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

FUNDING AGREEMENT PERIOD
FY 2019-2020

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 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 applicable program
MCAH #: 201910
BIH #: 201910
AFLP #:
Update Effective Date: 06/07/19 (only required when submitting updates)
Federal Employer ID#: 94-6000512
Complete Official Agency Name: County of Fresno
Business Office Address: 1221 Fulton Street, Fresno, CA
Agency Phone: (559) 600-3330
Agency Fax: (559) 455-4705
Agency Website: www.co.fresno.ca.us

AGREEMENT FUNDING APPLICATION
POLICY COMPLIANCE AND CERTIFICATION

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

MCAH #: 201910

BIH #: 201910

AFLP #:

Update Effective Date: _____(only required when submitting updates

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.

Original signature of official authorized to commit the Agency to a MCAH Agreement

Signature line: _____

Name (Print) Nathan Magsig

Title_Chairman of the Board of Supervisors of the County of Fresno_ Date November 5 2019

Original Signature of MCAH / AFLP Director

Signature line: _____

Name (Print)_Rose Mary Rahn_____

Title MCAH Director Date 6/7/19

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

	CONTACT	FIRST NAME	LAST NAME	TITLE	ADDRESS	PHONE	EMAIL ADDRESS
1	AGENCY EXECUTIVE DIRECTOR	David	Pomaville	Public Health Director	1221 Fulton Street, Fresno, CA, 93721	(559) 600-3200	dpomaville@fresnocount
2	MCAH DIRECTOR	Rose Mary	Rahn	Division Manager	1221 Fulton Street, Fresno, CA, 93721	(559) 600-3330	rrahn@fresnocountyca.g
3	MCAH COORDINATOR (Only complete if different from #2)	Lorraine	Hardy	Supervising PHN	1221 Fulton Street, Fresno, CA, 93721	(559) 600-3330	hardyl@fresnocountyca.g
4	MCAH FISCAL CONTACT	Aphivanh	Xayavath	Staff Analyst	1221 Fulton Street, Fresno, CA, 93721	(559) 600-3330	axayavath@fresnocounty
5	FISCAL OFFICER	Bruna	Chavez	Public Health Business Officer	1221 Fulton Street, Fresno, CA, 93721	(559) 600-3200	blchavez@fresnocountyc
6	CLERK OF THE BOARD or	Bernice	Seidel	Clerk of the Board	2281 Tulare Street, Room 301, Fresno, CA, 93721	(559) 600-1601	bseidel@fresnocountyca.
7	CHAIR BOARD OF SUPERVISORS	Nathan	Magsig	Chairman, Board of Supervisors	2281 Tulare Street, Room 300, Fresno, CA, 93721	(559) 600-5000	District5@fresnocountyc
8	OFFICIAL AUTHORIZED TO COMMIT AGENCY	Nathan	Magsig	Chairman, Board of Supervisors	2281 Tulare Street, Room 300, Fresno, CA, 93721	(559) 600-5000	District5@fresnocountyc
9	FETAL INFANT MORTALITY REVIEW (FIMR) COORDINATOR	Natalie	Adolph	Public Health Nurse	1221 Fulton Street, Fresno, CA, 93721	(559) 600-3330	nadolph@fresnocountyc
10	SUDDEN INFANT DEATH SYNDROME (SIDS) COORDINATOR/CONTACT	Natalie	Adolph	Public Health Nurse	1221 Fulton Street, Fresno, CA, 93721	(559) 600-3330	nadolph@fresnocountyc
11	PERINATAL SERVICES COORDINATOR	Linda	Griffith	Public Health Nurse	1221 Fulton Street, Fresno, CA, 93721	(559) 600-3330	lgriffith@fresnocountyca.

	CONTACT	FIRST NAME	LAST NAME	TITLE	ADDRESS	PHONE	EMAIL ADDRESS
1	AGENCY EXECUTIVE DIRECTOR	David	Pomaville	Public Health Director	1221 Fulton Street, Fresno, CA, 93721	(559) 600-3200	dpomaville@fresnocountyca.gov
2	BLACK INFANT HEALTH (BIH) COORDINATOR	Fanta	Nelson	Health Educator	142 E California Ave, Fresno, CA, 93706	(559) 600-3330	fnelson@fresnocountyca.gov
3	BIH FISCAL CONTACT	Aphivanh	Xayavath	Staff Analyst	1221 Fulton Street, Fresno, CA, 93721	(559) 600-3330	axayavath@fresnocountyca.gov
4	FISCAL OFFICER	Bruna	Chavez	Public Health Business Officer	1221 Fulton Street, Fresno, CA, 93721	(559) 600-3200	blchavez@fresnocountyca.gov
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California Department of Public Health — Maternal, Child and Adolescent Health Division

BUDGET SUMMARY

FISCAL YEAR	BUDGET	BUDGET STATUS	BUDGET BALANCE
2019-20	ORIGINAL	ACTIVE	0.00

Version 5.0 - 150 Quarterly 04.18.19

Program: Maternal, Child and Adolescent Health (MCAH)
Agency: 201910 Fresno
SubK:

		UNMATCHED FUNDING								NON-ENHANCED MATCHING (50/50)				ENHANCED MATCHING (75/25)			
		MCAH-TV		MCAH-SIDS		TBD		AGENCY FUNDS		0		MCAH-Cnty NE		0		MCAH-Cnty E	
	(1)	(2)	(3)	(4)	(5)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)
	TOTAL FUNDING	%	TITLE V	%	SIDS	%	TBD	%	Agency Funds*	%		%	Combined Fed/Agency*	%		%	Combined Fed/Agency*
ALLOCATION(S) →			210,795.00		7,372.00		0.00										#VALUE!
EXPENSE CATEGORY																	
(I) PERSONNEL	5,419,430.88		210,795.00		7,372.00		0.00		1,272,933.51		0.00		2,269,746.78		0.00		1,658,583.59
(II) OPERATING EXPENSES	126,238.00		0.00		0.00		0.00		34,160.00		0.00		92,078.00		0.00		0.00
(III) CAPITAL EXPENDITURES	0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00
(IV) OTHER COSTS	150,000.00		0.00		0.00		0.00		49,500.00		0.00		100,500.00		0.00		0.00
(V) INDIRECT COSTS	1,354,857.72		0.00		0.00		0.00		372,721.36		0.00		982,136.36		0.00		0.00
BUDGET TOTALS*	7,050,526.60	2.99%	210,795.00	0.10%	7,372.00	0.00%	0.00	24.53%	1,729,314.87	0.00%	0.00	48.85%	3,444,461.14	0.00%	0.00	23.52%	1,658,583.59
BALANCE(S) →			0.00		0.00		0.00										

TOTAL TITLE V	210,795.00	→	210,795.00		
TOTAL SIDS	7,372.00	→	7,372.00		
TOTAL TITLE XIX	2,966,168.26	→		[50%] 1,722,230.57	[75%] 1,243,937.69
TOTAL AGENCY FUNDS	3,866,191.34	→	1,729,314.87	[50%] 1,722,230.57	[25%] 414,645.90

$ 3,184,335.26 — Maximum Amount Payable from State and Federal resources

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

MCAH/PROJECT DIRECTOR'S SIGNATURE — DATE: 9-13-19

AGENCY FISCAL AGENT'S SIGNATURE — DATE: 9/16/19

* 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	TBD	AGENCY FUNDS	0	MCAH-Cnty NE	0	MCAH-Cnty E
PCA Codes		53107	53112	0		0	53118	0	53117
(I) PERSONNEL		210,795.00	7,372.00	0.00		0.00	1,134,873.39	0.00	1,243,937.69
(II) OPERATING EXPENSES		0.00	0.00	0.00		0.00	46,039.00	0.00	0.00
(III) CAPITAL EXPENSES		0.00	0.00	0.00		0.00	0.00	0.00	0.00
(IV) OTHER COSTS		0.00	0.00	0.00		0.00	50,250.00	0.00	0.00
(V) INDIRECT COSTS		0.00	0.00	0.00		0.00	491,068.18	0.00	0.00
Totals for PCA Codes	3,184,335.26	210,795.00	7,372.00	0.00		0.00	1,722,230.57	0.00	1,243,937.69

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

Program:	Maternal, Child and Adolescent Health (MCAH)
Agency:	201910 Fresno
SubK:	

		UNMATCHED FUNDING									NON-ENHANCED MATCHING (50/50)				ENHANCED MATCHING (75/25)				
		MCAH-TV		MCAH-SIDS		TBD		AGENCY FUNDS			0		MCAH-Cnty NE		0		MCAH-Cnty E		
	(1)	(2)	(3)	(4)	(5)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)		
	TOTAL FUNDING	%	TITLE V	%	SIDS	%	TBD	%	Agency Funds*	%		%	Combined Fed/Agency*	%		%	Combined Fed/Agency*		
(II) OPERATING EXPENSES DETAIL												% TRAVEL NON-ENH MATCH	49.22%			% TRAVEL ENH MATCH	24.20%	% PERSONNEL MATCH	72.94%
TOTAL OPERATING EXPENSES	126,238.00		0.00		0.00		0.00		34,160.00		0.00		92,078.00		0.00		0.00	Match Available	
TRAVEL	47,628.00	0.00%	0.00		0.00		0.00	27.06%	12,888.14		0.00	72.94%	34,739.86		0.00		0.00		0.48%
TRAINING	35,895.00	0.00%	0.00		0.00		0.00	27.06%	9,713.19		0.00	72.94%	26,181.81		0.00		0.00		0.00%
1 Telephones	27,730.00	0.00%	0.00		0.00		0.00	27.06%	7,503.74		0.00	72.94%	20,226.26						0.00%
2 Office Supplies	11,500.00	0.00%	0.00		0.00		0.00	27.06%	3,111.90		0.00	72.94%	8,388.10						0.00%
3 Postage	925.00	0.00%	0.00		0.00		0.00	27.06%	250.31		0.00	72.94%	674.70						0.00%
4 Duplicating	2,560.00	0.00%	0.00		0.00		0.00	27.06%	692.74		0.00	72.94%	1,867.26						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		0.00				

