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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,

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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

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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

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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). 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

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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.

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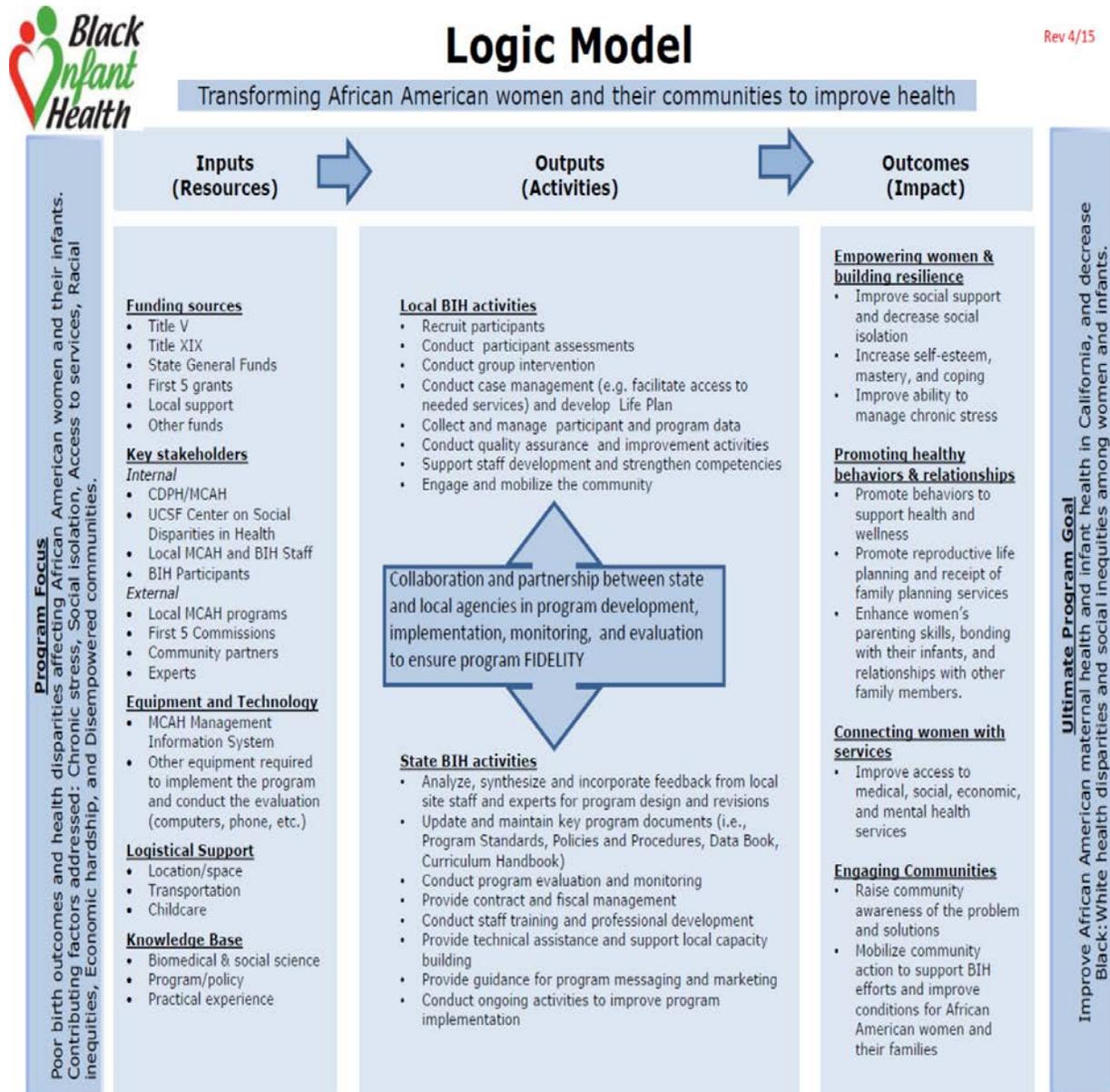
- During the postpartum group series, the FHA will schedule one Life Planning meeting between sessions 12-15 and 16-19.
 - Between 33 and 36 weeks gestation the FHA will complete Assessment #2 with the participant.
 - If participants complete the prenatal series prior to 33 to 36 weeks gestation, this 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.

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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



Confidentiality and Security of Records**100-20****POLICY:**

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

- All BIH staff must accept and adhere to HIPAA (American Health Insurance Portability and Accountability Act of 1996) in order to ensure that all records and participant accounts meet nationally recognized standards in regards to documentation, handling and privacy.
- The HIPAA establishes standards for Personal Health Information (PHI) from disclosure and informs participants of how their information will be used.¹
- Requests for non-public BIH program information must be reviewed by MCAH, which is responsible for the BIH Program's overall evaluation and oversight.

PROGRAM STANDARD:

All BIH participants will have a signed Rights and Responsibilities and Release of Information/Consent form signed upon enrollment into the BIH Program and before personal and demographic information is obtained.

PROCEDURE:

1. Upon enrollment, all participants sign requisite Rights and Responsibilities and Release of Information/Consent forms.
2. All BIH Program staff will have knowledge regarding HIPAA confidentiality standards and will protect participant records and take proper precautions to maintain confidentiality of information.
3. All BIH Program staff must have on file a Confidentiality Agreement signed by each staff member who has the ability to view data, either by collecting the data or by viewing it after it has been recorded. The individual Confidentiality Agreements must be renewed annually.
4. All BIH Programs will establish and adhere to procedures to ensure and maintain the confidentiality of participant exchange, records and electronic submissions.

¹ BIH does not furnish, bill, or receive payment for health care and is therefore, according to standards established by the HIPAA Final Rule adopted in January 2013, not a HIPAA-covered program. Although BIH is not a HIPAA-covered program, these policies set minimum standards are designed to meet or exceed standards established by the U.S. Department of Health & Human Services for the maintenance and release of protected health information.

Confidentiality and Security of Records

5. Participant information, written transactions and records, including copies, must be kept in a secure location that is inaccessible to unauthorized persons. Participant records include BIH data collection forms, consent and release of information forms, assessments, progress notes and other contacts with participants to be determined by the local agency. Appropriate safeguards include, but are not limited to:
 - a. Securing and maintaining all hard copy or other records containing PHI (such as CD-ROM, thumb-drives, diskettes, etc.) in a locked cabinet inaccessible to staff other than those directly involved with either the delivery of service to the participant, supervision of these direct-service delivery staff, or for data entry; and
 - b. Securing all electronic records in password protected encrypted files, with access only for staff directly involved in delivery of services to participants, supervision of these staff or data entry.
6. Each agency will establish a policy and maintain a system for the safe storage and retrieval of all participant records, as well as emergency and disaster procedures. Participants' 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.
7. Agency Incident Reports
 - a. 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 participants. 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. Written documentation will be submitted to CDPH.MCAH-BIH via the transmittal process.
8. All BIH Programs must retain participant records for at least three years for purposes of potential audits and/or to reconcile with data from ETO.
9. All BIH Programs must have policies in place to ensure that confidential information's discarded through secure and confidential means (e.g. shredded, locked confidential destruction bins, pulverized).

Confidentiality and Security of Records

- 10.** All BIH Programs must have a mechanism in place to ensure that removable media containing confidential, personal, or sensitive information is physically destroyed when no longer in use.
- 11.** Sending Confidential Information:
 - a. Prior to sending PHI or participant-related confidential information to MCAH-BIH, program staff must notify a member of the MCAH-BIH team;
 - b. When sending electronic PHI to MCAH-BIH, encrypt information by writing “[secure]” in the subject line of the email correspondence.
 - c. All BIH Program staff must add a confidentiality statement at the beginning or end of every fax or email that contains confidential, personal or sensitive information notifying persons receiving the fax or email in error to contact the sender and destroy the document.
- 12.** During the closure of an office or move, the LHJ must ensure that privacy and security of confidential, personal and sensitive information is maintained. If documents containing PHI must be transported to remote locations, these documents must be transported using a secure, bonded courier with a tracking system.
- 13.** Participant confidentiality and security of records are integral to BIH program integrity and success.
- 14.** Whenever possible, participants’ meetings with case managers should be conducted at the BIH office to ensure privacy and confidentiality for the participant.

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All Black Infant Health (BIH) Program Sites will follow MCAH-BIH policy and procedure guidelines as it relates to media relations in the MCAH-BIH Program. All BIH Program Sites shall contact the California Department of Public Health, Office of Public Affairs (CDPH-OPA) for approval prior to any communication with the media. The LHJ shall have no communication with the media about the BIH Program other than the gathering of needed approval information until approval is granted by the CDPH-OPA. Media inquiries include, but are not limited to, television, radio stations, newsletters, internet websites, social networking sites, and publications.

