POLICIES AND PROCEDURES
GUIDANCE FOR IMPLEMENTING THE BIH PROGRAM

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This Policy and Procedure (P & P) Manual is a guide for implementing the BIH Program. The P & P was developed collaboratively with the California Department of Public Health (CDPH), Maternal, Child and Adolescent Health (MCAH) Division, University of California, San Francisco (UCSF) Center on Social Disparities in Health (CSDH), and local MCAH and Black Infant Health (BIH) staff. This P & P is a living document that will be updated and changed as staff and client needs, data and research evolves.

I. INTRODUCTION: BACKGROUND ON THE BIH PROGRAM MODEL

Overview

The California Department of Public Health (CDPH), Maternal, Child and Adolescent Health (MCAH) Division, places a high priority on addressing poor birth outcomes that disproportionately impact the African American community. As the centerpiece of CDPH/MCAH's efforts to address the disproportionate burden of infant and maternal mortality, low-birth-weight, and preterm birth experienced by African American women and their babies in California, the Black Infant Health (BIH) Program was established in 1989 with the ultimate goal of *improving African American infant and maternal health in California and decreasing Black:White health disparities for women and infants.*

To better meet the health-related needs of pregnant and postpartum African American women who are the target population for BIH, CDPH/MCAH has developed and is beginning to implement a revised BIH Program that features both: (1) a *group intervention* designed to encourage empowerment and social support in the context of a life course perspective; and (2) *enhanced social service case management* to link clients with needed community and health related services. With the goal of providing BIH services in a culturally-relevant manner that respects clients' beliefs and cultural values while promoting overall health and wellness, and recognizing that women's health and health-related behaviors are shaped by non-medical factors (e.g., the effects of stress related to limited social and economic resources as well as racism and discrimination), the revised BIH Program has been developed to address these *social determinants* of health in ways that are relevant, culturally affirming and empowering to clients. ***This Policy and Procedure Manual is a guide for implementing the new intervention model developed by the MCAH Division with extensive stakeholder input over the past four years.***

History and New Direction

In 1989, with the passage of Senate Bill (SB) 165, Budget Act of 1989 (Alquist, Chapter 93, Statutes of 1988), California began to more aggressively address the challenge of improving the health of African American women, infants, and children by promoting health and health care during the prenatal and postpartum periods and providing services in a supportive and culturally-competent manner. Originally a pilot project in four sites, the BIH Program has expanded its reach to 15 local health jurisdictions (LHJ) where over 75 percent of all African-American births occur in California (BSMF, 2008).

The primary focus of the original BIH Program, established in 1989, was getting clients into prenatal care. In 1993, CDPH/MCAH contracted with the University of Southern California (USC) to conduct an assessment of the BIH Program. The assessment revealed that the client served had multiple, complex needs beyond the scope of the

services being provided by the program. Implementation of a standardized statewide "best practice" model was recommended based on findings from the assessment. It was recommended that the standardized services should encourage advocacy and empowerment skills and include outreach, case management, social support and empowerment, prevention, health behavior modification and male parenting.

Based on the findings in the USC assessment, six BIH models were developed to address the various needs of the clients and the fathers of the babies in 1995. These models were:

- Prenatal Care Outreach and Care Coordination
- Comprehensive Case Management
- Social Support and Empowerment
- The Role of Men
- Health Behavior Modification
- Prevention

The original intent was to combine the six models into a single program that could be evaluated statewide. The Health Behavior Modification and Prevention models were discontinued by the LHJs due to inadequate resources to effectively implement them and a shift in the target population from teens and adult women to only adult women. And the Prenatal Care Outreach and Care Coordination was the only model required to be implemented at every site, and each LHJ had the option of conducting the other service models based on local need and resources. In addition, some sites conduct additional activities at the individual, group and community levels, but these activities are not standardized. Because numbers of participants at individual sites are relatively small and variation across sites has precluded combining data for an overall evaluation, documenting the impact of the BIH Program has been very difficult.

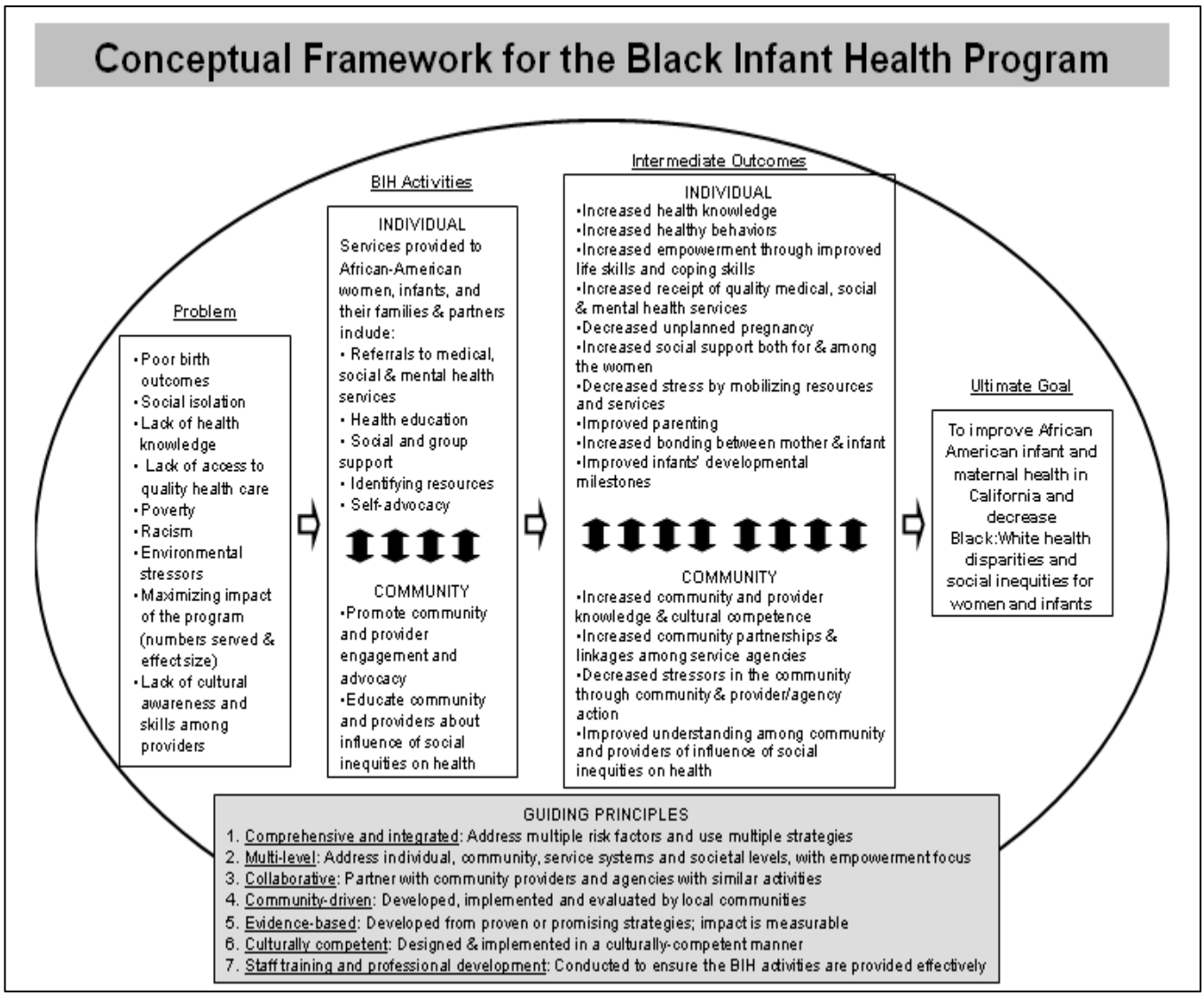
In 2006, CDPH/MCAH commissioned UCSF/CSDH to conduct an assessment of the BIH Program. *The Black Infant Health Program: Comprehensive Assessment Report and Recommendations* found that there is no definitive scientific evidence about how to decrease racial disparities in birth outcomes, but solely getting prenatal care will not close the gap. Interventions that have shown great promise are group-based prenatal care emphasizing social support and empowerment yielded promising results in one recent study. There is mixed evidence regarding the effect of social support on birth outcomes, but positive effects have been demonstrated on a variety of maternal health outcomes across the lifecourse, and social support has been shown to buffer against stress. Effects of empowerment on birth outcomes have not been tested but empowerment has improved a wide array of health behaviors and health-related outcomes in the health promotion literature.