(IV) OTHER COSTS DETAIL																	% PERSONNEL MATCH 72.94%
TOTAL OTHER COSTS	150,000.00		0.00		0.00		0.00		49,500.00		0.00		100,500.00		0.00		0.00		
SUBCONTRACTS																	
1 University of California, San Francisco	150,000.00	0.00%	(0.00)		0.00		0.00	33.00%	49,500.00		0.00	67.00%	100,500.00		0.00		0.00		
2			0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		
3			0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		
4			0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		
5			0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		
OTHER CHARGES																			Match Available
1			0.00		0.00		0.00		0.00		0.00		0.00						
2			0.00		0.00		0.00		0.00		0.00		0.00						
3			0.00		0.00		0.00		0.00		0.00		0.00						
4			0.00		0.00		0.00		0.00		0.00		0.00						
5			0.00		0.00		0.00		0.00		0.00		0.00						
6			0.00		0.00		0.00		0.00		0.00		0.00						
7			0.00		0.00		0.00		0.00		0.00		0.00						
8			0.00		0.00		0.00		0.00		0.00		0.00						

(V) INDIRECT COSTS DETAIL																	
TOTAL INDIRECT COSTS	1,354,857.72		0.00		0.00		0.00		372,721.36		0.00		982,136.36				
25.00% of Total Wages + Fringe Benefits	1,354,857.72	0.00%	0.00		0.00		0.00	27.51%	372,721.36		0.00	72.49%	982,136.36				

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

Program:	Maternal, Child and Adolescent Health (MCAH)
Agency:	201910 Fresno
SubK:	

		UNMATCHED FUNDING									NON-ENHANCED MATCHING (50/50)				ENHANCED MATCHING (75/25)			
		MCAH-TV		MCAH-SIDS		TBD		AGENCY FUNDS			0		MCAH-Cnty NE		0		MCAH-Cnty E	
	(1)	(2)	(3)	(4)	(5)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	
	TOTAL FUNDING	%	TITLE V	%	SIDS	%	TBD	%	Agency Funds*	%		%	Combined Fed/Agency*	%		%	Combined Fed/Agency*	
(I) PERSONNEL DETAIL																		
TOTAL PERSONNEL COSTS	5,419,430.88		210,795.00		7,372.00		0.00		1,272,933.51		0.00		2,269,746.78		0.00		1,658,583.59	
FRINGE BENEFIT RATE 79.69%	2,403,508.88		93,487.24		3,269.47		0.00		564,543.97		0.00		1,006,629.05		0.00		735,579.15	
TOTAL WAGES	3,015,922.00		117,307.76		4,102.53		0.00		708,389.55		0.00		1,263,117.73		0.00		923,004.43	

	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	Rose Mary Rahn	Division Manager	20.00%	133,789	26,758.00	0.00%			0.00		0.00	34.31%	9,180.67		0.00	54.46%	14,572.41		0.00	11.23%	3,004.92	69.4%	X
2	Rose Mary Rahn	MCAH Director	50.00%	133,789	66,895.00	0.00%			0.00		0.00	34.31%	22,951.67		0.00	54.46%	36,431.02		0.00	11.23%	7,512.31	69.4%	X
3	Bertha Conchas	Administrative Assistant II	70.00%	48,538	33,976.00	0.00%	(0.00)		0.00		0.00	31.40%	10,668.46		0.00	68.60%	23,307.54		0.00	0.00%	0.00	69.4%	X
4	Aphivanh Xayavath	Staff Analyst III	100.00%	73,583	73,583.00	0.00%	(0.00)		0.00		0.00	54.00%	39,724.02		0.00	46.00%	33,838.98		0.00	0.00%	0.00	69.4%	X
5	Dalgit Martinez	Account Clerk I	30.00%	39,878	11,964.00	0.00%	0.00		0.00		0.00	32.06%	3,835.66		0.00	67.94%	8,128.34		0.00	0.00%	0.00	69.4%	X
6	Linda Griffith	Public Health Nurse II -PSC	100.00%	95,362	95,362.00	35.46%	33,815.37		0.00		0.00		0.00		0.00	42.33%	40,366.73		0.00	22.21%	21,179.90	69.4%	X
7	Natalie Adolph	Public Health Nurse II -SIDS/FIMR Coord	100.00%	89,203	89,203.00	0.00%	0.00	4.60%	4,102.53		0.00	29.61%	26,413.81		0.00	50.47%	45,020.75		0.00	15.32%	13,665.90	69.4%	X
8	Jennifer Pino	Medical Social Worker II	85.00%	64,296	54,652.00	0.00%	0.00		0.00		0.00	11.16%	6,099.16		0.00	88.84%	48,552.84		0.00	0.00%	0.00	94.5%	X
9	Keesha Clark	Medical Social Worker II	50.00%	59,910	29,955.00	0.00%	0.00		0.00		0.00	8.71%	2,609.08		0.00	91.29%	27,345.92		0.00	0.00%	0.00	94.5%	X
10	Bee Vang	Epidemiologist	25.00%	77,313	19,328.00	0.00%	0.00		0.00		0.00	30.60%	5,914.37		0.00	69.40%	13,413.63		0.00	0.00%	0.00	69.4%	X
11	Ana Carbajal	Health Education Assistant	50.00%	42,090	21,045.00	0.00%	0.00		0.00		0.00	50.42%	10,610.89		0.00	49.58%	10,434.11		0.00	0.00%	0.00	69.4%	X
12	Tong Thao	Health Education Assistant	50.00%	46,869	23,435.00	0.00%	0.00		0.00		0.00	43.80%	10,264.53		0.00	56.20%	13,170.47		0.00	0.00%	0.00	69.4%	X
13	VACANT	Health Education Assistant	50.00%	37,743	18,872.00	0.00%	0.00		0.00		0.00	47.00%	8,869.84		0.00	53.00%	10,002.16		0.00	0.00%	0.00	69.4%	X
14	Christine Vang	Health Education Specialist	80.00%	50,457	40,366.00	0.00%	0.00		0.00		0.00	54.11%	21,842.04		0.00	45.89%	18,523.96		0.00	0.00%	0.00	69.4%	X
15	VACANT	Health Education Specialist	100.00%	45,086	45,086.00	0.00%	0.00		0.00		0.00	54.11%	24,396.03		0.00	45.89%	20,689.97		0.00	0.00%	0.00	69.4%	X
16	Ah Vang	Health Educator	80.00%	67,054	53,643.00	0.00%	(0.00)		0.00		0.00	53.08%	28,473.70		0.00	46.92%	25,169.30		0.00	0.00%	0.00	69.4%	X
17	Fanta Nelson	Health Educator	50.00%	59,579	29,790.00	0.00%	0.00		0.00		0.00	41.49%	12,359.87		0.00	58.51%	17,430.13		0.00	0.00%	0.00	69.4%	X
18	Valerie Wells	Supervising Office Assistant	100.00%	54,125	54,125.00	0.00%	0.00		0.00		0.00	41.77%	22,608.01		0.00	58.23%	31,516.99		0.00	0.00%	0.00	69.4%	X
19	Gabriel Torres	Office Assistant II	100.00%	28,013	28,013.00	0.00%	0.00		0.00		0.00	19.63%	5,498.95		0.00	80.37%	22,514.05		0.00	0.00%	0.00	94.5%	X
20	VACANT	Office Assistant I	100.00%	26,058	26,058.00	0.00%	0.00		0.00		0.00	7.56%	1,969.98		0.00	92.44%	24,088.02		0.00	0.00%	0.00	94.5%	X
21	Diana Colin	Office Assistant III	100.00%	40,576	40,576.00	0.00%	0.00		0.00		0.00	8.22%	3,335.35		0.00	91.78%	37,240.65		0.00	0.00%	0.00	94.5%	X
22	Linda Willome	Office Assistant III	100.00%	38,799	38,799.00	0.00%	0.00		0.00		0.00	8.40%	3,259.12		0.00	91.60%	35,539.88		0.00	0.00%	0.00	94.5%	X
23	Sophia Rodriguez	Office Assistant III	100.00%	40,576	40,576.00	0.00%	0.00		0.00		0.00	12.72%	5,161.27		0.00	87.28%	35,414.73		0.00	0.00%	0.00	94.5%	X
24	Martha Garcia	Office Assistant III	100.00%	40,576	40,576.00	0.00%	0.00		0.00		0.00	41.73%	16,932.36		0.00	58.27%	23,643.64		0.00	0.00%	0.00	94.5%	X
25	Melinda Meza	Office Assistant III	50.00%	33,901	16,951.00	0.00%	0.00		0.00		0.00	9.60%	1,627.30		0.00	90.40%	15,323.70		0.00	0.00%	0.00	94.5%	X
26	VACANT	Office Assistant I	100.00%	26,058	26,058.00	0.00%	0.00		0.00		0.00	7.56%	1,969.98		0.00	92.44%	24,088.02		0.00	0.00%	0.00	94.5%	X
27	Christina Wyrick	Program Technician I	100.00%	41,186	41,186.00	0.00%	0.00		0.00		0.00	15.00%	6,177.90		0.00	85.00%	35,008.10		0.00	0.00%	0.00	94.5%	X
28	Lia Vangyi	Public Health Nurse II (1677)	100.00%	100,314	100,314.00	0.00%	0.00		0.00		0.00	59.55%	59,736.99		0.00	29.74%	29,833.38		0.00	10.71%	10,743.63	69.4%	X
29	Fred Toshimitsu	Public Health Nurse II (1677)	100.00%	93,831	93,831.00	0.00%			0.00		0.00	76.56%	71,837.01		0.00	13.20%	12,385.69		0.00	10.24%	9,608.29	69.4%	X
30	Megan Gunn	Supervising Public Health Nurse (1615)	70.00%	114,783	80,348.00	0.00%			0.00		0.00	9.82%	7,890.17		0.00	39.83%	32,002.61		0.00	50.35%	40,455.22	94.3%	X
31	Barbara Besmer	Public Health Nurse II (1615)	100.00%	100,314	100,314.00	17.13%	17,183.79		0.00		0.00		0.00		0.00	15.01%	15,057.13		0.00	67.86%	68,073.08	94.3%	X
32	Eileen Murry	Public Health Nurse I (1615)	100.00%	82,057	82,057.00	0.00%	0.00		0.00		0.00	10.28%	8,435.46		0.00	21.16%	17,363.26		0.00	68.56%	56,258.28	94.3%	X
33	Nestor Yalong	Public Health Nurse I (1615)	100.00%	80,680	80,680.00	16.99%	13,710.99		0.00		0.00	0.02%	12.68		0.00	49.00%	39,533.20		0.00	33.99%	27,423.13	94.3%	X
34	Pon Chin	Public Health Nurse II (1615)	100.00%	101,679	101,679.00	20.72%	21,067.89		0.00		0.00		0.00		0.00	15.53%	15,790.75		0.00	63.75%	64,820.36	94.3%	X
35	Megan Gunn	Supervising Public Health Nurse (1670)	30.00%	114,783	34,435.00	8.35%	2,875.32		0.00		0.00		0.00		0.00	49.52%	17,052.21		0.00	42.13%	14,507.47	94.5%	X
36	Alexandria Lewis	Public Health Nurse I (1670)	100.00%	74,427	74,427.00	18.65%	13,880.64		0.00		0.00		0.00		0.00	18.91%	14,074.15		0.00	62.44%	46,472.22	94.5%	X
37	Elizabeth Martinez	Public Health Nurse I (1670)	100.00%	74,427	74,427.00	19.85%	14,773.76		0.00		0.00		0.00		0.00	14.42%	10,732.37		0.00	65.73%	48,920.87	94.5%	X
38	Lillarose Bangs	Supervising Public Health Nurse	85.00%	112,235	95,400.00	0.00%			0.00		0.00	16.04%	15,302.16		0.00	48.19%	44,065.26		0.00	37.77%	36,032.58	94.5%	X
39	Deborah Omolayo	Public Health Nurse II	30.00%	92,291	27,687.00	0.00%	0.00		0.00		0.00	7.26%	2,010.08		0.00	50.65%	14,023.47		0.00	42.09%	11,653.46	94.5%	X
40	Nadia Chavez	Public Health Nurse II	45.00%	93,831	42,224.00	0.00%			0.00		0.00	7.51%	3,171.02		0.00	23.05%	9,732.63		0.00	69.44%	29,320.35	94.5%	X
41	Janel Claybon	Public Health Nurse II	25.00%	92,120	23,030.00	0.00%			0.00		0.00	24.62%	5,669.99		0.00	3.38%	778.41		0.00	72.00%	16,581.60	94.5%	X
42	Attracta Ayoub	Public Health Nurse II (1688)	30.00%	101,420	30,426.00	0.00%			0.00		0.00	19.36%	5,890.47		0.00	36.05%	10,971.52		0.00	44.58%	13,563.91	94.5%	X
43	VACANT	Public Health Nurse I (1720)	100.00%	75,196	75,196.00	0.00%			0.00		0.00	29.71%	22,340.73		0.00	20.91%	15,723.48		0.00	49.38%	37,131.78	94.5%	X
44	VACANT	Public Health Nurse I (1720)	100.00%	75,196	75,196.00	0.00%	0.00		0.00		0.00	25.29%	19,017.07		0.00	39.05%	29,364.04		0.00	35.66%	26,814.89	94.5%	X
45	VACANT	Public Health Nurse I (1720)	100.00%	75,196	75,196.00	0.00%	(0.00)		0.00		0.00	30.60%	23,009.98		0.00	25.20%	18,949.39		0.00	44.20%	33,236.63	94.5%	X
46	Lorraine Hardy	Supervising Public Health Nurse-MCAH I	65.00%	120,773	78,502.00	0.00%	(0.00)		0.00		0.00	22.57%	17,717.90		0.00	55.71%	43,733.46		0.00	21.72%	17,050.63	94.3%	X
47	Lorraine Hardy	Supervising Public Health Nurse (1719)	20.00%	120,773	24,155.00	0.00%	0.00		0.00		0.00	13.50%	3,260.93		0.00	72.51%	17,514.79		0.00	13.99%	3,379.28	94.3%	X
48	Stella Holliman	Public Health Nurse II (1719)	100.00%	100,314	100,314.00	0.00%			0.00		0.00	36.95%	37,066.02		0.00	22.79%	22,861.56		0.00	40.26%	40,386.42	94.3%	X
49	Jaynie Ortiz	Public Health Nurse I (1719)	100.00%	77,546	77,546.00	0.00%	0.00		0.00		0.00	19.96%	15,478.18		0.00	22.78%	17,664.98		0.00	57.26%	44,402.84	94.3%	X
50	Melanie Deto	Public Health Nurse I	90.00%	80,233	72,210.00	0.00%	0.00		0.00		0.00	23.41%	16,904.36		0.00	28.06%	20,262.13		0.00	48.53%	35,043.51	94.3%	X
51	Mai Vang	Public Health Nurse II	90.00%	100,314	90,283.00	0.00%			0.00		0.00	23.65%	21,532.50		0.00	41.59%	37,548.70		0.00	34.56%	31,201.80	94.3%	X
52	Bridget Ballesteros	Public Health Nurse II	90.00%	100,314	90,283.00	0.00%	0.00		0.00		0.00	17.30%	15,618.96		0.00	31.46%	28,403.03		0.00	51.24%	46,261.01	94.3%	X
53	Rachel Nevarez	Public Health Nurse I	90.00%	85,938	77,344.00	0.00%	0.00		0.00		0.00	17.34%	13,411.45		0.00	34.39%	26,598.60		0.00	48.27%	37,333.95	94.3%	X
54	Hilary Davis	Public Health Nurse II (1501)	55.00%	93,831	51,607.00	0.00%			0.00		0.00	20.00%	10,321.40		0.00	20.00%	10,321.40		0.00	60.00%	30,964.20	94.3%	X

