-TV	(4) %	(5) MCAH-SIDS	(6) %	(7) Agency Funds*	(8) %	(9) Combined Fed/State	(10) %	(11) Combined Fed/Agency*	(12) %	(13) Combined Fed/State	(14) %	(15) Combined Fed/Agency*		
69					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
70					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
71					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
72					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
73					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
74					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
75					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
76					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
77					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
78					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
79					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
80					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
81					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
82					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
83					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
84					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
85					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
86					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
87					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
88					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
89					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
90					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
91					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
92					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
93					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
94					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
95					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
96					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
97					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
98					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
99					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
100					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
101					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
102					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
103					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
104					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
105					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
106					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
107					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
108					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
109					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
110					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
111					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
112					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
113					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
114					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
115					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
116					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
117					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
118					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
119					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
120					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
121					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
122					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
123					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
124					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
125					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
126					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
127					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
128					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
129					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
130					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
131					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
132					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
133					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
134					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
135					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
136					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
137					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
138					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
139					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
140					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
141					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
142					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
143					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
144					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
145					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	

Program:	Maternal, Child and Adolescent Health (MCAH)					UNMATCHED FUNDING						NON-ENHANCED MATCHING (50/50)				ENHANCED MATCHING (75/25)					
Agency:	202110 Fresno																				
SubK:						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*		
146					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
147					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
148					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
149					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
150					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	

Local Health Jurisdiction: Fresno
Agreement Number: 202110

Fiscal Year: SFY 2021-22

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
- Social Determinants of Health
- The Social-Ecological Modelhttp://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html
- Strengthening Families

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

Certification by MCAH Director:	Name: Rose Mary Rahn Title: MCAH Director Date: 7/22/2021 *I certify that I have seen and reviewed this Scope of Work for compliance with CDPH/MCAH Program Policies and Procedures.*
	Rose Mary Rahn Digitally signed by Rose Mary Rahn DN: cn=Rose Mary Rahn, c=US, email=rrahn@fresnocountyca.gov Date: 2021.07.27 13:13:22 -07'00'

Note: The Title V Maternal and Child Health Block Grant is the federal program that 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	Annual Progress Report and Year-End Survey	Complete and submit an Annual Progress Report with the included Year-End Survey each fiscal year to report on Scope of Work activities.	Annually, each fiscal year Due: August 15th	The Annual Progress 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.
CDPH/MCAH Requirement	Community Profiles and Data Information	Complete and submit a Community Profile for each fiscal year for posting on the CDPH/MCAH website.	Annually, each fiscal year Due with Agreement Funding Application (AFA)	Community Profiles (also known as Program Narratives) provide insight into the health and environment (community, home, and school) of California mothers, babies, children and teens. A template is provided to the LHJs for them to complete and submit each year. Use the most recent data available.
Title V Requirement	Toll-Free Line	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 general 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 • Number of calls received
Title V Requirement	MCAH Website	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 • Enter the number of hits to the website, if known
Title V Requirement CDPH/MCAH Requirement	Workforce Development and Training	Attend required trainings/meetings as outlined in the MCAH Program Policies and Procedures.	Annually, each fiscal year	Report in Annual Report on attendance at: • MCAH Director's meeting • SIDS Coordinators meeting

CDPH/MCAH Requirement	Recruitment and Retention	Maintain required key leadership personnel and recruit and retain qualified Title V program staff by as outlined in the MCAH Policies and Procedures.	Ongoing	If the LHJ is not able to meet key personnel requirements, the LHJ should submit a waiver request letter, as applicable per the MCAH Policies and Procedures. • Key Personnel leadership consists of the MCAH Director and the MCAH Coordinator, if the LHJ has one.
CDPH/MCAH Requirement	Community Resource and Referral Guide	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/Year-End Survey • Submit/upload a copy or link to the existing resource and referral guide
Title V Requirement	Conduct Local Needs Assessment	Conduct a Local Needs Assessment to acquire an accurate, thorough picture of the strengths and weaknesses of the local public health system that can be used in response to the preventive and primary care services needs for ALL pregnant women, mothers, infants (up to age one), and children, including children with special health care needs.	Once in five-year cycle	Complete Needs Assessment Deliverable Packet and Forms provided by CDPH/MCAH when requested by CDPH/MCAH.

Section B: Domain specific requirements and activities				
CDPH/MCAH Requirement	Sudden Infant Death Syndrome (SIDS)	**Required for Infant Domain - all LHJs** Provide Sudden Infant Death Syndrome/Sudden Unexpected Infant Death (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 activities in the Annual Report/Year-End Survey
CDPH/MCAH Requirement	Child Health - Developmental Screening	**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 activities in the Annual Report/Year-End Survey
CDPH/MCAH Requirement	Child Health – Family Economic Supports	**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 activities in the Annual Report/Year-End Survey
CDPH/MCAH Requirement	Children and Youth with Special Health Care needs (CYSHCN)	**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 activities in the Annual Report/Year-End Survey
CDPH/MCAH Requirement	Children and Youth with Special	**Required for CYSHCN Domain - all LHJs**	Annually, each fiscal year	Report on activities in the Annual Report/Year-End Survey

	Health Care needs (CYSHCN)	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. http://www.frcnca.org/frcnca-directory/		
CDPH/MCAH Requirement	Fetal Infant Mortality Review (FIMR)	**Required for FIMR funded LHJs only** LHJs funded for Fetal Infant Mortality Review (FIMR) will implement the FIMR Program in accordance with FIMR Policies and Procedures.	Annually, each fiscal year	Report on FIMR activities in the Annual Report/Year-End Survey
CDPH/MCAH Requirement	Black Infant Health (BIH)	**Required for BIH funded LHJs only** LHJs funded for Black Infant Health (BIH) will implement the BIH Program in accordance with BIH Policies and Procedures.	Annually, each fiscal year	Report on BIH activities in the Annual Reports.
CDPH/MCAH Requirement	Adolescent Family Life Program (AFLP)	**Required for AFLP funded LHJs only** LHJs funded for Adolescent Family Life Program (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 Domain

<table>
<tr><th colspan="2">Women/Maternal Health Domain</th></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>Performance Measures
(National/State Performance Measures and Evidence-Based Strategy Measure)</td><td>NPM 1: Well-woman visit (Percent of women with a preventive medical visit in the past year).</td></tr>
<tr><td colspan="2">Women/Maternal State Objective 1:
By 2025, reduce the rate of pregnancy-related deaths (up to 1 year after the end of pregnancy) from 11.3 deaths per 100,000 live births (2013 CA-PMSS) to 10.8 deaths per 100,000 live births.</td></tr>
<tr><td><u>Women/Maternal State Objective 1: Strategy 1:</u>
Lead surveillance and research associated with pregnancy-related deaths (up to 1 year after the end of pregnancy) in California.</td><td><u>Women/Maternal State Objective 1: Strategy 2:</u>
Partner to translate findings from pregnancy-related mortality surveillance and research into recommendations for action to improve maternal health and perinatal clinical practices.</td></tr>
<tr><td>Local Activities for Women/Maternal Objective 1: Strategy 1:</td><td>Local Activities for Women/Maternal Objective 1: Strategy 2:</td></tr>
<tr><td>☐Partner with CDPH/MCAH on dissemination of data findings, guidance and education to the public and local partners, including perinatal obstetric providers.

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?

How will impacts be measured?</td><td>☒Partner with CDPH/MCAH on dissemination of recommendations to improve maternal health and perinatal clinical practices, including quality improvement toolkits.

How will this activity be tracked and measured by the LHJ?

Every CPSP provider will receive the following Postpartum Preeclampsia Resource Toolkit to share with clients in the third trimester or when diagnosed with preeclampsia:
Signs & Symptoms of Heart Disease During Pregnancy and Postpartum (bilingual)
Postpartum Preeclampsia: You are STILL AT RISK after your baby is born. (bilingual)
Learn steps to mitigate problems related to postpartum preeclampsia
What is your anticipated outcome?

Clients will keep one-week, three-week, six-week, and/or eight-week postpartum check-ups as ordered.</td></tr>
</table>

	Clients diagnosed with antepartum preeclampsia will comply with postpartum plan of care. [monitor and log blood pressures; adhere to medication regimen; make lifestyle modifications] and keep all scheduled lab, referral, therapeutic, diagnostic, and medical appointments as ordered. Clients will recognize warning signs of postpartum preeclampsia and seek immediate medical attention. Clients will have a decrease in systolic and diastolic blood pressures and maintain BP within physician recommended parameters; if present, signs and symptoms will subside and overtime resolve. Clients will be open to implementing healthy lifestyle practices that are conducive to improving overall health. Clients will schedule well-woman appointment with PCP within first year after deliver. **How will impacts be measured?** Clients will complete Postpartum Preeclampsia Impact Intervention Questionnaire. The local LHJ will work with Medi-Cal Manage Care plans to identify women to be surveyed.
☐ Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**

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

Local Health Jurisdiction: Fresno
Agreement Number: 202110

Fiscal Year: SFY 2021-22

<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>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).</td></tr>
<tr><td colspan="3">Women/Maternal State Objective 2:
By 2025, reduce the rate of severe maternal morbidity from 91.0 per 10,000 delivery hospitalizations (2015 PDD) to 86.5 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 health 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>
<tr><td>☐Partner with CDPH/MCAH on dissemination of data findings, guidance and education to the public and local partners.

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?

How will impacts be measured?</td><td>☐Partner with local Regional Perinatal Programs of California (RPPC) Director to understand and promote efforts to establish Maternal Levels of Care.

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?

How will impacts be measured?</td><td>☐Partner with CDPH/MCAH to pilot test educational materials addressing chronic health conditions during pregnancy and disseminate to consumers and providers.

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?

How will impacts be measured?</td></tr>
<tr><td></td><td></td><td></td></tr>
</table>

☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Partner with CDPH/MCAH, RPPC, and Comprehensive Perinatal Services Program (CPSP) to coordinate resources and quality improvement efforts. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐For Black Infant Health (BIH) funded sites only, develop and disseminate statewide media campaigns to inform Black women on chronic health conditions. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**
☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Perinatal Service Coordinator (PSC) will partner with Women Infant Children (WIC), RPPC, CDPH/MCAH, Medi-Cal, and other key stakeholders to ensure a coordinated delivery system for women during and after pregnancy. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**

☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**

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

Local Health Jurisdiction: Fresno
Agreement Number: 202110

Fiscal Year: SFY 2021-22

<table>
<tr><th colspan="3">Woman/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 3: Improve mental health for all mothers in California.</td></tr>
<tr><td>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).</td></tr>
<tr><td colspan="3">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 49.6% (provisional 2018 MIHA) to 52.1%.</td></tr>
<tr><td><u>Women/Maternal State Objective 3: Strategy 1:</u>
Partner with state and local programs responsible for the provision of mental health services and early intervention programs to reduce mental health conditions in the perinatal period.</td><td><u>Women/Maternal State Objective 3: Strategy 2:</u>
Partner to strengthen knowledge and skill among health care providers, individuals and families to identify signs of maternal mental health-related needs.</td><td><u>Women/Maternal State Objective 3: Strategy 3:</u>
Partner to ensure pregnant and parenting women are screened utilizing standardized and validated tools and linked to needed services for mental health conditions in the perinatal period.</td></tr>
<tr><td>Local Activities for Women/Maternal Objective 3: Strategy 1</td><td>Local Activities for Women/Maternal Objective 3: Strategy 2</td><td>Local Activities for Women/Maternal Objective 3: Strategy 3</td></tr>
<tr><td>☒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.

