

BLACK INFANT HEALTH PROGRAM: PILOT IMPLEMENTATION (PHASE I) PRELIMINARY ASSESSMENT REPORT

Findings from the pilot implementation period

July 2010-November 2011

California Department of Public Health, Center for Family Health,
Maternal Child and Adolescent Health Program

University of California, San Francisco, Center on Social Disparities in
Health

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Black Infant Health Program: Pilot Implementation (Phase I) Preliminary Assessment Report

I. Executive Summary

This report from the California Department of Public Health, Maternal, Child and Adolescent Health Division (CDPH/MCAH) is based on experiences during the initial pilot period (July 2010-November 2011) of implementing the updated Black Infant Health (BIH) Program model at eight of the 15 BIH local health jurisdictions (LHJs) statewide. The report includes an overview of the model and implementation process, presents findings from the pilot implementation period, and concludes by summarizing identified needs and action steps for future implementation. Although the report presents preliminary findings about the impacts of program participation on BIH clients, staff and the broader community, its primary focus is on lessons learned about the *process* of implementing the updated BIH model. As additional quantitative and qualitative data are collected and analyzed, subsequent evaluation reports will include more comprehensive findings about program outcomes and the effectiveness of the updated model in meeting BIH program goals.

Based on observations during the pilot implementation period, the overall impression is that the BIH Program is moving in promising directions:

- The updated model was successfully implemented at all eight of the pilot LHJs. This success occurred despite challenges related to transitioning from several different existing service models at LHJs with a range of leadership and management styles, staffing configurations, client demographics, referral patterns, funding sources and levels of community support. Key aspects of the implementation process contributing to this success include: structured staff training that highlighted foundational theories supporting the updated model; establishing frequent and regular forums for communication to address challenges and share successes; and strengthening staff capacity and team building.
- More than 700 clients were enrolled in the updated BIH model at the eight LHJs during the pilot implementation period, and these clients appeared to be demographically similar to previous model clients at these LHJs. Although fewer clients were served during the pilot period than previously, the drop in caseload was anticipated as the pilot LHJs transitioned from their prior service models to a single model in which all clients received a standard and enhanced core intervention including both group-based and case management services. This comprehensive approach can be particularly beneficial for clients, but it is also extremely time- and labor-intensive for BIH staff.
- Although there was initial resistance to change, staff at all eight pilot LHJs have accepted the updated program model; most have embraced it with tremendous enthusiasm as they see the apparent benefits for their clients and themselves, including:
 - Clients are experiencing decreased isolation and increased social support through participation in group sessions.
 - Clients and their families are gaining health-related knowledge and are making changes based on what they have learned.
 - Clients are empowered as they learn to identify their strengths, to become better self-advocates, and to set and meet goals.

- BIH staff are learning new professional and personal competencies as they participate in mandatory trainings, engage in capacity-building activities across LHJs, and provide updated services to their clients.
- Both clients and staff have benefited from focused efforts to strengthen community partnerships and build community support for BIH.

All Group 1 sites collected extensive client data throughout the pilot implementation year using hard-copy versions of the new BIH Data Book forms. Analysis of relevant quantitative data for this report was limited due to delays in launching the electronic data system that will soon support the updated BIH Program model. Accordingly, the findings included in this report are based primarily on qualitative data about the process of program implementation.

FINAL RECOMMENDATION: CDPH/MCAH should continue with implementation of the updated BIH Program model at all BIH local health jurisdictions statewide. Future implementation efforts should apply knowledge gained during the pilot implementation period in four key program domains: program content, program delivery, data collection and reporting, and promoting the updated BIH program model. CDPH/MCAH will continue to monitor BIH Program needs and to assess the impacts of program activities and modifications.

II. Background

A. Program assessment and scientific rationale

Under contract from CDPH, a team of researchers at the University of California, San Francisco, Center on Social Disparities in Health (UCSF/CSDH) began an assessment of the prior BIH Program in 2006. This assessment synthesized information from a comprehensive literature review, interviews with subject matter experts, and extensive feedback from phone calls, site visits, interviews and meetings with local BIH program staff. This work was summarized in a 2007 report titled *The Black Infant Health Program: Comprehensive Assessment Report and Recommendations*.¹ The assessment found that, to make further gains in improving birth outcomes for African American women and their infants, the BIH Program would need to expand its focus beyond meeting clients' medical needs during and after pregnancy. When the BIH Program began in 1989, the prevailing assumption (in California and nationally) was that expanding access to early and adequate prenatal care represented the most promising direction for decreasing disparities in birth outcomes between African American and White women. Although receiving timely and adequate prenatal care is important, focusing solely on women's receipt of medical care during pregnancy is unlikely to lead to further improvements in African Americans' birth outcomes or to decrease long-standing racial/ethnic disparities in infant mortality. Rather, current scientific knowledge suggests that more effective solutions will be complex, with greater emphasis on social factors.

The assessment report recommended a single standardized core model focused on addressing the following issues for African American women:

- Increasing social support and reducing stress
- Building personal capacity and fostering empowerment
- Meeting social and economic needs
- Increasing health knowledge, motivation, and coping skills
- Increasing community involvement and mobilizing community resources

The report findings indicated that a group-based approach, supported by individual case management, would be optimal for African American women—providing social support, building personal capacity, and fostering empowerment. The benefits of this updated model of services could extend far beyond women's program participation by helping to strengthen African American families and communities.

B. Developing the updated BIH Program model

In response to the assessment report and recommendations, CDPH/MCAH began to develop the updated BIH model. The following key activities were instrumental in this process:

- Developing broad collaborative relationships. CDPH/MCAH formalized its collaborative relationship with UCSF/CSDH by establishing a contract for evaluation and program development activities and at the same time emphasized extensive involvement of local BIH staff throughout the model development process (See Appendix A). This collaborative process encouraged involvement at all levels, with approximately 70 local BIH program staff participating throughout the process.

¹ Braveman P, Nicholson G, Marchi K. The Black Infant Health Program: Comprehensive Assessment Report and Recommendations. University of California, San Francisco Center on Social Disparities in Health, Department of Family and Community Medicine. Prepared for the California Department of Public Health, Maternal Child and Adolescent Health. July 2007. <http://www.cdph.ca.gov/programs/bih/Documents/MO-BIH-ComprehensiveAssessmentReport-April-2008.pdf>

- Developing the logic model and conceptual framework. After extensive research and input from BIH local and CDPH/MCAH staff, the Evaluation Team, and selected experts, a conceptual framework and a program logic model were developed to illustrate relationships among program goals, activities and outcome measures. These documents informed the development of the updated model and key evaluation questions that guided the design of the evaluation strategy (see Appendices B and C).
- Developing a staff training. As part of the process of updating the program model, CDPH/MCAH developed a mandatory structured training for all BIH staff involved in implementing the updated model. The three-day training highlighted the scientific rationale and foundational theories (Cognitive Behavioral Therapy, Harm Reduction, Positive Psychology, Transtheoretical Model for Behavior Change, and Stages of Group Development) supporting the updated model; it also provided opportunities for building key skills, including group facilitation and data collection, and emphasized the importance of program fidelity and quality assurance. After completing the training, staff reported a clearer understanding of the updated model and a stronger desire to implement it in their LHJs.
- Developing the group-based intervention. The Group Intervention Subcommittee (See Appendix A) was convened to consider eight existing curricula for group interventions that were relevant to BIH Program clients. Two nationally-evaluated curricula—“Nurturing Parenting” and “Effective Black Parenting”—were selected as the primary basis for developing one cohesive group-based curriculum for the updated model. The subcommittee developed a standardized 20-session group intervention designed to provide a culturally affirming environment honoring the unique history of African American women, with the intent that participants would leave group sessions feeling empowered to make better decisions about health and wellness for themselves and their families, during and after pregnancy. Four LHJs (in Fresno, Sacramento, San Diego and Solano counties) were selected to pilot the new group-based curricula beginning in April 2010; two sites had group facilitation experience and two did not. Based on extensive feedback from staff at the pilot sites and further consultation with the Group Intervention Subcommittee, all curricula materials were revised prior to pilot implementation of the full updated program model.
- Developing the ‘enhanced case management’ intervention. The Client Assessment/Service Delivery Subcommittee (see Appendix A) focused on developing the case management intervention, intended to complement the group intervention. The Strength Model for Case Management was chosen as a framework because it is client-centered and focuses on identifying individual strengths and removing barriers to receiving services. The Strength Model was adapted with the addition of an Individual Client Plan (ICP) to guide the client as she works with the FHA to identify her priority goals and take steps toward meeting them, and to reinforce skills developed during the group intervention. Additional case management enhancements included: conducting periodic client assessments, creating a Birth Plan for labor and delivery, conducting the Edinburgh Postpartum Depression Screen, and assessing home readiness for the infant. Also central to case management is the client’s creation of her personal Life Plan, intended to provide her with a tangible course for her life beyond her participation in the BIH program.
- Developing program guidelines. To guide and standardize procedures across Group 1 BIH sites, the Evaluation Team drafted two key documents—a Policy and Procedures Manual, and Program Standards. These documents were both reviewed and endorsed by the BIH Workgroup (see Appendix A), with the understanding that they were intended to be ‘living documents’ that would be updated as the program model evolved.
- Developing data collection tools. In collaboration with the Data and Evaluation Subcommittee (see Appendix A), the Evaluation Team developed a comprehensive “Data Book” comprising a series of forms designed to follow each client from program intake to