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

BUDGET SUMMARY

FISCAL YEAR	BUDGET	BUDGET STATUS	BUDGET BALANCE
2019-20	ORIGINAL	ACTIVE	0.01

Version 5.0 - 150 Quarterly 04.18.19

Program: Black Infant Health (BIH)
Agency: 201910 Fresno
SubK:

	(1)	UNMATCHED FUNDING (2)	BIH-TV (3)	(4)	BIH-SGF (5)	(4)	TBD (5)	(6)	AGENCY FUNDS (7)	NON-ENHANCED MATCHING (50/50) (8)	BIH-SGF-NE (9)	(10)	BIH-Cnty NE (11)	ENHANCED MATCHING (75/25) (12)	BIH-SGF-E (13)	(14)	BIH-Cnty E (15)
	TOTAL FUNDING	%	TITLE V	%	SGF	%	TBD	%	Agency Funds*	%	Combined Fed/State	%	Combined Fed/Agency*	%	Combined Fed/State	%	Combined Fed/Agency*
ALLOCATION(S) →			259,379.00		248,467.00		0.00										#VALUE!
EXPENSE CATEGORY																	
(I) PERSONNEL	599,253.35		243,024.07		0.00		0.00		0.00		337,872.72		0.00		18,356.56		0.00
(II) OPERATING EXPENSES	23,200.00		0.00		9,092.10		0.00		0.00		14,107.90		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		0.00
(IV) OTHER COSTS	20,515.00		6,251.57		14,263.43		0.00		0.00		0.00		0.00		0.00		0.00
(V) INDIRECT COSTS	149,813.34		10,103.36		0.00		0.00		50,645.95		89,064.03		0.00		0.00		0.00
BUDGET TOTALS*	792,781.69	32.72%	259,379.00	2.95%	23,355.53	0.00%	0.00	6.39%	50,645.95	55.63%	441,044.65	0.00%	0.00	2.32%	18,356.56	0.00%	0.00
BALANCE(S) →			0.00		0.01		0.00										

TOTAL TITLE V	259,379.00 →	259,379.00					
TOTAL SGF	248,467.00 →		23,355.53	[50%]	220,522.33	[25%]	4,589.14
TOTAL TITLE XIX	234,289.75 →			[50%]	220,522.33	[75%]	13,767.42
TOTAL AGENCY FUNDS	50,645.95 →		50,645.95				

[50%]	0.00	[75%]	0.00
[50%]	0.00	[25%]	0.00

$ 742,135.74 — Maximum Amount Payable from State and Federal resources

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

MCAH/PROJECT DIRECTOR'S SIGNATURE — DATE 9/13/19

AGENCY FISCAL AGENT'S SIGNATURE — DATE 9/16/19

* 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	TBD	AGENCY FUNDS	BIH-SGF-NE	BIH-Cnty NE	BIH-SGF-E	BIH-Cnty E
PCA Codes		53113	53127	0		53124	53100	53125	53102
(I) PERSONNEL		243,024.07	0.00	0.00		337,872.72	0.00	18,356.56	0.00
(II) OPERATING EXPENSES		0.00	9,092.10	0.00		14,107.90	0.00	0.00	0.00
(III) CAPITAL EXPENSES		0.00	0.00	0.00		0.00	0.00	0.00	0.00
(IV) OTHER COSTS		6,251.57	14,263.43	0.00		0.00	0.00	0.00	0.00
(V) INDIRECT COSTS		10,103.36	0.00	0.00		89,064.03	0.00	0.00	0.00
Totals for PCA Codes	742,135.74	259,379.00	23,355.53	0.00		441,044.65	0.00	18,356.56	0.00

ORIGINAL

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

Program:	Black Infant Health (BIH)
Agency:	201910 Fresno
SubK:	

		(1)	UNMATCHED FUNDING								NON-ENHANCED MATCHING (50/50)				ENHANCED MATCHING (75/25)				
			BIH-TV		BIH-SGF		TBD		AGENCY FUNDS		BIH-SGF-NE		BIH-Cnty NE		BIH-SGF-E		BIH-Cnty E		
			(2)	(3)	(4)	(5)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	
		TOTAL FUNDING	%	TITLE V	%	SGF	%	TBD	%	Agency Funds*	%	Combined Fed/State	%	Combined Fed/Agency*	%	Combined Fed/State	%	Combined Fed/Agency*	
(II) OPERATING EXPENSES DETAIL													% TRAVEL NON-ENH MATCH				% TRAVEL ENH MATCH		% PERSONNEL MATCH
													59.70%				0.00%		60.95%
	TOTAL OPERATING EXPENSES	23,200.00		0.00		9,092.10		0.00		0.00		14,107.90		0.00		0.00		0.00	Match Available
	TRAVEL	2,600.00	0.00%	0.00	40.30%	1,047.80		0.00		0.00	59.70%	1,552.20		0.00		0.00		0.00	0.00%
	TRAINING	5,000.00	0.00%	0.00	39.05%	1,952.50		0.00		0.00	60.95%	3,047.50	0.00%	0.00		0.00		0.00	0.00%
1	Office Supplies	3,000.00	0.00%	0.00	39.05%	1,171.50		0.00		0.00	60.95%	1,828.50	0.00%	0.00					0.00%
2	Postage	100.00	0.00%	0.00	39.05%	39.05		0.00		0.00	60.95%	60.95	0.00%	0.00					0.00%
3	Duplication	1,000.00	0.00%	0.00	39.05%	390.50		0.00		0.00	60.95%	609.50	0.00%	0.00					0.00%
4	Media	11,500.00	0.00%	0.00	39.05%	4,490.75		0.00		0.00	60.95%	7,009.25	0.00%	0.00					0.00%
5				0.00		0.00		0.00		0.00		0.00		0.00					
6				0.00		0.00		0.00		0.00		0.00		0.00					
7				0.00		0.00		0.00		0.00		0.00		0.00					
8				0.00		0.00		0.00		0.00		0.00		0.00					
9				0.00		0.00		0.00		0.00		0.00		0.00					
10				0.00		0.00		0.00		0.00		0.00		0.00					
11				0.00		0.00		0.00		0.00		0.00		0.00					
12				0.00		0.00		0.00		0.00		0.00		0.00					
13				0.00		0.00		0.00		0.00		0.00		0.00					
14				0.00		0.00		0.00		0.00		0.00		0.00					
15				0.00		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		0.00		