PROGRAM STANDARD:

All BIH Program Sites shall contact the California Department of Public Health, Office of Public Affairs (CDPH-OPA) for approval prior to any communication with the media. This process will ensure that all media inquiries receive prior approval by the CDPH-OPA and all inquiry responses contain accurate data and information provided or verified by the MCAH Black Infant Health Program.

PROCEDURE:**I. Phone Inquiry:**

- Take a message; include reporter's name, phone number, media outlet, and subject of the call.
- Tell the reporter that the CDPH-OPA will return the call as soon as possible, and provide the reporter with the CDPH-OPA's phone number at (916) 440-7259, for their future use.
- Contact the CDPH-OPA at (916) 440-7259 and provide them with the reporter's name, phone number, media outlet, and subject of the call.
- The CDPH-OPA will respond to the reporter in consultation with MCAH-BIH and the local program staff.

II. E-Mail Inquiry:

- Forward the e-mail to Anita.Gore@cdph.ca.gov or call the CDPH-OPA mainline at (916) 440- 7259 for alternate contact.

III. Direct Inquiry:

- Do not contact the media directly or take media calls without first obtaining approval from the CDPH-OPA.

Program Staff Requirements

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POLICY

All BIH Sites will follow MCAH-BIH policy and procedure (P&P) guidelines to ensure program fidelity and standardization across all sites relating to staff requirements in the MCAH-BIH Program.

PROGRAM STANDARD:

Each LHJ must have a *minimum* number of qualified personnel with designated Full Time Equivalents (FTE) in place to carry out the following required key staffing roles to ensure fidelity and standardization across all sites:

- 0.5 FTE BIH Coordinator
- 2 FTE FHA/Group Facilitators
- 1 FTE Outreach Liaison
- 0.5 FTE Data Entry Lead
- 0.5 FTE Mental Health Professional

PROCEDURE:

1. Key staff 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.
2. Key staff roles *must* be filled (in some cases, more than one role may be performed by one staff member) at each local BIH site. In the event that BIH funding is not sufficient to cover key staff roles, other funding sources may be utilized.
3. If LHJ sites are unable to fill and maintain key staff at the required FTEs, a waiver will be submitted to MCAH-BIH and approval will be granted on a case-by-case basis. All waivers will be submitted to MCAH-BIH utilizing the MCAH-BIH Transmittal Form.
4. If key staff are unavailable to perform duties for 30 days or more (vacation, medical leave, etc.) that impact daily program operations, such as participant orientation/enrollment or group facilitation, the BIH Coordinator must notify the designated BIH Program Consultant (PC) by completing the *Staff Leave of Absence* form in the Efforts to Outcomes (ETO) data system.
5. Duty Statements:
 - a. Local BIH Program duty statements will include FTEs when submitted to MCAH-BIH.
 - b. Local BIH Program duty statements will include staff qualifications, including education and experience.
 - c. Local BIH Program duty statements will include specific duties related to the support of the BIH program.

Program Staff Requirements

- d. All changes in duty statements submitted after the LHJ Agreement Funding Application (AFA) packet has been submitted to MCAH-BIH are required to be sent via the MCAH-BIH Transmittal Form to the MCAH-BIH Program Consultant (PC).

ADDITIONAL INFORMATION

The Public Health Nurse (PHN) remains a critical component of BIH and CDPH/MCAH supports the need for this position on the BIH budget. CDPH/MCAH encourages all LHJs to consider this position at a minimum of at least .50 FTE with any additional funds available to them, including local funds.

Forms to complete:

- Staff Profile
- Staff Leave of Absence

See P&P 300-20 *Staff Requirements and Duties* for a more detailed description of qualifications for program staff.

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BIH Coordinator**Standards (education, experience, etc.):**

- 1) Master's Degree from an accredited college or university program in Social Work, Public Health, Nursing, Education, Health Education, or other health related or social science field; or Bachelor's Degree from an accredited college or university program in Social Work, Public Health, Nursing, Education, Health Education, or other health related or social science field plus three years management experience in a health/public health or social service setting.
- 2) The BIH Coordinator must be approved by the CDPH/MCAH Division prior to appointment.
- 3) Fully embraces and supports the *BIH Governing Concepts* of culturally relevant, client-centered, strength-based, and cognitive skill-building approaches.
- 4) Possesses strong leadership skills
- 5) Demonstrates the organizational and interpersonal skills needed to communicate at different levels and work in complex situations;
- 6) Demonstrates knowledge of the following:
 - a) Women's health, including prenatal and postpartum health
 - b) Life course perspective
 - c) Infant behavior and development
 - d) Health education, including breastfeeding, nutrition and physical activity
 - e) Local community and social services
- 7) Demonstrates cultural competence;
 - a) Ability to implement and maintain a culturally relevant BIH Program that recruits, trains, and retains staff who reflect and respond to the values of the African American community served by BIH.
 - b) Knowledgeable about community organizations and community resources serving the African American community in their local jurisdiction;
 - c) Demonstrates an understanding of the complex, interrelated issues and concerns contributing to health disparities affecting African Americans;
- 8) Reflects basic skills of the HRSA MCH Bureau *Leadership Competencies 1-8* (<http://leadership.mchtraining.net/>).

Duties:

- 1) Responsible for the management and coordination of local BIH program activities and staff;
- 2) Maintains confidentiality and adheres to Health Insurance Portability and Accountability Act (HIPAA) regulations;
- 3) Provides supervision and professional development for staff.

Staff Requirements and Duties Appendix

Family Health Advocate (FHA)

Standards (education, experience, etc.):

- 1) Possesses a Bachelor's Degree from an accredited college or university program in Social Work, Public Health, Nursing, Education, Health Education, or other health related or social science field.
- 2) Has one year of community work experience providing direct services to target population, performing tasks related to the program;
- 3) Possesses socio-cultural experiences comparable to the population served;
- 4) Possesses knowledge, understanding and respect of the values and beliefs of African American women and the African American community;
- 5) Fully embraces and supports the *BIH Governing Concepts* of cultural competence, client-centered, strength-based, and cognitive skill building approaches (details above in the Governing Concepts section);
- 6) Possesses knowledge of the following:
 - a) Women's health, including prenatal and postpartum health;
 - b) Life course perspective
 - c) Infant behavior and development
 - d) Health education, including breastfeeding, nutrition and physical activity
 - e) Local community and social services
- 7) Demonstrates:
 - a) Cultural competence and ability to operate in a culturally affirming manner;
 - b) Sound communication and interpersonal skills;
 - c) Basic counseling skills (i.e. reflecting, active listening, paraphrasing);
 - d) Critical thinking and problem solving skills;
 - e) Basic administrative skills (i.e. appointment scheduling, documentation, report writing, computer skills)
- 8) Is able to work collaboratively within a multidisciplinary team;
- 9) Possesses a valid California driver's license.

Duties:

- 1) Responsible for providing social service case management to clients;
- 2) Maintains awareness and familiarity with local community and social services for client referrals;
- 3) Responsible for the development of a Life Plan that is on-going throughout the intervention;
- 4) Completes subsequent client assessments, Birth Outcome form, etc.;

Staff Requirements and Duties Appendix

- 5) Develops a Birth Plan;
- 6) Enters data related to case management, Life Planning, etc. in a timely and accurate manner;
- 7) Coordinates and consults with group facilitators to ensure that case management goals are linked to group sessions goals;
- 8) Attends CDPH/MCAH-sponsored BIH Basic Training, as well as subsequent BIH Advanced Trainings;
- 9) Maintains confidentiality and adheres to HIPAA regulations
- 10) Develops a Professional Development Plan in conjunction with the BIH Coordinator and reflects basic skills of the HRSA MCH Bureau *Leadership Competencies 1-8* (<http://leadership.mchtraining.net/>);
- 11) Works under the supervision of the BIH Coordinator.

Group Facilitator

Standards (education, experience, etc.):

- 1) Possesses a Bachelor's Degree from an accredited college or university program in Social Work, Public Health, Nursing, Education, Health Education, or other health related or social science field.
- 2) Has one year of community work experience providing direct services to target population, performing tasks related to the program;
- 3) Possesses knowledge, understanding and respect of the values and beliefs of African American women and the African American community;
- 4) Fully embraces and supports the *BIH Governing Concepts* of cultural competence, client-centered, strength-based, and cognitive skill building approaches (details above in the Governing Concepts section);
- 5) Possesses knowledge of the following:
 - a) Women's health, including prenatal and postpartum health;
 - b) Life course perspective
 - c) Infant behavior and development
 - d) Health education, including breastfeeding, nutrition and physical activity
 - e) Local community and social services
- 6) Demonstrates:
 - a) Strong group facilitation skills;
 - b) Cultural competence and ability to operate in a culturally affirming manner;
 - c) Sound communication and interpersonal skills;
 - d) Basic counseling skills (i.e. reflecting, active listening, paraphrasing);

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- e) Basic administrative skills (i.e. appointment scheduling, documentation, report writing, computer skills);
- 7) Is able to work with a co-facilitator and collaboratively within a multidisciplinary team.