Based on these findings, the assessment recommended a *single core model* for the BIH program that addresses health promotion, social support, empowerment, and health education throughout a woman's pregnancy and early parenting that builds upon promising models. The assessment concluded that standardizing interventions across sites would help the program's long-term sustainability by generating information about program impact that is both scientifically sound and compelling to policy-makers, and that bringing program content in line with current scientific knowledge—e.g., regarding the importance of social support and empowerment in health behavior change and of social and economic factors in health outcomes—would make the BIH Program more effective in meeting its clients' needs and achieving program objectives.

CDPH/MCAH is strongly committed to a collaborative process in revising the BIH Program. Throughout this process, expertise from various sources (e.g. local BIH administrative and direct service staff, national experts, and UCSF/CSDH) has been accessed to create the single core model. This process has involved and will continue to involve close collaboration among local BIH and MCAH staff, CDPH/MCAH staff, UCSF/CSDH, and nationally recognized leaders in maternal and infant health, with the goal of developing a model program that is both scientifically sound and feasible in terms of its accessibility and acceptability for BIH clients. Over a three-year period, more than 100 people, most of them from local BIH programs, participated in the process. As illustrated in the conceptual framework diagram below (Figure 1), the model focuses on improving a series of ”intermediate outcomes” linked with birth outcomes, reflecting current scientific knowledge about the individual and community-level factors that influence health and health disparities. Building on successful components of existing BIH Program models and incorporating other promising practices, the resulting model supplements recommended medical care outside of BIH with client-centered social services--integrating prenatal, postpartum, parenting and infant health education and promotion with social support and empowerment into one standardized model that will be implemented at all sites.

To better meet the health-related needs of pregnant and postpartum African American women who are the target population for BIH, CDPH/MCAH is implementing a standardized BIH Program that features both: (1) a *group intervention* designed to encourage empowerment and social support in the context of a life course perspective; and (2) *enhanced social service case management* to link clients with needed community and health-related services. The goal of the program is to provide services in a culturally-relevant manner that respects clients’ beliefs and cultural values while promoting overall health and wellness, and recognizing that women’s health and health-related behaviors are shaped by non-medical factors (e.g., the effects of stress related to limited social and economic resources as well as racism and discrimination). The revised BIH Program has been developed to address these *social determinants* of health in ways that are relevant, culturally affirming and empowering to clients.

Figure 1. Conceptual Framework for the Black Infant Health Program



II. GUIDANCE FOR CLIENT ACTIVITIES

Governing concepts

All aspects of the BIH Program model have been developed with attention to four key ***governing concepts.***

Culturally-Relevant. One of the founding tenets of the BIH Program was to provide services in a culturally relevant manner. This means the ability to provide care to people with diverse values, beliefs and behaviors, including tailoring delivery to meet clients' social, cultural, and linguistic needs. It is essential to continue to institute this approach in the BIH Program. Providing services in a cultural competent manner has emerged as part of a strategy to reduce disparities.

Client-Centered. The client-centered model was originally developed by Carl Rogers and contains the key ingredients of a helping relationship: empathy, respect and genuineness. The fundamental tenet of the approach is that all people have a tendency to inherently strive toward growth, self-actualization, and self-direction. A client-centered approach places the needs, values and priorities of the client as the central core around which all interaction and activity revolve. The client-centered approach focuses on developing goals and strategies that are personalized and realistic and is conducted in an interactive manner that encourages clients to do most of the work, which empowers clients to take full responsibility for their lives. Understanding how clients perceive their needs, resources, and priorities for utilizing services is essential in providing client-centered services.

Strength-Based. The fields of health and mental health have long histories of focusing on deficits, problem behaviors, and pathologies. Within the last decade, researchers, clinicians and practitioners have begun to question the deficit-based approach and are moving toward a strength-based approach. This approach is a collaborative process that acknowledges that we all have strengths. These strengths are often untapped or unrecognized, but can be accessed and used to foster growth and healthy behavior change. This approach is recognized as empowering and supports self-sufficiency.

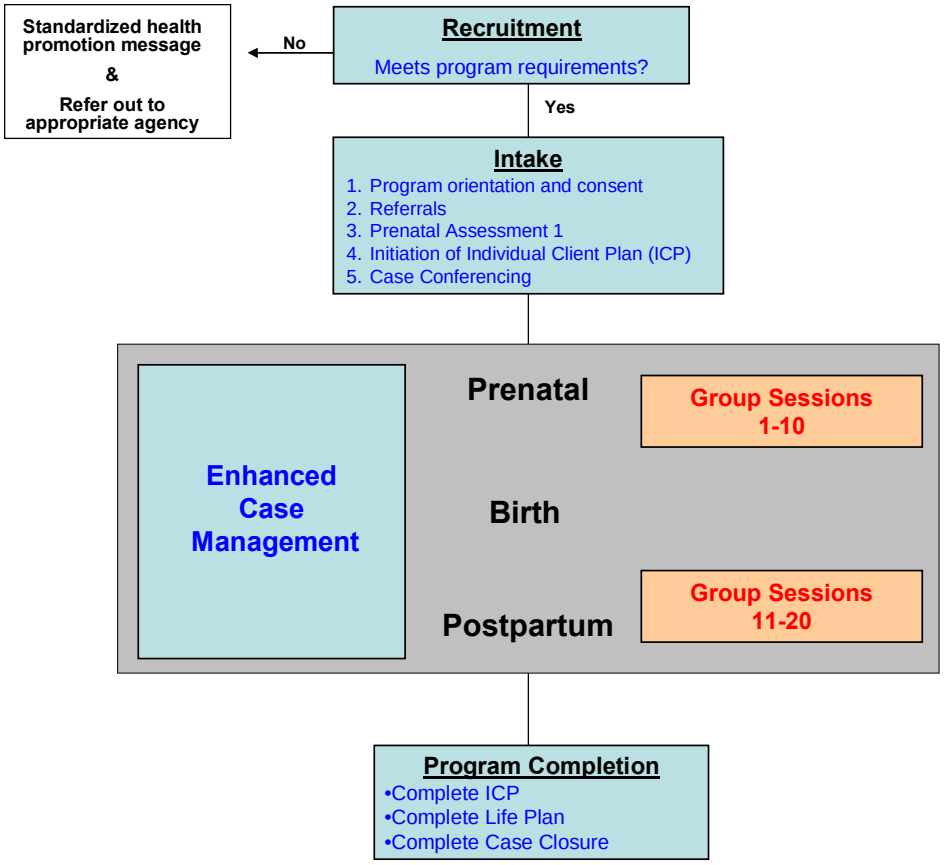
Cognitive Skill-building. Cognitive behavioral therapy (CBT) is an approach that aims to solve problems through a goal-oriented process, embracing the concepts that behaviors are learned and that clients can learn how to think differently and act on what they have learned. This approach is empowering and accepts that clients are capable of change; their success is measured by improved quality of life and well-being. CBT has been shown to be effective for many types of issues and can be readily practiced by paraprofessionals.

Sequence of activities

Figure 2 highlights the sequence of BIH activities that take place from the time a woman is referred to BIH until she exits the program. As noted, the sequence of activities is intended to begin prenatally and continue after the client gives birth (although eligible postpartum women may also be enrolled) and includes the following:

1. **Client recruitment**
2. **Client intake**
3. **Program participation:**
    a. **Enhanced case management**
    b. **Group intervention**
4. **Program Completion**

Figure 2. Black Infant Health Program Client Flow Chart



► Recruiting clients into BIH

Program standards: **The BIH Program serves pregnant and postpartum African American women ages 18 years of age or older; clients should be enrolled as early as possible during pregnancy. The program has traditionally served primarily low-income women, and will continue to serve women covered by Medi-Cal. Each LHJ will develop and follow its own site-specific Recruitment Plan that meets CDPH/MCAH requirements (see Section III. Guidance for Program Implementation at Local Health Jurisdictions and Program Sites).**

*****Forms to be completed:***
A. Client Recruitment

BIH target population and eligibility
Historically, the BIH Program has served a subgroup of African American women who are at relatively high risk of adverse maternal and infant health outcomes. Based on comparisons with African American childbearing women statewide, BIH clients are more likely to have unintended pregnancies, initiate prenatal care later in pregnancy, have Medi-Cal coverage, be unmarried, have lower educational attainment, and be younger. CDPH/MCAH anticipates that the BIH Program will continue to serve these higher-risk clients, and encourages BIH LHJs to secure matching federal funds for women who are Medi-Cal eligible.