(IV) OTHER COSTS DETAIL																% PERSONNEL MATCH
																60.95%
	TOTAL OTHER COSTS	20,515.00		6,251.57		14,263.43		0.00		0.00		0.00		0.00		0.00		0.00
	SUBCONTRACTS																	
1	Reading & Beyond	7,750.00	0.00%	0.00	100.00%	7,750.00		0.00		0.00		0.00		0.00		0.00		0.00
2				0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00
3				0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00
4				0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00
5				0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00
	OTHER CHARGES																	Match Available
1	Client Support Materials	12,765.00	48.97%	6,251.57	51.03%	6,513.43		0.00		0.00		0.00		0.00				60.95%
2				0.00		0.00		0.00		0.00		0.00		0.00				
3				0.00		0.00		0.00		0.00		0.00		0.00				
4				0.00		0.00		0.00		0.00		0.00		0.00				
5				0.00		0.00		0.00		0.00		0.00		0.00				
6				0.00		0.00		0.00		0.00		0.00		0.00				
7				0.00		0.00		0.00		0.00		0.00		0.00				
8				0.00		0.00		0.00		0.00		0.00		0.00				

(V) INDIRECT COSTS DETAIL															
TOTAL INDIRECT COSTS	149,813.34		10,103.36		0.00		0.00		50,645.95		89,064.03		0.00		
25.00%	of Total Wages + Fringe Benefits	149,813.34	6.74%	10,103.36		0.00		0.00	33.81%	50,645.95	59.45%	89,064.03	0.00%	0.00	

Program:	Black Infant Health (BIH)
Agency:	201910 Fresno
SubK:	

		UNMATCHED FUNDING								NON-ENHANCED MATCHING (50/50)				ENHANCED MATCHING (75/25)			
		BIH-TV		BIH-SGF		TBD		AGENCY FUNDS		BIH-SGF-NE		BIH-Cnty NE		BIH-SGF-E		BIH-Cnty E	
	(1)	(2)	(3)	(4)	(5)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)
	TOTAL FUNDING	%	TITLE V	%	SGF	%	TBD	%	Agency Funds*	%	Combined Fed/State	%	Combined Fed/Agency*	%	Combined Fed/State	%	Combined Fed/Agency*
(I) PERSONNEL DETAIL																	
TOTAL PERSONNEL COSTS	599,253.35		243,024.07		0.00		0.00		0.00		337,872.72		0.00		18,356.56		0.00
FRINGE BENEFIT RATE 82.42%	270,751.35		109,801.80		0.00		0.00		0.00		152,655.79		0.00		8,293.76		0.00
TOTAL WAGES	328,502.00		133,222.27		0.00		0.00		0.00		185,216.93		0.00		10,062.80		0.00

	FULL NAME (First Name Last Name)	TITLE OR CLASSIFICATION (No Acronyms)	% FTE	ANNUAL SALARY	TOTAL WAGES													JPers MOF Per Staff	Staff Traveling (X)
1	Janel Claybon	Public Health Nurse II	50.00%	89,328	44,664.00	71.93%	32,126.82		0.00		0.00		0.00	5.54%	2,474.39		0.00	22.53%	10,062.80		0.00	85.3%	X
2	Fanta Nelson	BIH Coordinator -Health Educator	50.00%	59,579	29,790.00	24.21%	7,212.16		0.00		0.00		0.00	75.79%	22,577.84		0.00		0.00		0.00	85.3%	X
3	Sabrina Beavers	Comm. Outreach Liaison -Health Educat	100.00%	55,987	55,987.00	22.27%	12,468.30		0.00		0.00		0.00	77.73%	43,518.70		0.00		0.00		0.00	85.3%	X
4	Denise Simon	FHA Group Facilitator -Health Education	100.00%	55,987	55,987.00	43.71%	24,471.92		0.00		0.00		0.00	56.29%	31,515.08		0.00		0.00		0.00	85.3%	X
5	Megan Black	FHA Comm. Outreach Liaison -Health E	100.00%	48,813	48,813.00	53.70%	26,212.58		0.00		0.00		0.00	46.30%	22,600.42		0.00		0.00		0.00	85.3%	X
6	Kim Murphy	FHA Group Facilitator -Health Education	100.00%	46,869	46,869.00	49.07%	22,998.62		0.00		0.00		0.00	50.93%	23,870.38		0.00		0.00		0.00	85.3%	X
7	Melinda Meza	Data Entry Manager -Office Assistant	50.00%	32,874	16,437.00	20.25%	3,328.49		0.00		0.00		0.00	79.75%	13,108.51		0.00		0.00		0.00	85.3%	X
8	Keesha Clark	Mental Health Professional -Medical Soc	50.00%	59,910	29,955.00	14.70%	4,403.39		0.00		0.00		0.00	85.30%	25,551.62		0.00		0.00		0.00	85.3%	X

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

☒ **IMPORTANT**: By clicking this box, I agree to allow the state MCAH Program to post my Scope of Work on the CDPH/MCAH website.

The Local Health Jurisdiction (LHJ), in collaboration with the State MCAH Program, 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 goals and objectives in this MCAH SOW incorporate local problems identified by LHJs in the 5-Year Needs Assessments and reflect the Title V priorities of the MCAH Division. The local 5-Year Needs Assessment identified problems that LHJs may address in their 5-Year Action Plans. The LHJ 5-Year Action Plans inform the development of the annual MCAH SOW.

All LHJs must perform the activities in the shaded areas in Goals 1-3 and monitor and report on the corresponding evaluation/performance measures. In addition, each LHJ is required to develop at least two local objectives in Goal 1, one to address the health of reproductive age women and one to address the needs of pregnant women and two local objectives for Goal 3, a SIDS/SUID objective and an objective to improve infant health. LHJs that receive FIMR funding will perform the activities in the shaded area in Goal 3.5, including one local objective addressing fetal, neonatal, post-neonatal and infant deaths. In the second shaded column of 3.5a, Intervention Activities to Meet Objectives, insert the number and percent of cases that will be reviewed for the fiscal year. Lastly, if resources allow, LHJs should develop additional objectives, which can be placed under any of the Goals 1-5. All activities in this SOW must take place within the fiscal year. Please see the MCAH Policies and Procedures for further instructions on completing the SOW.

The development of this 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
- The Spectrum of Prevention
- Life Course Perspective
- The Social-Ecological Modelhttp://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html
- Social Determinants of Health
- Strengthening Families

All Title V programs must comply with the MCAH Fiscal Policies and Procedures Manual, which is found on the CDPH/MCAH website

CDPH/MCAH Division expects each LHJ to make progress towards Title V State Performance Measures and Healthy People 2020 goals. These goals involve complex issues and are difficult to achieve, particularly in the short term. As such, in addition to the required activities to address Title V State Priorities and requirements, the MCAH SOW provides LHJs the opportunity to develop locally determined objectives and activities that can be realistically achieved given the scope and resources of local MCAH programs.

LHJs are required to comply with requirements as stated in the MCAH Program Policies and Procedures Manual, such as attending statewide meetings, conducting a Needs Assessment every five years, submitting Agreement Funding Applications, and completing Annual Progress Reports.

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 1: Women/Maternal Domain: Improve access to and utilization of comprehensive, quality health and social services

The shaded and/or highlighted areas represent required 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)**
Objective 1.1 **All women of reproductive age, pregnant women, infants, children, adolescents and children and youth with special health care needs (CYSHCN) will have access to needed and preventive, medical, dental, and social services by:** • Targeting outreach services to identify pregnant women, women of reproductive age, infants, children and adolescents and their families who are eligible for Medi-Cal assistance or other publicly provided health care programs and assist them in applying for these benefits[2] • Decreasing Medi-Cal eligible women, children, post-partum women without insurance[1]	**Assessment** **1.1a** i. Identify and monitor the health status of women of reproductive age, pregnant women, infants, children, adolescents, and CYSHCN, including the social determinants of health and access/barriers to the provision of: • Preventive, medical, dental, and social services ii. Review data books and monitor trends over time, geographic areas and population group disparities iii. Annually, share your data with key local health department leadership	**1.1a** i. This deliverable will be fulfilled by completing and submitting your Community Profile with your Agreement Funding Application each year ii. Briefly describe process for monitoring and interpreting data iii. Report the date data shared with the key health department leadership. Briefly describe their response, if significant.	**1.1a** Nothing is entered here.

[1] 2016-2020 Title V State Priorities
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[3] State Requirements

Goal 1: Women/Maternal Domain: Improve access to and utilization of comprehensive, quality health and social services

The shaded and/or highlighted areas represent required 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)
	1.1b Participate in collaboratives, coalitions, community organizations, etc., to review data and develop policies and products to address social determinants of health and disparities.	**1.1b** Report the total number of collaboratives with MCAH staff participation. Submit online Collaborative Surveys that document participation, objectives, activities and accomplishments of MCAH – related collaboratives.	**1.1b** List policies or products developed to improve infrastructure that address MCAH priorities.
	Policy Development **1.1c** i. Review, revise and enact protocols or policies that facilitate access to Medi-Cal, California Children's Services (CCS), Covered CA, and Women, Infants, and Children (WIC)	**1.1c** i. List types of protocols or policies developed or revised to facilitate access to health care services.	**1.1c** i. List formal and informal agreements in place including Memoranda of Understanding with Medi-Cal Managed Care Plans (MCP) or other organizations that address the needs of mothers and infants

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Goal 1: Women/Maternal Domain: Improve access to and utilization of comprehensive, quality health and social services

The shaded and/or highlighted areas represent required 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)
	ii. Develop and implement protocols to ensure all clients in MCAH programs are enrolled in a health insurance plan, linked to a provider, and complete an annual visit. Protocols include the following key components: • Assist clients to enroll in health insurance • Link clients to a health care provider for a preventive and/or medical visit • Develop a tracking mechanism to verify that the client enrolled in health insurance, completed a preventive or well medical visit	ii. Briefly describe the key components of the protocols developed to ensure all clients in MCAH programs are enrolled in insurance or a health plan, linked to a provider and complete an annual preventative and/or medical visit.	ii. Describe and summarize the impact of protocols or policy and systems changes that facilitate access to Medi-Cal, CCS, Covered CA, and WIC.
	Assurance **1.1d** Develop staff knowledge and public health competencies for MCAH related issues	**1.1d** Summarize staff knowledge and competencies gained	**1.1d** Nothing is entered here

