

**100-10****POLICY**

All BIH Sites will follow MCAH-BIH policy and procedure guidelines to ensure program fidelity as it relates to the administration of the MCAH-BIH Program. 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.

**BIH Program Overview and Administration**

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 a 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) *complementary social service case management* to link participants with needed community and health related services. With the goal of providing BIH services in a culturally-relevant manner that respects participants' 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 participants.

**Mandates & Statutes:**

Senate Bill (SB 165), Budget Act of 1989 (Alquist, Chapter 93, Statutes of 1988), made funds available for a new and innovative project to reduce the rate of black infant mortality in California. H&S §131051(d)(4) states that the Black Infant Health Program is under the jurisdiction of the Deputy Director for Primary Care and Family Health. W&I §14148.9(c) states that programs for pregnant women and infants shall focus on women who are at high risk of delivering a low or high birth weight baby or a baby who will suffer from major health problems or disabilities. W&I §14148.9(d) lists Black women as one of the target populations.

**Sexual Health and Accountability Act**

H&S §151000-§151003 The Sexual Health Education Accountability Act of 2007: Requires sexual health education programs (programs) that are funded or administered,

directly or indirectly, by the State, to be comprehensive and not abstinence-only. Information must be medically accurate, current and objective; age, culturally and linguistically appropriate for targeted audiences. Cannot promote or teach religious doctrine, nor promote or reflect bias. May be required to explain the effectiveness of one or more FDA-approved drugs and/or devices that prevent pregnancy or sexually transmitted diseases. Programs directed at minors are also required to state that abstinence is the only certain way to prevent pregnancy or sexually transmitted diseases.

### **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 17 local health jurisdictions (LHJ) where over 90 percent of all African-American births occur in California (BSMF, 2008). The primary focus of the original BIH Program, established in 1989, was getting participants 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 participants 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 participants 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. 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 were conducting 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/ Center on Social Disparities in Health (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 yielding 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 life course, 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 participants' 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 participants.

Over a three-year period, more than 100 people, most of them from local BIH programs, participated in the process. The BIH Program 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 participants-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 participants with needed community and health-related services. The goal of the program is to provide services in a culturally-relevant manner that respects participants' 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 BIH Program has been developed to address these *social determinants of health* in ways that are relevant, culturally affirming and empowering to participants.

## GUIDANCE FOR PARTICIPANTS ACTIVITIES

### Governing Concepts

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

1. 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 participants' 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.
2. Participants-Centered. The participants-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 participants-centered approach places the needs, values and priorities of the participants as the central core around which all interaction and activity revolve. The participants-centered approach focuses on developing goals and strategies that are personalized and realistic and is conducted in an interactive manner that encourages participants to do most of the work, which empowers participants to take full responsibility for their lives. Understanding how participants perceive their needs, resources, and priorities for utilizing services is essential in providing participants centered services.
3. 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.
4. 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 participants can learn how to think differently and act on what they have learned. This approach is empowering and accepts that participants 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.

### **Current Sequence of Participant Activities**

Outlined below, is 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 participant gives birth and includes the following:

1. **Participant recruitment**: BIH sites recruit African-American women, 18 years or older and no more than 26 weeks pregnant at the time of enrollment in order for participants to receive the full intervention; participation in 10 prenatal and 10 postpartum group sessions as well as case management/life planning activities. The Community Outreach Liaison (COL) role is a critical component to successful recruitment and outreach efforts for the BIH Program. This position should build relationships with health care practitioners and community service providers who can refer pregnant African-American women to BIH early in pregnancy. The recruitment strategies conducted by the COL will involve a combination of “active” and “passive” 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.
2. **Participant orientation and enrollment** - Orientation to the BIH program provides foundational information for the participant that should assist her in making a decision to participate in the BIH program or not. Orientation is conducted in a standardized manner by the Mental Health Professional (MHP) and should include an overview of the consent process and Assessment 1 if the participant agrees to enroll. The MHP will also provide referrals to community and social service agencies as necessary, provide support with setting and achieving the goals of the participant’s Life Plan and information about prenatal and postpartum group sessions. Orientation is comprised of the following components:
  - ***Consent to Participate***: By signing the BIH Rights, Responsibilities & Consent Form, participants are officially enrolled and have agreed to fully participate in the BIH program. Enrolled women must consent to participate in the entire intervention (group and case management).
  - Completion of the *VIA Character Strengths* online survey ([www.VIACharacter.org](http://www.VIACharacter.org)). This survey allows participants to assess and categorize her strengths and assists her in setting short and long term life planning goals.
  - Completion of Assessment #1: This initial assessment provides baseline information about the participant, and is intended to help identify her strengths and needs/concerns. Some of the baseline information will be measured at various points during her participation in BIH to assess any changes in the