A woman is eligible for entry into BIH if she meets the following criteria:

- Is a self-identified African American woman who is pregnant or parenting (up to 3 months postpartum);
- Is 18 years of age or older;
- Resides in the target area or within the LHJ;
- Consents to actively participate in the entire BIH program including:
    a. Group intervention;
    b. Individual enhanced case management;
    c. Consent to release information from her prenatal care provider, from her baby's birth certificate information, and LodeStar.

If a prospective client does not meet all Eligibility Criteria and local BIH staff believe that she would benefit from participation in the program, the BIH Coordinator should contact CDPH/MCAH to request an exception for that individual woman only.

Because participation in both the group intervention and enhanced case management are crucial for program effectiveness, fidelity and evaluation, women must be willing to commit to fully participate in all BIH Program activities. Participation in the BIH Program is voluntary. Once a client commits, it is to participation in the group intervention and enhanced case management.

Although this requirement may be waived in rare instances for a limited number of reasons (e.g., medical bed rest, active substance abuse), a woman's unwillingness to participate in the group intervention is not in and of itself a legitimate exception to the eligibility criteria described above.

If a prospective client does not meet the eligibility criteria or chooses on to participate in the BIH Program, staff should provide her with a standardized health promotion message and referrals to community/social services.

Recruitment procedures

Effective client recruitment is critical to the success of the BIH Program. As described in greater detail below (see Guidance for Program Implementation at Local Health Jurisdictions and Program Sites), each site must have a formal Recruitment Plan that provides a clear framework for strategic activities to bring women into the local BIH Program. At most sites, the recruitment strategy will be involve a combination of outreach activities focused on (a) referrals from other providers/agencies, (b) direct BIH staff outreach (e.g., street outreach, participation at community health fairs and other events, etc.), and (c) media outreach; women may also 'self-refer' to BIH based on any of these outreach activities.

Whether a woman is referred by another provider/agency or identified through direct BIH staff outreach, media outreach or self-referral, BIH staff must ensure that the following steps take place for every prospective client:

- Within 72 hours of referral/outreach, make an initial attempt to contact the woman to verify her interest in and eligibility for BIH participation. A minimum of three attempted contacts must be made.
  - If the referred/outreached client is successfully contacted and she is eligible and interested in participating in BIH, schedule an intake appointment within the next 30 days.
  - If a referred woman is contacted and interested but not eligible for BIH services, she should be referred whenever possible to other community services and receive a standard health promotion message.
  - If the referred/outreached woman cannot be contacted, she should be sent a letter outlining the value and importance of the BIH Program and requesting that she call if she would like to enroll; this letter should also include the standard health promotion message noted above.
- Record all contacts and final results of the referral/outreach in the BIH *Client Recruitment* form. Ideally, these activities will be completed within 30 days; however, some prospective clients may take longer to contact and enroll, and in those circumstances the timeline can be extended.

► Client intake

Program standard: **Intake of each eligible prospective client will be timely and complete.**

*****Forms to be completed:***
*B. Client Forms Checklist**
C. Rights &Responsibilities and Consent
*G. Prenatal Assessment 1**
*****Forms to be initiated:***
H. Individualized Client Plan (ICP)
*(*Note: If the client is enrolled after giving birth, Client Forms Checklist (For Postpartum Entry) will replace Client Forms Checklist and "Postpartum Assessment 1 for New Clients" will replace Prenatal Assessment 1.)*

Led by the Family Health Advocate (FHA), the **face-to-face intake process** provides an opportunity both to enroll the new client in the BIH Program, and to identify information about her needs, resources, and strengths as the ICP is initiated. To ensure that clients are processed into the BIH Program in a timely manner, intake should take place at the local BIH site within 30 days of successful staff follow-up. If the client is unable to make her appointment with the FHA, the appointment should be rescheduled as soon as possible; if the second appointment is missed, a home visit may be made to enroll the client if deemed appropriate and resources permit.

The BIH intake process includes three FHA-led activities:

- Orientation and Informed Consent
- Initial assessment, including completion of the *Prenatal Assessment 1* form (or the *Postpartum Assessment 1 for New Clients* form, for clients who enroll after giving birth)
- Initiation of the *ICP*

Orientation and Informed Consent

Orientation is conducted by the FHA and includes the following steps:

- Discuss the value of the BIH Program for the overall health of the prospective client, her family and the African American community.
- Referring to the *Rights & Responsibilities and Consent* form, explain (a) the range of services offered by the BIH Program and the role of the BIH staff, highlighting both program limitations and opportunities; and (b) requirements for client participation. The goal is to ensure clear and appropriate client expectations.
- After both the client and the FHA sign the *Rights & Responsibilities and Consent* form, place one signed copy in the client's file and give another copy to the client.

Initial Assessment
The Initial Assessment provides baseline social and health-related information about the client, intended to help identify her strengths and needs/concerns as the basis for initiating the ICP; it also provides an opportunity for the FHA to build rapport with the client. As part of the initial assessment, prenatal clients must complete the *Prenatal Assessment I*; clients who enroll after giving birth must complete a similar form, the *Postpartum Assessment 1(For Postpartum Entry).*

Initiation of the Individualized Client Plan (ICP)
The ICP provides a framework for the client's enhanced case management, which will continue throughout her participation in the BIH Program. At intake (or as soon as possible following intake), the FHA and client work together to initiate the ICP, building on the initial assessments to identify and prioritize client concerns that will be the focus of enhanced case management, including referrals to services outside of the BIH Program. The ICP also incorporates information about the client's own strengths and existing resources, with the goal of supporting client self-determination and empowering her to actively participate in problem-solving. The plan will also be used to guide service delivery, and becomes the basis for evaluating the provision and effectiveness of services. In addition, the group facilitator(s) will be informed of the information in the ICP to connect the activities in the group intervention to the efforts in the groups.

► **Program Participation: Enhanced Social Service Case Management**

Program Standard: **Every BIH client in the BIH Program will receive enhanced case management services coordinated by an FHA.**

*****Forms to be completed:***

H. Individualized Client Plan
D. Referrals (at each client contact)
E. Client Log: Case Management
F. Case Conference
J. Prenatal Assessment 2
K. Birth Plan
L. Prenatal Assessment 3
M. Prenatal Client Satisfaction (if not completed during Group)
N. Safety Checklist
O. Pregnancy Outcome
P. Edinburgh Postnatal Depression Scale
Q. Postpartum Assessment 1
R. Postpartum Assessment 2
S. Life Plan
T. Postpartum Assessment 3
U. Postpartum Client Satisfaction

(Note: If the client is enrolled after she gives birth, items J, K, L, and M will not be required.)

What are the key characteristics of enhanced case management? The BIH Program model uses a social service-oriented enhanced case management model that focuses on (a) identifying and triaging client needs and facilitating client access to prenatal and postpartum supportive services (and to medical care as needed), while at the same time, (b) working with the client to identify and build on her strengths and resources to problem-solve, and obtain the services and support she needs.

Who conducts enhanced case management? Enhanced case management will be led by the FHA, as part of an interdisciplinary team that includes the group facilitator and the public health nurse and a mental health professional if they are on staff at the site.

When and how often should case management occur? Following the intake and continuing on an ongoing basis until the client completes her ICP. The FHA and client should meet regularly. While the timing of some of these meetings will be set by required activities (e.g., Prenatal Assessments 2 and 3 should be completed based on the timing of the client's group intervention, while the Birth Plan and Home Safety Checklist should be completed 3-4 weeks prior to the client's due date), the timing and frequency of other meetings will be determined by the client's specific needs outlined in the ICP.

Where should case management occur? Whenever possible, case management appointments should be held at the BIH office to ensure privacy and confidentiality, and may coincide with the client's attendance at group intervention sessions. Other sites (e.g. the client's home/temporary residence, other sites in the community) that are private and confidential may be used, if necessary. If the FHA is conducting case management in the home, the local site must have a protocol to ensure staff safety.

What activities are included in enhanced case management? Building on the initial assessment and initiation of the client's ICP at intake, enhanced case management focuses on the following primary activities:

- Case conference (initial, and ongoing on an as-needed basis)
- Ongoing implementation of the *ICP*
- Referrals to services outside of BIH
- Periodic prenatal and postpartum assessments and completion of required forms
- Development of the Life Plan
- Coordination with Group Intervention

Case Conferencing

Separate from regular client contacts, case conferencing provides an opportunity for BIH staff to work together to develop a planned and coordinated approach to case management that enhances (and minimizes duplication of) services and resources. A *Case Conference* form should be completed whenever a client's case is reviewed in a case conference.