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Goal 1: Women/Maternal Domain: Improve access to and utilization of comprehensive, quality health and social services

The shaded and/or highlighted areas represent required 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)
	1.1e Conduct activities to facilitate referrals to Medi-Cal, Covered CA, CCS, and other low cost/no-cost health insurance programs for health care coverage[2]	**1.1e** Describe activities to ensure referrals to health insurance, programs and preventive visits	**1.1e** Report the number of referrals to Medi-Cal, Covered CA, CCS, or other low/no-cost health insurance or programs.
	1.1f Provide a toll-free or "no-cost to the calling party" telephone information service and other appropriate methods of communication, e.g., local MCAH Program web page to the local community[2] to facilitate linkage of MCAH population to services	**1.1f** Describe the methods of communication, including the, cultural and linguistic challenges and solutions to linking the MCAH population to services	**1.1f** Report the following: • Number of calls to the toll-free or "no-cost to the calling party" telephone information service • The number of web hits to the appropriate local MCAH Program webpage

[1] 2016-2020 Title V State Priorities
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Goal 1.2: WOMEN/MATERNAL DOMAIN: Improve access to and utilization of comprehensive, quality health and social services for <u>reproductive age women.</u>

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)**
<u>REQUIRED LOCAL OBJECTIVE</u>: Insert locally developed Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. Each LHJ is required to develop at least one specific short and/or intermediate SMART outcome objective(s) to address access to needed preventive services. ***Number each locally developed objective as follows: 1.2, 1.2a, 1.2b, 1.2c, 1.2d, etc.***			
Objective 1.2 **By June 30, 2020, increase the number of MCAH women of reproductive age who access and utilize preventative health services by 5%.** • Well-women visit • Mental health • Substance use • Chronic disease • Preconception/ Interconception care • Birth Intervals-Spacing • Unintended/mistimed pregnancy • Family planning • Intimate partner/domestic violence	**1.2** 1-key question (Reproductive Life Plan questions in Electronic Medical Record (EMR)) to all MCAH women (pregnant and non-pregnant) Collect number of women who access and utilize preventative health services Identify defined list of preventative services/activities to support mom's reproductive goals (American College of Obstetricians and Gynecologists (ACOG)) Develop a quality improvement process related to the process of collecting data on identified list of preventative services/activities	**1.2** Develop data reports in Avatar to measure outcomes Define/develop description of preventative health services for reproductive women to be collected in EMR/Management Information System (MIS) Participate in Preterm Birth Initiative (PTBi) Coordination of Care Workgroup to coordinate a Connectors' Conference to improve the coordination and integration of physical and behavioral healthcare, social services and other support for women, before, during and after pregnancy by sharing resources	**1.2** Percentage of MCAH women of reproductive age who access and utilize preventative health service such as well-woman visit, interconception care and or/family planning/Baseline of 57% Number of women utilizing preventative services/Total number of women served 100 attendees will attend Connector's Conference for Care Navigators, Case Managers to have an opportunity to share the services they offer to the community

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 1.3: WOMEN/MATERNAL DOMAIN: <u>All pregnant women</u> will have access to early, adequate, and high quality perinatal care with a special emphasis on low-income and Medi-Cal eligible women.

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)**
Objective 1.3 **All women will have access to quality maternal and early perinatal care, including CPSP services for Medi-Cal eligible women by:** • Increasing first trimester prenatal care initiation[1] • Increasing postpartum visit[1] • Increasing access to providers that can provide the appropriate services and level of care for reproductive age women[1]	**Assurance** **1.3a** i. Develop MCAH staff knowledge of the system of maternal and perinatal care ii. Develop a comprehensive resource and referral guide of available health and social services iii. Attend the yearly CPSP statewide meeting iv. Conduct local activities to facilitate increased access to early and quality perinatal care	**1.3a** Report the following: i. List of trainings received by staff on perinatal care, such as roundtables, regional meetings, collaborative work ii. Submit resource and referral guide iii. Date and attendance at the CPSP yearly meeting iv. List activities implemented to increase access of women to early and quality perinatal care. Identify barriers and opportunities to improve access to early and quality perinatal care	**1.3a** Provide the number and describe the outcomes of: • Roundtable meetings • Regional meetings • Other maternal and perinatal meetings

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[3] State Requirements

Goal 1.3: WOMEN/MATERNAL DOMAIN: <u>All pregnant women</u> will have access to early, adequate, and high quality perinatal care with a special emphasis on low-income and Medi-Cal eligible women.

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)**
	1.3b Outreach to perinatal providers, including Medi-Cal Managed Care i. Enroll in CPSP (Fee-for-Service and FQHC/RHC/IHC providers) ii. Identify and work with MCP liaisons to provide CPSP comparable services iii. Assist MCP providers to provide CPSP comparable services	**1.3b** i. Enroll FFS and FQHC/RHC/IHC providers Identify the MCP liaison(s). ii. Work with MCP(s) to provide CPSP comparable services iii. Work with MCP providers to provide CPSP comparable services	**1.3b** Nothing is entered here
	1.3c Coordinate perinatal activities between MCAH and the Regional Perinatal Programs of California (RPPC) to improve maternal and perinatal systems of care, including coordinated post-partum referral systems for high-risk mothers and infants upon hospital discharge	**1.3c** List number of meetings attended to facilitate coordination of activities between RPPC and MCAH and briefly describe outcomes	**1.3c** Nothing is entered here.
	1.3d Conduct technical assistance and face-to-face quality assurance/quality improvement (QA/QI) activities with CPSP providers or managed care providers in collaboration with	**1.3d** Report the number of CPSP provider technical assistance activities conducted by phone or email	**1.3d** Describe the results of technical assistance provided by phone or email

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[3] State Requirements

Goal 1.3: WOMEN/MATERNAL DOMAIN: <u>All pregnant women</u> will have access to early, adequate, and high quality perinatal care with a special emphasis on low-income and Medi-Cal eligible women.

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)**
	MCP(s) liaison to ensure that CPSP services are implemented and protocols are in place	Report the number of QA/QI face-to-face site visits conducted with: • Enrolled CPSP providers • MCPs providers (with MCP liaison(s)) • Number of chart reviews List common problems or barriers and successful interventions	Describe the results of QA/QI activities that were conducted with: • Enrolled CPSP providers • MCPs providers (with MCP liaison(s)) • Summary of findings from the chart reviews

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 1.4: WOMEN/MATERNAL DOMAIN: Improve access to and utilization of comprehensive, quality health and social services for <u>pregnant women.</u>

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)
<u>REQUIRED LOCAL OBJECTIVE</u>: Insert locally developed Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. Each LHJ is required to develop at least one specific short and/or intermediate SMART outcome objective(s) to address access to needed preventive services. *Number each locally developed objective as follows: 1.4, 1.4a, 1.4b, 1.4c, 1.4d, etc.*			
Objective 1.4 **Establish a collaborative exchange with Communicable Disease(CD)/STD program to provide a warm handoff of women/infants identified during investigation and treatment for syphilis to PHN home visitation and case management**	**1.4** Work with the CD/STD program to establish collaboration and warm handoff of women/infants identified during treatment for syphilis for case management/home visitation services Verbal agreement with the CD/STD program that all infants born to syphilis infected mothers will be referred to children's home visitation programs for case management	**1.4** Develop data reports in Avatar to measure outcomes of syphilis infected pregnant women and their infants	**1.4** Number of syphilis infected pregnant and/or parenting women referred from CD/STD program to PHN services /Total number of pregnant and/or parenting women identified by CD/STD as syphilis infected Number of infants referred from CD/STD program to PHN services /Total number of infants identified by CD/STD born to syphilis infected mothers
Objective 1.4a **Throughout the pregnancy, all CPSP providers will receive education on the importance of informing clients of the health benefits of fourth trimester care**	**1.4a** PSC will supply all CPSP providers with the ACOG Postpartum Toolkit and provide round table on use and implementation	**1.4a** Track the number of CPSP providers that received the Toolkit and that attended the round table	**1.4a** Number of CPSP providers that received Toolkit /Total number of CPSP providers Number of CPSP providers that attended round table/Total number of CPSP providers

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 2: CHILD/CYSHCN DOMAIN: Improve the cognitive, physical, and emotional development of all children, including children and youth with special health care needs.

The shaded and bolded areas represent required 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)**
Objective 2.1 **Provide developmental screening for all children[1] in MCAH programs** • All children, including CYSHCN, receive a yearly preventive medical visit • Increase the rate of developmental screening for children ages 0-5 years according to AAP guidelines – 9 months, 18 months and 30 months	**Child Objective** **2.1a** Promote the American Academy of Pediatrics (AAP) developmental screening guidelines. **The following bolded activities, i, ii, are required:** **i. Promote regular preventive medical visits for all children, including CYSHCN, in MCAH Home Visiting and Case Management programs, per Bright Futures/AAP,** **ii. Adopt protocols/policies, including a QA/QI process, to screen, refer, and link all children in MCAH Home Visiting or Case Management Programs**	**2.1a** **Required** **Describe or report the following for MCAH programs:** **i. Activities to promote the yearly preventive medical visit** **ii. Describe protocols/policies including QA/QI process to screen, refer and link all children in MCAH programs**	**2.1a** **Required** **Describe or report the following for children in MCAH programs** **i. Number of children, including CYSHCN, receiving a yearly preventive medical visit** **ii. Number of children in MCAH programs receiving developmental screening** • **Number of children with positive screens that complete a follow-up visit with their primary care provider** • **Number of children with positive screens linked to services**

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Goal 2: CHILD/CYSHCN DOMAIN: Improve the cognitive, physical, and emotional development of all children, including children and youth with special health care needs.