Duties:

- 1) Responsible for the management, facilitation and organization of the group intervention with another group facilitator (each group session must have two trained facilitators conducting the session);
- 2) Enters data related to group sessions in a timely and accurate manner;
- 3) Coordinates and consults with FHAs to ensure that group sessions goals are linked to case management goals;
- 4) Attends CDPH/MCAH-sponsored BIH Basic Training, as well as subsequent BIH Advanced Trainings;
- 5) Maintains confidentiality and adheres to HIPAA regulations;
- 6) Develops a Professional Development Plan in conjunction with the BIH Coordinator and reflects basic skills of the HRSA MCH Bureau *Leadership Competencies 1-8* (<http://leadership.mchtraining.net/>);
- 7) Works under the supervision of the BIH Coordinator.

Community Outreach Liaison

Standards (education, experience, etc.):

- 1) Possesses a Bachelor's Degree from an accredited college or university program in Social Work, Public Health, Nursing, Education, Health Education, or other health related or social science field.
- 2) Possesses knowledge, understanding and respect of the values and beliefs of African American women and the African American community;
- 3) Fully embraces and supports the *BIH Governing Concepts* of cultural competence, client-centered, strength-based, and cognitive skill building approaches;
- 4) Demonstrates:
 - a. Cultural competence and ability to operate in a culturally affirming manner;
 - b. Excellent communication and interpersonal skills;
- 5) Basic administrative skills (i.e. appointment scheduling, documentation, report writing, computer skills, organizational skills)
- 6) Experience working on a multidisciplinary team
- 7) 1-3 years' experience in community based organizations

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- 8) Foundational knowledge of the community resources and programs of the Local Health Jurisdiction in which they will be working

Duties:

- 1) Develops and maintains a site-specific Recruitment Plan for BIH;
- 2) Establishes a database of community agencies and creates relationships to obtain BIH referrals
- 3) Maintains relationships with medical and community service providers who are the primary referral sources into BIH;
 - a. Develops Partnership Agreements to assist in providing referrals to the BIH Program
 - b. Conducts outreach activities on a regular basis; for example, conducting in-service trainings and BIH Orientations for Partnership Organizations;
 - c. Attends inter-agency and community meetings
- 4) Attends CDPH/MCAH-sponsored BIH Basic Training, as well as subsequent BIH Advanced Trainings;
- 5) Maintains confidentiality and adheres to HIPAA regulations;
- 6) Develops a Professional Development Plan in conjunction with the BIH Coordinator and reflects basic skills of the HRSA MCH Bureau *Leadership Competencies 1-8* (<http://leadership.mchtraining.net/>);
- 7) Works under the supervision of the BIH Coordinator.

Data Entry Lead

Standards (education, experience, etc.):

- 1) Possesses a high School diploma or completion of General Education Development (GED)
- 2) Possesses sound data entry skills;
- 3) Excellent communication skills (verbal and written);
- 4) Experience working on a multidisciplinary team.

Duties:

- 1) Enters BIH case management and program data in a timely and accurate manner into the State data system and downloads program information from the MCAH- BIH-ETO.
- 2) Oversees the maintenance of clean and complete participant and site-specific data.
- 3) Complies with or assists in the compilation of statistical information for special reports.
- 4) Assists in developing and maintaining filing system for the BIH Program.
- 5) Utilizes computerized data entry equipment and various word processing, spreadsheet and file maintenance programs to enter, store and/or retrieve information as requested or necessary, and summarizes data in preparation of standardized reports.

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- 6) Provides support to Skilled Professional Medical Personnel working with the BIH Program.
- 7) Attends CDPH/MCAH-sponsored BIH Basic Training, as well as subsequent BIH Advanced Trainings;
- 8) Maintains confidentiality and adheres to HIPAA regulations;
- 9) Develops a Professional Development Plan in conjunction with the BIH Coordinator and reflects basic skills of the HRSA MCH Bureau *Leadership Competencies 1-8* (<http://leadership.mchtraining.net/>);
- 10) Works under the supervision of the BIH Coordinator.

Mental Health Professional (MHP)

Standards (education, experience, etc.):

- 1) Education and training
 - a) Master's Degree in social work, psychology or counseling from an accredited college or university;
 - b) One year of professional experience working as a mental health professional that included maternal, infant and child health.
- 2) Understands and respects the values and beliefs of African American women and the African American community;
- 3) Fully embraces and supports the *BIH Governing Concepts* of cultural competence, client-centered, strength-based, and cognitive skill-building approaches (details above in the Governing Concepts section);
- 4) Knowledge of the following:
 - a) Women's health, including prenatal and postpartum mental health and psychosocial issues;
 - b) Life course perspective;
 - c) Impact of psychosocial, cultural and economic factors on the health of women, their infants and their families;
 - d) Psychosocial risk status of BIH participants, including stress, health, social relationships, environment (housing), financial status, transportation that may impact their pregnancies or participation in the BIH Program;
 - e) Prevailing trends and policies in mental health, public health and public welfare;
 - f) Knowledge, understanding and location of community services, including, but not limited to: social services, mental health, substance abuse treatment programs, domestic violence programs, legal systems, housing and other resources for referral;

Staff Requirements and Duties Appendix

- 5) Demonstrates:
 - a) Cultural competence and ability to operate in a culturally-affirming manner;
 - b) Clinical experience in individual and group psychotherapies dealing with individuals in multiple health and social systems;
 - c) The ability to identify behavioral tendencies that impact functioning, and recommend cognitive behavioral approaches that integrate client strengths into improving functioning;
 - d) The ability to conduct crisis intervention as needed or as resources allow;
 - e) Sound communication and interpersonal skills;
 - f) Critical thinking and problem solving skills;
 - g) Basic administrative skills (i.e. appointment scheduling, documentation, report writing, computer skills).
- 6) Ability to work collaboratively within a multidisciplinary team.

Duties:

- 1) Conducts client enrollment activities, which includes orientation, informed consent, and the initial assessment. Refers participant to FHAs for on-going case management;
- 2) Responsible for conducting case conferencing with local BIH staff and any other members of a multidisciplinary team;
- 3) Develops and maintains relationships with local mental health professionals for client referrals;
- 4) Participates in the group sessions that focus on mental health issues by being available to answer participant questions and provide support to the group facilitators.
- 5) Provides medical health education to clients when requested by the FHAs.
- 6) Conducts trainings on the basics of maternal and infant mental health;
- 7) Attends CDPH/MCAH-sponsored BIH Basic Training, as well as subsequent BIH Advanced Trainings;
- 8) Maintains confidentiality and adheres to HIPAA regulations;
- 9) Develops a Professional Development Plan in conjunction with the BIH Coordinator and reflects basic skills of the HRSA MCH Bureau *Leadership Competencies 1-8* (<http://leadership.mchtraining.net/>);
- 10) Works under the supervision of the BIH Coordinator.

(Optional Staff Position)***Public Health Nurse (PHN)*****Standards (education, experience, etc.):**

- 1) Education and training:
 - a) Bachelor of Science degree in nursing from an accredited college or university;
 - b) Public Health Nurse Certificate and license issued by the State of California;
 - c) Valid California driver's license;
 - d) Performs all duties within the legal scope of practice as described in the Nurse Practice Act and other laws, rules, regulations.
 - e) One year of responsible, professional experience working as a PHN that included maternal, infant and child health.
- 2) Knowledge, understanding and respect of the values and beliefs of African American women and the African American community;
- 3) Fully embraces and supports the *BIH Governing Concepts* of cultural competence, client-centered, strength-based, and cognitive skill building approaches (details above in the Governing Concepts section);
- 4) Knowledge of the following:
 - a) Women's health, including prenatal and postpartum health;
 - b) Life course perspective;
 - c) Infant behavior and development;
 - d) Health education, including breastfeeding, nutrition and physical activity;
 - e) Local community and social services;
 - f) Clinical expertise of maternal, infant and child health nursing;
 - g) Epidemiological methods of health promotion, disease prevention and control of communicable diseases;
- 5) Demonstrates:
 - a) Cultural competence and ability to interact with clients and staff in a culturally affirming manner;
 - b) Sound communication and interpersonal skills;
 - c) Critical thinking and problem solving skills;
 - d) Basic administrative skills (i.e. appointment scheduling, documentation, report writing, computer skills);
- 6) Ability to work collaboratively within a multidisciplinary team.