The initial case conference. Each new client will receive an initial case conference within a month of the intake into the BIH Program. Key BIH site staff (the FHA, and Group Facilitators along with the public health nurse (PHN) and mental health professionals as available) will meet to jointly review the client's initial ICP. Led by the FHA and drawing on insights gained during the intake process, this first case conference should provide other members of the team with an overview of the individual client, including information about the client's:

- Basic demographics
- Practical, health-related and psychosocial needs and concerns,
- Strengths and emotional/behavioral capacity to meet her own needs
- Available resources for social, emotional and practical support

Information about the initial case conference (participants, topics discussed, recommendations for action/ follow-up) should be documented in the *Case Conference* form. Results and recommendations should be integrated into the ICP, and a summary of the discussion should be distributed to participants within two weeks following the case conference. Insights from the case conference should help the group facilitators assess the client's ability to participate in the group intervention and any possible issues that may interfere with client retention. For clients assessed as being at particularly high risk, additional follow-up by other professionals may be appropriate.

Subsequent case conferences. Ideally, case conferences should continue on an as-needed basis during the course of the client's participation in the BIH Program to ensure that any emergent medical, mental health and social service issues (identified during the periodic reassessments described below, for example) are addressed. Again, follow-up case conferencing would include the FHA and at least Group Facilitator, along with a PHN and/or mental health professional when possible; results and recommendations should be summarized in a *Case Conference* form, shared with key staff within two weeks, and integrated into the ICP.

Ongoing ICP Implementation

Beginning at intake and continuing throughout the case management process, the FHA will work collaboratively with the client to identify and prioritize her concerns and to set goals and plan of action for addressing them. As noted above, the FHA and client should meet regularly, with the timing of those meetings determined by the timing of the required assessments as well as by the client's specific needs. These follow-up contacts could be conducted before or after the group session.

Although additional attention will need to be paid to urgent issues as they arise and the ICP should be revised accordingly, at any given time the client and FHA will focus on strategies to address the client's *three highest priority concerns*; when the client has successfully addressed/resolved one of these concerns, she and the FHA will add another to their focus. The FHA and client will work

together to decide what actions are necessary to address each concern and who will take responsibility for each task.

Referrals to services outside of BIH

For many concerns faced by BIH clients, successful resolution will require that the client receive services from resources outside of the BIH Program. The FHA coordinates the referral process, helping the client obtain access to outside resources and monitoring her progress. Having strong relationships with referral agencies will enhance the process, and the relevant local agencies should be contacted on a regular basis to confirm that they have enough referral forms, discuss the disposition of current clients, and determine whether additional orientation about the BIH Program is needed. Building on these ongoing collaborative relationships, the FHA should direct the client to the appropriate agency for the services she needs, advocating for and assisting her as needed but encouraging and supporting her to act on her own behalf whenever possible.

Timely and systematic *documentation* and *follow-up*—either by telephone or in person at a client appointment—of all referrals are essential for effective implementation of the ICP, allowing the FHA and client to review successes and continued challenges and revise the referral process accordingly. A *Client Referral* form should be completed by the FHA at every client encounter, whether face-to-face or by phone. If a client has difficulty completing her planned efforts to obtain services, the FHA should take a more active role by helping the client to identify barriers she herself may not necessarily recognize and to develop concrete feasible strategies to overcome them. The FHA should encourage the client to report back to her with regular updates throughout the referral process.

**Note: All clients reporting drug, alcohol and/or tobacco use at any point in case management process will be provided (and/or referred to outside services to receive) appropriate health information/counseling.

Periodic prenatal and postpartum assessments and completion of required forms

As noted above, regular face-to-face and/or telephone meetings of the FHA and client will need to be scheduled to ensure that the required assessments and forms are completed; the timing of these meetings will largely correspond with the timing of her prenatal and postpartum participation in the group intervention.

Before the client gives birth:

- *Corresponding with the client's participation in group sessions 4 through 7,* the FHA should meet with the client to complete the *Prenatal Assessment 2* form.
- *After the client's completion of group session 10 and approximately 1 month prior to her due date (or as soon as possible, if she completes group session 10 less than 1 month before her due date),* the FHA should meet with the client to complete:

- *Prenatal Assessment 3*
- The client's personal *Birth Plan,* including her plans for feeding her infant. The client's work with the FHA to complete this plan will build on discussion of these topics during group session 6. (Note: Local sites should obtain copies of birthing plan from each of the delivery hospitals at which their clients give birth, and use these templates to guide clients as they complete their own plans; in addition to helping clients prepare, this process should also foster greater coordination between the local BIH Program and hospitals/providers in the community.)
- The *Safety Checklist,* intended to be reviewed and completed as the the FHA and client discuss important safety concerns to be addressed during the baby's first few months of life; the client should be given a copy of the Safety Checklist to keep at home. *(*Note*:* If local sites decide to conduct optional home visits during which the Safety Checklist could be reviewed and completed, they must establish a protocol to ensure staff safety.)
- *Prenatal Client Satisfaction (if client does not complete during Group)*

After the baby is born:

- *Before the client participates in group session 11,* the FHA should meet with the client to complete:
  - The *Pregnancy Outcome* form*.*
  - *Postpartum Assessment 1. (*Note*:* For newly-enrolled clients, use the *'Postpartum Assessment 1 (For Postpartum Entry)* version of this form and complete the *Safety Checklist* at this time as well*.)*
  - *Edinburgh Postnatal Depression Scale (EPDS).* (Note: This assessment *must* be administered 6-8 weeks after the client gives birth; if the client begins her participation in the postpartum group sessions sooner than 6 weeks or after 8 weeks postpartum, the FHA will need to schedule a separate meeting to complete the *EDPS*.)
  - An optional *Home Safety Assessment* may be conducted for women who are of concern to the FHA or group facilitators.

  Note: At this initial postpartum contact with the client, the FHA should also answer any questions and reinforce the importance of the client's continued participation in the group intervention.
- *Corresponding with the client's participation in group sessions 14 through 17,* the FHA should meet with the client to complete *Postpartum Assessment 2* .
- *After the client completes group session 20,* the FHA should meet with her to complete:
  - *Postpartum Assessment 3*
  - *Postpartum Client Satisfaction*

Coordination of Individual Case Management and the Group Intervention

Throughout the one-on-one work with the client, the FHA also plays a key role in ongoing client retention efforts--ensuring that the client continues to fully participate in all aspects of the BIH Program, including the group intervention (see below). For example, following the first 10 prenatal sessions of the group

intervention, the FHA can encourage client retention for the remaining 10 postpartum group sessions during her meetings—including reminders about the postpartum sessions and emphasizing the important benefits of the group intervention.

The FHA and group facilitators should meet regularly to discuss clients to identify their strengths, success and emergent needs. In addition, the group facilitators can support the work done during the enhanced case management contacts and vice versa.

► Program Participation: Group Intervention

Program Standard: **Every BIH client in the BIH Program will participate in and complete the full group intervention.**

*****Forms to be completed:***

M. Prenatal Client Satisfaction
S. Life Plan
U. Postpartum Client Satisfaction
**Group Sessions: Facilitator Summary and Feedback*

**Note: The Group Sessions form is not a client-specific form so is not included in the Data Book; it will be available on SharePoint as a separate document.*

What are the key characteristics of the new group intervention?

- The group intervention is the central component of the BIH Program, in conjunction with enhanced case management. Adapted from other evidence-based and promising curricula (e.g. BIH Social Support and Empowerment, Nurturing Parenting, Effective Black Parenting and Legacy), the group intervention reflects all four BIH governing concepts—it is culturally relevant, client-centered, strength-based, and utilizes cognitive skill building approaches. The curriculum focuses on building each client's knowledge and skills while enhancing her self-esteem and confidence, with the goal of empowering her to take active responsibility for her own health and that of her family and new baby. It is culturally-relevant and incorporates opportunities to build clients' awareness of how health is shaped by social determinants including economic and social factors like income, education and discrimination. At the same time, providing this curriculum in a group setting provides clients with a source of social support while allowing them to share their experiences with each other. Participants learn to identify their strengths and develop strategies to apply those strengths in their daily lives. The BIH group intervention brings together women with common issues and provides opportunities for open and honest dialogue about the issues they face. This unique experience positions the women as experts as they assist each other in the process of self-discovery and personal growth.