exit. Whenever feasible, these forms were adapted from existing BIH forms and included validated instruments and questions from existing state and national surveys to permit comparisons that would strengthen the program evaluation. One additional form to be completed by the group facilitators was developed to monitor activities related to the group sessions. Throughout this process, the goal was to balance demands on staff and client time with the need for data that adequately address both case management and evaluation needs.

- Developing the CDPH/MCAH Management Information System (MIS). Based on an extensive assessment of the existing BIH MIS coupled with updated evaluation needs, it was determined that an updated MIS was needed. The updated MIS would include improved analytic capabilities for case management and program evaluation and the ability to link BIH client data with official vital statistics data. CDPH/MCAH decided to adapt an existing in-house system to meet program management and evaluation needs of the updated model.
- Convening an Expert Panel. National leaders in maternal-infant health met with the BIH Workgroup and CDPH/MCAH leadership in May 2010 to provide feedback on the updated model design and plans for implementation. The Expert Panel (see Appendix A) felt that the updated model was scientifically “cutting-edge,” but recommended that CDPH/MCAH continue to build on approaches with a life course perspective, ensure linkage between the group-based and individual services, and broaden the program scope to engage the community in addressing the deep roots of disparities in birth outcomes. The same Expert Panel was reconvened in January 2012 to review findings from the pilot implementation evaluation. They felt that the program’s overall success in transitioning from an existing program with variation in services across sites to an updated model with standardized services is a significant accomplishment. While reaffirming that the updated model represents an appropriate step forward in providing client-level services to address the issue of poor birth outcomes among African Americans, they again encouraged CDPH/MCAH to continue efforts to expand the BIH model to include even more activities with community-level impacts.

The updated model features a single standardized program to be implemented across all BIH LHJs. It includes 20 weekly group sessions—10 sessions during pregnancy and 10 sessions postpartum—integrated with ongoing one-on-one case management, and emphasizes the following (see Appendix D):

- Group participation to *promote social support, reduce isolation and encourage healthy decision-making*, focusing both on *health education* and on learning practical life skills such as *stress management techniques* and strategies for *setting and meeting goals*.
- Client-centered case management that complements the group intervention by *empowering women* to identify their own health and social needs and to use their own strengths and resources to meet those needs. BIH Staff will connect clients *with appropriate medical, social, economic and mental health services* while also helping them to *become self-advocates* who can navigate systems on their own.
- Building community support around BIH among providers and other key stakeholders, including developing formal and informal *partnerships* with community-based organizations (CBOs), hosting open houses, and attending provider meetings and community health fairs.

C. Implementing the updated BIH Program model

During development of the updated model, CDPH/MCAH and UCSF/CSDH charted an implementation process taking into account two key issues: individual LHJ characteristics (including site leadership and staffing, geography, number of clients served, and LHJ experience with groups) and external funding sources. The timeline and activities related to the three overlapping phases of the implementation process are described below:

- Phase 1—Pilot implementation at “Group 1” LHJs (July 2010-November 2011)
Beginning in July 2010, each of the eight Group 1 LHJs (Contra Costa, Fresno, Kern, Sacramento, San Diego, San Francisco, San Mateo and Solano counties) submitted a formal *transition plan* with details about how the LHJ would move from its current model to the updated model. During the transition period, CDPH/MCAH conducted four regional *mandatory staff trainings* for all BIH staff at Group 1 LHJs. These LHJs began serving clients using the updated model during November 2010. To facilitate *communication* across Group 1 LHJs and with the Evaluation Team, Group 1 staff participated in monthly capacity-building calls as a way to share their experiences and provide feedback as the pilot implementation proceeded. CDPH/MCAH also initiated the use of Microsoft SharePoint technology to disseminate program documents securely and efficiently to all Group 1 LHJ staff.

During this pilot implementation phase, the remaining LHJs collected a limited set of supplementary baseline data, participated on monthly transition calls and attended mandatory staff trainings as part of their preparation for the transition to the updated model in Phase 2.

- Phase 2—Implementation at “Group 2” LHJs (July 2011-November 2012)
Beginning in July 2011, the six Group 2 LHJs (Alameda, San Joaquin and Santa Clara counties, and the cities of Berkeley, Long Beach and Pasadena,) submitted formal transition plans to the CDPH/MCAH and participated in the mandatory staff trainings. Each of the Group 2 LHJs transitioned to serving clients in the updated model by November 2011.
- Phase 3—Implementation at “Group 3” LHJs (April 2013-Ongoing)
Phase 3 of implementation is scheduled to begin in April 2013 when the five sites within the Los Angeles County LHJ will provide a formal transition plan and align their activities with the updated model. On July 1, 2013, all BIH LHJs will be serving clients using the updated model.

III. Findings

A. Preliminary findings about program outcomes

Overall qualitative evidence from the pilot implementation period indicates that BIH clients, staff and local communities have benefited from clients’ participation in the updated model. Below are some specific examples of qualitative findings, including client testimonials and staff anecdotes, that were collected from BIH staff at the pilot LHJs on monthly capacity-building calls, an online survey and other written feedback, quarterly/annual reports, and facilitator observations (see Appendix E). While additional quantitative and qualitative information about program outcomes will be available in future evaluation reports, these examples illustrate the early successes of the updated program model.

Clients are experiencing decreased isolation and increased social support.

- Clients often ask if the groups will continue beyond the 20-week sessions and appear to enjoy the weekly group ‘check-in’ with each other. They inform and support each other during group sessions and encourage each other.
 - BIH staff reported clients calling or texting fellow clients when they have not shown up for a group session.
 - One FHA shared a challenging experience she had trying to motivate a client to complete her application for Medi-Cal coverage, which was resolved when her fellow group members reinforced the importance of applying.
 - As reported by a Group Facilitator, one client stated that she was influenced by her fellow group members’ encouragement to enroll in school.
 - FHAs have heard from participants that they do not feel judged; their overall impression is that the group process creates positive feelings and recognizes participants’ mutual strengths. For example, a client with literacy issues continued attending group sessions, despite her struggles.
- Group participation has reduced clients’ isolation and helped them develop positive connections with other women in their own community. One staff member wrote: “...our clients are saying that they enjoy coming to a group for them and facilitated by someone who can understand their struggles and show them a better way. They also like that they are with other African American women that are going through some of their same struggles. They have a safe place to talk about things they have not been able to share before and find that they are not alone.”
- BIH staff reported that participants are learning to socialize with each other in positive and supportive ways that create community. According to participants, some are experiencing this positive interaction with a group of black women for the first time. Participants feel they are defeating the stereotype that black women can never get along. As one BIH client wrote, “Black Infant Health is a Sistah Circle that helps us sistahs survive—a gathering, a lesson, a prayer to keep our families alive. Whether married or single, we are supported as queens. Motherhood is activism and we have accepted the challenge. This group constantly reminds me that we all have our talents.”
- Local BIH staff reported that clients are meeting informally outside of group and continuing to do so even after the group sessions end.