How will this activity be tracked and measured by the LHJ?
Track referrals received from Perinatal Wellness Center for MCAH Home Visitation clients served in MCAH programs

What is your anticipated outcome?
Provide health education materials and resources during the perinatal period for better birth outcomes.
How will impacts be measured?
The number of contacts made by PHN and services provided to receptive clients served by MCAH programs in the FCDPH EMR system.</td><td>☒Perinatal Service Coordinators (PSCs) will provide technical assistance on new requirements for provider screening of mental health.

How will this activity be tracked and measured by the LHJ?

All CPSP providers received information on AB 2193 Obstetric/PCP Provider Screening & Insurer Programs, which requires obstetric providers to confirm screening has occurred or perform screening at least once during the perinatal period.

CPSP providers and staff receive training on utilization of PHQ-9 and GAD-7 screening tools.

What is your anticipated outcome?
All pregnant women served by CPSP will receive at least three psychosocial assessments during pregnancy, more if needed. Those identified with maternal mental health conditions will be screened and scheduled for a consultation with a mental health clinician for follow-up.</td><td>☒Implement and utilize standardized and validated mental health screening tools for pregnant and parenting women in MCAH programs.

How will this activity be tracked and measured by the LHJ?

Monitor and track in FCDPH electronic medical record system number of women being served by MCAH programs screened utilizing PHQ-9 during the prenatal and postpartum

Review current protocols and procedures and identity timelines for screening

What is your anticipated outcome?

80% of women served in FCDPH MCAH program will be screened for perinatal mood and anxiety disorders

How will impacts be measured?</td></tr>
</table>

	How will impacts be measured? Review initial, second, and third trimester psychosocial assessments Determine the number of mental health screenings that were conducted Number of clients referred for services Number of clients kept consultation/referral appointments Number of clients completed recommended treatment Documentation of treatment and health outcome recorded in patient's health record.	Track number of women screened and linked to needed services unless already in treatment
☐Partner with local mental health service providers to improve referral and linkages to mental health services. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Partner with local Mental Health Services Act (MHSA)/Prop. 63 funded programs to increase available services to women during perinatal period. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Lead the development of a county maternal mental health algorithm that outlines a referral system and the services available to address maternal mental health. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**
☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?**	☐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. **How will this activity be tracked and measured by the LHJ?**	☒Other local activity (Please Specify/Optional): MCAH Program Medical Social Worker will provide supportive services to home visitation clients who refuse referral to existing mental health services or programs

What is your anticipated outcome? **How will impacts be measured?**	**What is your anticipated outcome?** **How will impacts be measured?**	**How will this activity be tracked and measured by the LHJ?** Tracking number of MCAH clients served by MSW for supportive services **What is your anticipated outcome?** Provide supportive services to home visitation participants during linkage to mental health services/programs. **How will impacts be measured?** The number of referrals to MSW linked to services
☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**

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

Local Health Jurisdiction: Fresno
Agreement Number: 202110

Fiscal Year: SFY 2021-22

<table>
<tr><th colspan="4">Woman/Maternal Health Domain</th></tr>
<tr><td colspan="4">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.</td></tr>
<tr><td>Performance Measures
(National/State Performance Measures and Evidence-Based Strategy Measure)</td><td colspan="3">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.</td></tr>
<tr><td colspan="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 73.6% (2017 CCMBF) to 76.4%.</td></tr>
<tr><td>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.</td><td>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.</td><td>Women/Maternal State Objective 4: Strategy 3:
Lead the implementation of the Comprehensive Perinatal Service Provider (CPSP) program to ensure access to comprehensive prenatal care for Medi-Cal Fee-for-Service clients.</td><td>Women/Maternal State Objective 4: Strategy 4:
Fund the DHCS Indian Health Program (IHP) to administer the American Indian Maternal Support Services (AIMSS) to provide case management and home visitation program services for American Indian women during and after pregnancy.</td></tr>
<tr><td>Local Activities for Women/Maternal Objective 4: Strategy 1</td><td>Local Activities for Women/Maternal Objective 4: Strategy 2</td><td>Local Activities for Women/Maternal Objective 4: Strategy 3</td><td>Local Activities for Women/Maternal Objective 4: Strategy 4</td></tr>
<tr><td>☐Partner with CDPH/MCAH to disseminate and promote best practices and resources from key preconception initiatives.

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?

How will impacts be measured?</td><td>☐Partner with CDPH/MCAH in the development of the Maternal Infant Health Assessment (MIHA) Survey.

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?

How will impacts be measured?</td><td>☐Partner with Perinatal Service Coordinators (PSCs) to identify and recruit providers in medically underserved areas to increase access to care.

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?

How will impacts be measured?</td><td>☐Other local activity (Please Specify/Optional):

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?

How will impacts be measured?</td></tr>
<tr><td>☐Coordinate with CDPH/MCAH to identify uninsured populations, and conduct outreach and awareness of health insurance options.</td><td>☐Partner with CDPH/MCAH to disseminate MIHA data findings and guidance to the general public and local partners.</td><td>☐Lead in implementing the local CPSP program and provide monitoring and oversight of providers to ensure quality of care for CPSP</td><td>☐Other local activity (Please Specify/Optional):</td></tr>
</table>

How will this activity be tracked and measured by the LHJ? **What is your anticipated outcome?** **How will impacts be measured?**	**How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	clients. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	**How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**
☐Partner with CDPH/MCAH to disseminate Healthier Her campaign materials. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**
☐Partner with CDPH/MCAH to promote preconception/inter-conception health programs. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?**

How will impacts be measured?	**How will impacts be measured?**	**How will impacts be measured?**	**How will impacts be measured?**
☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**

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

<table>
<tr><th colspan="2">Woman/Maternal Health Domain</th></tr>
<tr><td colspan="2">Priority Need: Ensure women in California are healthy before, during and after pregnancy.
Women/Maternal Focus Area 5: Reduce maternal substance use.</td></tr>
<tr><td>Performance Measures
(National/State Performance Measures and Evidence-Based Strategy Measure)</td><td>NPM 1: Well-woman visit (Percent of women with preventive medical visit in the a past year).</td></tr>
<tr><td colspan="2">Women/Maternal State Objective 5:
By 2025, reduce the rate of maternal substance use from 20.7 per 1,000 delivery hospitalizations (2018 PDD) to 19.7 per 1,000 delivery hospitalizations.</td></tr>
<tr><td><u>Women/Maternal State Objective 5: Strategy 1:</u>
Lead surveillance and research on maternal substance use in California.</td><td><u>Women/Maternal State Objective 5: Strategy 2:</u>
Partner at the state and local level to increase prevention and treatment of maternal opioid and other substance use.</td></tr>
<tr><td>Local Activities for Women/Maternal Objective 5: Strategy 1</td><td>Local Activities for Women/Maternal Objective 5: Strategy 2</td></tr>
<tr><td>☐Coordinate with CDPH/MCAH to disseminate data findings, guidance and education to the public and local partners.

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?

How will impacts be measured?</td><td>☒Identify county specific resources on treatment and best practices to address substance use and collaborate to improve referral and linkages to services.

How will this activity be tracked and measured by the LHJ?
Evaluation of current County Perinatal SUD Resources, and current practices and protocols in place with local OB offices and L&D Departments.

What is your anticipated outcome?
Training for all OB providers and L&D hospital staff interested in perinatal SUD education, identification, and referral into services.

How will impacts be measured?
Number of OB offices and L&D departments contacted and surveyed.

Number of attendees at Perinatal SUD Training</td></tr>
<tr><td>☐Other local activity (Please Specify/Optional):

How will this activity be tracked and measured by the LHJ?</td><td>☐Partner with CDPH/MCAH to disseminate a social media campaign on maternal opioid use.

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?</td></tr>
</table>

What is your anticipated outcome? **How will impacts be measured?**	**How will impacts be measured?**
☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Disseminate the Association of State and Territorial Health Officials (ASTHO) Public Health Perinatal Opioid Toolkit. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**
☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☒Other local activity (Please Specify/Optional): Collaborate with Fresno County Jail and Jail Medical Services to allow Public Health Nurse to meet with pregnant inmates weekly to provide health information, resources and linkage to MCAH, substance use programs and SUD services **How will this activity be tracked and measured by the LHJ?** Number of pregnant women seen at jail, referrals to MCAH programs will be tracking in electronic medical record system **What is your anticipated outcome?** 80% of all pregnant women in Fresno County Jail will receive a visit in jail by Public Health **How will impacts be measured?** Number of women linked to MCAH services

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 Domain

<table>
<tr><th colspan="4">Perinatal/Infant Health Domain</th></tr>
<tr><td colspan="4">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 and caregiver/infant bonding.</td></tr>
<tr><td colspan="2">Performance Measures
(National/State Performance Measures and Evidence-Based Strategy Measure)</td><td colspan="2">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".</td></tr>
<tr><td colspan="4">Perinatal/Infant State Objective 1:
By 2025, increase the percent of women who report exclusive in-hospital breastfeeding from 70.2% (2018 GDSP) to 73.0%.</td></tr>
<tr><td><u>Perinatal/Infant State Objective 1: Strategy 1:</u>
Lead surveillance of breastfeeding practices and assessment of initiation and duration trends.</td><td><u>Perinatal/Infant State Objective 1: Strategy 2:</u>
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.</td><td><u>Perinatal/Infant State Objective 1: Strategy 3:</u>
Partner to develop and disseminate information and resources about policies and best practices to promote breastfeeding duration, including lactation accommodation within all MCAH programs.</td><td><u>Perinatal/Infant State Objective 1: Strategy 4:</u>
Partner with birthing hospitals to support infant/caregiver bonding.</td></tr>
<tr><td>Local Activities for Perinatal/Infant Objective 1: Strategy 1</td><td>Local Activities for Perinatal/Infant Objective 1: Strategy 2</td><td>Local Activities for Perinatal/Infant Objective 1: Strategy 3</td><td>Local Activities for Perinatal/Infant Objective 1: Strategy 4</td></tr>
<tr><td>☒Monitor and track breastfeeding initiation and duration rates and disseminate data to community and local partners.

How will this activity be tracked and measured by the LHJ?

WIC data and other available breastfeeding data will be obtained monthly or as available from participating partners

What is your anticipated outcome?

Increase available breastfeeding information</td><td>☐Promote breastfeeding education to prenatal women in local MCAH programs.

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?

How will impacts be measured?</td><td>☒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.

How will this activity be tracked and measured by the LHJ?

The Fresno County Breastfeeding Taskforce will develop material(s) that will be distributed to and by partner agencies, included on the local MCAH website, and distributed to women enrolled in MCAH programs</td><td>☐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.

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?