The shaded and bolded areas represent required 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)**
			• **Number of calls received for referrals and linkages to services**
	CYSHCN Objective(s) At least one activity is required. Choose from activities 2.1.b-2.1. (highlight your choices in yellow):	***Report the following based on the activities you chose to implement in the second column (highlight your choices in yellow):***	***Describe the following based on the activities you chose to implement in the second column (highlight your choices in yellow):***
	2.1b Promote the use of Birth to 5; Watch Me Thrive, Learn the Signs, Act Early or other screening materials consistent with AAP guidelines	**2.1b** Number of providers or provider systems receiving information about Birth to 5, Learn the Signs, Act Early or other screening materials	**2.1b** Nothing is entered here
	2.1c Participate in Help Me Grow (HMG) or programs that promote the core components of HMG	**2.1c** Describe participation in HMG or HMG like programs	**2.1c** Outcomes of participation in HMG or HMG like programs. Describe results of work to implement HMG core components
	2.1d Increase understanding of the specific barriers to referral and evaluation by early intervention or pediatric specialists (including mental/behavioral health)	**2.1d** Describe barriers to referral and evaluation by early intervention or pediatric specialists	**2.1d** Nothing is entered here

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Goal 2: CHILD/CYSHCN DOMAIN: Improve the cognitive, physical, and emotional development of all children, including children and youth with special health care needs.

The shaded and bolded areas represent required 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)**
	2.1e Plan and implement a family engagement project to improve local efforts to serve children and youth with special health care needs (e.g., convene a family advisory group to assess how CYSHCN are served in local home visiting or case management programs)	**2.1e** Describe project activities, goals, and outcomes such as number of family members engaged, number of community meetings, and other process measures specific to the planned project	**2.1e** Nothing is entered here
	2.1f Work with health plans (HPs), including MCPs, to identify and address barriers to screening, referral, linkage and to assist the HPs in increasing developmental screenings for their members, per AAP guidelines, through education, provider feedback, incentives, quality improvement, or other methods	**2.1f** Describe barriers and strategies to increase screening, referral and linkage • Number of HPs requiring screenings per AAP guidelines	**2.1f** Nothing is entered here
	2.1g Identify methods to measure and monitor rates of developmental and other types of childhood screening, referrals, and successful linkages to care in your jurisdiction	**2.1g** If applicable, provide data on developmental and other screening rates, referrals, and successful linkages to care for the target population	**2.1g** Nothing is entered here

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Goal 2: CHILD/CYSHCN DOMAIN: Improve the cognitive, physical, and emotional development of all children, including children and youth with special health care needs.

The shaded and bolded areas represent required 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)
	2.1h Based on local needs, develop strategies to promote awareness of and address childhood adversity and trauma, including Adverse Childhood Experiences (ACEs), and build family and community resilience	**2.1h** Provide a description, and data if applicable, on process measures and outcomes relevant to the planned activities	**2.1h** Nothing is entered here
	2.1i Outreach and education to providers to promote developmental screening, referral and linkages	**2.1i** Describe type of outreach/education performed and results of outreach to providers	**2.1i** Nothing is entered here
	2.1j Provide care coordination for CYSHCN, especially non-CCS eligible children or children enrolled in CCS in need of services not covered by CCS	**2.1j** Describe activities for care coordination provided	**2.1j** List the number of children receiving care coordination

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Goal 2: CHILD/CYSHCN DOMAIN: Improve the cognitive, physical, and emotional development of all children, including children and youth with special health care needs.

The shaded and bolded areas represent required 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)
<u>OPTIONAL LOCAL OBJECTIVE</u>: Insert locally developed Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. ***Number each locally developed objective as follows: 2.2, 2.2a, 2.2b, 2.2c, etc.***			
Objective 2.2 **By June 30, 2020 120 children identified through referrals from Community Partners at high risk for unintentional injuries, child abuse and neglect, will receive PHN home visitation, including developmental screening**	**2.2** Monitor, screen and refer as needed all children for physical, emotional and cognitive delays. Assess, monitor and refer as needed all home environments for inadequate, unsafe and or unhealthy living conditions. Screen all families for maternal depression and intimate partner violence.	**2.2** Collect data on the number of children that receive assessment over the total number of children served Collect data on the number of completed referrals for a physical, emotional, or cognitive delay over the total number of children referred Collect data on the number of preventable re-hospitalizations over the number of children served	**2.2** The number of children in PHN division's children's programs who received developmental screening/120 At least 35% of clients referred will complete referrals made to community services Preventable re-hospitalization rate will be less than 10%
Objective 2.2a **By June 30, 2020, 125 children receiving services from Nurse-Family Partnership Program (NFP) and Babies First at risk for cognitive, emotional or physical delays will receive**	**2.2a** All families served will be educated on the optimal emotional, physical and cognitive environments for children with a	**2.2a** Collect data on the number of children that receive assessment over the number of children served	**2.2a** The number of children in Nurse Family Partnership and Babies First Programs who received developmental screening/125

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The shaded and bolded areas represent required 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)**
<u>OPTIONAL LOCAL OBJECTIVE</u>: Insert locally developed Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. ***Number each locally developed objective as follows: 2.2, 2.2a, 2.2b, 2.2c, etc.***			
PHN home visitation including developmental screening Examples of focus areas can include but are not limited to: • Reducing unintentional injuries[1] • Reducing child abuse and neglect[1]	focus on the positive characteristics of each family All children identified with a cognitive, physical, or emotional delay will be referred to the appropriate resource to address the problem identified The number of completed referrals for developmental delays will be tracked in Avatar and MIS system		

[1] 2016-2020 Title V State Priorities
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[3] State Requirements

Goal 3: PERINATAL/INFANT DOMAIN: Reduce infant morbidity and mortality by reducing the rate of SIDS/SUID deaths

The shaded area represents required 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)**
Objective 3.1 **All parents/caregivers experiencing a sudden and unexpected death will be offered grief and bereavement support services**	**Assurance** **3.1a** Establish contact with parents/caregivers of infants with presumed SIDS death to provide grief and bereavement support services[3] Provide grief and support materials to parents	**3.1a** (Insert number) of parents/caregivers who experience a presumed SIDS death and the number who are contacted for grief and bereavement support services.	**3.1a** Nothing is entered here
	3.1b Contact local coroner office to ensure timely reporting and referral of parents of all babies who die suddenly and unexpectedly regardless of circumstances of death	**3.1b** Report the coroner's notifications received Briefly describe barriers and opportunities for success	**3.1b** Nothing is entered here
Objective 3.2. **All professionals, para-professionals, staff, and community members will receive information and education on SIDS risk reduction practices and infant safe sleep**	**3.2a** Disseminate AAP guidelines on infant safe sleep and SIDS risk reduction to providers, pediatricians, CPSP providers, parents, community members and other caregivers of infants	**3.2a** Numbers receiving AAP guidelines on infant safe sleep: • Providers • Pediatricians • CPSP providers • Child care providers • Other – list	**3.2a** Nothing is entered here

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[3] State Requirements

Goal 3: PERINATAL/INFANT DOMAIN: Reduce infant morbidity and mortality by reducing the rate of SIDS/SUID deaths

The shaded area represents required 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)
	3.2b Attend the SIDS Annual Conference/SIDS training(s), SIDS Coordinators' meeting and other conferences/trainings related to infant health[3].	**3.2b** Provide staff member name and date of attendance at SIDS Annual Conference/SIDS training(s) and other conference/trainings related to infant health.	**3.2b** Describe results of staff trainings related to infant health.

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 3: PERINATAL/INFANT DOMAIN: Reduce infant morbidity and mortality by reducing the rate of SIDS/SUID deaths

The shaded area represents required 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)
REQUIRED LOCAL OBJECTIVE: Insert Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. Each LHJ must provide at least one specific short and/or intermediate SMART outcome objective(s) to address SIDS/SUID. ***Number each locally developed objective as follows: 3.3, 3.3a, 3.3b, 3.3c., etc.***			
Objective 3.3 **By June 30, 2020, provide at least 1 training per month for the Department of Social Services prospective resource families to obtain required Safe Sleep education for completion of resource family application requirements**	**3.3** Collaborate with Department of Social Services to provide required SIDS/SUIDS/Safe Sleep education monthly to prospective resource families	**3.3** Track number of Resource Family trainings provided	**3.3** Number of Resource Family trainings provided/12

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 3: PERINATAL/INFANT DOMAIN: Reduce infant morbidity and mortality

The shaded area represents required 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)
<u>REQUIRED LOCAL OBJECTIVE</u>: Insert Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. Each LHJ must provide at least one specific short and/or intermediate SMART outcome objective(s) to address perinatal/infant health. ***Number each locally developed objective as follows: 3.4, 3.4a, 3.4b, 3.4c., etc.***			
Objective 3.4 **By June 30, 2020, increase breastfeeding duration among participants enrolled in home visitation services at 2 months and 6 months by 10%**	**3.4** Partner with local WIC agencies to educate staff on available WIC resources to support breastfeeding moms Identify and link families to supportive services to sustain/increase breastfeeding duration Update Electronic Medical Record system to a) capture client breastfeeding history and goals; b) WIC site utilized by participant; c) track breastfeeding initiation, breastfeeding at 2 months and 6 months; d) breastfeeding duration by race/ethnicity	**3.4** Collaborate with WIC agencies and maintain sign-in sheets for presentation(s) to staff Update the Breastfeeding Resources Directory Monitor and summarize breastfeeding duration and efforts quarterly for breastfeeding duration at 2 months and 6 months Utilize QI process to address and summarize breastfeeding duration challenges	**3.4** Total number of staff trained on WIC services Number of pregnant clients who plan to breastfeed/Total number of pregnant clients who delivered Number of clients breastfeeding at 2 months/Total number of clients who delivered Number of clients breastfeeding at 6 months/Total number of clients with baby at least 6 months

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 3: PERINATAL/INFANT DOMAIN: Reduce infant morbidity and mortality

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 FIMR LHJs only complete **Objective 3.5** **Reduce preventable fetal, neonatal and post-neonatal and infant deaths.**	**For FIMR LHJs only complete Assessment** **3.5a** Complete the review of at least __ cases, which is approximately __% of all fetal, neonatal, and post-neonatal deaths.	**For FIMR LHJs only complete Assessment** **3.5a** Develop a process for sample. Submit number of cases reviewed as specified in the Annual Report table.	**For FIMR LHJs only complete Assessment** **3.5a** Submit annual local summary report of findings and recommendations (periodicity to be determined by consulting with MCAH).
	Assurance **3.5b** Establish, facilitate, and maintain a Case Review Team (CRT) to review selected cases, identify contributing factors to fetal, neonatal, and post-neonatal deaths, and make recommendations to address these factors.	**3.5b** Submit FIMR Tracking Log and FIMR Committee Membership forms for CRT and CAT with the Annual Report.	**3.5b and c** Nothing is entered here
	3.5c Establish, facilitate, and maintain a Community Action Team (CAT) to recommend and implement community, policy, and/or systems changes that address review findings.		