- outcome measures. Other baseline information is the basis for initiation of her Life Plan in subsequent meetings with the FHA.
- After completion of the Assessment #1, the MHP in collaboration with the BIH Coordinator, assigns the participant to a Family Health Advocate (FHA) for on-going case management/Life Planning meetings and discusses enrollment in an upcoming group series.
3. Case management – Case management activities for Life Planning are conducted by the FHA. The FHA is also responsible for on-going assessments, which provide a structured opportunity for participants to update the FHA and for the FHA to measure changes in the participant's level of social support and other program outcomes over time. Participants work with the FHA to develop a Life Plan. Life planning is the core of the case management intervention. Life planning is a process that identifies a participant's desire for her future and clarifies goals and challenges, along with developing SMART (Specific, Measureable, Attainable, Realistic and Time-bound) tasks to move forward. It turns participants' hopes and dreams into a written plan for their future. The Life Plan focuses on goals in three broad areas: (1) health, (2) relationships, and (3) finances. The Life Plan is initiated in the first meeting following the assessment.

Each case management meeting starts with an assessment of the participant's success in accomplishing each task identified in the Life Plan. Case management meetings conclude with the participant establishing one task she needs to address in order to accomplish her long-term goals. Successful goal setting is reinforced by group session activities and integrated into the Life planning process. Participants bring their goals to the group sessions and the FHA will support goal attainment by ensuring participant goals are communicated to the group facilitator. This process is designed to ensure group session activities are consistent with the participant's Life Plan. An effective, seamless process requires a high degree of coordination and collaboration between FHAs and group facilitators.

The time intervals and frequency for Life Planning meetings are:

- Following enrollment and prior to the first prenatal group, the FHA should schedule two life planning appointments with the participant. The meetings should assist the participant with establishing a vision to support and develop her long term goals while in BIH.
  - Depending on when the participant enrolls, the amount of time between enrollment and start of group may vary, thus the second Life Planning meeting may occur after the group session has started.
- During the prenatal group series, the FHA will schedule one Life Planning meeting between sessions 2-5 and 6-9.
- During the postpartum group series, the FHA will schedule one Life Planning

- meeting between sessions 12-15 *and* 16-19.
- Between 33 and 36 weeks gestation the FHA will complete Assessment #2 with the participant.
    - If participants complete the prenatal series prior to 33 to 36 weeks gestation, this assessment should still be completed during the designated time during monthly Life Planning meetings.
  - Between birth and start of postpartum group series, the FHA will conduct monthly Life Planning meetings with the participant. These meetings may be conducted via telephone or face-to-face.
  - After completion of the prenatal series, participants may enroll in a postpartum series within six months of the delivery of her infant.
  - Upon completion of the postpartum group sessions, the FHA will schedule up to four Life Planning meetings (within 60 days) with the participant to complete the Life Plan and outstanding referrals if necessary.
  - All participant cases will be closed within 60 days of completing the last postpartum session.
4. Group sessions – The BIH program is designed to increase social support among BIH participants through the group-based program component. Increasing social support is one of the primary BIH program outcomes. All BIH participants are required to attend and participate in group sessions. The groups sessions are designed to provide participants with a culturally affirming environment that honors the unique history of African-American women in order to help participants develop life skills, learn strategies for reducing stress, and build social support. All group facilitators must be trained by CDPH/MCAH to conduct the curriculum with fidelity.
- Participants are expected to attend weekly group sessions (10 prenatal and 10 postpartum) designed to help them access their own strengths and set health-promoting goals for themselves and their babies. Group facilitators are required to use a standardized curriculum provided by CDPH/MCAH. The curriculum was developed based on other nationally recognized curricula (e.g. Effective Black Parenting) and was adapted for BIH. It focuses on health issues for pregnant women, health disparities for African-American women, and culturally relevant health information.
  - Enrolled women must consent to participate in the entire intervention (group and case management/Life Planning). If circumstances arise that prevent them from continuing in group sessions, they may receive 60 days of brief case management and then closed out of the program.
5. Program completion - BIH case closure is a formal process between the participant and FHA. BIH participant cases are expected to be closed within 60 days of the last postpartum group. The 60 days should be focused on finalizing the participant's Life Plan and transitioning the participant to any additional services. Although most

participants are likely to complete the entire BIH program, a formal process should be completed for every participant when her case is closed, whether or not the participant completed the entire BIH program. Examples of reasons for case closure:

- Brief Case management without group participation
- Participants who transfer to another BIH site
- Request to exit the BIH program
- Lost-to-follow-up after several attempts to contact

Figure 1 - BIH Logic Model



# Logic Model

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Transforming African American women and their communities to improve health