Staff Requirements and Duties Appendix**Duties:**

- 1) Conducts client enrollment activities, which includes orientation, informed consent, and the initial assessment. Refers participant to FHAs for on-going case management;
- 2) Conducts care coordination activities such as referrals and linkages for participants to Medi-Cal services;
- 3) Participates in all formal Case Consultations;
- 4) Provides informal case consultation with FHAs on clients who require more immediate medical attention;
- 5) Conducts home visits for the purpose of completing the Edinburgh Postpartum Depression Screen (EPDS), home safety check list, and birth plan at required intervals;
- 6) Participates in the group sessions that focus on medical issues by being available to answer participant questions and provide support to the group facilitators;
- 7) Co-facilitates group sessions featuring Sudden Infant Death Syndrome (SIDS), Breastfeeding and other health-related topics;
- 8) Provides medical health education to clients when requested by the FHAs;
- 9) Conducts staff trainings on relevant medical topics;
- 10) Attends CDPH/MCAH-sponsored BIH Basic Training, as well as subsequent BIH Advanced Trainings;
- 11) Maintains confidentiality and adheres to HIPAA regulations;
- 12) Develops a Professional Development Plan in conjunction with the BIH Coordinator and reflects basic skills of the HRSA MCH Bureau *Leadership Competencies 1-8* (<http://leadership.mchtraining.net/>);
- 13) Works under the supervision of the BIH Coordinator.

Public Health Nurse Duties

300-30

POLICY

All BIH Sites will follow MCAH-BIH policy and procedure (P&P) guidelines to ensure program fidelity and standardization across all sites relating to Public Health Nurse (PHN) requirements in the MCAH-BIH Program.

PROGRAM STANDARD:

The Public Health Nurse (PHN) remains a critical component of BIH and CDPH/MCAH supports the need for this position on the BIH budget. CDPH/MCAH encourages all LHJs to consider this position at a minimum of at least .50 FTE with any additional funds available to them, including local funds.

PROCEDURE

1. PHN will assist Mental Health Professional (MHP) with the intake and enrollment process for participants in the BIH program.
2. PHN will assist in providing medical case management and care coordination activities in order to provide linkages to Medi-Cal and other community agencies.
3. PHN will participate in community outreach efforts in collaboration with the Community Outreach Liaison, specifically targeting medical providers and health clinics for the purposes of developing linkages for BIH program participants and their families to health services, increasing interagency collaboration and establishing a referral network.
4. PHN 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.
5. PHN will co-facilitate group sessions when Sudden Infant Death Syndrome (SIDS) and Breastfeeding topics are discussed.
6. PHN will be available for group sessions to address health disparities affecting African-American women and other health-related questions/concerns of participants and provide support to group facilitators.
7. PHN will conduct home visits for the purpose of completing the Edinburgh Postpartum Depression Screen (EPDS), home safety check list, and birth plan at required intervals;
8. PHN will conduct home visits for the purpose of providing prenatal, postpartum and infant health education topics.
9. PHN will conduct staff trainings for health-related issues and health disparity updates to BIH Program staff.
10. PHN will participate in all formal Case Conferences.
11. PHN will provide informal case consultation with BIH program team for participants who require more immediate medical attention.

Public Health Nurse Duties

12. PHN will participate in quality improvement efforts.
13. PHN will maintain confidentiality and adherence to HIPAA guidelines.
14. PHN will review literature to stay current on practices and issues related to African American women and their infants.

Forms to complete:

- Staff Profile
- Staff Leave of Absence

See P&P 300-20 *Staff Requirements and Duties* for a more detailed description of qualifications for program staff.

Staff Training Requirements

300-40

POLICY

All BIH Program Sites will follow MCAH-BIH policy and procedure guidelines to ensure program fidelity as it relates to staff training requirements in the MCAH-BIH Program.

PROGRAM STANDARD:

All BIH Program Sites will ensure that all staff complete MCAH-BIH required trainings.

PROCEDURE:

All BIH Coordinators will require that all key BIH Program staff participate in mandated trainings and meetings scheduled by MCAH-BIH, including:

- Basic and Advanced BIH Program Trainings
 - BIH Statewide Meetings and/or Conferences
 - Data System Trainings
1. All BIH Coordinators will ensure that all key BIH Program staff are trained in BIH implementation activities *before* conducting prenatal and postpartum group sessions.
 2. All Group Facilitators will participate in a basic MCAH-BIH orientation/training before conducting group sessions.
 3. All local BIH Program staff must attend an in-person basic MCAH-BIH training within one year of starting with the LHJ.
 4. All key local BIH Program staff will participate in MCAH-BIH capacity-building calls related to BIH programmatic, training and data-related topics as scheduled.
 5. All BIH Coordinators will ensure that all key staff participates in training or educational opportunities designed to enhance cultural sensitivity.
 6. Any training needs identified by BIH Coordinators that deviate from those required to support the core BIH Program model or those specified to support the core BIH Program model, will be approved by MCAH-BIH *prior* to implementation using the BlackInfantHealth@cdph.ca.gov transmittal process.
 7. Additional site-specific trainings identified by the LHJ—such as additional training sessions, in-services or workshops—must be consistent with MCAH-BIH trainings in place to support the core BIH Program model.

400-10**POLICY**

All BIH Program sites will follow MCAH-BIH policy and procedure guidelines to ensure program fidelity as it relates to participant recruitment and outreach in the MCAH-BIH Program.

PROGRAM STANDARD:

All BIH sites will ensure that all staff have knowledge regarding BIH Program goals and services and the social determinants of health related to BIH. All sites will have a local recruitment plan that will be reviewed on an annual basis and updated as needed. The Community Outreach Liaison is responsible for the coordination of the BIH Recruitment Plan in conjunction with the other members of the team.

PROCEDURE:

1. The BIH Program serves pregnant and postpartum African American women 18 years of age or older, 26 weeks pregnant or less. The program has traditionally served primarily low-income women, and will continue to serve women covered by Medi-Cal, although income is not an eligibility requirement for participation in the program.
2. Each site must have a formal Recruitment Plan that provides a clear framework for strategic activities for recruiting eligible to into the local BIH Program. The recruitment plan will describe the outreach activities conducted with referral agencies, community partners and potential participants.
3. The Community Outreach Liaison (COL) role is a critical component to successful recruitment and outreach efforts for the BIH Program, therefore, the recruitment plan will also include a schedule utilized by the COL outlining the frequency of contacts with referral partners as well as a designated contact person at each location.
4. 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. The COL will also assist the BIH Coordinator with presentations to community partners during collaborative board meetings and other forums as necessary.
5. BIH staff must ensure that the following steps take place for every prospective participant, whether she is referred by another provider/agency or identified through direct BIH staff outreach, media outreach or self-referral:

Recruitment and Outreach

- Within 48 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 as soon as possible, within the next 14 days. All potential participants should be willing and able to participate in the full intervention, which includes group sessions and case management/life planning meetings.
 - 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 also receive standardized health-related disparities information affecting African-American women and infants, including Hypertension, Obesity, Diabetes, Sexually Transmitted Infections (STI's), Sudden Infant Death Syndrome (SIDS), and Breastfeeding.
 - If the referred/outreached woman cannot be contacted, she should receive 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 information noted above.
6. Record all contacts and final disposition results for all referred/outreach women on the BIH *Recruitment* form, whether or not successful contact is made.
 7. BIH Program staff will ensure that a mechanism is in place to provide referral partner agencies with disposition of all referrals to BIH Program.

Forms to complete:

Recruitment

Communication Log

Community Contacts Log

Service Provider Details

400-20**POLICY**

All BIH Sites will follow MCAH-BIH policy and procedure (P&P) guidelines to ensure program fidelity as it relates to the eligibility, orientation and enrollment of participants in the MCAH-BIH Program.

PROGRAM STANDARD:

The BIH Program serves pregnant and postpartum African American women who are 18 years of age or older and up to 26 weeks pregnant at the time of enrollment. All prospective BIH Program participants will meet face-to-face with the BIH Program Local Health Jurisdiction (LHJ) Mental Health Professional (MHP) or the Public Health Nurse (PHN) for a standardized orientation about the BIH Program. Following the orientation, each prospective participant will either formally enroll in the BIH Program by signing the BIH *“Rights, Responsibilities and Consent”* form or choose not to enroll in the BIH Program.

- 100% of prospective participants will attend an in-person orientation conducted by the MHP or PHN prior to enrollment.
- 100% of prospective participants who decide to enroll in BIH will sign the BIH *“Rights, Responsibilities and Consent”* form.
- 100% of BIH Program participants will be 18 years of age or older at enrollment.
- 100% of participants will be pregnant at enrollment and enroll at or before 26 weeks of pregnancy.
- 100% of prospective participants who decline enrollment in BIH after orientation will receive standardized health-related disparities information affecting African-American women and infants, including Hypertension, Obesity, Diabetes, Sexually Transmitted Infections (STI’s), Sudden Infant Death Syndrome (SIDS), and Breastfeeding.