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 3: PERINATAL/INFANT DOMAIN: Reduce infant morbidity and mortality

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)**
REQUIRED LOCAL OBJECTIVE for FIMR LHJs Only: Insert Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. Each LHJ must provide at least one specific short and/or intermediate SMART outcome objective(s) to address perinatal/infant health. *Number each locally developed objective as follows: 3.6, 3.6a, 3.6b, 3.6c, etc.*			
Objective 3.6 **By June 30, 2020, MCAH home visiting staff will receive training on interventions to reduce the occurrence of preterm birth**	**3.6** Conduct a staff training and educate on evidence based interventions to reduce the occurrence of a preterm delivery and how to present this information to a client, once identified	**3.6** Revise and update Policy & Procedures Guide for Case Review for Poor Birth Outcomes	**3.6** Number of staff trained on evidence based intervention to reduce the occurrence of a preterm delivery/Total number of home visitation staff
Objective 3.6a **By June 30, 2020, 100% of women enrolled in PHN case management services with a history of preterm delivery will be identified and provided educational materials to increase their knowledge of preterm delivery risks**	**3.6a** Provide culturally appropriate educational materials to all clients identified with a history of preterm delivery	**3.6a** Collaborate with our IT department to: • pull data and identify in the EMR the number of enrolled women with a history of a preterm delivery • collect data on interventions to prevent preterm birth	**3.6a** Number of enrolled women with a history of preterm delivery who received education materials/Total number of enrolled women with a history of preterm delivery
Objective 3.6b **By June 30, 2020, Fresno County MCAH in partnership with March of Dimes, Fresno Economic Opportunity Commission, First 5 Fresno County and West Fresno Family**	**3.6b** Develop community engagement strategy and network to identify interventions and resources to develop community lead intervention aimed at improving birth outcomes	**3.6b** Year one objectives: • Hire Project Coordinator • Develop community engagement strategy	**3.6b** Verification of hiring of Project Coordinator Identification of community engagement strategy developed

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 3: PERINATAL/INFANT DOMAIN: Reduce infant morbidity and mortality

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)**
Resource Center will establish a Best Babies Zone – Fresno GROWS (Growing Real Opportunities for West Fresno) in the 93706 zip code with the goal of reducing poor birth outcomes among African Americans residing in the greatest impacted census tracts.		• Host 3 community wisdom gatherings in the targeted census tract areas • Launch pilot of first community-generated intervention	Number of community wisdom gatherings held Identification of intervention

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 4: CROSSCUTTING DOMAIN: Increase the proportion of children, adolescents and women of reproductive age who maintain a healthy weight.

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)**
<u>OPTIONAL LOCAL OBJECTIVE:</u> Insert locally developed Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. *Number each locally developed objective as follows: 4.1, 4.1a, 4.1b, 4.1c, etc.*			
Objective 4.1 **By June 30, 2020, 1 labor and delivery hospital will have implemented the model hospital policies or the Baby-Friendly USA Hospital requirements to comply with the Infant Feeding Act (Health and Safety Code Section 123360-123367)**	**4.1** Support the continuation of the Cross County Collaborative (San Joaquin, Merced & Fresno) to develop and share "Best Practices" Technical assistance and support for hospitals to meet the requirements of Model Hospital policies and/or Baby-Friendly USA Hospital requirements will be provided by RPPC	**4.1** Dates, number and names of hospitals contacted and types of technical assistance provided Describe how continuation of the Cross County Collaborative will be continued Briefly describe barriers, challenges and solutions to implementing the model hospital policies or the Baby-Friendly USA Hospital requirements to comply with the Infant Feeding Act (Health and Safety Code Section 123360-123367).	**4.1** Number of hospitals that have implemented the model hospital policies or the Baby-Friendly USA Hospital requirements/Total number of hospitals Scores for the implementation of the 10 Steps to Successful Breastfeeding Attendance and minutes of the collaborative.
Objective 4.1a **By June 30, 2020, in collaboration with RPPC, will develop and adopt a process to monitor & recognize labor & deliver hospitals who are striving to achieve Model Hospital Policies and/or Baby-Friendly USA Hospital requirements as well as a process to provide Quality Assurance for hospitals that have attained this designation to be**	**4.1a** Utilize PDSA cycles to develop a Continuous Quality Improvement/Quality Assurance (CQI/QA) process, to monitor and recognize hospital achievements and maintain quality of care for recertification with RPPC	**4.1a** Description of the CQI/QA process developed	**4.1a** Describe the outcome of the CQI/QA process including methods of measurements and results.

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 4: CROSSCUTTING DOMAIN: Increase the proportion of children, adolescents and women of reproductive age who maintain a healthy weight.

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)
ready for recertification every 2 years			

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 5: ADOLESCENT DOMAIN: Promote and enhance adolescent strengths, skills, and supports to improve adolescent health.

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)
<u>OPTIONAL LOCAL OBJECTIVE:</u> Insert locally developed Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. *Number each locally developed objective as follows: 5.1, 5.1a, 5.1b, 5.1c, etc.*			
Objective 5.1 Insert a local objective that promotes and enhances adolescents strengths, skills and supports improve health by: • Decreasing teen pregnancies[1] • Reducing teen dating violence, bullying and harassment [1] Examples of focus areas can include but not limited to: • Adolescent sexual health, including contraception, preconception health, STIs • Racial ethnic disparities in adolescent birth rates • Adolescent injuries • Adolescent violence • Adolescent mental health • Development of a Positive Youth Development framework • Reducing suicides	**5.1** List evidence-based or informed activities to meet the objective(s) here Organize intervention activities and performance measures using the three core functions of public health: Assessment, Policy Development, and Assurance	**5.1** Develop process measures for applicable intervention activities here	**5.1** Develop short and/or intermediate outcome related performance measures for the objectives and activities here

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

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

Black Infant Health Program

The BIH Program is a specialized CDPH MCAH program under the local MCAH system and helps to address MCAH SOW Goal 2 – Improve Maternal and Women's Health. The goals in this SOW incorporate local problems identified by the Local Health Jurisdiction's (LHJs') 5-Year Needs Assessments and reflect the Title V priorities of the MCAH Division.

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

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

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

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

All BIH Sites are required to comply with the following tiered staffing matrix per the BIH 2015 Request For Supplemental Information (RSI) BIH RSI Instructions 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, Solano, Kern	San Diego, Alameda, Riverside	Sacramento, San Bernardino	Los Angeles
BIH Coordinator	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE
FHA/Group Facilitator	2.0 FTE	3.0 FTE	4.0 FTE	6.0 FTE	8.0 FTE
Mental Health Professional	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE	0.5 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 (Optional)	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:

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, Solano, Kern	San Diego, Alameda, Riverside	Sacramento, San Bernardino	Los Angeles
	64	96	128	192	240

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 the Agreement or amend it to reflect reduced funding.** Continued participation in the BIH program beyond the current fiscal year is also subject to successful performance of agreed upon activities.

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

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

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

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

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

Coordinator Quarterly Report:

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

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

Part II: Black Infant Health (BIH) Program

Goal 1: BIH will assure program implementation, staff competency, data management, and maintain program fidelity and fiscal management to administer the program as required by the Program's Policy and Procedures (P&P's) and Scope of Work (SOW) guidelines.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
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, ETO Data Book, Group Curriculum, and MCAH Fiscal P&Ps.	**1.1** • Implement the program activities as defined in the SOW. • Annually review and revise internal local policies and procedures for delivering services to eligible BIH participants. • BIH Coordinator will coordinate and collaborate with 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 3)
1.2 Hire and maintain culturally competent/relevant personnel and required Full Time Equivalent (FTE) to implement a BIH Program that is relevant to the cultural heritage of African-American women, and the community.	**1.2** • 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: o 0.5 FTE BIH Coordinator o Family Health Advocates (FHA)/Group Facilitators (GF)	**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)
	based on MCAH-BIH designated tier level. o 1 FTE Community Outreach Liaison (COL) o 0.5 FTE Data Entry o 0.5 FTE Mental Health Professional (MHP) o 0.5 FTE PHN (Optional) • 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	**1.3** • List staff training activities in quarterly report. (N) • Describe improved staff performance and confidence in implementing the program model as a result of 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 being 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.	**1.3** • Maintain records of staff attendance at trainings. (N) • Number of trainings and conferences (both state and local) attended by staff during FY 2018-19. • Completion of at least 2 group observation feedback forms by the BIH Coordinator for every group facilitator during FY 2018-19. (E)

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	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 trainings, conference calls, meetings and/or conferences as scheduled by MCAH Division. • Quarter 1: o Annual 2-day Basic Training o Annual COL Meeting • Quarter 2: o Annual 2-day Advanced FHA/GF Meeting • Quarter 3: o Annual MHP/Public Health Nurse (PHN) Meeting • Quarter 4: o Annual Coordinator Meeting o 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' case management activities.	• Recommend training topic suggestions for statewide meetings. (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)
1.4 DATA COLLECTION AND ENTRY All BIH participant program information and outcome data will be collected and entered timely and accurately using BIH required forms at required intervals.	**1.4** • Ensure that all direct service staff participate in data collection, data entry, data quality improvement, and use of data collection software determined by MCAH. • Ensure that all subcontractor agencies providing direct service enter data in the ETO as determined by MCAH. • Ensure accuracy and completeness of data input into ETO system. • Ensure that all staff receives updates about changes in ETO and data book forms. • Ensure that a selected staff member with advanced knowledge of the BIH Program, data collection, and ETO is selected as the BIH Site's Data Entry lead and participates in all Data and Evaluation calls. • Accurately and completely collect required participant information, with timely data input into the appropriate data system(s). • Work with MCAH to ensure proper and continuous operation of the MCAH-BIH- ETO. • Store Participant level Data forms on paper per guidelines in P&P. • Define a data entry schedule for staff and monitor for adherence.	**1.4** • Review ETO and fidelity reports and discuss during calls with BIH State Team. • Review ETO Utilization Reports for all staff at BIH Sites. • Enter all data into ETO within seven (7) working days of collection. • Review of the BIH Data Collection Manual by all staff. • Completion of ETO training by all staff. • Participation in periodic MCAH-Data calls. • Participation in role-specific trainings by the Data Entry Lead. • Review of ETO data quality reports by the BIH Coordinator and Data Entry staff on at least a monthly basis. • Conduct and report on audits of recruitment, enrollment, and service delivery paper forms against ETO reports; audit sample must include at least 10% of recruitment records and 10% of enrollment records.	**1.4** • Number and percent of forms that were entered within seven (7) days of collection. (E)