How will impacts be measured?</td></tr>
</table>

How will impacts be measured? Will document breastfeeding data source and identify how partners have used the data.		**What is your anticipated outcome?** Information will be shared with MCAH programs, participants, outreach events and on the program website **How will impacts be measured?** Summarize efforts and include information from annual client survey if women enrolled in MCAH programs received and/or used the information	
☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Partner to disseminate information to the community regarding evidence-based breastfeeding initiation guidance. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Partner with community leaders to promote infant bonding, skin to skin training and outreach activities to dads, partners, and caretakers. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**
☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?**	☐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. **How will this activity be tracked and measured by the LHJ?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?**

How will impacts be measured?	**What is your anticipated outcome?** **How will impacts be measured?**	**How will impacts be measured?**	**How will impacts be measured?**
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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 2: Reduce infant mortality with a focus on reducing disparities.</td></tr>
<tr><td>Performance Measures
(National/State Performance Measures and Evidence-Based Strategy Measure)</td><td colspan="2">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 4.2 per 1,000 live births (2017 BSMF/DSMF) to 4.0.</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>
Fund the implementation of local fetal infant review programs to identify state and local strategies to reduce infant mortality.</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>Local Activities for Perinatal/Infant Objective 2: Strategy 2</td><td>Local Activities for Perinatal/Infant Objective 2: Strategy 3</td></tr>
<tr><td>☒Monitor and track fetal and infant mortality and disseminate data to community and local partners.

How will this activity be tracked and measured by the LHJ?

Annual report published by DPH Epidemiologist on infant mortality rate by race and ethnicity

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.

How will impacts be measured?

Increased community awareness of infant mortality rates in Fresno County by race and census tracks.</td><td>☐For non-FIMR funded LHJs, utilize a FIMR-like framework to reduce infant mortality.

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?

How will impacts be measured?</td><td>☒Promote and disseminate information and resources related to SIDS and other Sleep Related Deaths to reduce risk factors and promote safe sleep.

How will this activity be tracked and measured by the LHJ?

Provide Safe Sleep training to all MCAH case managers/home visitors to ensure staff provide up to date safe sleep information for all clients serves

What is your anticipated outcome?

Increased understanding of SIDs and other sleep related infant deaths
Utilization of teaching materials that promote safer sleep

Shared resources to promote safer sleep in the community

How will impacts be measured?

Pre and Post test of training materials to measure increased understanding</td></tr>
</table>

☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐For non-FIMR funded LHJs, develop guidelines for investigating fetal and infant death and implement best practices and strategies to reduce infant mortality. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☒Disseminate Safe to Sleep® campaign and Safe Sleep strategies that address SIDS and other sleep-related causes of infant death. **How will this activity be tracked and measured by the LHJ?** Track number of participants at safe sleep presentations provided to foster care & resource families, group homes, community partners, and community events **What is your anticipated outcome?** Wide-spread community awareness and knowledge of safe sleep strategies and dissemination of safe sleep materials in the community **How will impacts be measured?** Track number of organizations who have received or requested Safe Sleep information and trainings.
☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐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. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**

☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☒Partner with local childcare licensing, birthing facilities, clinics, Women Infant Children (WIC) sites, and medical providers to provide SIDS/SUID and Safe Sleep education. **How will this activity be tracked and measured by the LHJ?** Document collaboration with MCAH Child Care Linkages Program to ensure up to date Safe Sleep education is provided to childcare providers. Track number of medical providers, WIC sites, clinics and hospitals who receive Safe Sleep materials and education. Document providers who participate in the Central Valley Safe Sleep Coalition recommendations. **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 **How will impacts be measured?** Number of Coalition meeting attended and dissemination of Coalition recommendations. Documentation of Safe Sleep information disseminated to medical providers, hospitals, clinics, childcare providers and community partners
☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?**	☒Other local activity: Improve Grief and Loss support for families who have experienced an infant loss by:

What is your anticipated outcome? **How will impacts be measured?**	**What is your anticipated outcome?** **How will impacts be measured?**	• Participating in trainings on Grief/Loss and support for families • Attend CA SIDS council meetings and trainings, Northern CA SIDS meetings and National SIDS meetings • Work closely with Fresno Angel Babies to link families for grief support **How will this activity be tracked and measured by the LHJ?** Document number of trainings and meetings attended Document number of Angel Baby Referrals. **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. **How will impacts be measured?** Documentation of improvement made to educational materials and outreach materials provided to parents, DPH staff, and the community.

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

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Perinatal/Infant Health Domain				
Perinatal/Infant Priority Need: Reduce infant mortality with a focus on eliminating disparities. *Perinatal/Infant Focus Area 3: Reduce preterm births.*				
Performance Measures (National/State Performance Measures and Evidence-Based Strategy Measure)		**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 8.7% (2017 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 Perinatal Equity Initiative (PEI) to increase perinatal equity in California.	**Perinatal/Infant State Objective 3: Strategy 4:** Lead the implementation of the Community Birth Plan (CBP), being piloted in Los Angeles, to build community systems to galvanize health care, public health sectors and communities to collaboratively reduce Black preterm birth.	**Perinatal/Infant State Objective 3: Strategy 5:** 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**	**Local Activities for Perinatal/Infant Objective 3: Strategy 5**

☒Monitor and track local preterm birth rates and disseminate data to community and local partners. **How will this activity be tracked and measured by the LHJ?** Annual report published by DPH Epidemiologist on infant mortality rate by race and ethnicity **What is your anticipated outcome?** Shared with community partners and stakeholders **How will impacts be measured?** Increased community awareness of infant mortality rates in Fresno County by race and census tracks.	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☒Develop and disseminate preterm birth reduction materials and resources to the Black community (moms, fathers, grandparents, community leaders, and churches) and agencies providing services to Black moms and babies. **How will this activity be tracked and measured by the LHJ?** Partner with Black Infant Health, Perinatal Equity Initiative, Fresno GROWS Best Baby Zone project and Black Wellness Prosperity Center to disseminate information and track number of families, community leaders and churches reached. **What is your anticipated outcome?** Reach at minimum 100 families and leadership members who work with the Black community. **How will impacts be measured?** By number of families reached and tracking of any changes in practices.	☐Partner with local birthing hospitals, and community stakeholders to disseminate social media campaigns about preterm birth reduction strategies. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**

☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Develop and disseminate preterm birth reduction materials and resources to the community and agencies providing services to moms and babies. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**
☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**

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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 25.9% (NSCH 2017-18) to 32.4%.			
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 foster coordination and collaboration between systems to improve developmental screening for young children.	**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 developmental screening quality measure and reimbursements to health care providers.
Local Activities for Child Objective 1: Strategy 1	**Local Activities for Child Objective 1: Strategy 2**	**Local Activities for Child Objective 1: Strategy 3**	**Local Activities for Child Objective 1: Strategy 4**
☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Partner with CDPH/MCAH, Statewide Screening Collaborative, and local stakeholders, such as the local First 5 program or Help Me Grow system, to identify key local resources for developmental screening/linkage. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☒Partner with CDPH/MCAH and early childhood and family-serving programs to assess current policies and practices on developmental screening and monitoring of developmental milestones to determine whether additional monitoring or screening can be incorporated into the programs. **How will this activity be tracked and measured by the LHJ?** ASQ 3 and ASQ SE 2 questionnaires completed on children participating in FCDPH MCAH home visitation programs as well as the Community Health Team contract will be entered into the appropriate EMR and/or database	☒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. **How will this activity be tracked and measured by the LHJ?** Developmental screening information and reimbursement will be shared via Managed Care Medi-cal plans and through the Help Me Grow Leadership table to all the Pediatric Providers in their networks.

		What is your anticipated outcome? 250 children ages 2 to 60 months of age will receive a developmental screening (ASQ 3 or ASQ SE 2). Staff will attend collaborative meetings to discuss use of the ASQ and standardizing policies and procedures for administration to increase number of children screened. **How will impacts be measured?** The number of children who receive a developmental screening will be compared to the number of children served in FCDPH MCAH home visitation programs	**What is your anticipated outcome?** Improved Developmental screening rates by providers with appropriate referral to early intervention services. **How will impacts be measured?** Date of when and number of Pediatric service providers reached regarding sharing of information on Developmental Screenings and reimbursement. Number of pediatric providers who billed for Development Screening
☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Lead the development of a community resource map that links referrals to services. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Partner with providers to educate families in MCAH programs about specific milestones and developmental screening needs. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Track county Medi-Cal managed care health plan developmental screening data. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**
☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?**	☐Develop a social media campaign or other outreach activity for families who missed well-child visits and/or developmental screening due to COVID-19 to educate families on the importance of resuming preventive services. **How will this activity be tracked and measured by the LHJ?**	☒Partner with Help Me Grow (HMG) and other key partners to educate providers and families about developmental screening recommendations and tools. **How will this activity be tracked and measured by the LHJ?**	☐Support provider organizations or health plans to implement quality improvement learning collaboratives to improve rates of developmental screening. **How will this activity be tracked and measured by the LHJ?**

How will impacts be measured?	**What is your anticipated outcome?** **How will impacts be measured?**	MCAH director will participate in monthly Fresno County HMG Leadership Meetings Monitor number of providers and families reached through local HMG outreach and education efforts **What is your anticipated outcome?** Improved awareness and education on Help Me Grow and the centralized access point to refer families. Increased call volume from families and providers on developmental screening recommendations and tools. **How will impacts be measured?** Number of calls coming into the centralized access point Number of families referred for services.	**What is your anticipated outcome?** **How will impacts be measured?**
☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Partner with Women Infant Children (WIC) and other stakeholders to disseminate developmental milestone information, educational resources, and tools. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**
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How will this activity be tracked and measured by the LHJ? What is your anticipated outcome? How will impacts be measured?	How will this activity be tracked and measured by the LHJ? What is your anticipated outcome? How will impacts be measured?	How will this activity be tracked and measured by the LHJ? What is your anticipated outcome?	How will this activity be tracked and measured by the LHJ? What is your anticipated outcome? How will impacts be measured?

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 through 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 82.0% (95% CI: 78.2-85.3%) 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 resilience 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>☐Identify and examine local county data sources for childhood adversity, childhood poverty, and social determinants of health affecting child health and family resilience.

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?

How will impacts be measured?</td><td>☐Assess current MCAH program practices to promote healthy, safe, stable, and nurturing parent-child relationships.

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?

How will impacts be measured?</td><td>☒Participate and promote the California Surgeon General's Adverse Childhood Experiences (ACEs) Aware trainings within local county agencies.

How will this activity be tracked and measured by the LHJ?
All FCDPH MCAH program staff will attend a ACE's Aware Training

What is your anticipated outcome?
FCDPH MCAH program staff and Home Visitors will increase their knowledge of ACES and impacts on families being served by MCAH programs.