Clients and their families are gaining health-related knowledge and making changes based on what they have learned.

- Coordinators and Group Facilitators report that clients find the curriculum content relevant and empowering, particularly with respect to health disparities affecting African American women and their families and the inclusion of African American history and discussion of cultural icons; for many clients, this is their first tangible exposure to these topics.
 - One FHA reported that clients have expressed concern about the health disparities between African Americans and other racial/ethnic groups.
 - One Group Facilitator shared a conversation she had with a client who commented on what she learned during the group session and how it related to her efforts to be a good parent.
- Clients told BIH staff that they have been sharing the information they’ve learned at home with their partners and children.
- BIH staff reported that clients are changing health-related behaviors affecting themselves and their families. For example, one FHA wrote, “Many of our clients report making healthier food choices by including leafy greens, whole wheat, less sugar, and drinking more water. They are cooking at home instead of eating fast foods.”

- Clients are developing important skills that lead to reduced stress. As reported by BIH staff, clients are practicing relaxation exercises and have said that they are able to communicate more effectively with their partners. One FHA wrote, “The new model has addressed many of the social-emotional needs of the clients by allowing them to have a platform or forum to speak candidly about their stressors in a group context.”
- BIH staff commented that the group sessions give participants the opportunity to share experiences and learn from each other as well as learning new ways of handling difficult situations.

Clients are empowered as they learn to identify their own strengths, to become better self-advocates, and to set and meet goals.

- BIH staff report that for many of their clients the process of thinking about and identifying their own strengths is a novel and transforming experience.
 - Clients who initially were “stepping back” (not interacting in group) began “stepping up.” Some clients reported that the men in their lives saw these positive changes and wanted to be a part of it.
 - BIH staff reported that the updated model emphasis on building clients’ skills as self-advocates appears to have reduced the extent to which clients view themselves as ‘entitled’ to receive services from BIH and other programs.
 - One FHA/Group Facilitator wrote, “I have seen personal growth in the clients' demeanor and how they've applied what they learned in group. Those that were reluctant to participate enjoyed sharing and being a part of a group that gave them a lot of support.”
 - Following one of the group sessions, clients commented on their experience as well saying, “I knew I had strengths and the group help me give them names” and “I have a better understanding of myself.”
- BIH staff have commented that clients recognize the importance of setting goals and have been able to follow through on the weekly goals they set for themselves in their lives.
 - One FHA reported working with a client who suffered from depression to take steps to return to psychotherapy; the client is now seeing a therapist weekly and feels a sense of accomplishment at achieving this “goal.”
 - During one group session a client reported that her goal for the week was to be happier and that four people had actually told her that she looked happier.
 - One client wrote that: “Black Infant Health encourages and challenges us to be confident, educated, courageous and stylish having fun along the way. We must also have a vision and set goals for our lives so that we may live on purpose and remember that we are valuable and have a very important role.”
- In reference to participants in the updated model, one staff member wrote, “The women love the experience, and appear to have developed a stronger sense of hope and are planning for the future in regards to self-improvement and becoming more self-sufficient.” Another staff member wrote, “Group has definitely empowered our clients to be more proactive and be advocates for themselves and for their children.”

BIH staff are learning new professional and personal competencies.

BIH Coordinators, FHAs, and Group Facilitators have noted that the mandatory training and their experiences during the pilot implementation period have transformed how they approach their work and affected them personally. The following are comments from BIH staff:

- The updated model has “...helped us to be more creative and to think out of the box for our program and for ourselves. I have really seen staff grow in areas that they

did not see themselves as equipped to handle. Especially when it came to facilitating groups, there was initially fear and hesitation, but with the training and continued growth, their comfort levels have increased and they are a natural with being in tuned with the process and with the women.”

- “The training process has shined new light on the existing strengths and talents that exist with co-workers that may not have come out because of the routine process of working.”
- “The new model has personally made me become more reflective and introspective about my own life. You can't ask the BIH women to be more future oriented and driven, if you haven't done the work yourself to address your own stressors.”
- “It [the updated model] makes me far more cognizant and accountable in the way I live my own life, because I wholeheartedly believe that authenticity is the key to being a good facilitator. For example, I am much more aware of the types of food I eat, my exercise routine and the way I handle my relationships because I know I may have to share (honestly) with the ladies [participants], in order to lead them to at least think about better choices.”
- “The new model encouraged me to achieve my goals. I have been saying for years that I was going back for my MSW. Once the new model started and I was encouraging clients to go after their educational goals, I realized that I was letting the same way of thinking stop me from pursuing mine (i.e. I can't because I'm a single parent, I have small children, I work fulltime, etc.). I decided to apply to the program and was accepted. I just successfully completed my 1st quarter of the MSW program at CSU Eastbay with a B+ average.”
- “It [the updated model] has allowed me to see the resiliency in people. The women who come into our program are dealing with a lot of issues and they continue to seek our resources, to care for themselves and their families and to trust. That is so powerful to me to see in action through the group process.”
- “The new model has made me want to be more active in my community because there is a great need that has to be met for the future of our youth.”

Both clients and staff have benefited from focused efforts to strengthen community partnerships and build community support for BIH.

LHJs are taking important steps to increase connections and inform their communities about the BIH Program. Local-level community engagement activities have been important for recruitment and retention and include the following:

- Creating a good rapport with community organization’s staff, establishing partnerships through formal agreements (e.g., Memoranda of Understanding, Community Partnership Agreements), and working with key referral sources to implement efficient referrals systems.
- Attendance by BIH staff at community events such as health fairs has been successful for recruitment. Although this approach does not necessarily produce immediate results, it keeps the program and program staff visible in the community so that people will think of BIH when they hear about someone in need of services.
- Some LHJs connected with local community businesses and organizations in an effort to secure donations; LHJs have received donations including material goods to be used as incentives, food for the group sessions, and facilities for BIH activities.
- Several LHJs invited family and other community members to group graduation celebrations and other events.
- Several LHJs hosted “open houses” and conducted presentations to providers as a way to inform the local community and referral sources about the updated BIH model.

B. Findings about the implementation process

Key findings about the implementation process are based on both qualitative and quantitative data collected during the pilot implementation period through regular staff calls and meetings, trainings, staff interviews, standard program reporting and client forms (see Appendix E). While all Group 1 LHJs collected extensive client data throughout the pilot implementation period using hard-copy versions of the new BIH Data Book forms, due to the delayed launch of the electronic data system only a limited subset of these data were available for this report.

Findings on client caseload numbers and demographic characteristics.

Based on the quantitative data summarized in Table 1:

- The caseload, or number of active clients served at any point during the pilot implementation year, was approximately 740 for the eight Group 1 LHJs combined, representing smaller overall caseload numbers at those sites than in the prior year. This drop in caseload was anticipated given shifts in recruitment and other procedures as the pilot LHJs transitioned from their prior service models. While all of these LHJs began enrolling clients into the updated program model during the pilot year, most also continued to serve previously-enrolled clients in the prior program model until those clients had completed services or exited the program.
- Comparing client demographics from the prior model with those at Group 1 LHJs during the pilot implementation, the available data indicate that clients served by the new model generally appeared to be similar to clients in the prior model. Overall, the caseloads at these eight LHJs continued to include African American women who were relatively young, more likely to be single than married, and more likely to be unemployed than employed. During both time periods, approximately one third of clients had not finished high school while another third had at least some college education, and most clients had Medi-Cal coverage for their health care.
- Although fewer clients were served in a year during the pilot period than in the previous model, it is important to note that clients at all LHJs in the updated model received *a standard core intervention including both group-based and individual case management services*. As acknowledged by both BIH Program staff members and expert advisors to the Program, this comprehensive approach can be particularly beneficial for clients but is also extremely time- and labor-intensive.

Table 1: Selected demographics at Group 1 LHJs: Prior to and during implementation of the updated BIH model.