PROCEDURE:**A. Eligibility Criteria:**

1. Self-identified African American pregnant women no more than 26 weeks pregnant upon enrollment in the BIH Program.
2. 18 years of age or older at enrollment.
3. Resides in the target area or within the Local Health Jurisdiction (LHJ)
4. Consents to actively participate in the *entire* BIH program, including both the:
 - a) Group intervention (10 prenatal sessions and 10 postpartum sessions)
 - b) Individual case management focused on life planning
5. Consents to release information from her prenatal care provider, from her baby’s birth certificate, and from the ETO data system.

Participation Orientation and Enrollment

B. Orientation and Enrollment:

1. Timing and setting. The emphasis of the BIH Program model is to enroll eligible women as early in pregnancy as possible in order to ensure that they receive the full benefit of BIH services.
 - To ensure that prospective participants are informed about and begin active participation in the BIH Program in a timely manner, a face-to-face meeting with the MHP or PHN for orientation and enrollment should be scheduled and conducted as soon as possible (no later than two weeks) after successful contact with the prospective participant.
 - If at all possible, the meeting should occur at the local BIH site. In order to complete enrollment before the eligibility cut-off of 26 weeks of pregnancy, it may take place at the prospective participant's home or in another setting, if necessary.
 - The orientation may be conducted one-on-one with each prospective participant or with a group of prospective participants. If the orientation is conducted with a group, the MHP or PHN must allow time to meet individually with each woman who chooses to enroll in order to obtain consent and complete the initial assessment (see below).

2. Content of orientation. Led by the MHP or PHN, the **face-to-face orientation** provides an opportunity to provide the participant(s) with a description of BIH Program services, emphasizing that they are designed to encourage empowerment and social support in a culturally-affirming manner. Participation in the BIH Program is voluntary, but women must be willing to fully commit and participate in all BIH Program activities, which include the group intervention component *and* complementary case management. Participation in both components of the group intervention and case management that focuses on life planning, are crucial for program effectiveness, fidelity and evaluation. The orientation will include the following steps:
 - Discuss the value of the BIH Program for the overall health of the prospective participant, 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 participation. The goal is to ensure clear and appropriate participant expectations.

3. If prospective participant consents to participate:
 - A completed "*Rights, Responsibilities and Consent*" Form must be signed by both the enrolling woman and the MHP (or other designated BIH local staff person) before any additional demographic or health information is obtained from

Participation Orientation and Enrollment

the participant. A copy of the signed consent form must be given to the participant and the original must be placed in the participant's BIH file.

- Completion of the *VIA Character Strengths* online survey (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. This survey may be conducted at the beginning of the first case management/Life Planning meeting.
 - 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.
 - During the initial assessment, there are scripted sections for the MHP or PHN to read to the participant. The majority of the assessment is self-administered. For women with literacy issues, the MHP or PHN can read the questions to the participant, and indicate in the appropriate area on the assessment form that it was staff-administered.
 - At the conclusion of the assessment, the MHP or PHN will ask the participant a series of questions related to the various sections. This provides an opportunity to identify: (1) immediate needs/concerns, (2) needs/concerns that will be address in the group sessions, and (3) needs/concerns that can be addressed during the 1:1 case management/Life Planning meetings.
 - Schedule group session:
 - Participants will enroll in a group series within 30 days of initial contact.
 - Participants will be assigned to a FHA for ongoing case management.
 - The FHA will coordinate with the participant for subsequent case management/Life Planning meetings.
4. If prospective participant declines to participate:
- If a prospective participant does not meet the eligibility criteria or chooses not to participate in the BIH Program, staff will provide standardized health-related disparities information affecting African-American women and infants, including Hypertension, Obesity, Diabetes, Sexually Transmitted Infections (STI's), Sudden Infant Death Syndrome (SIDS), and Breastfeeding, and referrals to community/social service agencies as applicable.

C. Exceptions:

1. If a prospective participant does not meet all eligibility criteria and local BIH staff believes that she would benefit from participation in the program, the BIH Coordinator

Participation Orientation and Enrollment

will contact their designated MCAH-BIH Program Consultant (PC) to request an exception for that individual woman only.

2. Attendance in group sessions may be waived in rare instances for otherwise eligible women for a limited number of reasons (e.g., medical bed rest).

D. Dual Enrollment in Other MCAH Programs

1. MCAH Division recommends that BIH Coordinators develop client triage policies based on the availability of local resources and knowledge of client and community needs.
2. Local policies should consider the possibilities of allowing an eligible woman to participate in more than one MCAH-funded program may exclude other potential clients from the benefits of program participation, may result in duplication of services, and could add significant data collection responsibilities to the local programs.
3. Local policies should provide guidance on the criteria for program eligibility and participation that best meets the needs of clients and provides them the most benefit.
4. It is the responsibility of the Local Health Jurisdiction MCAH Director or designated staff, in consultation with the client, to determine the program(s) that best meets the client's needs.
5. LHJ staff will enroll clients in the program(s) that will have the greatest benefit to the individual client using a local assessment process and considering the following:
 - Existing science and best practice guiding program implementation
 - Individual MCAH program goals, objectives, activities, and guidelines
 - Client input, needs, strengths, and goals
 - Duplicate or overlapping services, programs and supports currently provided to the client by other programs
 - Existing absolute contradictions to group interventions. Some clients may need an intensive home visiting program or other healthcare services to address the following situations:
 - Client medical issues that are severe enough that they logistically prohibit group involvement and/or attendance.
 - Client mental health issues that are incapacitating, uncontrolled or prevent effective participation or disruptive of group activities.
6. The BIH program should coordinate the decision making process with other local programs, for example, CHVP.

Participation Orientation and Enrollment

Forms to be completed for every enrolled woman:

- *Rights, Responsibilities and Consent*
- *Assessment #1- Enrollment*

Definition of Participant Enrollment – BIH enrollment is considered to be complete when the participant signs the BIH Participant “Rights, Responsibilities and Consent” Form. The date of the participant’s signature on the consent form is the official enrollment date.

400-30

POLICY

All BIH Program Sites will follow MCAH-BIH policy and procedure guidelines to ensure program fidelity as it relates to case management and life planning activities in the MCAH-BIH Program.

PROGRAM STANDARD:

As part of the BIH program's mission to improve outcomes for African American mothers and infants, the program complements the group intervention with *case management* to link participants with community and health related services and to assist with setting short and long term goals for life planning. In order to be eligible for the BIH program, the woman consents to actively participate in the entire intervention including individual case management. The client-centered case management services are led by the Family Health Advocate (FHA) in coordination with an interdisciplinary team that includes the Group facilitator, Mental Health Professional, and/or a Public Health Nurse.

The BIH Program model uses a client-centered case management model that focuses on (a) identifying and triaging participant needs and facilitating participant access to prenatal and postpartum supportive group services (and to medical care as needed); (b) working with the participant to identify and build on her strengths and resources to problem-solve, and obtain the services and support she needs; and (c) to participate in Life Planning to create a written plan for her future.

PROCEDURE:

1. Case management activities for life planning are conducted by the FHA. The FHA is expected to employ interpersonal skills, including basic counseling skills that enhance FHA-participant interactions. By listening, exploring, and encouraging, the FHA assists participants in making healthier choices for themselves and their families. In addition, all interactions should reflect the BIH Governing Concepts by being culturally competent, client-centered, and strength-based, and by building the participant's cognitive skills. 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 actively work with their FHA to develop a Life Plan, one of the core case management activities.

Life Planning is a process that identifies a participant's desires 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 session

following Assessment #1.

2. Each Case Management/Life Planning meeting begins with an assessment of the participant's success in accomplishing each task identified in her Life Plan. Life Planning meetings conclude with the participant establishing one task that moves her toward her long-term goal. Successful goal setting is reinforced in 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 that 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.
3. The time intervals and frequency for Life Planning activities:
 - 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.