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
OUTREACH **1.5** All BIH LHJs will increase and expand community awareness of BIH by conducting 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 2018-19. (E) • Number of new Memorandum of Understanding (MOUs) established in FY 2018-19. (E) • Total number (overall and by type) of outreach activities completed by all staff during FY 2018-19. (E)
PARTICIPANT RECRUITMENT **1.6** All BIH LHJs will recruit African- American women 18 years of age, less than 30 weeks pregnant.	**1.6** • 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.	**1.6** • 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.	**1.6** • 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)
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 2018-19. (E)
PARTICIPANT ENROLLMENT **1.8** BIH Coordinator, under the guidance and leadership of the MCAH Director will ensure the following: • All participants enrolled • in BIH will be African-American. • All participants will be 18 years or older when enrolled in BIH. • All participants will be enrolled during pregnancy. o All participants will be enrolled at or before 30 weeks of pregnancy. • All women will participate in group intervention.	**1.8** • Enroll women that are African-American. • Enroll women at or before 30 weeks of pregnancy. • Enroll women that will participate in the group intervention.	**1.8** • Visual inspection of all recruitment eligibility fields on incoming referral forms for completeness. • Inclusion of eligibility criteria with materials used for referral and recruitment.	**1.8** • Number and percent of enrolled women who meet eligibility criteria defined by age and timing of pregnancy. (E) – *Fidelity Indicator A1b*
PROGRAM PARTICIPATION **1.9.1** BIH Coordinator, under the guidance and leadership of the MCAH Director will ensure the following:	**1.9.1** • Assign participants to a prenatal group as part of enrollment process.	**1.9.1** • Describe barriers, challenges and successes of enrolling women in a prenatal group within 30-45 days of first successful contact	**1.9.1** • Number and percent of enrolled women who attended a prenatal group session within 45 days of

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
• All women will participate in a prenatal group. • All women will participate in a group within 45 days of enrollment. • All groups will be implemented according to the 20-group intervention model as specified in the P&P. (see 1.9.3)	• Schedule prenatal groups to allow participants to attend within 30 days of enrollment. • Enroll participants in a prenatal group within 45 days of first successful contact. • Begin groups with the minimum required number of participants per the BIH P&P.	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)	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.
1.9.2 BIH Coordinator, under the guidance and leadership of the MCAH Director will ensure the following: • All BIH participants will receive case management support as defined in the P&P. • All BIH participants will complete all prenatal and postpartum assessments within the recommended time intervals. • All BIH participants will receive referrals to services outside of BIH based on Life Planning meetings.	**1.9.2** • Assign participants to a FHA as part of enrollment process. • Conduct case management services that align with Life Plan activities (goal setting). • Collect completed self-assessment administered scaled questions as described in P&P. • Collect the required number of assessments per timeframe outlined in P&P. • Develop and implement a Life Plan based on goal setting during Life Planning meetings for each BIH participant; complete all prenatal and postpartum assessments; provide ongoing identification of her specific concerns/needs and referral to services outside of BIH as needed based on Life Planning meetings. • Ensure participant referrals are generated and completed for all services identified.	**1.9.2** • 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)	**1.9.2** • Number and percent of enrolled women who complete prenatal and postpartum assessments at the P&P-designated time intervals. (E) • Number and percent of enrolled women who received at least one (1) case conference attended by a FHA or GF, and either the MHP or PHN. (E) – *Fidelity Indicator A2a* • Percent of enrolled women who have (a) a long-term goal and (b) one (1) or more short-term goals documented in one (1) of the three (3) focus areas (health, relationship, and finances) (among women enrolled 30 days or longer) during Life Planning meetings. (E) – *Fidelity Indicator P1a* • Number and percent of enrolled women with a Birth Plan collected before the expected date of delivery (among women past

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)
	• Conduct participant dismissal activities. • Conduct participant satisfaction surveys. • Submit complete and accurate reports in the timeframe specified by MCAH.		due). (E) – *Fidelity Indicator (supplemental) A4ai.* • Number and percent of enrolled women who have a known referral status for every documented referral at time of exit from the program (among women dismissed from BIH).(E) – *Fidelity Indicator Q4a* • Number and percent of enrolled women who have been dismissed from BIH with a completed participant satisfaction survey. (E)
1.9.3 BIH Coordinator, under the guidance and leadership of the MCAH Director will ensure that all BIH participants will participate in Group Intervention Sessions.	**1.9.3** • 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.	**1.9.3** • Collect and record Group Intervention Session attendance records for all enrolled women into ETO. • Submit FY 2019-20 Group Intervention Sessions Calendar to MCAH-BIH Program with submission of AFA and upon request. • Describe participant successes or challenges with completing seven (7) of ten (10) prenatal and/or postpartum Group Intervention Sessions. (N)	**1.9.3** • Number of Group Intervention Sessions entered into ETO that began during FY 2018-19. (E) • Number and percent of enrolled women who attend at least one (1) prenatal Group Intervention Session. (E) • Number and percent of enrolled women who attended the expected number of Group Intervention Sessions based upon the number of days in program (E) – *Fidelity Indicators D1a and D1b.*

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)
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). • 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: o Improve access to health care services	**2.1** • Document efforts of Community Advisory Board, collaborations or other similar formal or informal partnerships to address maternal and infant health disparities, social determinants of health, well-woman visits and postpartum visits at least once per quarter. (N) • Submit quarterly reports that describe outreach activities electronically using ETO in a timely manner. (N) • Document the local plan for community linkages, including an effective referral process that will be reviewed on an annual basis and updated as needed. (N) • Document successes and barriers to community education activities or events at least once per quarter in the ETO through quarterly reporting. (E/N) • List and maintain current documentation on the nature of formal and informal partnerships with community and referral agencies at least once a quarter; record MOUs and referral relationships in the ETO service provider details form. (E/N) • Enter all outreach activities in the Community Contacts Log in ETO.	**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 2018-19. (E/N)

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	o Increase utilization of well-woman and postpartum visits o Identify Preterm Birth (PTB) reduction strategies o Increase the utilization of preconception health services. • Collaborate with local MCAH programs and Regional Perinatal Programs to improve maternal and perinatal systems of care. • Participate in collaboratives with community partners to review data and develop strategies and policies to address social determinants of health and disparities. • Collaborate with agencies providing services to AA moms to develop and disseminate tangible Reproductive Life Planning training materials (e.g. power point presentation, webinars, toolkits, etc.) to focus on Before, During, and Beyond Pregnancy for dissemination and integration in their service delivery protocols.	• Document collaborative efforts with local MCAH programs and Regional Perinatal Programs 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	**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 2018-19. (E)

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	participants and for referrals of active participants. • Develop a clear point(s) of contact with collaborating community agencies on a regular basis as it relates to outreach, enrollment, referrals, care coordination, etc. • Assess referrals from partner agencies to determine enrollment points of entry quarterly.	• 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 2018-19 group intervention schedules upon request. (N) • Percent of participants who meet expected prenatal life planning session attendance (prenatal dose). (E) – *Fidelity Indicator D2a* • Percent of participants who meet expected prenatal group session attendance (prenatal dose). (E) – *Fidelity Indicator D1a and D1b.*	**3.1** • 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-	**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)
	setting skills and create their Life Plans. • Teach participants about the importance of stress reduction and guide them in applying stress reduction techniques. • Support participants as they become empowered to take actions toward meeting their needs. • Teach participants how to express their feelings in constructive ways. • Help participants to understand societal influences and their impact on African-American health and wellness.		

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

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
4.1 BIH Coordinator 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: o Stress management o Sexual health o Healthy relationships o Nutrition o 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 psycho-social 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.	**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)
	• Assist participants with completion of the birth plan that outlines specific labor/delivery and birthing requests to be conveyed to their prenatal care provider.		
4.2 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	**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)
ensure that all BIH participants will be screened for Perinatal Mood and Anxiety Disorders (PMAD) and those with positive screens will be given a referral to mental health services.	o Understand how mental health contributes to overall health and wellness, o Recognize the connection between stress and mental health and practice stress reduction techniques, o Help participants understand the connection between physical activity and mental health, o 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	**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	**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)
	conveyed to their prenatal care provider. • Provide participants with health education materials addressing the benefits of breastfeeding. • Assist participants with identifying and using bonding strategies, including breastfeeding, with their newborns.	practices/SIDS/SUID risk reduction. (N) • Provide anecdotes/participant success stories about infant safe sleep practices and SIDS/SUID risk reduction with submission of BIH Quarterly Reports. (N) • Document collaborative activities with State MCAH Programs used to identify strategies, provide technical assistance and disseminate resource materials that address the benefits of breastfeeding. (N) • Provide anecdotes/participant success stories about breastfeeding practices with submission of BIH Quarterly Reports.	

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

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
5.1 BIH Coordinator under the guidance and leadership of the MCAH Director will ensure that all BIH participants are linked to services that support timely prenatal care, postpartum visits and well-woman check-ups while enrolled in the BIH Program.	**5.1** • 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; from MCAH-BIH and MOD. • LHJ staff will distribute any customized preterm birth resources to local medical providers and monitor/track how providers utilize and/or incorporate resources to engage clients in service delivery. • LHJ staff will support, promote, and attend preterm birth educational webinars for medical providers. • Assist participants with increasing knowledge of infant safe sleep practices, SIDS, SUID risk reduction by participating in local SIDS collaborative meetings and trainings. • Provide participants with health education materials addressing the benefits of breastfeeding.	**6.1** • 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) o Reducing Preterm Birth: What Black Women Need to Know Tip Sheet o Reducing Premature Birth: What Providers Need to Know Tip Sheet o Reducing Premature Birth Discussion Points – guidance to encourage conversation with women about • Facilitate one – two educational webinars for medical providers on topics such as: (N) o Roles and Responsibilities: Steps to Prevent Preterm Birth o The use of 17P to prevent preterm birth o Reducing Preterm Birth: Evidence-Based Strategies to Improve Outcomes	**6.1** • Maintain records of staff attendance at trainings. (N) • Maintain attendee records of trainings/Webinars hosted by LHJ. (N) • Number and percent of participants who complete the safety checklist prior to delivery. (E) – *Fidelity Indicator A4aii* • Number and percent of postpartum participants who initiate breastfeeding. (E)

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
		• Provide participants with health education materials related to safe sleep practices and SIDS reduction. (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)	

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.

California Department of Public Health

Name/No.: MATERNAL, CHILD AND ADOLESCENT HEALTH (MCAH) Agreement Funding Application (AFA). Agreement No. 201910 MCAH and Agreement No. 201910 Black Infant Health (BIH)

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Organization #:	56201700; 56201706
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