How will impacts be measured?
Number of staff attending the ACE's Aware Training</td></tr>
<tr><td>☐Partner with CDPH/MCAH to identify opportunities to expand data collection on key childhood adversity and family resilience measures.</td><td>☐Partner with CDPH/MCAH to understand statewide initiatives that address social determinants of health and strengthen economic supports for families.</td><td>☐Share information to support the California Surgeon General's and Department of Health Care Services (DHCS) efforts on trauma screening and training for health care providers.</td></tr>
</table>

How will this activity be tracked and measured by the LHJ? **What is your anticipated outcome?** **How will impacts be measured?**	**How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	**How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**
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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: NPM 13.2: By 2025, increase the percentage of children, ages 1 through 17 years, who had a preventive dental visit in the past year from 80.2% (95% CI: 76.0- 83.9) [NSCH 2017-18] 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	
☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	

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

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Child Focus Area 3: Support and build partnerships to improve the physical health of all children.</td></tr>
<tr><td>Performance Measures
(National/State Performance Measures and Evidence-Based Strategy Measure)</td><td>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="2">Child State Objective 4:
SPM: By 2025, decrease the percentage of 5th grade students who are overweight or obese from 40.5% (2018) to 39.3%.</td></tr>
<tr><td><u>Child State Objective 4: Strategy 1:</u>
Partner to enable the reporting of data on childhood overweight and obesity in California.</td><td><u>Child State Objective 4: Strategy 2</u>:
Partner with WIC and others to provide technical assistance to local MCAH programs to support healthy eating and physically active lifestyles for families.</td></tr>
<tr><td>Local Activities for Child Objective 4: Strategy 1</td><td>Local Activities for Child Objective 4: Strategy 2</td></tr>
<tr><td>☐Utilize guidance to inform local-level prevention initiatives (contingent upon CDPH/MCAH procuring sub-State-level data on child overweight and obesity).

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?

How will impacts be measured?</td><td>☐Partner with Women Infant Children (WIC), local healthy community programs and initiatives, CDPH/MCAH programs, stakeholders to identify resources, best practices and tools on healthy eating to share with families in MCAH programs.

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?

How will impacts be measured?</td></tr>
<tr><td>☐Other local activity (Please Specify/Optional):

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?</td><td>☐Partner with Women Infant Children (WIC), and other local programs to refer and link eligible families to WIC and other healthy food resources.

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?</td></tr>
</table>

How will impacts be measured?	**How will impacts be measured?**
☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐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. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**
☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Share the child MyPlate and related messaging with families and providers to promote healthy eating in children. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**
☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?**

How will impacts be measured?	How will impacts be measured?

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 CYSHCN Health Domain

<table>
<tr><th colspan="4">Children and Youth with Special Health Care Needs (CYSHCN) Domain</th></tr>
<tr><td colspan="4">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.</td></tr>
<tr><td colspan="2">Performance Measures
(National/State Performance Measures and Evidence-Based Strategy Measure)</td><td colspan="2">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: Percentage of local MCAH programs that implement a Scope of Work objective focused on CYSHCN public health systems.</td></tr>
<tr><td colspan="4">CYSHCN State Objective 1:
By 2025, increase the percentage (from 0 to x%) of local MCAH programs that implement a Scope of Work objective focused on CYSHCN public health systems and services.*
*Number to be determined</td></tr>
<tr><td><u>CYSHCN State Objective 1: Strategy 1:</u>
Lead state and local MCAH capacity-building efforts to improve and expand public health systems and services for CYSHCN.</td><td><u>CYSHCN State Objective 1: Strategy 2:</u>
Lead program outreach and assessment within State MCAH to ensure best practices for serving CYSHCN are integrated into all MCAH programs.</td><td><u>CYSHCN State Objective 1: Strategy 3:</u>
Partner to build data capacity to understand needs and health disparities in the CYSHCN population.</td><td><u>CYSHCN State Objective 1: Strategy 4:</u>
Lead the establishment of a state-level learning collaborative to improve systems for CYSHCN through a national collaboration with the five largest states (CA, FL, IL, NY, and TX), known collectively as the Big 5.</td></tr>
<tr><td>Local Activities for CYSHCN Objective 1: Strategy 1</td><td>Local Activities for CYSHCN Objective 1: Strategy 2</td><td>Local Activities for CYSHCN Objective 1: Strategy 3</td><td>Local Activities for CYSHCN Objective 1: Strategy 4</td></tr>
<tr><td>☐ Conduct an environmental scan focused on children and youth with special health care needs and their families, including needs, gaps, and resources available in your county or region.

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?

How will impacts be measured?</td><td>☐Create or update a resource guide or diagram to help families, providers, and organizations understand the landscape of available local resources in the community.

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?

How will impacts be measured?</td><td>☒Other local activity (Please Specify/Optional): Collaborate with FCDPH CCS division on mutual clients to improve quality of case management services and care coordination

How will this activity be tracked and measured by the LHJ?
Meetings and consultations with FCDPH CCS staff

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.</td><td>☐Other local activity (Please Specify/Optional):

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?

How will impacts be measured?</td></tr>
</table>

		How will impacts be measured? Number of CCS children in MCAH FCDPH children's home visitation programs that received a joint MCAH PHN consultation with CCS staff will be compared to the total number of CCS children served in MCAH children's home visitation programs	
☒Improve coordination of emergency preparedness and disaster relief support for Children and Youth with Special Health Care Needs (CYSHCN) and their families (COVID-19, wildfires, earthquakes, etc.) **How will this activity be tracked and measured by the LHJ?** Number of meetings with managers of MCAH, CMS, Emergency preparedness and Community Health (CH) Development of a plan and best practices for CYSHCN during a PH emergency and/or natural disaster **What is your anticipated outcome?** Improved Coordination with Emergency Preparedness, MCAH, CMS and CH(CDI) to provide support and relief for CYSHCN and families impacted by an emergency. **How will impacts be measured?** Completion of a CYSHCN response plan	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**
☐Conduct a local data/evaluation project focused on CYSHCN.	☐Other local activity (Please Specify/Optional):	☐Other local activity (Please Specify/Optional):	☐Other local activity (Please Specify/Optional):

How will this activity be tracked and measured by the LHJ? **What is your anticipated outcome?** **How will impacts be measured?**	**How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	**How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	**How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**
☐Create or join a public health taskforce focused on the needs of CYSHCN in your county or region. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**
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If you have additional local activities, please add a row.

Local Health Jurisdiction: Fresno
Agreement Number: 202110

Fiscal Year: SFY 2021-22

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:** Percentage 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 % of adolescents with special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care from 12.6% to 13.9%. (NSCH 2017-18)		
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 CYSHCN in Medi-Cal and CCS 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 CYSHCN in Medi-Cal and CCS clients to facilitate coordinated care.
Local Activities for CYSHCN Objective 2: Strategy 1	**Local Activities for CYSHCN Objective 2: Strategy 2**	**Local Activities for CYSHCN Objective 2: Strategy 3**
☐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. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**
☐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. **How will this activity be tracked and measured by the LHJ?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?**

What is your anticipated outcome? **How will impacts be measured?**	**How will impacts be measured?**	**How will impacts be measured?**
☐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. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**
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If you have additional local activities, please add a row.

Local Health Jurisdiction: Fresno
Agreement Number: 202110

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<table>
<tr><th colspan="3">Children and Youth with Special Health Care Needs (CYSHCN) Domain</th></tr>
<tr><td colspan="3">CYSHCN Priority Need 2: Increase engagement and build resilience among CYSHCN and their families.
CYSHCN Focus Area 2: Empower and support CYSHCN, families, and family-serving organizations to participate in health program planning and implementation.</td></tr>
<tr><td>Performance Measures
(National/State Performance Measures and Evidence-Based Strategy Measure)</td><td colspan="2">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: Percentage of local MCAH programs that implement a Scope of Work objective focused on CYSHCN public health systems.</td></tr>
<tr><td colspan="3">CYSHCN State Objective 3:
By 2025, x of 61 local MCAH programs will select a SOW objective focused on family engagement, social/community inclusion, and/or family strengthening for CYSHCN.*

*To be determined.</td></tr>
<tr><td><u>CYSHCN State Objective 3: Strategy 1:</u>
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.</td><td><u>CYSHCN State Objective 3: Strategy 2:</u>
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.</td><td><u>CYSHCN State Objective 3: Strategy 3:</u>
Support statewide and local efforts to increase resilience among CYSHCN and their families.</td></tr>
<tr><td>Local Activities for CYSHCN Objective 3: Strategy 1</td><td>Local Activities for CYSHCN Objective 3: Strategy 2</td><td>Local Activities for CYSHCN Objective 3: Strategy 3</td></tr>
<tr><td>☐Attend a Family Voices of California Project Leadership Training-of-Trainers and implement local Project Leadership Trainings.
http://www.familyvoicesofca.org/project-leadership/

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?

How will impacts be measured?</td><td>☐Other local activity (Please Specify/Optional):

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?

How will impacts be measured?</td><td>☐Design and implement a project focused on social and community inclusion for CYSHCN and their families.

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?

How will impacts be measured?</td></tr>
</table>

Local Health Jurisdiction: Fresno
Agreement Number: 202110

Fiscal Year: SFY 2021-22

☐Within your county or region, create and deliver a training on family engagement for LHJ staff and partners. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Promote trauma-informed practices specific to CYSHCN and families to ensure local MCAH programs such as home visiting and public health nursing have a trauma-informed approach that is inclusive of CYSHCN. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**
☐Other (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**

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

Local Health Jurisdiction: Fresno
Agreement Number: 202110

Fiscal Year: SFY 2021-22

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 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**
☐Utilize California Adolescent Sexual Health Needs Index (CASHNI) to target adolescent sexual health programs and efforts to high need youth. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Partner with CDPH/MCAH to disseminate education materials and resources related to effective protective sexual health practices for youth, with a focus on reaching local health care professionals and parents/caregivers. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐For non- California Personal Responsibility Education Program (CA PREP) and Information and Education Program (I&E) funded counties, partner with local PREP and I&E agencies and other community partners to ensure local implementation of evidence-based and/or evidence-informed sexual health education to high need youth. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?**

		How will impacts be measured?
☐Utilize and disseminate Adolescent Sexual Health County Profiles to the public and local partners. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐For Adolescent Family Life Planning (AFLP)-funded counties, promote healthy sexual behaviors and healthy relationships among expectant and parenting youth. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Partner with stakeholders to review and ensure all sexual health education curricula provided in the county align with the California Healthy Youth Act (CHYA). **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**
☐Utilize and disseminate California's Adolescent Birth Rate (ABR) data report to the public and local partners. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐For non-Adolescent Family Life Planning (AFLP) funded counties, partner with local AFLP-funded agencies and other community partners to ensure utilization of best practices to promote healthy sexual behaviors and healthy relationships among high need youth populations. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**
☐Other (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?**	☒Build capacity of local MCAH workforce to promote protective adolescent sexual health practices.	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?**

What is your anticipated outcome? **How will impacts be measured?**	**How will this activity be tracked and measured by the LHJ?** Provide Sexual and Reproductive Health training to all MCAH case managers/home visitors to ensure staff are providing up to date sexual and reproductive health information for all clients served. **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 **How will impacts be measured?** Pre and Post test of training attendees to measure increased understanding	**What is your anticipated outcome?** **How will impacts be measured?**
☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Improve parent and caring adult engagement in supporting adolescent sexual health. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**

☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**

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

Local Health Jurisdiction: Fresno
Agreement Number: 202110

Fiscal Year: SFY 2021-22

<table>
<tr><th colspan="2">Adolescent Domain</th></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>Performance Measures
(National/State Performance Measures and Evidence-Based Strategy Measure)</td><td>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.</td></tr>
<tr><td colspan="2">Adolescent State Objective 2:
By 2025, increase the percent of adolescents 12 through 17 with a preventive medical visit in the past year from 76.2% to 83.8%.</td></tr>
<tr><td><u>Adolescent State Objective 2: Strategy 1:</u>
Lead to develop and implement best practices in MCAH funded programs to support youth with accessing youth-friendly preventative care, sexual and reproductive health care, and mental health care.</td><td><u>Adolescent State Objective 2: Strategy 2</u>:
Partner with the CDPH Adolescent Preventive Health Initiative to increase the quality of preventive care for adolescents in California.</td></tr>
<tr><td>Local Activities for Adolescent Objective 2: Strategy 1</td><td>Local Activities for Adolescent Objective 2: Strategy 2</td></tr>
<tr><td>☐Implement evidence-based screening tools or assessments to connect adolescents in local MCAH programs to needed services.