Selected Demographics	Previous BIH Model (Oct. 2009 – Oct. 2010)	Revised BIH Model (Nov. 2010- Nov. 2011)
Average age	23	24
Marital status		
Single	85%	88%
Married	11%	7%
Divorced/Separated/Widowed	4%	5%
Highest level of completed education		
Less than high-school graduate	30%	32%
High-school graduate or GED	32%	31%
At least some college	34%	37%
Employment status		
Not employed	73%	81%
Part time	14%	11%
Full time	12%	7%
Insurance status		
Medi-Cal	89%	85%
Other	11%	15%
Number of LHJs	8	8
Total Caseload	2,026	740

Notes:

- (1) Percentages and totals are preliminary and approximate because of the transition from prior to revised models. Some clients may appear in both columns because of the transition.
- (2) Total percent for each category may not add to 100% due to rounding and/or exclusion of small categories.
- (3) Some categories were combined to align demographics for both program models.
- (4) Percentages in all categories were calculated based on the number of clients enrolled minus the number of clients with missing data for that category.
- (5) Caseload numbers are for the 8 pilot LHJs only and do not reflect total caseloads for the BIH Program overall in either period.

Findings on differences in implementation across LHJs during the pilot year.

As noted above, a primary goal in developing and implementing the updated BIH Program model was to move toward standardization of services and delivery of a single core model across the BIH LHJs statewide. Efforts toward accomplishing this goal were complicated by the fact that the updated program model implementation occurred *within the context of an existing program*, including 15 LHJs characterized by a range of prior service models, leadership and management styles, staffing configurations, client demographics, referral patterns, funding sources and levels of community support. For example, some LHJs had previously focused exclusively on providing individual case management to a medically high-risk subset of African American women, while others had experience with group-based activities including *Social Support and Empowerment*, an optional component of the previous BIH Program model.

During the pilot period, variation was observed across LHJs in several aspects of model implementation including:

- The total number of group series conducted by LHJs
- Schedules for conducting the prenatal and postpartum groups (e.g., some LHJs ran the two groups concurrently with a scheduled break between group series, while others offered groups on an overlapping and staggered basis)
- Types of accommodations and facilities in which group sessions were held
- Ways in which group facilitators adapted the curricula by adding activities or including additional resources
- Coordination of staffing roles and responsibilities (e.g., at some LHJs staff members filled both the Group Facilitator and FHA roles, while at other LHJs staff roles were distinct; some LHJs held regular team meetings and retreats, while at other LHJs staff worked more independently)
- Availability of referral resources and services outside of BIH to meet clients' case management needs
- The extent to which program “enablers” (i.e., food, transportation, childcare and material incentives) were available to support client participation
- Provision of additional ‘non-core’ services, such as regular home visits and medically-oriented case management
- Plans for accommodating clients who had enrolled prior to implementation of the updated model (e.g., while most pilot LHJs continued to offer prior services to at least some of their clients, one discontinued its prior model completely once pilot implementation began)

Findings on implementation challenges and successes during the pilot period.

The matrix below describes findings related to (a) challenges and concerns that arose during pilot implementation of the updated program model, and (b) strategies pursued by CDPH/MCAH or LHJs in response to these challenges/concerns that appear to have been successful. These findings are grouped into four domains of program implementation:

- Client recruitment and retention
- Program service delivery
- Staffing, resources and funding
- Data collection and reporting

Client recruitment and retention
Challenges and concerns encountered during the pilot implementation
<ul style="list-style-type: none"> • <i>Having the right messaging to “sell” the program to potential clients and referral sources.</i> At least initially, staff at some LHJs demonstrated limited “buy in” for the updated program model, making it difficult for them to effectively promote BIH to potential clients and/or referral sources. • <i>Updating expectations among community providers.</i> As BIH sites have transitioned from their prior models to the updated model, some providers who have been a steady source of referrals may continue to expect BIH to deliver particular program services that are no longer emphasized in the updated model. • <i>Appropriateness of group intervention for women referred to BIH.</i> Some staff expressed concern that some women (i.e., those who could no longer enroll in BIH because they could not fully participate in the updated model) would “fall through the cracks” of the established service delivery system. • <i>Difficulty retaining clients with complex circumstances (e.g., mental health issues or homelessness).</i> These clients may have difficulty completing the group sessions or addressing their ICP goals without ongoing peer support.
Strategies employed to address these concerns
<ul style="list-style-type: none"> • <i>Mandatory training for all BIH staff</i> to ensure clarity (a) about the rationale and potential benefits of the updated BIH Program model for pregnant and postpartum African American women and (b) about the importance of recruiting women who are able and willing to participate in all aspects of the updated model. • <i>Keeping referral sources informed and educating providers</i> about the BIH Program and activities of the updated model, and developing a good rapport with contact people at these organizations; participating in health fairs, holding open houses and attending provider meetings. • <i>Strengthening and formalizing relationships</i> with WIC, hospitals, and providers—entities that local BIH Programs rely upon for client referrals. • <i>Hosting a program orientation session</i> with new clients before the group-based intervention begins, to help them understand the program goals and activities. • <i>Hosting activities such as classes or workshops</i> during the intervals between the group series (e.g., infant massage classes, a series of 4 weekly financial education sessions, and weekly drop-in groups). • <i>Providing a space for clients</i> to keep meeting as a group after the ‘core’ group sessions had concluded. • <i>Promoting word of mouth</i> about the program as an effective method of client recruitment and referral into BIH. • <i>Following up with clients between group sessions</i>, particularly with clients who missed sessions—some LHJs had staff contact clients routinely by phone or email, and in some cases clients themselves organized ways to ‘check-in’ with fellow group members.

Program service delivery
Challenges and concerns encountered during the pilot implementation
<ul style="list-style-type: none"> • <i>Lag times between client enrollment and group participation.</i> Due to the limited staff availability and time constraints affecting the scheduling of client services, many clients may complete enrollment and then need to wait for weeks or even months before the next group series begins. • <i>Program length and time commitment.</i> Some women found it difficult initially to commit to 20 weeks of group sessions. A subset of clients began the group but could not continue to attend due to scheduling conflicts with school and work or finding childcare. • <i>Difficulty with group curriculum delivery.</i> LHJs shared that some activities did not appeal to clients and sometimes there was too much information to cover within a session. • <i>Provision of services beyond those included in the ‘core’ program model.</i> This concern—which has clear implications for model fidelity—arose as CDPH/MCAH received feedback from the Group 1 LHJs during capacity-building calls and written reports. • <i>Lack of coordination between group-based and individual services.</i> While in part this reflected a lack of explicit guidance about integrating and reinforcing shared key themes in the group curriculum and ICP, this was exacerbated in some sites where staff roles were defined in ways that discouraged working as a client-centered team.
Strategies employed to address these concerns
<ul style="list-style-type: none"> • <i>Keeping clients engaged</i> before they have the opportunity to participate in group via enhanced case management (specifically the ICP). • <i>Taking steps to better accommodate clients’ needs/preferences/schedules</i>—e.g., by trying later start times (“after work hours”) for group sessions, identifying locations for group sessions near transportation, providing transportation either directly or with bus/taxi vouchers, and providing childcare on site. • <i>Revising the curriculum</i> to ensure content continues to be relevant and up to date. CDPH/MCAH reconvened the Group Intervention Subcommittee to review findings from the Group Facilitator Feedback Forms and recommend content changes in the current curriculum; a revised version will replace the current version at some point in 2012. • <i>Documentation of client services</i> to ensure model fidelity. CDPH/MCAH scheduled calls with each individual LHJ to discuss the full range of client services it provides to BIH clients; all LHJs are currently required to provide comprehensive documentation of additional services outside the core model by using the referrals form in the client Data Book. • <i>Adapting the mandatory training and redefining staff roles.</i> As the importance of staff coordination become evident, CDPH/MCAH shifted from separate but overlapping trainings for FHAs and group facilitators to a single 3-day mandatory training session for all BIH staff; whenever possible, local MCAH Directors and others with responsibility for BIH (e.g., First 5 funders) were invited to participate in the trainings as well. At the LHJ level, staff members at several LHJs have assumed both the FHA and group facilitator roles, in effect improving the connection between the individual and group-based services; many LHJs schedule monthly case-conferencing or regular staff meetings as strategies for improving this connection and team-building. • <i>Clarifying protocols</i> in response to questions and concerns raised by staff about client-related procedures from recruitment through case closure. Building on reported experiences during the pilot implementation, the Evaluation Team created an updated protocol document for BIH staff that includes guidance about key decision points during client case management.