- The full group intervention includes *20 sequential group sessions*, divided into two series of 10 weekly sessions--prenatal sessions 1-10 and postpartum sessions 11-20. While important concepts and themes are reinforced throughout all 20 sessions, the first 10 sessions focus on pregnancy-related issues and sessions 11-20 focus on newborn care and parenting issues. (Note: The emphasis in the BIH Program model is on enrolling clients as early in pregnancy as possible to give them the full benefit of all BIH services; however, eligible women who have not participated during their pregnancies may enroll within 3 months after giving birth and participate in the 10 postpartum sessions of the group intervention.)

- Sites should seek to enroll 8-12 clients for each group intervention series to ensure that the ideal number of 5 to 8 participants attends each session.

Who conducts the group intervention?

- Each group session will be led by two group facilitators who will be trained at a CDPH/MCAH-sponsored Group Facilitators Training. CDPH/MCAH requires that the group intervention be co-facilitated, which provides opportunities to share tasks and responsibilities, to pay greater attention to participants during group, to model appropriate communication/behavior between facilitators, to introduce diversity and connect with a broader range of clients, and to bring different talents and knowledge to the group. Effective co-facilitation also requires coordination of tasks prior to the group, with clear and mutually agreed-upon definitions of roles, responsibilities, and expectations. For example, co-facilitators will want to discuss how they will manage distractive/disruptive participants and how to handle controversial issues; any disagreement should be discussed outside of the group and not in front of participants. At least one of the facilitators should be part of the initial case conferences for new clients to gain better understanding of each group participant's strengths, challenges and concerns/needs and how these can be best addressed during the group intervention.

- Effective facilitation is key to the success of the group intervention, and the facilitators' primary role is to guide the group in self-discovery. This is accomplished by managing and maintaining a group process, and ensuring that it takes place in a respectful and safe environment that allows participants to be themselves. Building on requisite skills of good communication and effective listening, the required CDPH/MCAH-sponsored group facilitation training helps group facilitators develop an array of tested strategies for effective facilitation including group management. At the same time, becoming a proficient facilitator takes time, effort and practice, and BIH group facilitators are expected to become even more effective as they gain experience.

When and how often will the client participate in the group intervention?

- As noted above, the complete group intervention includes 10 *weekly* prenatal sessions and 10 *weekly* postpartum sessions. Clients who enroll during pregnancy will participate in the full 20-session group intervention; clients who enroll after giving birth will participate in 10 postpartum group sessions. Exceptions to this expectation must be clearly documented and meet defined criteria (e.g., medical bed rest, untreated mental illness, active substance abuse).

- Each site will need to schedule group sessions based on several considerations including:
  - The number of current clients who are eligible to join either a prenatal or postpartum group intervention series
  - When those clients are most likely to be able to attend group sessions (e.g., sites should consider scheduling evening and/or weekend sessions for clients who work or have other daytime commitments)
  - Staffing capabilities—the number of group facilitators available to lead groups

- A pregnant client will be eligible to join an upcoming series of prenatal group sessions if her anticipated due date is after the scheduled date for session 10; a postpartum client will be eligible to join an upcoming series of postpartum group sessions if she is no more than 3 months postpartum when those sessions are scheduled to begin.

- A client must begin her participation in the group intervention series by session 3 (prenatal) and by session 13 (postpartum).

- Every client who enrolls in BIH prenatally is expected to complete the full 20-session series, with completion defined as participation in at least 7 prenatal sessions and at least 7 postpartum sessions; a client who enrolls after giving birth is expected to participate in at least 7 postpartum sessions.

***<u>Note</u>: Maximizing client retention.* The group intervention provides both opportunities for and challenges to ensuring that enrolled clients continue to participate in the BIH Program until successfully completing all requirements for case closure (see below). Dynamic facilitation and client engagement in the group are key, but will need to be reinforced through other strategies such as weekly follow-up by the facilitator and/or a client "buddy," particularly if a client misses a group session. In addition, local sites are often familiar with their clients' needs and should anticipate them, finding ways to provide "enablers" (e.g., transportation, childcare, food, incentives for participation) that can make a critical difference in whether or not clients attend their groups. As noted above, the FHA can also play an important role by reinforcing the importance of the group intervention during her one-on-one work with the client.

What activities are included in the group intervention?

- The majority of activities included in the group intervention will be curriculum-based. Each session includes engaging interactive activities designed to reinforce key themes, an exercise designed to help clients manage and

reduce stress, and an opportunity for clients to set personal goals to improve their health. Specifically, each group session will be 2 ½ hours long and divided into five sections:

1. A welcome and follow-up from last week's goal (15 minutes)
2. A health promotion/knowledge activity designed to demonstrate a key theme that is interactive and engaging (50 minutes)
3. A break with a nutritious snack--reinforcing the importance of healthy foods (15 minutes)
4. A second health promotion/knowledge activity designed to demonstrate a different key theme that is interactive and engaging (50 minutes)
5. Setting a new personal goal based on the day's activities, a relaxation exercise and a concluding Gratitude Circle (20 minutes)

- While key information will be introduced by the Group Facilitators in each session, participants will also be given a new chapter every week of a Participant's Handbook including additional resource information related to that session's focus.

- The full series culminates in session 20 as each client develops her own *Life Plan* for achieving her personal goals associated with health, family and relationships, and finances.

- In addition to the *Life Plan*, each client should complete two *Client Satisfaction* forms during her participation in the group intervention—the first should be completed at the conclusion of prenatal group session 10 and the second at the conclusion of the final postpartum group session 20. (If the client does not attend those group sessions, she should fill out these forms as part of her individual case management.)

**Note: Group facilitators are also expected to regularly complete *the Group Sessions* providing essential information to guide CDPH/MCAH in making necessary revisions in the group intervention; at least during early implementation of the BIH program model, group facilitators will be required to complete a *Group Sessions* form after every group session.

Coordination of Individual Case Management and the Group Intervention
The client's participation in the group intervention and her relationship with the group facilitators also provide a key resource for the FHA in her ongoing one-on-one work with the client during the process of enhanced case management. For example, the group facilitators may recognize during group activities that the client is struggling with an issue that requires more individualized attention, which they can then share with the FHA. Logistically, the FHA may arrange meetings with the client to coincide with her attendance at the group sessions; because the client will be in group for 20 weeks, the FHA often has the opportunity to follow-up with the ICP prior to or following the group sessions. In addition, many key components of BIH services (e.g., the Birth Plan, Safety Checklist, the Life Plan)

are addressed in both the group intervention and enhanced case management, providing opportunities for reinforcing important concepts and ensuring that the client has the help, preparation and skills she needs to successfully advocate for herself in setting and achieving her goals.

► BIH Client Case Closure

Program Standard: **Staff will follow required procedures for every client as she leaves BIH, including completion of a *Client Case Closure* form.**

*****Forms to be completed:***
H. Individual Client Plan (ICP)
S. Life Plan
V. Case Closure

Case closure should be a formal process between the client and FHA. Although most clients will complete services, others may transfer to another BIH site, request to exit the BIH Program or be lost-to-follow up. While the specific steps to be taken will depend on how the client exits BIH, a *Case Closure* form should be completed for every client.

Program completion
Like all aspects of the program, completion is client-centered and while a client may continue in BIH for up to 18 months postpartum, the criteria for program completion are related to the following substantive (rather than chronologic) milestones that reflect successful completion of both enhanced case management and the group intervention:

- Completion of her *Life Plan*, following session 20 of the group intervention
- Completion of the *ICP* that she initiated with the FHA at intake
- Completion of all *Postpartum Assessments*

The *Life Plan* will be introduced to clients during session 19 of the group intervention. Each client will create a vision of her life and set personal goals in three main areas--relationship/family, financial and health (including reproductive health and family planning). As part of the process of enhanced case management, the FHA will work individually with each client to further develop and complete her Life Plan.

Completing the program represents a significant accomplishment for the client, who leaves the BIH Program with a new set of skills to live her life more fully as an empowered African American woman and mother. These events deserve to be celebrated and acknowledged in a significant way in a *final meeting with the FHA*. At that meeting, the FHA should:

- Review the changes the client has made to have a more fulfilling life and the skills she has learned;

- Identify the resources she will need to be successful;
- Allow the client to talk about her feelings surrounding completion;
- Ask if she would like to participate in any other informal support groups that may be available at the BIH site.

Transfer to another BIH Site

During the course of her participation in the BIH Program, a client may move to another California LHJ with a BIH Program. A formal transfer process—including the following steps--should minimize disruption and ease the client's transition between programs, and ensure that her information is transferred. The following steps will facilitate a smooth transition from one site to another.