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?

How will impacts be measured?</td><td>☐Partner with CDPH/MCAH on dissemination of Adolescent Preventive Health Initiative (APHI) communications platform to health care providers to improve adolescent health care.

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?

How will impacts be measured?</td></tr>
<tr><td>☐Lead the development of a community pathway map that links referrals to services for young people.

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?

How will impacts be measured?</td><td>☐Other (Please Specify/Optional):

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?

How will impacts be measured?</td></tr>
</table>

☐Partner to disseminate adolescent preventive care recommendations to improve the quality of adolescent health services. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other local activity (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**
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If you have additional local activities, please add a row.

<table>
<tr><th colspan="3">Adolescent Domain</th></tr>
<tr><td colspan="3">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.</td></tr>
<tr><td>Performance Measures
(National/State Performance Measures and Evidence-Based Strategy Measure)</td><td colspan="2">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.</td></tr>
<tr><td colspan="3">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 77.2% to 79.7%.</td></tr>
<tr><td><u>Adolescent State Objective 3: Strategy 1:</u>
Partner to strengthen resilience among expectant and parenting adolescents to improve health, social, and educational outcomes.</td><td><u>Adolescent State Objective 3: Strategy 2:</u>
Partner to identify opportunities to build protective factors for adolescents at the individual, community and systems levels.</td><td><u>Adolescent State Objective 3: Strategy 3:</u>
Partner to strengthen knowledge and skills among providers, individuals and families to identify signs of distress and mental health related-needs among adolescents.</td></tr>
<tr><td>Local Activities for Adolescent Objective 3: Strategy 1</td><td>Local Activities for Adolescent Objective 3: Strategy 2</td><td>Local Activities for Adolescent Objective 3: Strategy 3</td></tr>
<tr><td>☐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.

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?

How will impacts be measured?</td><td>☐Utilize the Adolescent Sexual Health Workgroup (ASHWG) Positive Youth Development (PYD) Organizational Assessment and Toolkit to build agency capacity to engage and promote youth leadership and youth development.

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?

How will impacts be measured?</td><td>☐Identify local needs and assets relating to adolescent mental health.

How will this activity be tracked and measured by the LHJ?

What is your anticipated outcome?

How will impacts be measured?</td></tr>
</table>

☐For non-Adolescent Family Life Planning (AFLP)-funded counties, participate on local AFLP agency's Local Stakeholder Coalition. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Establish or join a local youth advisory board to incorporate youth voice and feedback into local MCAH health programs. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Partner with or join a local adolescent health coalition and develop a strategic plan to improve adolescent mental health. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**
☐Partner with CDPH/MCAH in utilization and dissemination of updated physical activity and nutrition guidelines to promote well-being among adolescent parents. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Partner to understand and promote efforts to improve youth engagement and leadership opportunities. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Partner to disseminate training opportunities and resources related to adolescent mental health such as Mental Health First Aid and Question Persuade Refer (QPR), a suicide prevention training. **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**

☐Other (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**	☐Other (Please Specify/Optional): **How will this activity be tracked and measured by the LHJ?** **What is your anticipated outcome?** **How will impacts be measured?**

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

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

BUDGET SUMMARY

FISCAL YEAR	BUDGET	BUDGET STATUS	BUDGET BALANCE
2021-22	ORIGINAL	ACTIVE	0.00

Version 7.0 - 150 Quarterly 4.20.20

Program: Black Infant Health (BIH)
Agency: 202110 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) →			259,379.00		1,065,557.00										#VALUE!
EXPENSE CATEGORY															
(I) PERSONNEL	823,743.58		129,615.23		140,270.08		0.00		528,279.06		0.00		25,579.22		0.00
(II) OPERATING EXPENSES	52,320.00		0.00		52,320.00		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	608,214.71		88,164.59		520,050.12		0.00		0.00		0.00		0.00		0.00
(V) INDIRECT COSTS	186,775.62		41,599.18		19,588.51		0.00		125,587.93		0.00		0.00		0.00
BUDGET TOTALS*	1,671,053.91	15.52%	259,379.00	43.82%	732,228.71	0.00%	0.00	39.13%	653,866.99	0.00%	0.00	1.53%	25,579.22	0.00%	0.00
BALANCE(S) →			0.00		0.00										
TOTAL BIH-TV	259,379.00	→	259,379.00												
TOTAL BIH-SGF	1,065,557.00	→			732,228.71			[50%]	326,933.49			[25%]	6,394.80		
TOTAL TITLE XIX	346,117.92	→						[50%]	326,933.50	[50%]	0.00	[75%]	19,184.42	[75%]	0.00
TOTAL AGENCY FUNDS	0.00	→					0.00			[50%]	0.00			[25%]	0.00

$ 1,671,053.92 — 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.

Rose Mary Rahn — Digitally signed by Rose Mary Rahn
DN: cn=Rose Mary Rahn, c=US, email=rrahn@fresnocountyca.gov
Date: 2021.09.21 14:59:14 -07'00'

MCAH/PROJECT DIRECTOR'S SIGNATURE — DATE

Bruna Chavez — Digitally signed by Bruna Chavez
DN: cn=Bruna Chavez, c=US, o=Department of Public Health, ou=Co. of Fresno, email=blchavez@fresnocountyca.gov
Reason: Reviewed and approved
Date: 2021.10.05 08:51:37 -07'00'

AGENCY FISCAL AGENT'S SIGNATURE — DATE

* 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		129,615.23	140,270.08		528,279.06	0.00	25,579.22	0.00
(II) OPERATING EXPENSES		0.00	52,320.00		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		88,164.59	520,050.12		0.00	0.00	0.00	0.00
(V) INDIRECT COSTS		41,599.18	19,588.51		125,587.93	0.00	0.00	0.00
Totals for PCA Codes	1,671,053.92	259,379.00	732,228.71		653,866.99	0.00	25,579.22	0.00

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

Program:	Black Infant Health (BIH)
Agency:	202110 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 66.42%				% TRAVEL ENH MATCH 0.00%	% PERSONNEL MATCH 70.27%
TOTAL OPERATING EXPENSES	**52,320.00**		**0.00**		**52,320.00**		**0.00**		**0.00**		**0.00**		**0.00**		**0.00**	Match Available
TRAVEL	13,000.00	0.00%	0.00	100.00%	13,000.00		0.00		0.00		0.00		0.00		0.00	**66.42%**
TRAINING	10,000.00	0.00%	0.00	100.00%	10,000.00		0.00		0.00		0.00		0.00		0.00	**70.27%**
1 Office Supplies	8,500.00	0.00%	0.00	100.00%	8,500.00		0.00		0.00		0.00					**70.27%**
2 Postage	500.00	0.00%	0.00	100.00%	500.00		0.00		0.00		0.00					**70.27%**
3 Duplication	1,000.00	0.00%	0.00	100.00%	1,000.00		0.00		0.00		0.00					**70.27%**
4 Media	15,000.00	0.00%	0.00	100.00%	15,000.00		0.00		0.00		0.00					**70.27%**
5 Communications	4,320.00	0.00%	0.00	100.00%	4,320.00		0.00		0.00		0.00					**70.27%**
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					
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	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)
TOTAL CAPITAL EXPENDITURES			0.00		0.00		0.00		0.00		0.00				

(IV) OTHER COSTS DETAIL	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	% PERSONNEL MATCH 70.27%
TOTAL OTHER COSTS	**608,214.71**		**88,164.59**		**520,050.12**		**0.00**		**0.00**		**0.00**		**0.00**		**0.00**	
SUBCONTRACTS																
1 Reading & Beyond	20,687.00	100.00%	20,687.00		0.00		0.00		0.00		0.00		0.00		0.00	
2 JP Marketing	500,000.00	0.00%	0.00	100.00%	500,000.00		0.00		0.00		0.00		0.00		0.00	
3 Kim Wilson	2,700.00	100.00%	2,700.00		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	57,700.00	74.14%	42,777.59	25.86%	14,922.41		0.00		0.00		0.00					**70.27%**
2 Participant Transportation	22,000.00	100.00%	22,000.00		0.00		0.00		0.00		0.00					**70.27%**
3 Client Refreshments	5,127.71	0.00%	0.00	100.00%	5,127.71		0.00		0.00		0.00					**70.27%**
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	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)
TOTAL INDIRECT COSTS	**186,775.62**		**41,599.18**		**19,588.51**		**0.00**		**125,587.93**		**0.00**				
22.67% of Total Wages + Fringe Benefits	186,775.62	22.27%	41,599.18	10.49%	19,588.51		0.00	67.24%	125,587.93	0.00%	0.00				

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

Program:	Black Infant Health (BIH)
Agency:	202110 Fresno
SubK:	

(I) PERSONNEL DETAIL

						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*		
	TOTAL PERSONNEL COSTS				823,743.58		129,615.23		140,270.08		0.00		528,279.06		0.00		25,579.22		0.00		
	FRINGE BENEFIT RATE		81.93%		370,960.58		58,370.28		63,168.53		0.00		237,902.56		0.00		11,519.22		0.00		
	TOTAL WAGES				452,783.00		71,244.95		77,101.55		0.00		290,376.50		0.00		14,060.00		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	75.00%	98,667.00	74,000.00	38.00%	28,120.00	39.00%	28,860.00		0.00	4.00%	2,960.00		0.00	19.00%	14,060.00		0.00	89.8%	X
2	Fanta Nelson	BIH Coordinator -Health Educator	100.00%	63,452.00	63,452.00	4.14%	2,623.74	13.00%	8,248.76		0.00	82.87%	52,579.50		0.00		0.00		0.00	89.8%	X
3	Sabrina Beavers	FHA Outreach Liaison -Health Educatio	100.00%	57,656.00	57,656.00	12.51%	7,212.77	12.00%	6,918.72		0.00	75.49%	43,524.51		0.00		0.00		0.00	89.8%	X
4	Denise Simon	FHA Group Facilitator -Health Educatior	100.00%	57,656.00	57,656.00	12.82%	7,390.06	14.00%	8,071.84		0.00	73.18%	42,194.10		0.00		0.00		0.00	89.8%	X
5	Megan Black	Comm. Outreach Liaison -Health Educa	100.00%	53,523.00	53,523.00	13.99%	7,487.87	13.00%	6,957.99		0.00	73.01%	39,077.14		0.00		0.00		0.00	89.8%	X
6	Kim Murphy	FHA Group Facilitator -Health Educatior	100.00%	46,873.00	46,873.00	22.11%	10,362.45	20.00%	9,374.60		0.00	57.89%	27,135.95		0.00		0.00		0.00	89.8%	X
7	Melinda Meza	Data Entry Manager -Office Assistant	100.00%	34,990.00	34,990.00	10.08%	3,526.99	10.00%	3,499.00		0.00	79.92%	27,964.01		0.00		0.00		0.00	89.8%	X
8	Keesha Clark	Mental Health Professional -Medical So	100.00%	64,633.00	64,633.00	7.00%	4,521.08	8.00%	5,170.64		0.00	85.01%	54,941.28		0.00		0.00		0.00	89.8%	X
9					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
10					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
11					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
12					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
13					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
14					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
15					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
16					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
17					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
18					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
19					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
20					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
21					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
22					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
23					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
24					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
25					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
26					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
27					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
28					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
29					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
30					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
31					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
32					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
33					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
34					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
35					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
36					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
37					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
38					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
39					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
40					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
41					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
42					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
43					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
44					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
45					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
46					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
47					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
48					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
49					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
50					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
51					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
52					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
53					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
54					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
55					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
56					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	