Staffing
Challenges and concerns encountered during the pilot implementation
<ul style="list-style-type: none"> • <i>Staff feeling inadequately prepared to handle difficult client circumstances</i>—e.g., mental health issues, domestic violence, sexual abuse, substance abuse. • <i>Lack of clarity about staff roles and responsibilities</i>, including: the extent to which FHA and group facilitator roles could (and should) overlap; the roles of public health nurses and mental health professionals in providing core vs. ‘non-core’ services to BIH clients. • <i>Lack of coordination among staff members</i> with respect to roles and responsibilities. • <i>Insufficient time</i> for completing the full range of staff activities—e.g., some LHJs reported difficulty maintaining recruitment activities while running the prenatal and postpartum group series. Others reported that staff were ‘exhausted’ after completing a full group series and that finding sufficient restorative down-time was challenging. • <i>Unmet staffing needs</i> at some LHJs—e.g., limited access to licensed mental health professionals, social workers and nurses for case-conferencing and referral to serve medically high-risk clients.
Strategies employed to address these concerns
<ul style="list-style-type: none"> • <i>Problem-solving</i> with staff across Group 1 LHJs. Staff from Group 1 LHJs shared their experiences (both challenges and successes) with others during monthly staff capacity-building calls, as documented in call summaries that were subsequently circulated; CDPH/MCAH collected, summarized and distributed similar information as part of the mandatory quarterly reporting process. While CDPH/MCAH develops plans for further training, staff were encouraged to contact CDPH/MCAH staff for guidance and efforts were made to respond to all such requests in a timely and constructive way. • <i>Expanding the scope of mandatory trainings</i>. As noted above, CDPH/MCAH moved from holding separate trainings for group facilitators and FHAs to a single 3-day training for all BIH staff and funders. • <i>Reorganizing activity schedules</i>. Some LHJs scheduled their group series with an interim period of several weeks to allow for staff preparation, planning and recruitment activities; this strategy appeared to be particularly useful at LHJs with smaller staffs, also helping address the need for adequate ‘down-time.’ • <i>Developing team-building activities</i>, including regular staff meetings, staff retreats, shared responsibility for clients and activities. • <i>Exploring alternate staffing approaches</i>, i.e., finding ways to more effectively structure staff to fill necessary roles and utilize LHJ staff expertise (e.g., using public health nurses on-staff), identifying agencies that can provide counseling on issues not covered in the curriculum and using student interns from local graduate programs to cover gaps in staffing.

Resources and funding
Challenges and concerns encountered during the pilot implementation
<ul style="list-style-type: none"> • <i>Difficulty with securing a sustainable stream of enablers</i>, including adequate facilities, transportation, childcare, food and program participation incentives to promote client recruitment and retention. While most Group 1 LHJs were successful in securing at least some of these enablers during the pilot implementation year, all reported challenges to doing so on an ongoing basis. • <i>Lack of community resources for needed referrals</i>. Many LHJs reported that their work with clients on ICPs was limited by the lack of available local resources that could provide practical help with meeting clients' housing, food assistance, childcare services mental health and other needs. • <i>Difficulty with securing additional staff resources</i> such as bringing additional staff and interns on board. • <i>Challenges related to external funding requirements</i> that require services other than those included in the core BIH Program model. The Group 1 LHJs varied with respect to both the extent of external funding and the degree to which external funders required them to provide non-core services to women enrolled in the BIH Program. In many cases, CDPH/MCAH only became fully aware of these differences (which have clear implications for model fidelity) during the pilot implementation period.
Strategies employed to address these concerns
<ul style="list-style-type: none"> • <i>Expanding collaborations with CBOs</i> to gain access to appropriate meeting space for group sessions and to recruit volunteers and interns (nursing and mental health) when funding for additional staff was not available. • <i>Collaborating with other organizations to obtain funding</i> (e.g., submitting joint grants that would provide support for shared resources). • <i>Inviting the community</i> and outside organizations to support graduation celebrations (e.g., partnering with a local church to host graduation celebrations, family/friends are invited to the celebration). • <i>Informing other programs and providers</i> through BIH LHJ-hosted events about health disparities in the African American community and the intended role of the updated BIH Program model in addressing those disparities by helping clients and their families live healthier lives. • <i>Taking steps to better document differences in external funding sources across LHJs</i> to ensure more systematic assessment of relevant information about available resources and related requirements. CPDH/MCAH required additional information from the LHJs in their regular written reports and held a follow-up conference call with each LHJ. • <i>Distinguishing clients who are receiving additional services</i> (by indicating funding that required the service) for the purposes of future program evaluation and provide guidance about what types of activities are appropriate within the scope of the core model. • <i>Including representatives from external funding sources</i> (e.g., First 5) in staff trainings, to increase their understanding and endorsement of the updated program model.

Data collection and reporting
Challenges and concerns encountered during the pilot implementation
<ul style="list-style-type: none"> • <i>Lack of clarity about specific data forms/items.</i> LHJ staff expressed concerns about aspects of data collection (e.g., asking clients for similar information over a series of assessments). • <i>Lack of information for use at the site level.</i> Delays in implementing the new electronic CDPH/MCAH MIS contributed to an inability to produce standardized reports to provide staff with feedback and information for funding partners. • <i>Differences in data quality across LHJs.</i> Although the trainings and FHA calls attempted to promote data quality across the LHJs, the lack of an electronic data system made it difficult to systematically assess data quality and provide feedback to promote quality assurance.
Strategies employed to address these concerns
<ul style="list-style-type: none"> • <i>Providing ongoing training in data collection procedures.</i> In addition to data collection guidance included in the mandatory staff training, CDPH/MCAH staff addressed BIH staff concerns by providing additional direction about the rationale for and use of the new Data Book forms on the monthly FHA capacity-building calls and during a workshop at the annual statewide meeting. • <i>Improvising tracking systems.</i> With the electronic data management system still under development, many local BIH Programs improvised manual systems for tracking client data or systems based on Microsoft Excel software. One program also incorporated BIH forms into a local electronic charting and information system. • <i>Monitoring data quality.</i> Based on review of the submitted data forms, CDPH/MCAH provided each LHJ with written feedback focused on areas needing improvement and with follow-up discussion during the individual site calls. • <i>Revising the Data Book.</i> The Data and Evaluation Subcommittee (including FHAs from all Group 1 LHJs) was reconvened late in the pilot implementation period to review and recommend content and format changes in every current data form. Building on this work, the Evaluation Team developed a revised version of the Data Book that will eventually replace the current version.

IV. Next Steps: Planned Actions to Address Identified Program Needs

Based on findings from the pilot implementation period, CDPH/MCAH has identified ongoing needs and planned actions to address those needs going forward focusing on four areas: program content, program delivery, data collection and reporting, and promotion of the updated program model. In all these efforts, CDPH/MCAH will continue to emphasize *the importance of maintaining fidelity to the updated BIH Program model* as BIH Program staff at 14 of the 15 LHJs continue with the next phase of updated model implementation.

AREA OF FOCUS	IDENTIFIED NEEDS	PLANNED ACTIONS
<p>1. PROGRAM CONTENT: Update the BIH Program model based on lessons learned during the pilot implementation.</p>	<ul style="list-style-type: none"> • To update model materials such as the facilitators' guide and PowerPoint, participants' handbook, and case management forms like the ICP and Life Plan to include more effective integration of these components to meet clients' needs and interests. • To begin the process of expanding the current model to address the broader social conditions in the community that contributes to health disparities affecting African American women, infants and families. 	<ul style="list-style-type: none"> • Incorporate recommended changes to the group-based curricula and guidance for case management, with subsequent review by the BIH Workgroup. • Conduct a needs assessment and systematic planning process to initiate the development and expansion of the community components of the updated model.
<p>2. PROGRAM DELIVERY: Provide BIH staff with ongoing guidance for delivering standardized services to their clients.</p>	<ul style="list-style-type: none"> • To update protocols for group intervention and enhanced case management, balancing the needs for LHJs to respond appropriately to individual clients' needs and priorities while maintaining fidelity to a single core model. • To ensure more effective integration of group-based and individual client services. • To ensure adequate staffing and lead workforce development efforts. • To clarify appropriate methods of outreach that highlight current program services. 	<ul style="list-style-type: none"> • Update the Policies and Procedures and Program Standards related to: <ul style="list-style-type: none"> ○ <i>Client recruitment</i>, including suggestions for keeping referral sources informed and strategies for implementing word-of-mouth recruiting. ○ <i>Program interventions</i>, including redirecting women whose needs cannot be best met within BIH and adjusting group schedules to accommodate women who work or go to school. ○ <i>Staffing</i>, including specific staff qualifications and recommended coordination of roles among staff. ○ <i>Integration of services</i>, including more systematic links between group-based and individual client services. • Focus on staff training and development: <ul style="list-style-type: none"> ○ Providing <i>additional staff trainings</i>, including an advanced training for current staff. ○ Expanding training on data collection.