- Request that the client sign a *Release of Information* to share information with other BIH sites.
- Send a copy of all client forms that are not included in the MIS (including the current version of ICP, along with completed Prenatal and Postpartum Assessments, and other completed forms and client notes) to the new BIH site.
- Convene a conference call with the new FHA to share relevant information about the client.
- The new FHA should meet with the client and update her ICP based on her current needs.

Voluntary Exit from BIH

Some clients will exit the program prior to the completion of services for a range of reasons, including: relocation to an area without a BIH Program; incarceration; participation in another program with services that are duplicative of BIH services; and the client's decision to discontinue her participation in BIH. BIH is a voluntary program, and a client may decide at any point after enrolling that she no longer wants to participate. Although staff may feel that the client's withdrawal from BIH may result in a negative outcome for her and/or her baby. Staff should try to suspend judgment and allow the client to make her own decision. ***If, however, the client is planning to harm herself or her infant (born or unborn), this information must be reported to the appropriate agency;*** in many cases, BIH staff are mandated to report these type of incidents. LHJs must have a policy in place to deal with reportable situations.

When clients decide to voluntarily terminate their participation in the BIH Program, the following steps will facilitate the process:

- Assist the client in understanding the implications of the issues she faces and the possible outcomes and consequences of her decisions.
- Present her with options from which she may select a course of action, including accessing other community resources.
- Let her know that if she is welcome to return to the BIH Program as long as she meets eligibility criteria.
- Ask her about her reasons for exiting the program and document that in her chart and the Client Closure form.

Loss-to-Follow Up (unable to locate or unresponsive)
Some clients may exit the BIH Program without notifying staff, and would thus be classified as 'lost-to-follow up.' The following steps should be taken for these clients:

- The FHA should make at least 5 attempts (all documented in the *Client Case Closure form*) over at least 2 months to contact the client via phone messages, follow up with her provider or emergency contacts, or home visits.
- If able to contact the client, encourage her to continue participating in the BIH Program. If she opts not to continue, follow the above steps for Voluntary Exit, including asking about her reasons for exiting the program and documenting that information in her chart and the Client Closure form.
- If the client can*not* be contacted during the 2-month period, send a letter to her last known mailing address indicating intent to terminate her from BIH. The letter should have a positive tone and include:
    - Encouragement to continue participating in BIH
    - Information about the value of BIH services
    - Encouragement to obtain prenatal and postpartum care for her and her baby
    - Notification that her BIH file will be closed if she does not respond within one week of receiving the letter.
- Document all attempts and outcomes of those attempts in the *Case Closure* form.

► <u>Collecting client-specific data</u>

As noted above, data will be collected for each client throughout her participation in the BIH Program using a series of standard forms. While the referring agency or provider and the Group Facilitators will be responsible for collecting some client data, most forms will be completed during the client's encounters with the FHA as part of recruitment, intake, enhanced case management, and case closure.

The data collected will be used both for client management and for program evaluation. To ensure that these data are as accurate and complete as possible, it is critical that: (1) the forms be administered at the specified time, (2) all directions on the forms be followed as closely as possible, and (3) the forms be filled out as completely as possible by providing answers to all questions. Guidance for administering required forms is included in all relevant trainings.

General tips for administering the forms:

- Read the overall introduction for each section before continuing on to the individual questions.
- Unless otherwise directed, read each question to the client (most forms are designed to be administered by the FHA). When a form notes that a question or set of questions is intended to be self-administered by the client,

read the introduction for the question(s) to the client before allowing her to record her answer(s).

- Do not read response options unless needed by the client for clarification.
- Avoid additional prompting that could 'lead' the client to a particular answer.

III. GUIDANCE FOR PROGRAM IMPLEMENTATION AT LOCAL HEALTH JURISDICTIONS AND PROGRAM SITES

For clarity and fidelity, each local BIH site should maintain an organizational structure that assures the operation and oversight of the BIH Program to meet its current Scope of Work and the BIH Policies and Procedures outlined in this document. This section presents policies and procedures related to the following components of successful implementation at the local program level:

- **Location and staffing**
- **Client recruitment**
- **Referrals to services outside of BIH**
- **Community involvement**
- **Data collection**
- **Quality assurance**

► Location and staffing

Location of BIH services

> ***Program Standard:*** **Client services should be provided at the local program sites whenever possible. While BIH staff may need to meet with clients in their homes under special circumstances and the required safety checklist may be reviewed and completed in the client's home if resources permit, the BIH Program does not include mandatory home visiting.**

BIH Program client services should be provided at the local program sites whenever possible. At minimum, the clients are required to attend the group intervention sessions at the local site or at the site of a community partner. This approach helps women learn to obtain services in their community, empowering them to advocate and take practical action for themselves and their families. While BIH staff may need to meet with clients in their homes under special circumstances (e.g., if the client is on medical bed rest) and the required safety checklist may be reviewed and completed in the client's home if resources permit, the BIH Program does not include mandatory home visiting. As stated earlier, if staff does conduct visit at a client's home, a staff safety protocol must be in place.

- Whenever possible, *case management* appointments should be held at the BIH office to ensure privacy and confidentiality, and may coincide with the client's attendance at group intervention sessions. Other sites (e.g. the client's home/temporary residence, other sites in the community) that are private and confidential may be used, if necessary.

- Where the group sessions are held can be important, influencing both clients' ability to attend groups and their level of engagement when they do attend.
  - The *location* should be safe and accessible (e.g., with adequate parking and/or near mass transportation).
  - The *space* should be comfortable and welcoming (e.g., consider décor that reflects African American culture/heritage and contributes to the theme of social support and empowerment). It should also accommodate curriculum-related activities (e.g., permit use of an LCD projector and laptop, include room for a flipchart, have tables to allow the participants space for their materials and to record information in their Participant Handbook).

Key BIH personnel

> ***Program Standard:*** **Each LHJ must have a minimum number of qualified personnel in place to carry out the following required key staffing roles:**
> - **1 BIH Coordinator**
> - **2 Group facilitators**
> - **1 FHA**
> - **1 Data entry person**
>
> ***Program Standard*****: Key personnel will complete all required trainings; adhere to guidance specified in the P & P; provide required feedback to CDPH/MCAH; and attend required meetings and participate in required capacity building calls.**

The following key core staff roles *must* be filled (in some cases, more than one role may be performed by one staff member) at each local BIH site: BIH Coordinator, FHA, group facilitators (two per group), and data entry. Although core BIH funding should be sufficient to cover these key staff roles, they may also be covered by other funding sources. In addition, it is **strongly** recommended that each site have access to the services of a PHN and a mental health professional to provide medical and mental health consultation on higher acuity clients. CDOH/MCAH encourages support for these staff through local collaborations with public health and mental health programs.

- **Staff roles that must be filled at each local BIH site:**

BIH Coordinator.

Given her key role as the staff member with primary responsibility for managing, coordinating and supervising all local BIH Program activities and staff, the BIH Coordinator must possess recommended qualifications and her hiring is subject to CDPH/MCAH approval (see P & P Appendix for more detailed description of these requirements).

Each BIH Coordinator will: (1) complete the required FHA, facilitators' and data entry trainings; (2) comply with all guidance in the P & P; (3) provide feedback on the P & P and other aspects of program implementation to CDPH/MCAH; and (4) attend required trainings, meetings and calls.

Family Heath Advocate (FHA.)

Supervised by the BIH Coordinator and collaborating closely with the group facilitators, the FHA is primarily responsible for providing the enhanced case management services received by each BIH client from the time she is recruited until she exits the program. (See P & P Appendix for more detailed description of recommended qualifications.)

Each FHA will (1) complete the required BIH Basics training; (2) adhere to the enhanced case management services guidelines outlined in the P & P; (3) provide feedback to CDPH/MCAH on the effectiveness of those services and the data collection forms she administers; and (4) attend required trainings, and meetings and calls.

Group facilitators.

Group facilitators are primarily responsible for the management, facilitation and organization of the group intervention, under supervision of the BIH Coordinator. Each group <u>must</u> be led by two group facilitators who have received the CDPH/MCAH-sponsored group facilitation training. (See P&P Appendix for more detailed description of recommended qualifications.)

Each group facilitator will (1) complete the required facilitators' training; (2) adhere to the P&P guidance for implementing the group intervention; (3) provide regular feedback to CDPH/MCAH on the effectiveness of the group intervention; and (4) attend required trainings, meetings and calls.