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

Program: **Black Infant Health (BIH)**

Agency: **202110 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*		
57					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
58					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
59					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
60					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
61					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
62					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
63					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
64					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
65					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
66					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
67					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
68					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
69					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
70					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
71					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
72					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
73					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
74					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
75					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
76					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
77					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
78					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
79					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
80					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
81					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
82					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
83					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
84					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
85					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
86					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
87					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
88					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
89					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
90					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
91					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
92					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
93					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
94					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
95					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
96					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
97					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
98					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
99					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
100					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
101					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
102					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
103					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
104					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
105					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
106					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
107					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
108					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
109					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
110					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
111					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
112					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
113					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
114					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
115					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
116					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
117					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
118					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
119					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
120					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
121					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	

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

Program:	Black Infant Health (BIH)
Agency:	202110 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*			
122					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%		
123					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%		
124					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%		
125					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%		
126					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%		
127					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%		
128					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%		
129					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%		
130					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%		
131					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%		
132					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%		
133					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%		
134					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%		
135					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%		
136					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%		
137					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%		
138					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%		
139					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%		
140					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%		
141					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%		
142					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%		
143					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%		
144					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%		
145					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%		
146					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%		
147					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%		
148					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%		
149					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%		
150					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%		

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

Black Infant Health Program

The BIH Program is a specialized CDPH MCAH program under the local MCAH system and helps to address MCAH SOW - Women/Maternal Domain: Focus Areas 1-5: Ensure women in California are healthy before, during and after pregnancy. Perinatal/Infant Domain: Ensure all infants are born healthy and thrive in their first year of life. Focus Area 2: Reduce infant mortality with a focus on reducing disparities. The goals in this SOW incorporate local problems identified by the Local Health Jurisdiction's (LHJs') 5-Year Needs Assessments and reflect the Title V priorities of the MCAH Division.

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

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

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

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

All BIH Sites are required to comply with the following tiered staffing matrix per the BIH 2015 Request For Supplemental Information (RSI) BIH RSI Instructions and Fiscal Year (FY) 2019-20 State General Fund expansion funding requirements to ensure fidelity and standardization across all sites:

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

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

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

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

Additional Enrollment Target for Expansion Funding to be served through BIH Model or Case Management	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
Local Health Jurisdiction	San Francisco, Santa Clara,	Contra Costa, Long Beach, Fresno, San Joaquin, Kern	San Diego, Alameda, Riverside	Sacramento, San Bernardino	Los Angeles
Enrollment Target	40	50	66	90	208
Local Health Jurisdiction		Solano			
Enrollment Target		8			

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

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

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

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

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

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

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

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

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

Coordinator Quarterly Report:

Reporting Period	**From**	**To**	**Due Date**
First Report	July 1, 2021	September 30, 2021	October 15, 2021
Second Report	October 1, 2021	December 31, 2021	January 15, 2022
Third Report	January 1, 2022	March 31, 2022	April 15, 2022
Fourth Report (WAIVED) Information during this reporting period will be included in the Annual Progress Report	April 1, 2022	June 30, 2022	August 15, 2022

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

Part II: Black Infant Health (BIH) Program

Goal 1: BIH local staff will assure program implementation, staff competency, data management, and maintain program fidelity and fiscal management to administer the program as required by the Program's Policy and Procedures (P&P's) and Scope of Work (SOW) guidelines. Local staff will also support, as their capacity allows, activities related to the revisions of the BIH model.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
IMPLEMENTATION **1.1** BIH Coordinator, under the guidance and leadership of the MCAH Director will provide oversight, maintain program fidelity, fiscal management and demonstrate that BIH activities are conducted as required in the BIH P&Ps, SOW, Data Collection Manual, BIH data collection forms, Group Curriculum, and MCAH Fiscal P&Ps.	**1.1** Implement the program activities as defined in the SOW. Annually review and revise internal local policies and procedures for delivering services to eligible BIH participants. BIH Coordinator will coordinate and collaborate with MCAH Director to complete, review, and approve the BIH budget prior to submission. Submit Agreement Funding Application (AFA) timely. Submit BIH Annual report by August 15. Submit BIH Quarterly Reports as directed by MCAH.	**1.1** Define and describe MCAH Director and BIH Coordinator responsibilities as they relate to BIH. (N) Provide organization chart that designates the delineation of responsibilities of MCAH Director and BIH Coordinator from MCAH to the BIH Program in AFA packet. Describe collaborative process between MCAH Director and BIH Coordinator related to BIH budget prior to AFA submission. (N)	**1.1** Submit BIH Annual report by August 15. Submit BIH Quarterly Reports as directed by MCAH. (See page 4)
1.2 Hire and maintain culturally competent/relevant personnel and required Full Time Equivalent (FTE) to implement a BIH Program that is relevant to the cultural heritage of African-American women, and the community.	**1.2** Maintain culturally competent staff to perform program services that honors the unique history/traditions of people of African-American descent as outlined in the P& P. At a minimum, the following key staffing roles are required: 1.0 FTE BIH Coordinator Family Health Advocates (FHA)/Group Facilitators (GF) based on MCAH-BIH designated tier level.	**1.2** • Describe process of recruiting and hiring staff at each site that are filled by personnel meeting qualifications in the P&P. • Include duty statements of all staff with submission of AFA packet. • Submission of all staff changes per guidelines outlined in BIH P&P.	**1.2** • Percent of key staffing roles at site filled by personnel who meet qualifications in the P&P. (N)

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	1 FTE Community Outreach Liaison (COL) 0.5 FTE Data Entry 1.0 FTE Mental Health Professional (MHP) 0.5 FTE Public Health Nurse (PHN) Utilization of a staff-hiring plan.		
TRAINING **1.3** All BIH staff will maintain and increase staff competency.	**1.3** Develop a plan to assess the ability of staff to effectively perform their assigned tasks, including regular observations of group facilitators. Identify staff training needs and ensure those needs are met, notifying MCAH of any training needs. Ensure that all key BIH staff participates in on-going training or educational opportunities designed to enhance cultural sensitivity. Ensure that all new and key BIH staff attend the Annual MCAH Sudden Infant Death Syndrome (SIDS) Conference to receive the latest AAP guidelines on infant safe sleep practices and SIDS risk reduction strategies. Establish local SIDS collaborative workgroups with community partners in order to enhance awareness of AA SIDS rates and to develop SIDS risk reduction strategies. Require that all key BIH staff (i.e. BIH Coordinator, and ALL direct service staff) attend mandatory MCAH Division-sponsored in-person or virtual trainings,	**1.3** List staff training activities in quarterly report. (N) Describe improved staff performance and confidence in implementing the program model due to participating in staff development activities and/or trainings. (N) List gaps in staff development and training in quarterly report. (N) Describe plan to ensure that staff development needs are met in quarterly report. (N) Describe how cultural sensitivity training has enhanced LHJ staff knowledge and how that knowledge is applied. (N) Describe how staff utilized information from the MCAH SIDS conference with participants. Document strategies and action plans related to SIDS risk reduction strategies developed from SIDS collaborative workgroup meetings. Recommend training topic suggestions for statewide meetings. (N)	**1.3** Maintain records of staff attendance at trainings. (N) Number of trainings and conferences (both state and local) attended by staff during FY 2021-22. Completion of at least two (2) group observation feedback forms by the BIH Coordinator for every group facilitator during FY 2021-22. (E)

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	conference calls, meetings and/or conferences as scheduled by MCAH Division. Quarter 1: Annual 2-day Basic Training Annual COL Meeting Quarter 2: Annual 2-day Advanced FHA/GF Meeting Quarter 3: Annual MHP/Public Health Nurse (PHN) Meeting Quarter 4: Annual Coordinator Meeting Annual 2-day Statewide Meeting Ensure that the BIH Coordinator and all direct service staff attend mandatory MCAH Division-sponsored training(s) prior to implementing the BIH Program. 2-day Abbreviated Training – scheduled by MCAH based on LHJ needs. 2-day Basic Training Quarter 1 Ensure that the BIH Coordinator and/or MCAH Director perform regular observations of GFs and assessments of FHAs, MHPs and/or PHNs case management activities.		

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
DATA COLLECTION AND ENTRY **1.4** All BIH participant program information and outcome data will be collected and entered timely and accurately using BIH required forms at required intervals.	**1.4** Ensure that all direct service staff participate in data collection, data entry, data quality improvement, and use of data collection software determined by MCAH. Ensure that all subcontractor agencies providing direct service enter data in the ETO as determined by MCAH. Ensure accuracy and completeness of data input into ETO system. Ensure that all staff receives updates about changes in ETO and forms. Ensure that a selected staff member with advanced knowledge of the BIH Program, data collection, and ETO is selected as the BIH Site's Data Entry lead and participates in all Data and Evaluation calls. Accurately and completely collect required participant information, with timely data input into the appropriate data system(s). Work with MCAH to ensure proper and continuous operation of the MCAH-BIH- ETO. Store Participant level Data forms on paper per guidelines in P&P. Define a data entry schedule for staff and monitor for adherence. Ensure that all staff that have ETO access are current in the SharePoint roster by completing	**1.4** Review ETO and fidelity reports, discuss during calls with BIH State Team. Review ETO Utilization Reports for all staff at BIH Sites. Enter all data into ETO within ten (10) working days of collection. Review of the BIH Data Collection Manual by all staff. Completion of ETO training by all staff. Participation in periodic MCAH-Data calls. Read data alerts or other data guidance sent via email or posted on SharePoint. Participation in role-specific trainings by the Data Entry Lead. Review of ETO data quality reports by the BIH Coordinator and Data Entry staff on at least a monthly basis. Conduct and report on audits of recruitment, enrollment, and service delivery paper forms against ETO reports; audit sample must include at least 10% of recruitment records and 10% of enrollment records.	**1.4** Number and percent of required forms that were entered within ten (10) days of collection. (E)