Case Management and Life Planning

4. Case management activities for Life Planning focus on the following primary activities:
 - Life Planning: Each participant develops a plan for achieving her personal goals associated with health, finances and relationships. The Life Plan is the core of the case management intervention.
 - The Life Plan provides a framework for enhanced case management and is used to guide service delivery as well as forming the basis for evaluating provision and effectiveness of services.
 - The Life Plan incorporates information about the participants' strengths and existing resources with the goal of supporting participant self-determination, and empowering her to actively participate in problem-solving, as well as goal setting during group sessions.
 - Referrals to appropriate services outside of BIH (ongoing and as-needed basis): The FHA coordinates the referral process, helping the participant obtain access to outside resources and monitors her process.
 - The FHA will work with the participant to help her create personal goals that are based on her own values and needs that can be realistically achieved, i.e., goals that are specific, measurable, attainable, relevant and time-bound (S.M.A.R.T.) and integrate those goals into the Life Plan.
 - The Life Plan will be finalized as a culmination of their work in BIH and will provide the participants with clear direction for their futures.
 - Additionally, Group Facilitators will be informed of the Life Plan by the FHA to connect group activities to individual efforts.
 - Periodic prenatal and postpartum assessments and completion of required forms.
 - Coordination with Group Intervention: The FHA plays a key role in ongoing participant retention efforts, including the full group intervention. For example; encourage participant participation and retention for the post-partum group intervention, after successful completion of the pre-natal group intervention.
 - Knowledgeable about core agencies that participants are referred to (e.g. WIC, housing).
 - Case conference (initial, and ongoing as needed): The multidisciplinary BIH team will meet regularly to discuss individual participant cases in order to enhance resources and minimize duplication of services.

Prenatal Case Management-Life Planning before a group series begins:

1. The Life Planning meetings 1 and 2 following enrollment, will take place face-to-face in the BIH office or where group sessions are held. Subsequent Life Planning meetings are conducted face-to-face or via telephone as needed. As stated earlier, the second case management session may happen after the first group starts based on the group schedule. Session 1 starts with the completion of the *VIA Character Strengths* online survey (www.VIACharacter.org). This survey allows participants to identify their

Case Management and Life Planning

strengths, and FHAs can help participants use them to accomplish their short and long term life planning goals. This survey is 120 questions and takes about 10-15 minutes to complete. The results of the survey will be a list of strengths from 1 to 24. During their time in BIH, FHA's should request that participants focus on using and enhancing their top 3-5 goals.

A. Forms to be completed during these sessions are:

- "About Me"
- Life Planning Log
- Short-Term Goal
- Referral

Prenatal Case Management-Life Planning during group sessions:

1. Conducted once between sessions 2-5 and 6-9 to follow-up on referrals and status of goal setting/attainment.

A. Forms to be completed during these sessions are:

- Life Planning Log
- Short-Term Goal Update (if applicable)
- Referral

2. Completion of Prenatal Assessment #2 at 33 to 36 weeks gestation by the FHA in the office.

A. Forms to be completed during these sessions are:

- Assessment #2
- Life Planning Log
- Short-Term Goal
- Short-Term Goal Update
- Referral

3. The PHN or the FHA meets with the participant 3-4 weeks before delivery during a home visit.

A. Forms completed during these sessions:

- Birth Plan
- Safety Checklist

B. Activities completed during these sessions:

- Discussion of health related topics covered during the group sessions.
- Provide participant with postpartum group schedule and discuss possible enrollment dates.

Prenatal Case Management when a participant can no longer attend group sessions due to medical reasons:

1. FHA and/or the PHN work with the participant on the following:
 - Status of referrals
 - Completion of Birth Plan
 - Completion of Home Safety Checklist
 - Progress on Life Plan and goal setting/attainment

Postpartum Case Management

1. The PHN will conduct a post-delivery check-in telephone call or home visit within one week after delivery. The following *forms and activities* will be completed:
 - Birth Information
 - Referral
 - Schedule follow-up Case Management-Life Planning meeting
 - Schedule Postpartum Group session
2. Monthly Life Planning meetings occur when participants are waiting to attend a postpartum group series in order for the FHA to check on the status of goal setting.
 - *After completion of the prenatal series, participants may enroll in a postpartum series within six months of the delivery of her infant.*
3. Postpartum Life Planning appointments are held primarily in the BIH office and /or in the home. The FHA, PHN or MHP works with the participant on the following forms and activities:
 - Edinburgh Postnatal Depression Scale (EPDS) at 6-8 weeks postpartum (PHN or MHP)
 - Assessment #3 at 6-10 weeks postpartum (can be completed during the same time as EPDS if meeting with participant at 6-8 weeks postpartum).
 - Life Planning
 - Referral Tracking
 - Post-partum group attendance reminders
4. During postpartum group sessions, Life Planning meetings are held once during sessions 12-15 and 16-19.

5. Final Case Management/Life Planning Meetings:

- The FHA transitions participant out of the program and finalizes Life Plan.
- The FHA may conduct up to four life planning meetings in order to finalize Life Plan and referrals as necessary.
- The FHA completes the following forms:
 - Assessment #4
 - Short-Term Goal Update
 - About Me
 - Life Planning Log
 - Referral
 - Participant Satisfaction
 - Participant Dismissal

Prenatal or Postpartum Case Management services for 60 days

When circumstances arise that prevent women from participating in group sessions, 60 days of brief case management will be provided. The following forms and activities will be completed:

- The FHA will provide appropriate referrals
- The FHA will assist participant in setting short and/or long term goals
- Participant cases will be closed out after 60 days.
- Complete Participant Dismissal form.

For participants who leave the program early, are lost to follow-up, or are unable to complete the program for any reason, please see the BIH Participant Dismissal policy and procedure in order to close participant cases out in a correct and timely manner.

Group Implementation and Participation**400-40****POLICY**

All BIH Sites will follow MCAH-BIH policy and procedure (P&P) guidelines to ensure program fidelity as it relates to group implementation in the MCAH-BIH Program. Every enrolled BIH participant is expected to participate in and complete the full group intervention.

PROGRAM STANDARD:

- 100% of BIH participants who participate in a group series will join the series no later than session 3 (prenatal) or session 13 (postpartum).
- 100% of BIH participants will complete both the prenatal and postpartum group series.
- 100% of participants who are not attending their assigned group series will have clearly documented reasons in ETO for non-attendance.
- 100% of BIH participants who are not attending their assigned group series and do not have a documented reason that meets defined criteria for non-attendance will be closed from the Program within 60 days of missing the third consecutive group session.
- 100% of BIH Program Local Health Jurisdiction (LHJ) staff will complete all required MCAH-BIH trainings related to the group intervention component before conducting the group intervention with enrolled BIH Participants.
- 100% of group sessions will be conducted by two trained co-facilitators.
- 100% of group sessions will have 8-12 BIH participants in attendance.

Key characteristics of the group intervention

1. The group intervention is the central component of the BIH Program, in conjunction with case management/life planning. 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, participant-centered, strength-based, and utilizes cognitive skill-building approaches.
2. The curriculum focuses on building each participant’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.
3. It is culturally-relevant and incorporates opportunities to build participants’ awareness of how health is shaped by social determinants including economic and social factors such as income, education and discrimination.
4. Providing the curriculum in a group setting provides participants 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.

Group Implementation and Participation

5. 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 themselves as experts as they assist each other in the process of self-discovery and personal growth.

PROCEDURE:

A. Group intervention content

The emphasis of the BIH Program model is on engaging participants as early in pregnancy as possible in order to provide them the full benefit of all BIH services. 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. Sessions 1-10 focus on pregnancy-related issues and life planning. Sessions 11-20 focus on health disparities, healthy relationships and continued life planning.

1. The activities included in the group intervention are curriculum based. Each session includes engaging, interactive activities designed to reinforce key themes, an exercise designed to help participants manage and reduce stress, and an opportunity for participants to set personal goals to improve their health. Each group session will be 2½ hours long and divided into five sections:
 - a) A welcome and follow-up from last week's goal (15 minutes);
 - b) A health promotion/knowledge activity designed to demonstrate a key theme that is interactive and engaging (50 minutes);
 - c) A break that includes a nutritious snack provided by the LHJ and an exercise activity--reinforcing the importance of health (15 minutes);
 - d) A second health promotion/knowledge activity designed to demonstrate a different key theme that is interactive and engaging (50 minutes);
 - e) Setting a new personal goal based on the day's activities, a relaxation exercise and a concluding Gratitude Circle (20 minutes).
2. Key information will be introduced by the Group Facilitators in each session, with the intention of building on concepts and information introduced in prior sessions. Participants will also be given a new chapter to read every week from the *Participant's Handbook* including additional resource information related to that session's focus.
3. Group facilitators are required to complete the *Group Session Information* form after every group session. This form documents participant attendance at the group session and provides essential information to guide MCAH-BIH in monitoring model fidelity.

B. Group Participation

1. Every participant who enrolls in BIH is expected to participate in the full 20-session series. Exceptions to this expectation must meet defined criteria (e.g., medical bed

Group Implementation and Participation

rest). And be clearly documented in ETO on the Participant Medical Leave form. Participants who do not attend their assigned group and do not have a documented reason that meets defined criteria for non-attendance will be closed from the Program within 60 days of missing their third consecutive group session.

2. Every participant will have the opportunity to begin a group series within 30 days of initial contact.
3. A participant must begin her participation in the group intervention series by session 3 (prenatal) and by session 13 (postpartum).