Data entry.

At least one staff member at each local BIH site must be responsible for entering on a timely basis required client and site-specific data into the new

BIH MIS. The data entry role will be supervised by the BIH Coordinator. (See P&P Appendix for more detailed description of recommended qualifications.)

Each staff member entering data into the MIS will (1) complete the Data Entry training (2) adhere to the P&P; and (3) participate actively on the Data Committee.

- **Recommended staff roles to which each local BIH site have access:**

Public Health Nurse (PHN).

A PHN should be available to help BIH staff assess and respond to clients' medical issues, through participation in formal case conferencing and on an as-needed basis. If resources are available at local sites, the PHN may collaborate with the site staff to provide more direct medical assessments and services to BIH clients, and may help to coordinate client services from community medical/health care providers. (See P&P Appendix for more detailed description of recommended qualifications.)

Mental Health Professional.

A mental health professional should be available to help BIH staff assess and respond to clients' mental health issues, through participation in formal case conferencing and on an as-needed basis. If resources are available at local sites, the mental health professional may collaborate with site staff to provide mental health assessments and services to BIH clients, in coordination with community mental health services. (See P&P Appendix for more detailed description of recommended qualifications.)

► **Client recruitment**

Program Standard: **Each LHJ will develop a *Recruitment Plan*, including plans and goals for strategies to recruit eligible women into BIH.**

Recruitment plan

Effective client recruitment is critical to the success of the BIH Program. Based on its own specific circumstances but following a basic template provided by CDPH/MCAH, each site must have a formal Recruitment Plan that provides a clear framework for strategic activities to bring eligible women into the local BIH Program. The Recruitment Plan must balance staff time and effort devoted to recruitment activities with results in terms of client enrollment. In addition, the Recruitment Plan, as with all aspects of the BIH Program, must be fully supported at all levels within local MCAH programs—from the local MCAH Director, to the BIH Coordinator, to direct service and support staff.

At most sites, the recruitment strategy will involve a combination of outreach activities focused on:

- **Referrals from other providers and agencies (required)**
- **Direct BIH staff outreach (optional)**
- **Media outreach (optional)**

Note: Women may also 'self-refer' to BIH as a result of any of these strategies.

Provider/Agency referrals (Required)

As part of its Recruitment Plan, each local BIH site should describe as specifically as possible the types and number of provider/agency partnerships that will be established to encourage referrals of eligible women into the BIH Program. Sites should look for providers/agencies with a large pool of women who are potentially eligible to participate in the BIH Program, and ensure that these potential referral sources understand and appreciate the value of the program.

Procedures for Provider/Agency outreach include:

- Identify providers/agencies that have significant numbers of African American clients and an interest in referring clients for participation in the BIH Program.

- Develop Partnership Agreements with providers and agencies to ensure that each referring source has a clear understanding of the program vision along with expectations, roles, and responsibilities to ensure program success. Examples of potential referring partners include:
  - Kaiser Permanente
  - OB-GYN medical provider groups
  - Prenatal care providers
  - Family PACT providers
  - County health and social service departments
  - Churches and other faith based organizations
  - Community based organizations
  - Family Resource Centers
  - Elementary schools
  - Preschools
  - Head Start and Early Head Start programs
  - Crisis Pregnancy Centers
  - Food closets
  - Comprehensive Perinatal Services Program (CPSP) providers
  - Adolescent Family Life Program (AFLP)
  - Special Supplemental Food Program for Women, Infants and Children (WIC)
  - Planned Parenthood
  - First 5
  - Child Health and Disability Prevention
  - California Children's Services (CCS)
  - Child Protective Services (CPS)
  - Temporary Assistance for Needy Families (TANF)
  - CalWORKs and /CalLearn

- Maintain established relationships with providers/agencies by conducting outreach activities on a regular basis; these activities should be included in the Recruitment Plan. Some examples include:
  - Conduct presentations at various agencies, including health and social service providers' staff meetings.

- Conduct periodic orientations of the BIH Program with staff at all partner providers/agencies.
- Attend AFLP and CPSP client orientation enrollment meetings;
- Create a database of community agencies.
- Attend inter-agency and community meetings.

- Referring provider/agency responsibilities:
  - Inform potentially eligible women about the BIH Program and its activities.
  - For each potentially-eligible and interested woman, fill out relevant portions of the BIH *Client Recruitment* form.
  - Notify the local BIH Program about the referral via fax, email, or phone.

Note: Sites should follow local HIPAA regulations related to transmitting client information.

- Local BIH Program responsibilities:
  - Fax or email the disposition of referral to the referring provider/agency within 5 days, or another agreed-upon time-frame.
  - .Contact the referred woman within 72 hours to confirm her eligibility for BIH and schedule the intake appointment.
    - FHA will make a minimum of three attempts to contact the referred woman, noting the attempts on the *Client Recruitment* form.
    - If the referred woman cannot be contacted, she should be sent a letter outlining the value and importance of the BIH Program and requesting that she call if she would like to enroll.
  - Record all contacts and final outcomes of the referral in the BIH *Client Recruitment* form. Ideally, these activities will be completed within 30 days. However, some prospective clients may take longer to contact and enroll, and in those circumstances the timeline can be extended.
  - If a referred woman is contacted and interested but not eligible for BIH services, she should: (1) receive a standardized health promotion message, and (2) be referred whenever possible to other community services.

Recruitment through Direct BIH Staff Outreach (Optional)
These outreach activities have generally involved providing information about the BIH Program to potentially eligible women in a community setting. This kind of "street outreach" typically is labor intensive and often focuses on relatively high-risk women who would not traditionally be referred to the BIH Program from other agencies/providers. In addition, these women are often recruited later in their pregnancies and have less time to complete the prenatal group sessions.

Specific procedures for direct staff outreach include:

1. Identify community target areas or "hot spots," e.g., :
    - Homeless shelters
    - Parks
    - Low income housing complexes
    - Check cashing facilities
    - Day care centers
    - Healthcare facilities
    - Beauty shops
    - Laundromats
    - Night clubs
    - Gas stations
    - Libraries
    - Discount store

2. Develop a safety protocol for staff conducting street outreach, particularly when targeted areas are characterized by high crime levels. Basic field safety includes appropriate training, having identification as an outreach worker, wearing comfortable clothing, knowing the location of the nearest police station, carrying a cell phone and checking in with sites at least twice a day.

2. If staff will conduct outreach outside a business, staff should explain the BIH Program and obtain permission from the business owner or manager.

3. Staff should carry all necessary program information, including *Client Recruitment* forms.

4. Once a potentially eligible woman is identified, complete a *Client Recruitment* form and schedule an intake appointment

5. Follow-up for a woman for whom an intake appointment is not scheduled should occur within 72 hours of initial contact. The FHA should make at least three attempts to contact the prospective client, noting each attempt in the *Client Recruitment* form. If the prospective client cannot be contacted, she should be sent a letter outlining the value and impo*rtance of the BIH* Program and requesting that she call if she would like to enroll.

Media Outreach (Optional)
Because CDPH/MCAH recognizes that most local BIH Programs have neither the funding nor expertise to fully implement a comprehensive media strategy, media outreach is optional. Local programs that do conduct media outreach activities should describe these activities in their Recruitment Plans. CDPH/ MCAH approval must be obtained before these activities begin; specific materials should be forwarded to the Program Consultant, allowing one month for review and approval. Any CDPH/MCAH-produced materials/information will be distributed to each site and can be used as desired.

Specific procedures for media outreach include:

- Identify types of media outreach activities. Examples of media outreach that have been conducted by BIH sites include:
  - Post information about BIH services and activities on community calendars, informational listservs, websites (i.e. KidsCal, family health services, EPA.net)
  - Include BIH in published community resource directories (i.e. Community Information Program).
  - Distribute press releases to local news media outlets.
  - Create public service announcements with local radio stations.
  - Conduct interviews for local radio and television related to important events.
  - Write articles about BIH for local newspapers and magazines.
  - Disseminate culturally-relevant posters, door hangers, flyers and pamphlets and business cards throughout the community (churches, beauty shops, barber shops, laundromats, shopping centers, healthcare facilities, schools, community centers, housing complexes, and libraries). BIH staff must get approval from CDPH/MCAH before posting/distributing any information.

- Once a prospective client has been identified, BIH staff should begin a *Client Recruitment* form and contact the woman within 72 hours to confirm that she is eligible and schedule an intake appointment. Staff will make a minimum of three attempts to contact the prospective client and *note the attempts* on the *Client Recruitment* form. If the client cannot be contacted, it is recommended that a letter be sent to the prospective client outlining the value and importance of the BIH Program with instructions request that she call if she would like to enroll.