AREA OF FOCUS	IDENTIFIED NEEDS	PLANNED ACTIONS
	<ul style="list-style-type: none"> • To develop strategies for securing adequate resources for effective delivery of the program, including (location and timing of groups, childcare, food, transportation, and incentives). 	<ul style="list-style-type: none"> ○ Developing trainings focused on specific issues. ○ Creating a catalog of brief intersession workshops that support the 'core' BIH Program model. ○ Exploring state-level approaches for securing adequate program resources across LHJs. • Monitor progress and provide structured guidance on delivery of program services through individual calls with each LHJ and site visits (pending approval of state travel).
<p>3. DATA COLLECTION AND REPORTING: Continue to develop expectations and procedures for uniformly high data completeness and quality across LHJs.</p>	<ul style="list-style-type: none"> • To provide regular feedback on data completeness and quality. • To provide detailed and comprehensive training support on the Data Book forms and the new CDPH/MCAH MIS. • To transition from collection of data on paper forms to the new CDPH/MCAH MIS. • To update the Data Book forms based on feedback from the Data & Evaluation Subcommittee. 	<ul style="list-style-type: none"> • Update the Policies and Procedures manual to provide guidance on chart auditing and data quality assurance. • Continue with full implementation of the MCAH MIS: <ul style="list-style-type: none"> ○ Conducting staff trainings on use of the MCAH MIS. ○ Creating data entry plans and procedures for entering the backlog of paper Data Book forms. ○ Providing site specific information on client demographics and caseload. ○ Adapting the CDPH/MCAH MIS (in future releases) to correspond with the revised Data Book. ○ Adapting the CDPH/MCAH MIS (in future releases) to include case management features and advanced query capabilities. ○ Developing reports and processes to support ongoing QA/QI (e.g., with respect to client recruitment and retention).
<p>4. PROMOTING THE UPDATED BIH PROGRAM MODEL: Develop effective and standardized targeted messaging for a range of audiences</p>	<ul style="list-style-type: none"> • To develop targeted messages for potential and current clients about the value of program participation. • To develop specific language for communicating with referral sources about the updated BIH Program model. • To develop targeted messages that can be used by BIH staff when talking with individuals and organizations in the community. 	<ul style="list-style-type: none"> • Initiate more effective communication about the updated BIH Program model: <ul style="list-style-type: none"> ○ Engaging the BIH Workgroup to develop clearer and more effective statements of the mission, vision and goals reflected in the updated model. ○ Collecting existing marketing materials from across LHJs to be shared program-wide. ○ Conducting focus groups with clients to develop 'word-of-mouth' messaging. ○ Developing a core set of standard templates to be used in all LHJs statewide.

V. Summary and Recommendations

Data collected about the implementation process during the Phase 1 pilot implementation year indicate that the BIH Program is moving in a very promising direction:

- The updated model has been successfully implemented at all eight of the pilot LHJs, despite challenges related to making the transition within the context of an existing program characterized by variation across LHJs in prior service models, leadership and management styles, staffing configurations, client demographics, referral patterns funding sources and levels of community support. Several key aspects of the implementation process contributed to its overall success, including structured staff training that highlighted foundational theories supporting the updated model, establishing frequent and regular communication to address challenges as they arose, and strengthening staff capacity and team-building.
- Despite expected declines in caseload during the transition period, more than 700 clients were enrolled in the updated model during the pilot period and these clients appeared to be demographically similar to prior clients at the pilot LHJs. It is also important to note that:
 - Across LHJs, clients who participated in the updated model received a more standardized and *enhanced* set of core BIH services.
 - For BIH staff at the pilot LHJs, providing clients with both group-based and case-management services is particularly time- and labor-intensive.
- Staff are now on board with the updated model; most have embraced it with tremendous enthusiasm because they see how it appears to benefit their clients and themselves:
 - Clients are experiencing decreased isolation and increased social support; they and their families are gaining health-related knowledge and making changes based on what they have learned; and they are empowered as they learn to identify their strengths, to become better self-advocates, and to set and meet goals.
 - BIH staff are learning new professional and personal competencies as they participate in mandatory trainings, capacity-building activities with other staff, and what for many is a new approach to providing services to their clients.
 - In addition, LHJs are taking important steps in the ongoing process of strengthening community partnerships and building community support for BIH.

FINAL RECOMMENDATION: CDPH/MCAH should continue with implementation of the updated BIH Program model at all BIH local health jurisdictions statewide. Future implementation efforts should apply knowledge gained during the first implementation year to four key program domains: program content, program delivery, data collection and reporting, and promoting the updated BIH program model. Reinforcing its commitment to ongoing quality improvement, CDPH/MCAH will continue to monitor BIH Program needs and to assess the impacts of program activities and modifications.

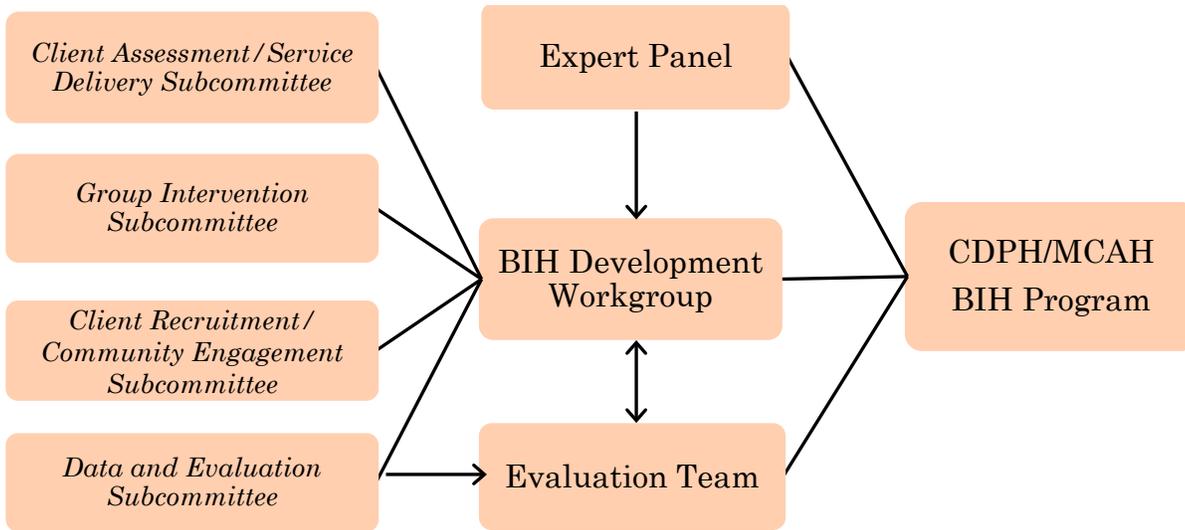
Appendix A.

As described in the text and organizational chart below, several workgroups, subcommittees, and advisory panels were convened to help inform CDPH/MCAH on aspects of BIH Program development, implementation, and evaluation.