C. Group Implementation

1. Group Facilitation

- a) Each group session will be led by **two** group facilitators who have *completed required MCAH-BIH sponsored trainings*. Building on requisite skills of good communication and effective listening, the required training helps group facilitators develop an array of tested strategies for effective facilitation including group management.
- b) MCAH-BIH requires that the group intervention be co-facilitated, which provides opportunities for the group facilitators to share tasks and responsibilities, to pay greater attention to participants during group, to model appropriate communication/behavior with each other, to introduce diversity and connect with a broader range of participants, and to bring different talents and knowledge to the group experience.
- c) 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.
- d) 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 distracting/disruptive participants and how to handle controversial issues; any disagreement should be discussed outside of the group and not in front of participants.

2. Group Size

- a) Each group session should be attended by a minimum of 8 participants and a maximum of 15 participants.
- b) Before a new group series begins, LHJ Program staff are required to notify their designated MCAH-BIH Program Consultant (PC) if participant group enrollment is less than or exceeds the recommended guidelines.

Group Implementation and Participation**3. Group Scheduling**

- a) Each site will need to schedule group sessions based on several considerations, including:
 - i. The number of current participants who are eligible to join either a prenatal or postpartum group intervention series.
 - ii. When those participants are most likely to be able to attend group sessions (e.g., sites should consider scheduling evening and/or weekend sessions for participants who work or have other daytime commitments).
 - iii. Staffing capabilities—the number of group facilitators available to lead groups.
 - iv. Minimizing the amount of time between group series.
- b) Sites are required to submit upcoming group schedules to MCAH-BIH annually by December 31st of each calendar year and upon request.

4. Promoting Participant Retention

- a) The group intervention provides both opportunities for and challenges to participant retention in the BIH Program—i.e., ensuring that enrolled participants continue to actively participate in the BIH Program until they have successfully completed all program requirements.
- b) Dynamic facilitation and participant engagement in the group intervention are key for participant retention, but need to be reinforced through other strategies such as:
 - i. Weekly follow-up by the facilitator and/or a participant “buddy,” particularly if a participant misses a group session.
 - ii. Provision of “motivators” (e.g., transportation, childcare, food, other incentives) that can make a critical difference in whether participants attend groups; local site staff should assess their participants’ needs and select motivators that best address those needs.
 - iii. The FHA or PHN can also play an important role by reinforcing the importance of the group intervention during her one-on-one work with the participant.

5. Coordinating the Group Intervention with Individual Case Management/Life Planning

- a) The Program participant’s engagement with the group intervention and her relationship with the group facilitators also provide a key resource for the FHA or PHN in ongoing one-on-one work with the participant during case management/life planning.
- b) At least one facilitator should be part of the initial case conference for new participants to gain a better understanding of each group participant’s strengths, challenges and concerns/needs and how these can be addressed during the group intervention.

Group Implementation and Participation

- c) Group facilitators may recognize during group activities that the participant is struggling with an issue that requires more individualized attention, which they can then share with the FHA, MHP or PHN. Appropriate program staff may arrange meetings with the participant to provide support for this issue one-on-one. For convenience, meeting times should coincide with the participant's attendance at the group sessions. Since participants will be in group for 20 weeks, the FHA often has the opportunity to follow-up to work with the participant individually prior to or following the group sessions.
- d) Many key components of BIH services (e.g., completion of the Birth Plan, Safety Checklist, and the Life Plan) are addressed during the group intervention or case management/life planning meetings, providing opportunities to reinforce important concepts and ensure that the participant has the assistance, preparation and skills she needs to successfully advocate for herself in setting and achieving her goals.

Forms to complete:

Group Session Information

400-50

POLICY

All BIH Sites will follow MCAH-BIH policy and procedure guidelines to ensure program fidelity as it relates to the participant dismissal requirements in the MCAH-BIH Program.

PROGRAM STANDARD:

100% of all participants closed from the BIH Program will have a completed *Participant Dismissal* form.

PROCEDURE:

- A. Participant dismissal should be a formal process between the participant and FHA. Although most participants will complete services, others may transfer to another BIH site, request to exit the BIH Program or be lost-to-follow up. **The Participant dismissal form must be completed for every participant.**
- B. Participant dismissal will be client-centered.
- Participants may continue in BIH up to 60 days after completion of the last postpartum group session.
 - Program completion is related to substantive milestones that reflect successful completion of both case management/life planning and the group intervention.
- C. ***Forms to be completed:***
- About Me
 - Short-Term Goal Update
 - Life Planning Log
 - Assessment #4
 - Referral (if applicable)
 - Participant Dismissal
 - Participant Satisfaction

Reasons for Participant Dismissal:**End of Intervention**

1. The participant has reached the end of her time in the BIH program (maximum: 60 days after postpartum group).

Participant Dismissal**Forms to complete:**

- About Me
- Short-Term Goal Update
- Life Planning Log
- Assessment #4
- Referral (if applicable)
- Participant Dismissal
- Participant Satisfaction

Moved-transferred to another BIH Jurisdiction

1. During the course of her participation in the BIH Program, a participant may move to another California LHJ with a BIH Program. A formal transfer process minimizes disruption, eases the participant's transition between programs, and ensures that her information is transferred. The following steps will facilitate a smooth transition from one site to another:
 - Request that the participant sign a *Release of Information* to share information with other BIH site.
 - The BIH Coordinator from the transferring site will call the BIH Coordinator in the new BIH site to inform her of the impending transfer.
 - Send a copy of all participant forms (including the current version of the Life Plan, along with completed Prenatal and Postpartum Assessments, and other completed forms and participant notes) to the new BIH site.
 - The FHA from the transferring BIH site will convene a conference call with the new FHA to share relevant information about the participant.
 - Close participant case in ETO.
 - The new FHA will meet with the participant and update her Life Plan based on her current needs.

Forms to complete:

- Referral (if applicable)
- Assessments (as applicable)
- Participant Satisfaction
- Life Plan if applicable
- Participant Dismissal

Voluntarily exited

Participant Dismissal

1. Some participants will exit the program prior to the completion of services for a range of reasons, including: relocation to an area without a BIH Program; participation in another program with services that are duplicative of BIH services; conflict with work or school obligations, and the participant's decision to discontinue her participation in BIH. BIH is a voluntary program, and a participant may decide at any point after enrolling that she no longer wants to *or* can no longer continue to participate
2. When participants decide to voluntarily terminate their participation in the BIH Program, the following steps will facilitate the participant dismissal process:
 - 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.
 - Discuss her reasons for exiting the program and document that in her chart and the Participant Dismissal form.
 - Discuss transition plan related to short and/or long term goals and life planning.
 - Close participant case in ETO.

Forms to complete:

- Referral (if applicable)
- Assessments (as applicable)
- Participant Satisfaction
- Life Planning
- Participant Dismissal

Unable to locate/unresponsive

1. Some participants 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 participants:
 - The FHA should make at least 5 attempts (all documented in the *Participant Dismissal form*) over 30 days to contact the participant via phone messages, follow up with her provider or emergency contacts, or home visits.
 - If able to contact the participant, encourage her to continue participating in the BIH Program. If she opts not to continue, follow the steps for Voluntarily exited, including asking about her reasons for exiting the program and documenting that information in her chart and the Participant Dismissal form.

Participant Dismissal

2. If the participant *cannot* be contacted during the 30 day 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 Communication Log.

Insufficient group attendance

1. Some participants may not be able to participate in the group intervention component of the BIH program for various reasons:
 - Logistics of where group sessions are conducted
 - Schedule of groups conflict with work and/or school obligations
 - Participant has not attended an available group 60 days after enrollment
 - Family obligations/circumstances
 - No desire to participate in group sessions
2. The FHA will make attempts between missed sessions to contact the participant to find out if she is still interested in participating in the BIH Program. These attempts should be either written (letter or email), via telephone and/or text message. Document all attempts and outcomes of those attempts in the Communication Log.
3. If the participant has missed three consecutive group sessions, the FHA should take steps to close her case in BIH if the participant has not communicated with the FHA. The FHA should send a letter to her last known mailing address indicating that her case with BIH has been closed. The letter should have a positive tone and include:
 - Encouragement to obtain prenatal and postpartum care for her and her baby.
 - Document all attempts and outcomes of those attempts in the Participant dismissal form.
 - Standardized health-related disparities information affecting African-American women and infants, including Hypertension, Obesity, Diabetes, Sexually Transmitted Infections (STI's), Sudden Infant Death Syndrome (SIDS), and Breastfeeding.

Participant Dismissal

4. The FHA will ensure that referrals are made for necessary services identified by the participant and short-term goal setting is initiated.