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	the Quarterly Roster Assessment.		
OUTREACH **1.5** All BIH LHJs will increase and expand community awareness of BIH by collaborating with other BIH counties and individually as a county on communication outreach activities, including the use of social media.	**1.5** All BIH LHJs will conduct outreach activities and build collaborative relationships with local Women, Infants, and Children (WIC) providers, Comprehensive Perinatal Services Program (CPSP) Perinatal Service Coordinators, social service providers, health care providers, the Faith-based community, and other community-based partners and individuals to increase and maximize awareness opportunities to ensure that eligible women are referred to BIH. All BIH LHJs will establish referral mechanisms that will facilitate reciprocity with partner agencies as appropriate. At a minimum, all BIH LHJs will utilize social media campaigns developed by MCAH to increase community awareness while conducting outreach activities.	**1.5** Describe the types of community partner agencies contacted by LHJ staff. (N) Describe outreach activities performed in order to reach target population. (N) Describe deviations in outreach activities, noting changes from local recruitment plan. (N) Document type, frequency and number of social media activities conducted on the BIH Primary Contact Table and submit with Quarterly and Annual Report. (N)	**1.5** Number of existing MOUs prior to FY 2021-22. (N) Number of new Memorandum of Understanding (MOUs) established in FY 2021-22. (N) Total number (overall and by type) of outreach activities completed by all staff during FY 2021-22. (N)
PARTICIPANT RECRUITMENT **1.6a** For BIH Group Sessions, all BIH LHJs will recruit African-American women 18 years of age and older, and less than 30 weeks pregnant.	**1.6a** Develop and implement a Participant Recruitment Plan (standardized intake process) according to the target population and eligibility guidelines in MCAH-BIH P&P and submit upon request. Review Recruitment plan annually and update as needed.	**1.6a** Submit participant triage algorithm with submission of AFA packet. Track and document progress in meeting goals of the Participant Recruitment Plan, review annually and update as needed.	**1.6a** Number and percent of recruited and referred women that were eligible (at least 18 years old and less than 30 weeks pregnant) based on their recruitment date. (E)

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
1.6b For Case Management Only, all BIH LHJs will recruit African-American teens at least 16 years of age and adult women, pregnant or up to 6 months postpartum.	**1.6b** Develop and implement a Participant Recruitment Plan (standardized intake process) according to the target population and eligibility guidelines in MCAH-BIH P&P and submit upon request.	**1.6b** • Track and document progress in meeting goals of the Participant Recruitment Plan, review annually and update as needed.	**1.6b** Total number of women enrolled in Case management services only.
PARTICIPANT REFERRAL **1.7** All BIH LHJs will establish a network of referral partners.	**1.7** Collaborate with network of established partners (community-based organizations, traditional and non-traditional partners, etc.) to develop a network of referral partners who will refer eligible women to BIH. Provide referrals to other MCAH programs for women who cannot participate in group intervention sessions.	**1.7** Describe process for ensuring that referral partner agencies are referring eligible women to BIH in quarterly reports and during technical assistance calls. (N)	**1.7** Total number of service providers that made referrals to the BIH Program in FY 2021-22. (E)
PARTICIPANT ENROLLMENT **1.8a** BIH Coordinator, under the guidance and leadership of the MCAH Director will ensure the following: • All participants enrolled in the BIH group model will be African-American. • All participants will be 18 years or older when enrolled. • All participants will be enrolled during pregnancy or postpartum.	**1.8a** Enroll women that are African-American. Enroll women at or before 30 weeks of pregnancy or up to 6 months postpartum. Enroll women that will participate in the group intervention.	**1.8a** Visual inspection of all recruitment eligibility fields on incoming referral forms for completeness. Inclusion of eligibility criteria with materials used for referral and recruitment.	**1.8a** Number and percent of enrolled women who meet eligibility criteria defined by age and timing of pregnancy. (E) – Fidelity Indicator A1b

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

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
• Participants enrolled in Case Management-Only intervention are not required to attend BIH Group sessions.			
PROGRAM PARTICIPATION **1.9.1** BIH Coordinator, under the guidance and leadership of the MCAH Director will ensure the following: All women will participate in a prenatal or postpartum group. All women will participate in a group within 45 days of enrollment. All groups will be implemented according to the 20-group intervention model as specified in the P&P. (see 1.9.3)	**1.9.1** Assign participants to a prenatal or postpartum group as part of enrollment process. Schedule groups to allow participants to attend within 30 days of enrollment. Enroll participants in a group within 45 days of first successful contact. Begin groups with the minimum required number of participants per the BIH P&P.	**1.9.1** Describe barriers, challenges and successes of enrolling women in a group within 30-45 days of first successful contact during technical assistance calls. (N) Describe barriers, challenges and successes of beginning groups with the minimum required number of participants during technical assistance calls. (N)	**1.9.1** Number and percent of enrolled women who attended a prenatal group session within 45 days of enrollment. (E) – Fidelity Indicator A3a Percent of group sessions that were conducted in the prescribed sequence and at the prescribed time intervals. (E) – Fidelity Indicator A3c Percent of group sessions in a series that were attended by at least 5 participants. (E) - Fidelity Indicator A3b.
1.9.2a BIH Coordinator, under the guidance and leadership of the MCAH Director will ensure the following: All BIH participants (enrolled in BIH Group) will complete all prenatal and postpartum assessments, as applicable within the recommended time intervals. All BIH participants (enrolled in BIH Group) will receive referrals to services outside of BIH based on Life Planning meetings. All BIH participants (enrolled in BIH Group) will receive door-to-door transportation assistance as	**1.9.2a** Assign participants to a FHA as part of enrollment process. Conduct services that align with Life Plan activities (goal setting). Collect completed self-assessment administered scaled questions as described in P&P. Collect the required number of assessments per timeframe outlined in P&P. Develop and implement a Life Plan based on goal setting during Life Planning meetings for each BIH participant; complete all prenatal and postpartum assessments; provide ongoing identification of her specific concerns/needs and referral to services outside of BIH	**1.9.2a** Collect and record service delivery activities for enrolled women into ETO. (E) Describe successes and/or challenges in assisting participants with setting short and long-term goals during Life Planning meetings. (N) Describe program improvements resulting from participant satisfaction survey findings at least quarterly. (N)	**1.9.2a** Number and percent of enrolled women who complete prenatal and/or postpartum assessments at the P&P-designated time intervals. (E) Number and percent of enrolled women who received at least one (1) case conference attended by a FHA or GF, and either the MHP or PHN. (E) – Fidelity Indicator A2a Number and percent of enrolled women with a Birth Plan collected before the expected date of delivery (among women past due). (E) – Fidelity Indicator (supplemental) A4ai.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
needed to attend group sessions and Life Planning meetings. All BIH locations will include a space dedicated for Child Watch during group sessions. All BIH Participants will be provided with necessary tools for participation in virtual services as necessary.	as needed based on Life Planning meetings. Ensure participant referrals are generated and completed for all services identified. Ensure participants have access to transportation assistance via Uber/Lyft or other door-to-door services in order to attend group sessions and Life Planning meetings. Ensure location of group services have dedicated child watch staff and space when group sessions are conducted. Ensure participants have access to necessary tools in order to participate in virtual services. Conduct participant dismissal activities. Conduct participant satisfaction surveys. Submit complete and accurate reports in the timeframe specified by MCAH.		Number and percent of enrolled women who have a known referral status for every documented referral at time of exit from the program (among women dismissed from BIH).(E) – Fidelity Indicator Q4a Number and percent of enrolled women who have been dismissed from BIH with a completed participant satisfaction survey. (E)
1.9.2b BIH Coordinator, under the guidance and leadership of the MCAH Director will ensure the following: Case Management participants will receive BIH Case Management support as defined in the P&P.	**1.9.2b** Assign participants to a FHA, MHP and/or PHN as part of enrollment process. Conduct case management services that align with identified needs of each participant. Collect required assessments per timeframe outlined in P&P. Develop and implement a Care Plan based on participant needs during case management meetings for each BIH participant; complete all prenatal and postpartum assessments;	**1.9.2b** Collect and record service delivery activities for enrolled women into ETO. (E) Describe program improvements resulting from participant satisfaction survey findings at least quarterly. (N)	**1.9.2b** • Number and percent of enrolled women who complete assessments at the P&P-designated time intervals. • Number and percent of enrolled women who received at least one (1) case conference attended by a FHA or GF, and either the MHP or PHN.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	provide ongoing identification of her specific concerns/needs and referral to services outside of BIH as needed based on case management meetings. Ensure participant referrals are generated and completed for all services identified. Conduct participant dismissal activities. Conduct participant satisfaction surveys. Submit complete and accurate reports in the timeframe specified by MCAH. BIH Case Management support will be provided until the child turns one year of age.		
1.9.3a BIH Coordinator, under the guidance and leadership of the MCAH Director will ensure that all BIH participants will participate in virtual or in-person Group Intervention Sessions.	**1.9.3a** Schedule Group Intervention Sessions with guidance from State BIH Team. All participants will have the opportunity to enroll in Group Intervention Sessions within 30-45 days of the first successful contact. Conduct and adhere to the 20-group intervention model as specified in the P&P.	**1.9.3a** Collect and record Group Intervention Session attendance records for all enrolled women into ETO. Submit FY 2021-22 Group Intervention Sessions Calendar to MCAH-BIH Program with submission of AFA and upon request. Describe participant successes or challenges with completing seven (7) of ten (10) prenatal and/or postpartum Group Intervention Sessions. (N)	**1.9.3a** Number of Group Intervention Sessions entered into ETO that began during FY 2021-22. (E) Number and percent of enrolled women who attend at least one (1) prenatal or postpartum Group Intervention Session. (E) Number and percent of enrolled women who attended the expected number of Group Intervention Sessions based upon the number of days in program (E) – Fidelity Indicators D1a and D1b.
1.9.3b BIH Participants enrolled in the Case Management only intervention are not required	**1.9.3b** • Schedule case management meetings per guidance in the BIH P&P.	**1.9.3b** • Describe participant successes or challenges with completing case management services.	**1.9.3b** • Number and percent of enrolled women who complete case management

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
to attend BIH group sessions.	• Participants enrolled in the BIH Case Management only intervention may enroll in the BIH Group model on a case-by-case basis.		meetings at the P&P-designated time intervals.
PARTICIPANT RETENTION **1.9.4** BIH Coordinator, under the guidance and leadership of the MCAH Director will ensure that participant retention strategies are in place.	**1.9.4** Discuss and develop participant retention strategies during team meetings. Plan participant retention strategies as they relate to program implementation components (outreach/recruitment, enrollment, Life Planning, group sessions, program completion). Ensure participants have access to transportation assistance via Uber/Lyft or other door-to-door services in order to attend group sessions and Life Planning meetings. Ensure location of group services have dedicated child watch staff and space when group sessions are conducted. Ensure participants have access to necessary tools in order to participate in virtual services. Designated staff will conduct participant satisfaction surveys after group sessions and at program completion to obtain feedback related to improvement of retention strategies.	**1.9.4** Discuss participant retention strategies during technical assistance calls. (N) Review participant retention strategies quarterly and update as needed. (N) Document participant retention strategies in ETO and in Quarterly Reports. (E/N) Submit participant retention strategy successes and challenges with Annual Report. (N)	**1.9.4** Submit Participant Retention Strategies with Quarterly and Annual Report. (N)