Description of BIH Program Subcommittees, Workgroups, and Advisory Panels:

- *CDPH/MCAH BIH Program staff* manages and makes decisions regarding development, implementation, and evaluation of an empowerment-focused, client-centered intervention.
- The *Evaluation Team*, made up of UCSF/CSDH staff and CDPH/MCAH BIH Program and evaluation staff, provides scientific guidance and oversight for the design and implementation of the updated model BIH Program and will plan and conduct the evaluation.
- *Expert Panel*, made up of experts in the field of maternal and infant health outside of the BIH Program, provides feedback and recommendations about the revised BIH Program. Members include:
 - Carol Brady, Executive Director of Northeast Florida Healthy Start Coalition, Inc.
 - Mario Drummonds, Executive Director of Northern Manhattan Perinatal Partnership
 - Vijaya Hogan, Clinical Associate Professor at the University of North Carolina Gillings School for Global Public Health
 - Milton Kotelchuck, Senior Scientist in Maternal and Child Health at Massachusetts General Hospital
- *BIH Development Workgroup (the “BIH Workgroup”)*, made up of selected local BIH Coordinators and MCAH Directors who have specific expertise and experience to provide ongoing community perspectives, advice and recommendations regarding the planning and development of the revised BIH Program.
- A series of subcommittees, each comprising staff from CDPH/MCAH, UCSF/CSDH, and the local BIH LHJs, was convened to develop specific aspects of the program:
 - *Client Assessment/Service Delivery Subcommittee* to develop the assessment protocol and define the individual services provided in the revised model.
 - *Group Intervention Subcommittee* to develop a standardized group intervention that can be employed by all LHJs.
 - *Client Recruitment/Community Engagement Subcommittee* to develop the client recruitment protocol and strategize efforts for community engagement.
 - *Data and Evaluation Subcommittee* to focus on standardized data collection for both administrative purposes and for the evaluation to assess program effectiveness.

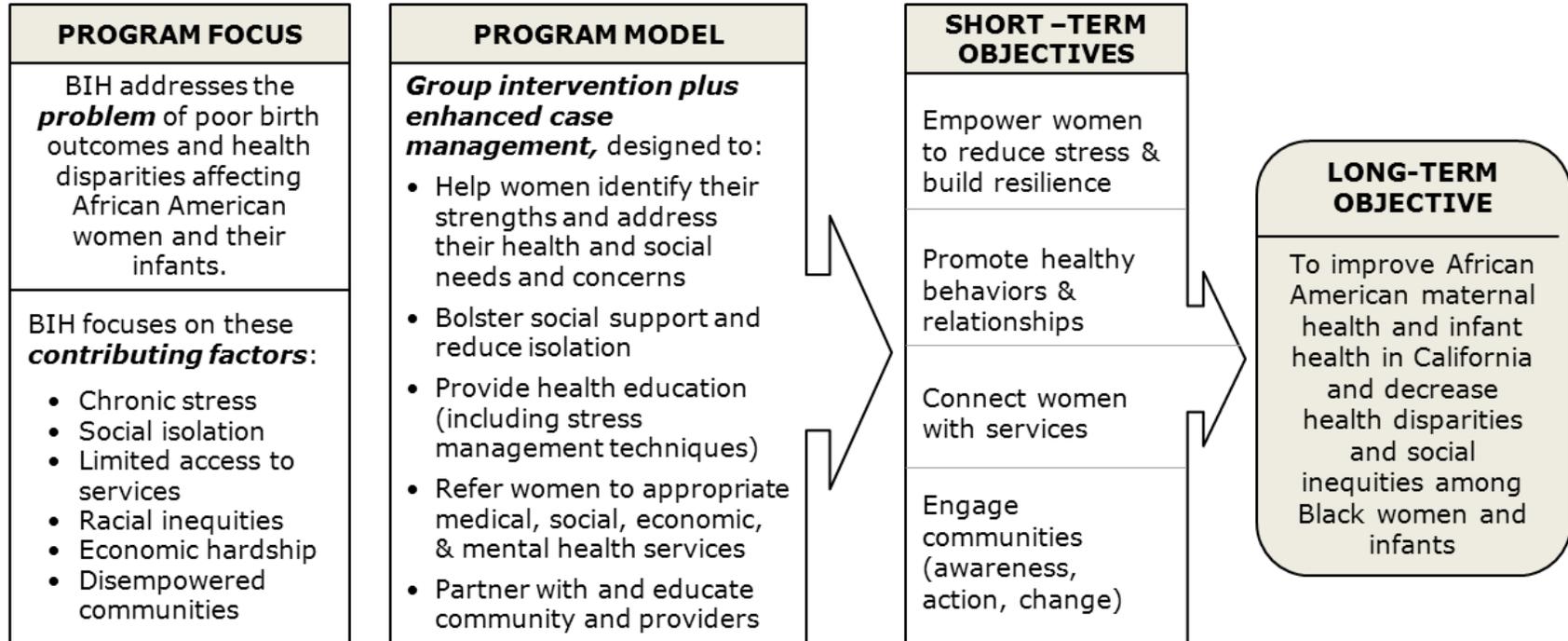
BIH Program Development Organizational Chart





The Black Infant Health Program (BIH)

Transforming African American women & their communities to improve health

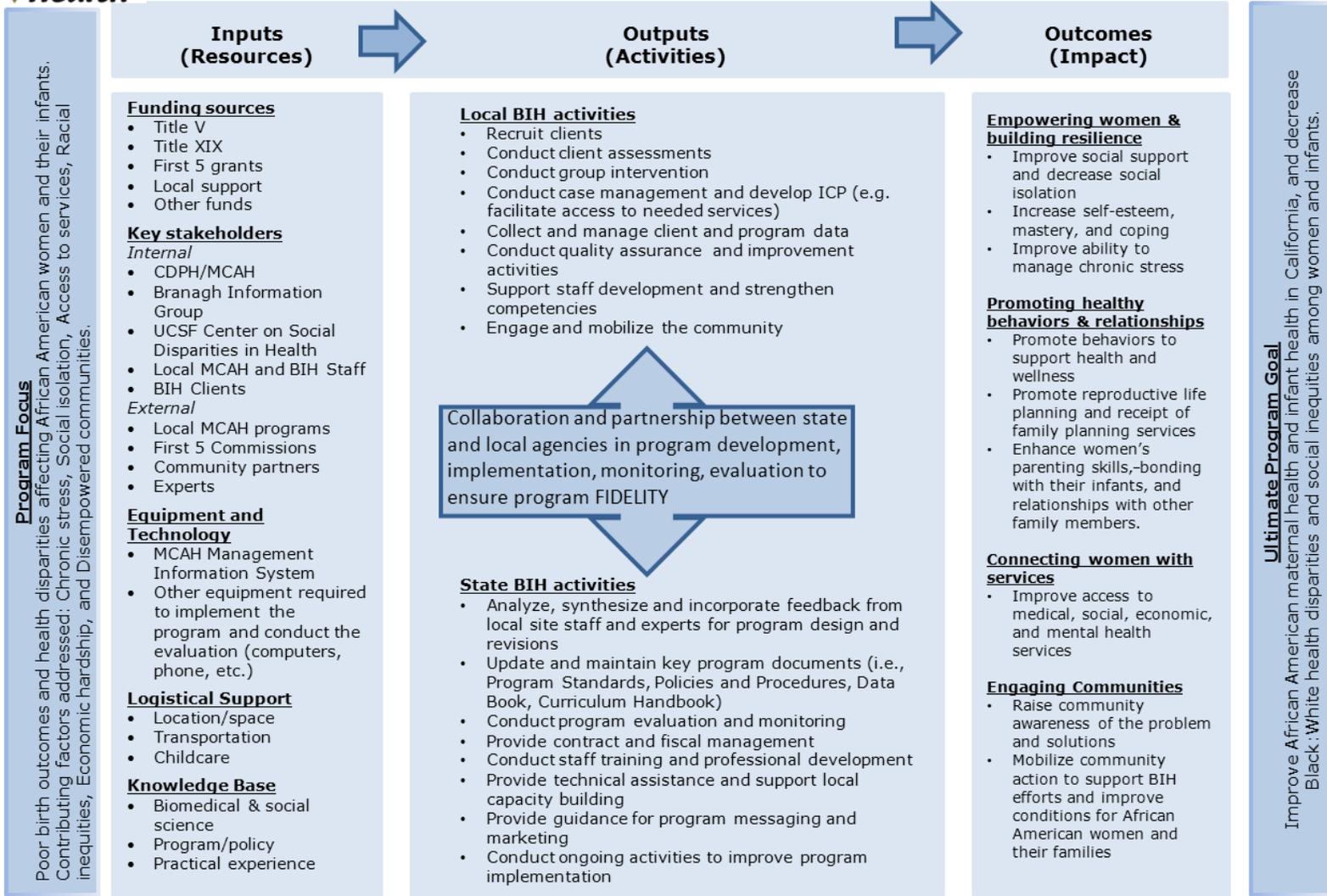


- GOVERNING CONCEPTS**
- 1. Cultural competence:** Providing culturally relevant information that is important to African American women and honors the unique history and traditions of people of African descent.
 - 2. Client-centered:** Placing the client’s own needs, values, priorities and goals at the core of every interaction and activity, recognizing that people have an inherent tendency to strive toward growth.
 - 3. Strength-based:** Building on each client’s strengths to enrich her, her family and her community by empowering her to make healthy decisions.
 - 4. Cognitive skill-building:** Encouraging the client to think differently about her behaviors and to act on what she has learned, recognizing that problem solving is a goal-oriented process.