Forms to complete:

- Communication Log
- Referral (if applicable)
- Assessments (as applicable)
- Participant Satisfaction
- Life Plan if applicable
- Participant Dismissal

Fetal or Infant Loss

1. The BIH Program staff (FHA/MHP/PHN) will ensure that the participant receives supportive services from BIH and other community agencies as appropriate.

Forms to complete:

- Participant Dismissal

Other

1. Please carefully read through all other options and their accompanying descriptions above first. If none of these apply, then use *Other* when completing the Participant Dismissal form.

Forms to complete:

- Participant Dismissal

500-10

POLICY

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

PROGRAM STANDARD:

Every BIH Local Health Jurisdiction (LHJ) will develop and implement a Quality Assurance (QA) Plan that includes a systematic process both for monitoring the quality of participant services and for seeking ways to improve the development and ongoing implementation of program activities.

PROCEDURE:

1. MCAH-BIH 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. MCAH-BIH is committed to this process and will work collaboratively with local sites.
2. Each LHJ will develop a QA Plan that specifies site-specific quality management efforts. Monitoring and maintaining a QA plan is the responsibility of the BIH Coordinator, but the entire staff should be knowledgeable about the plan and fully support its implementation.
3. To support QA efforts, each LHJ 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 implementing the QA plan based on ongoing feedback and review with the goal of improving BIH Program services.
4. In addition to program fidelity, the QA plan will include regular assessments of participant satisfaction with BIH services at specific intervals such as at the conclusion of a group series or case management sessions, after prenatal and postpartum assessments, at voluntary exit from BIH, and at program completion/formal case closure. Participant satisfaction surveys are an important tool for assessing the quality of the services provided by each LHJ.
5. The BIH Coordinator will conduct quarterly audits of at least 10 percent of participant records. Records should be selected randomly for documentation accuracy and completeness, provision of referrals for identified services, and appropriate follow-up. Quality assurance fidelity elements in participant records should be consistent with participant information entered in the Efforts to Outcomes (ETO) data system.

6. The BIH Group Facilitators will complete the Group Session Information form after each group session and discuss feedback with BIH Program staff in order to strategize ways for improving programmatic activities. Summaries of participant feedback can be included in BIH Quarterly Coordinator Reports for review and consideration by the MCAH-BIH State Team.
7. The BIH Coordinator will observe at least one group session on a quarterly basis (prenatal or postpartum session) and complete the Group Observation Feedback form in ETO.
8. The BIH Coordinator and/or Data Entry lead will review standard reports issued by MCAH at least quarterly as a management tool to assess data accuracy and completeness.
9. MCAH-BIH will conduct QA activities with LHJ sites via site visits, technical assistance calls, data quality reports and/or calls, and annual and quarterly BIH reports.
10. MCAH-BIH Annual and Quarterly reports serve as a formal communication process from the LHJ to MCAH-BIH regarding activities implemented in the areas of participant recruitment, referrals, best practices, quality improvement activities and participant success stories. The reports also assist in identifying areas requiring follow-up by MCAH-BIH and the BIH Coordinator such as outreach activities, lower than anticipated participant enrollment, or low group participation.

Forms useful for quality assurance activities:

- BIH Data Collection Checklist
- BIH Data Collection Schedule
- Participant Satisfaction
- Life Planning Schedule
- Referral
- Case Conference

Forms to complete:

- Group Session Information

Reports to complete:

- *BIH Annual Reports are due to MCAH on August 15th of each year*
- *Three BIH Coordinator Reports are due to MCAH at the end of January, April, and October of each fiscal year. Information contained in reports normally due end of July will be incorporated into the BIH Annual Report.*

Data System Requirements

600-10

POLICY

All BIH Sites will follow MCAH-BIH policy and procedure guidelines to ensure program fidelity as it relates to the data system requirements in the MCAH-BIH Program.

PROGRAM STANDARD:

All Local BIH Sites will ensure that systems are in place in order to participate in MCAH-BIH data related calls and trainings.

DATA SYSTEM REQUIREMENTS:

1. Minimum hardware requirement
 - 256 MB memory (1 GB of memory recommended)
 - Intel Pentium II processor, 500 MHz or above
2. PC running Microsoft Windows 7 or higher (recommended)
 - Must download Windows updates on a regular basis
 - Windows 7 Starter is not currently supported (this is a stripped down version of Windows 7 that is typically only found on netbooks)
3. Internet Connection
 - Minimum speed is 500kb/s, but recommended speed is at least 1 Mb/s.
4. Microsoft Internet Explorer 9 or above
 - Temporary Internet Files set to check for newer versions of stored pages every time webpage is visited.
 - Must have the following trusted sites added:
 - <https://www.etosoftware.com>
 - <https://www.ettoreports.com>
 - The application site www.etosoftware.com should NOT be viewed in compatibility mode.
 - Other Internet settings:
 - Pop-up blockers turned off
 - Disable any auto-fill tool bars
 - Use SSL 3.0
 - Use TLS 1.0
 - Use TLS 1.1
 - Use TLS 1.2
 - Cipher strength greater than 128 bit
5. Crystal Reports
 - Install from the following link: <https://www.ettoreports.com/npviewer.exe>

Data System Requirements

- ActiveX controls need to be installed for printing and exporting reports. Users will be prompted for install. In order to complete install, users must have administrative privileges to the machine.
 - MS Office 2010 64-bit version is not currently supported
- 6. Live Office**
- MS Office and Live Office updates must be downloaded on a regular basis
 - MS Office 2010 64-bit version is not currently supported
- 7. Firewall Settings (does not apply to all customers - check with your IT department if you are not sure)**
- If using Content Filtering on your internal firewall, add https://*.etosoftware.com and https://*.etoreports.com to the firewall's filtering "white list" (trusted sites).

600-20**POLICY**

All BIH Sites will follow MCAH-BIH policy and procedure guidelines to ensure program fidelity as it relates to the data collection and entry requirements in the MCAH-BIH Program. BIH sites are not allowed to alter any MCAH-BIH developed forms/standardized tools/instruments and/or data operations without prior approval from MCAH-BIH.

PROGRAM STANDARD:

All Local BIH Sites will ensure that collection of program data and its subsequent entry into the Efforts to Outcomes (ETO) system is timely, accurate and complete. LHJs are responsible for entering both participant and non-participant level data into ETO within 7 working days of collection.

PROCEDURE:

1. The data entry lead will be supervised by the BIH Coordinator.
2. In addition to paper data collection, MCAH-BIH requires data to be entered into the ETO system.
3. At each LHJ all on-site staff are expected to complete training to use ETO, which includes the following:
 - Watching the ETO User Training recording
 - Completing practice work identified through training
 - Completion of ETO Post-Training Assessment
 - Attending ETO Role-Specific Advanced Trainings
4. At least one staff member at each local BIH site must be selected as the “Data Entry Lead,” who will be responsible both for communicating all data-related matters to staff and for overseeing the maintenance of accurate and complete participant and site-specific data.
5. Each staff member entering data into ETO will:
 - Complete the ETO user training
 - Adhere to the BIH Policy and Procedures
6. LHJs are required to respond in a timely manner to MCAH-BIH data requests and data cleaning exercises.

Data Collection and Entry

7. LHJs wanting to modify any data entry procedures must submit their request in writing to BlackInfantHealth@cdph.ca.gov using the transmittal process.
8. Data related correspondence and reports from MCAH-BIH will be sent to County/Government/subcontractor designated email accounts only. MCAH-BIH will not send data related information to personal email accounts ending in @yahoo.com, gmail.com. etc.
9. Data will be collected for each participant throughout her participation in the BIH Program using a series of standard forms that will be either self-administered or completed by Program staff in encounters with the participant during recruitment, enrollment, case management and case closure activities.
10. The data that are collected will be used for case management, local/state program monitoring, and program evaluation. To ensure that the data are accurate and complete, it is crucial that: (1) the forms be administered at the specified time per the BIH Data Collection Manual; (2) all directions on the forms be followed as closely as possible, and (3) the forms be filled out as completely as possible with answers to all questions.
11. Guidance for administering required forms is included in MCAH-BIH relevant trainings and the BIH Data Collection Manual. The data collected using the BIH ETO data book forms provide critical information about key topics related to program evaluation including:
 - Whether participant needs were met by setting short and long-term goals, referral services, and the group intervention.
 - Maternal health behaviors and knowledge
 - Psychological well-being, including social support, self-esteem, mastery, and resiliency.
 - Birth outcomes
12. Many of these topics are assessed multiple times during each participant's time in the BIH Program, so that snapshots of participant life-change can be created. These data will help document how the BIH Program impacts lives of participating women, their infants, and families.
13. Program evaluation data are critical to MCAH-BIH 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 policy makers why investment in the BIH Program is so important.