► **Community Linkages and Referrals to services outside of BIH**
Program Standard: **Each LHJ should develop and implement plans to ensure community linkages and effective referrals to clients for services and resources outside of BIH.**

There are multiple steps to providing effective referrals to clients for services and resources outside of BIH:

- BIH staff must be aware of the full array of services and resources that are at least potentially available to meet clients' needs outside of the BIH Program. They must also be knowledgeable about the service delivery process, including eligibility requirements, for each referral agency or provider. BIH staff at each local site is required to create and maintain a database of community agencies, including specific descriptions of eligibility and other requirements, that could be updated annually; the "211" resource line is another potential tool.
- At the same time, each site must develop and maintain ongoing collaborative relationships with the outside agencies and providers that provide resources and services to BIH clients. This relationship as well as recruitment activities should be outlined in the Partnership Agreement.

A BIH Program that is viewed by the community as vital in improving the health of African American women, their families and their community will likely have a stronger presence and be seen as an important part of the health of their community. In addition, it will also ensure strong community linkages and provide easier access to community referrals. This requires local BIH Programs FHA to develop and maintain on-going collaborative relationships with their community providers. These community linkages are just one part of a concept to community engagement.

► **Community Engagement Activities (Optional)**

Community engagement is the process of working collaboratively with people affiliated with each other by way of geographic proximity, a specific desire/interest, or other similar situations to involve them as equal, vital decision makers in program design and implementation. Through this process, programmatic decisions and processes are informed by the needs, experiences, and insights of the community members being served, and meaningful improvements are incorporated into the program.

Community engagement is a powerful vehicle for bringing about environmental and behavioral changes that will improve the health of the community and its members. It involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices.

There is a consensus in the literature that engaging and supporting the empowerment of the community for community health decision-making and

action is a critical element in health promotion, health protection, and disease prevention. The tenets of community engagement include:

- Develop and nurture personal relationships with individuals/participants/community members in order to develop trust, knowledge, and organizational strength and capacity.
- Seek out and involve a range of diverse participants, including program clients, in contributing to the program's vision and planning activities.
- Identify the kinds of gifts, interests, and talents participants bring to the table, and engage participants in selecting ways they want to be involved.

CDPH/MCAH and the BIH Program understands the power of involving the broader community in helping decrease Black:White disparities. While formal efforts may be beyond the scope of work for many local BIH sites at present, the three aspects of community involvement should continue to receive limited attention in the BIH Program are:

- Community awareness;
- Community partnerships;
- Community Advisory Boards.

The appendix outlines some efforts that local sites can initiate.

► Data Collection

Program Standard: **Each LHJ should ensure that collection of client and program data (including entry into the BIH MIS, as required) is timely and complete.**

Data collection is an integral part of the BIH Program and supports two critical functions: (1) client management and (2) program evaluation. Data will first be collected directly on paper forms, with subsequent entry into the MIS database.

BIH Databook forms are important for client management and provide information about the client. The FHAs, group facilitators, and BIH Coordinators will be able to identify and track BIH services for their clients using these forms.

BIH Databook forms provide critical information needed for program evaluation. Key topics related to program evaluation are:

- Whether client needs were met by the Individual Client Plan and referral services
- Maternal health behaviors and knowledge
- Psychological well-being, including self-esteem, mastery, and coping
- Birth outcomes
- Infant health
- How clients enter the BIH Program and why they exit

Many of these topics are assessed multiple times during each client's time in the BIH Program, so that snapshots of client life-change can be created. These data will help document how the BIH Program impacts lives of its client women and their infants and families.

Program evaluation data are critical to CDPH/MCAH for monitoring the effectiveness of local BIH Programs, fulfilling federal and state reporting requirements, determining budget allocations to LHJs, and for demonstrating to the legislature and other policymakers why investment in this the BIH Program is so important.

The accuracy and completeness of BIH data will strengthen the quality of client management and program evaluation. It is important to use the forms during suggested time intervals, to follow all directions on forms, and to fill in answers to all questions. Please carefully read the directions on all the forms--while most *client-specific forms* are intended to be administered to the client by the FHA, some forms or sections of forms are to self-administered (i.e., filled out by the client herself). Other forms—e.g., the Facilitator Feedback forms to be filled out by group facilitators after group intervention sessions—do not include client-specific data but are important for site management purposes.

General tips for administering the forms:

- Read the overall introduction for each section before continuing on to the individual questions.
- Unless otherwise directed, read each question to the client (most forms are designed to be administered by the FHA). When a form notes that a question or set of questions is intended to be self-administered by the client, read the introduction for the question(s) to the client before allowing her to record her answer(s).
- Do not read response options unless needed by the client for clarification.
- Avoid additional prompting that could 'lead' the client to a particular answer.

All BIH Program staff should protect client records and take proper precautions to maintain confidentiality of information. Some general rules for protecting client information include:

- Store completed client forms in a locked room or locked file cabinet.
- Never share your password to the MIS database.
- Always remember to close or logout of the MIS program when not in use or when away from the computer.

In addition to paper data collection, CDPH/MCAH will also require client data to be entered into the CDPH/MCAH MIS system by a BIH Program staff person within the time period specified in the Program Standards. LHJs are expected to have at least *two* persons trained to use the CDPH/MCAH MIS data system; those individuals are responsible for maintaining clean and complete data and for conducting routine data quality checks on local program data. LHJs are also required to respond in a timely manner to CDPH/MCAH data requests and data cleaning exercises.

► Quality Assurance (QA)

Program Standard: **Each LHJ must develop and implement a QA Plan.**

CDPH/MCAH strongly supports QA as an integral part of the fidelity of the BIH Program. QA is a continuous process that will require attention at the state and local level. CDPH/MCAH is committed to this process and will work collaboratively with local sites.

Each LJH must have a QA Plan that monitors quality management efforts. Monitoring and maintaining a QA plan is the responsibility of the BIH Coordinator, but the entire staff should be knowledgeable of the plan and fully support is its implementation. CDPH/MCAH will provide a template of a QA plan and work with LHJs on its implementation.

To support these QA efforts, each program should establish a multidisciplinary team—including the local MCAH Director or his/her designee, the BIH Coordinator, and at least two key BIH staff--to develop and follow a systematic stepwise approach to implement the QA plan based on ongoing feedback and review with the goal of improving services.

In addition to program fidelity, the QA plan will include regular assessments of client satisfaction with BIH services.

► Confidentiality and Security of Client Records

All BIH Programs will establish and adhere to procedures to ensure and maintain the confidentiality of client exchange, records and electronic submissions.

- Confidentiality

Client information, written transactions and records, including copies, must be kept in a secure location that is inaccessible to unauthorized persons. Client records include BIH data collection forms, consent and release of information forms, assessments, progress notes and other contacts with clients to be determined by the local agency.

- Storage of Records

Each agency will establish a policy and maintain a system for the safe storage and retrieval of all client records, as well as emergency and disaster procedures. Clients' records and copies must be kept in a secure location that is inaccessible to unauthorized persons. Original records are not removed from the program site unless the agency exceeds the storage limitations set by the agency. In this case, overflow closed cases may be stored in a secure offsite location.

- Agency Incident Reports

The BIH Coordinator must notify the CDPH/MCAH Program Consultant and Contract Manager, by telephone and in writing, within 24 hours of any incident or

occurrence that impairs or compromises the agency's ability to deliver services to clients. Notification should include the nature of the incident and a proposed plan for the continuation of services. Incidents or occurrences may include but not be limited to the following: (1) damage to the program site caused by fire, water, wind, earthquake or other destruction, and (2) legal action against the agency.

► **Report**

Relevant information and data are collected in the BIH Progress and Annual Reports for evaluation, analysis and monitoring of program performance and for meeting Title V Block Grant and CDPH/MCAH objectives.

CDPH/MCAH will provide a template for quarterly reports with instructions and a deadline for submission. All agencies receiving CDPH/MCAH funding are required to complete the Annual Report which is due August 15th each year. CDPH/MCAH has the option to withhold payment on current invoices for failure to submit a complete and timely report.

The MCAH Director is responsible for submitting the BIH Annual Report, Form 3B. See the submission instructions at www.cdph.ca.gov/MCAH.

Click on the following links:

- MCAH Program and Fiscal Administration
- Program and Fiscal Policy and Procedures Manual
    - Choose FY