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

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
2.1 BIH Coordinator under the guidance and leadership of the MCAH Director will increase and expand community awareness of African-American birth outcomes and the role of the Black Infant Health Program.	**2.1** Implementation of a Community Advisory Board (CAB) in order to: Inform the community about disparate birth outcomes among African-American women by delivering standardized messages describing how the BIH Program addresses these issues. Create partnerships with community and referral agencies that support the broad goals of the BIH Program, through formal and informal agreements. Develop and implement a community awareness plan that outlines how community engagement activities will be conducted. Develop and implement activities related to multi-level community engagement and awareness with referral partners to identify service gaps in the LHJ target area. Develop performance strategies with local organizations that provide services to AA women and infants to improve referrals and linkage to BIH services. Collaborate with local MCAH programs and other partners such as Medi-Cal to identify strategies, activities and provide technical assistance to: ○ Improve access to health care services	**2.1** • Document efforts of Community Advisory Board, collaborations or other similar formal or informal partnerships to address maternal and infant health disparities, social determinants of health, well-woman visits and postpartum visits at least once per quarter. (N) • Submit quarterly reports that describe outreach activities electronically using ETO in a timely manner. (N) • Document the local plan for community linkages, including an effective referral process that will be reviewed on an annual basis and updated as needed. (N) • Document successes and barriers to community education activities or events at least once per quarter in the ETO through quarterly reporting. (E/N) List and maintain current documentation on the nature of formal and informal partnerships with community and referral agencies at least once a quarter; record MOUs and referral relationships in the ETO service provider details form. (E/N) • Enter all outreach activities in the Community Contacts Log in ETO. • Document collaborative efforts with local MCAH programs and Regional Perinatal Programs	**2.1** Submit CAB meeting materials (roster, agenda, minutes) with BIH quarterly report. (N) Number, format, and outcomes associated with community outreach activities conducted by BIH Coordinator and/or MCAH Director during FY 2021-22. (E/N)

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	○ Increase utilization of well-woman and postpartum visits ○ Identify Preterm Birth (PTB) reduction strategies ○ Increase the utilization of preconception health services. Collaborate with local MCAH programs and Regional Perinatal Programs to improve maternal and perinatal systems of care. Participate in collaboratives with community partners to review data and develop strategies and policies to address social determinants of health and disparities. Collaborate with agencies providing services to AA moms to develop and disseminate tangible Reproductive Life Planning training materials (e.g. power point presentation, webinars, toolkits, etc.) to focus on Before, During, and Beyond Pregnancy for dissemination and integration in their service delivery protocols.	describing strategies to improve maternal and perinatal systems of care at least quarterly. (N) • Maintain current lists of community providers and Service Provider details in ETO.	
2.2 BIH COL will increase information sharing with other local agencies providing services to African-American women and children in the community and establish a clear point of contact.	**2.2** Develop collaborative relationships with local Medi-Cal Managed Care, Commercial Health Plans, WIC and local agencies in the community that provide services to African-American women and children, to establish strong resource linkages for recruitment of potential participants and for referrals of active participants.	**2.2** Enter all outreach activities in the Community Contacts Log in ETO. Maintain current lists of community providers and Service Provider details in ETO. Describe materials used to inform community partners about BIH. (N)	**2.2** Number of agencies where the COL has a documented point(s) of contact and with whom information is regularly exchanged. (N) Total number of agencies with outreach records during FY 2021-22. (N)

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	Develop a clear point(s) of contact with collaborating community agencies on a regular basis as it relates to outreach, enrollment, referrals, care coordination, etc. Assess referrals from partner agencies to determine enrollment points of entry quarterly.	List and describe barriers, challenges and/or successes related to establishing community partnerships and point(s) of contact at least quarterly. (N)	

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

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
3.1 BIH Coordinator under the guidance and leadership of the MCAH Director will ensure that all BIH participants will have their social support measured at baseline and after attending the prenatal and/or postpartum group intervention and completing Life Planning activities using the Social Provisions Scale – Short (SPS-S).	**3.1** Implement the prenatal and postpartum group intervention with fidelity to the P&P. Encourage participants to attend and participate in group sessions. Support clients in fostering healthy interpersonal and familial relationships. Report results from group session information form, including description of participant engagement in group activities for each group session.	**3.1** Provide FY 2021-22 group intervention schedules upon request. (N) Percent of participants who meet expected prenatal life planning session attendance (prenatal dose). (E) – Fidelity Indicator D2a Percent of participants who meet expected prenatal group session attendance (prenatal dose). (E) – Fidelity Indicator D1a and D1b.	**3.1** Number and percent of enrolled participants who have both a baseline and follow-up measurement. (E) – Fidelity Indicator P3aii
3.2 BIH Coordinator under the guidance and leadership of the MCAH Director will ensure that all BIH participants will have their self-esteem, mastery, coping and resiliency measured at baseline and after attending prenatal and/or postpartum group intervention and completing Life Planning activities using the Rosenberg Self-Esteem, Pearlin Mastery and the Brief Resilience Scales.	**3.2** LHJ staff will facilitate the administration of the self-esteem, mastery, coping, and resiliency tools and their frequency as outlined in the P&P focused on the participant's ability to be resilient and manage chronic stressors presenting during pregnancy. All activities are delivered with an understanding of African-American culture and history. Assist participants in identifying and utilizing their personal strengths. Develop and implement a Life Plan with each participant. Teach and provide support to participants as they develop goal-setting skills and create their Life Plans. Teach participants about the importance of stress reduction	**3.2** Describe challenges/barriers why participants did not have their self-esteem, mastery, coping and resiliency measured after attending prenatal and/or postpartum group intervention and completing Life Planning activities. (N)	**3.2** Number and percent of enrolled participants who have both a baseline and follow-up measurement. (E) – Fidelity Indicator P3aii

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	and guide them in applying stress reduction techniques. Support participants as they become empowered to take actions toward meeting their needs. Teach participants how to express their feelings in constructive ways. Help participants to understand societal influences and their impact on African-American health and wellness.		

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

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

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	Provide information on the benefits and importance of delivering a full term baby. Provide information related to the risks associated with delivering via cesarean section in order to make an informed decision related to their delivery.		
4.2 BIH LHJ staff will coordinate with State MCAH and BIH staff to assist BIH Participants with increased knowledge and understanding of a Reproductive Life Plan and Family Planning services by providing culturally and linguistically appropriate tools for integration into existing program materials.	**4.2** Promote and support family planning by providing information and education on birth spacing and interconception health during group sessions and Life Planning Meetings. Help participants understand and value the concept of reproductive life planning as Life Plans are completed and discussed with Family Health Advocates during Life Planning Meetings and Group Facilitators during group sessions. Provide referrals and promote linkages to family planning providers including Family Planning, Access, Care, and Treatment (Family PACT). • Help participants understand the characteristics of healthy relationships and provide resources that can help participants deal with abuse, reproductive coercion or birth control sabotage.	**4.2** Summarize challenges/barriers of birth control usage among enrolled women who have delivered. (N) Document collaborative activities with local MCAH programs and other partners such as Medi-Cal Managed Care and CPSP Provider networks to identify strategies, activities and provide technical assistance to improve access to health care services and increase utilization of the postpartum visit. (N) Describe collaborative efforts with Violence Prevention Organizations such as Futures without Violence to determine service capacity to adequately meet needs identified by participants and LHJ staff providing case management services. (N)	**4.2** Number and percent of participants who use any method of birth control to prevent pregnancy after their babies are born. (E) Number and percent of participants who attend a 4-6 week postpartum checkup with a medical provider. (E)
4.3 BIH Coordinator under the guidance and leadership of the MCAH Director will ensure that all BIH participants will be screened	**4.3** Local staff will work with or support participants to:	**4.3** Summarize successes and challenges in addressing mental health issues, including mental	**4.3** Number and percent of enrolled participants who completed the EPDS 6-8 weeks postpartum. (E) – Fidelity Indicators A5a

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

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

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

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

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

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
6.1 BIH Participants will have an increased knowledge of strategies and interventions they can utilize to reduce the occurrence of preterm births.	**6.1** Provide participants with health education materials that address preterm birth reduction strategies and breastfeeding including those from MCAH-BIH and MOD. LHJ staff will distribute any customized preterm birth resources to local medical providers. LHJ staff will support, promote, and attend preterm birth educational webinars for medical providers. Increase knowledge of infant safe sleep practices, SIDS, SUID risk reduction by participating in local SIDS collaborative meetings and trainings.	**6.1** Participate in MOD webinars and trainings that provide LHJ staff with opportunities to increase their knowledge of preterm birth reduction strategies and other approaches for having a healthy pregnancy. (N) Distribute and encourage MCAH programs to integrate the following preterm birth resources to educate women and providers on preventing preterm births: (N) ○ Reducing Preterm Birth: What Black Women Need to Know Tip Sheet ○ Reducing Premature Birth: What Providers Need to Know Tip Sheet ○ Reducing Premature Birth Discussion Points – guidance to encourage conversation with women about preterm birth reduction strategies Provide participants with health education materials related to safe sleep practices and SIDS reduction. (N) Conduct and document collaborative activities with State MCAH Programs used to identify strategies, provide technical assistance and disseminate resource materials that address the benefits of breastfeeding. (N)	**6.1** Maintain records of staff attendance at trainings. (N) Maintain attendee records of trainings/Webinars hosted by LHJ. (N) Maintain a list of local medical providers LHJ staff distribute preterm birth resources to. (N) Number and percent of participants who complete the safety checklist prior to delivery. (E) – Fidelity Indicator A4aii Number and percent of postpartum participants who initiate breastfeeding. (E)

Goal 7: To educate the public about the Black Infant Health Program and the factors leading to the disparities in maternal and infant birth outcomes by providing information that is consistent, culturally responsive.

Objectives	Activity	Evaluation/Deliverables
7.1 Create and/or maintain a statewide public awareness campaign to inform the State about African American birth outcome inequities and/or the root causes of these inequities.	7.1 Develop public awareness materials that are focus tested with targeted community.	7.1 Provide a report that describes outreach engagement plan in the community. Share ongoing progress in developing/maintaining campaign during quarterly BIH Statewide Media Campaign meetings/reports. LHJ Program Coordinator to review all staff/contractor/subcontractor deliverables and methodologies to ensure materials: o honor the unique history/traditions of people of African American descent o reflect/include the targeted community o are culturally responsive and engaging LHJ to share final campaign deliverables and methodologies with the State for final review and approval.
7.2 Hire and maintain culturally competent staff/contractors/subcontractors to develop campaign materials that are relevant and respectful to the cultural heritage of African American women and the community.	7.2 Maintain culturally competent staff/contractors/subcontractors to perform media campaign services that honors the unique history/traditions of people of African American descent	7.2 Describe process of recruiting and hiring staff/contractors/subcontractors. Include resumes of staff/contractors/subcontractors with submission of AFA packet. Submit all staff/contractor/subcontractor changes to the State for review

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

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

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

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

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

[PRELIMINARY][2] – Percent of women enrolled for at least 30 days who have attended the expected number of life planning meetings

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

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

Agreement Between the County of Fresno and the California Department of Public Health

Name/No.: CDPH Maternal, Child and Adolescent Health (MCAH) Division Agreement Funding Application (AFA). Agreement - Agreement No. 202110 MCAH and Agreement No. 202110 Black Infant Health (BIH)

Fund/Subclass:	0001/10000
Organization #:	56201700; 56201706
Revenue Account #:	4382, 3530