Logic Model

Transforming African American women and their communities to improve health



Program Focus

Poor birth outcomes and health disparities affecting African American women and their infants. Contributing factors addressed: Chronic stress, Social isolation, Access to services, Racial inequities, Economic hardship, and Disempowered communities.

Inputs (Resources)

Funding sources

- Title V
- Title XIX
- First 5 grants
- Local support
- Other funds

Key stakeholders

Internal

- CDPH/MCAH
- Branagh Information Group
- UCSF Center on Social Disparities in Health
- Local MCAH and BIH Staff
- BIH Clients

External

- Local MCAH programs
- First 5 Commissions
- Community partners
- Experts

Equipment and Technology

- MCAH Management Information System
- Other equipment required to implement the program and conduct the evaluation (computers, phone, etc.)

Logistical Support

- Location/space
- Transportation
- Childcare

Knowledge Base

- Biomedical & social science
- Program/policy
- Practical experience

Outputs (Activities)

Local BIH activities

- Recruit clients
- Conduct client assessments
- Conduct group intervention
- Conduct case management and develop ICP (e.g. facilitate access to needed services)
- Collect and manage client and program data
- Conduct quality assurance and improvement activities
- Support staff development and strengthen competencies
- Engage and mobilize the community

Collaboration and partnership between state and local agencies in program development, implementation, monitoring, evaluation to ensure program FIDELITY

State BIH activities

- Analyze, synthesize and incorporate feedback from local site staff and experts for program design and revisions
- Update and maintain key program documents (i.e., Program Standards, Policies and Procedures, Data Book, Curriculum Handbook)
- Conduct program evaluation and monitoring
- Provide contract and fiscal management
- Conduct staff training and professional development
- Provide technical assistance and support local capacity building
- Provide guidance for program messaging and marketing
- Conduct ongoing activities to improve program implementation

Outcomes (Impact)

Empowering women & building resilience

- Improve social support and decrease social isolation
- Increase self-esteem, mastery, and coping
- Improve ability to manage chronic stress

Promoting healthy behaviors & relationships

- Promote behaviors to support health and wellness
- Promote reproductive life planning and receipt of family planning services
- Enhance women's parenting skills, bonding with their infants, and relationships with other family members.

Connecting women with services

- Improve access to medical, social, economic, and mental health services

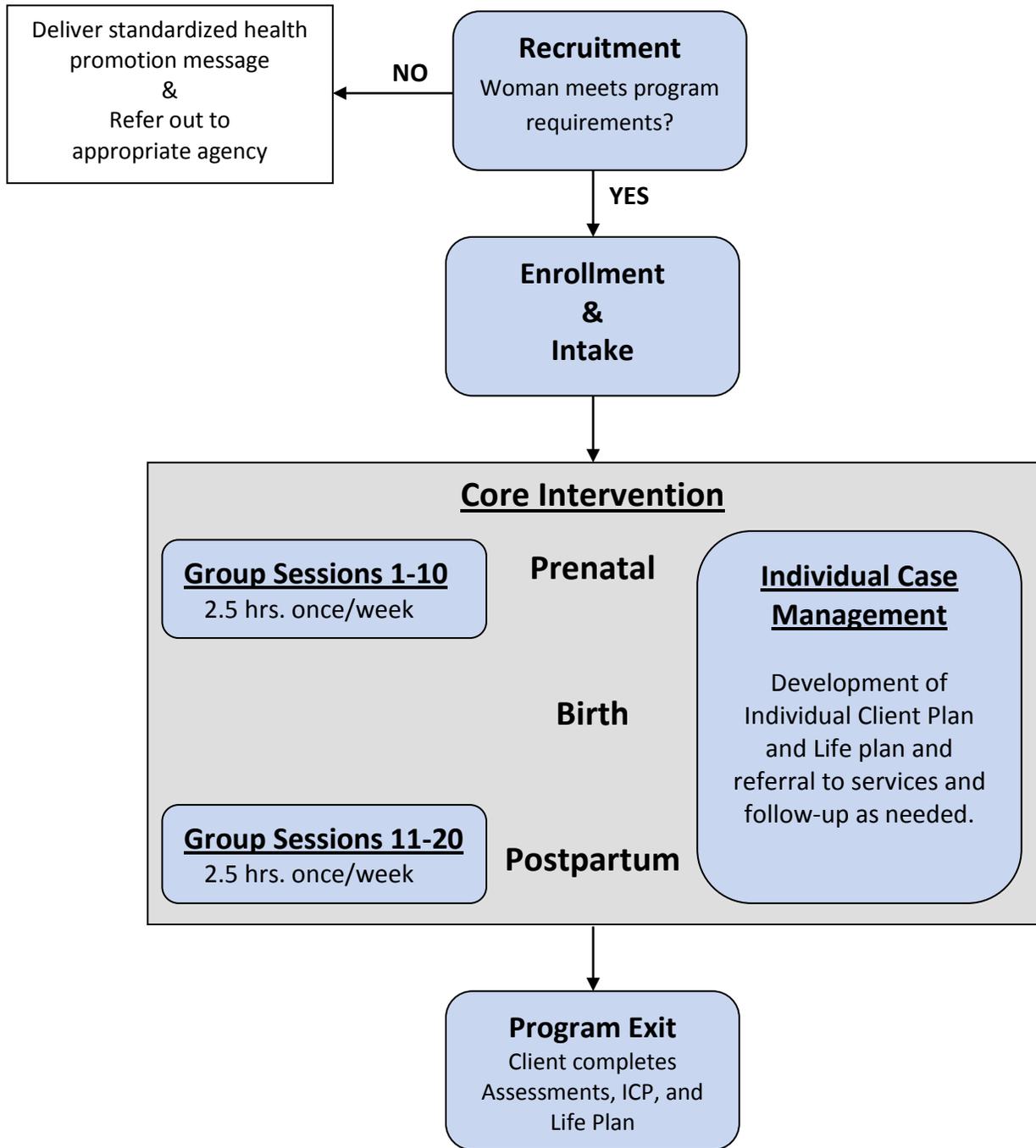
Engaging Communities

- Raise community awareness of the problem and solutions
- Mobilize community action to support BIH efforts and improve conditions for African American women and their families

Ultimate Program Goal

Improve African American maternal health and infant health in California, and decrease Black-White health disparities and social inequities among women and infants.

Appendix D. Updated Model Client Flow Chart



Appendix E. Analytic Strategy and Methods for Pilot Implementation Evaluation Report

Based on both qualitative and quantitative information collected over the pilot year, the Phase 1 evaluation focused on describing and interpreting the challenges and successes encountered during the *process* of implementing the updated program model at the eight Group 1 sites and at the statewide program level. The goal was to guide modifications to program procedures and standards, and promote model fidelity as additional LHJs begin to implement the updated model. As the CDPH/MCAH MIS comes online and more data are available for relevant analyses on an ongoing basis, subsequent evaluation reports will include additional findings on program impact.

Qualitative data. CDPH/MCAH has collected qualitative data from Group 1 BIH staff and clients about the trainings and use of the new curriculum and updated program model. The primary sources of qualitative data for this pilot implementation evaluation report were:

- LHJ quarterly and annual reports. Following templates specified by CDPH/MCAH, each Group 1 LHJ was required to submit 3 quarterly reports during the pilot implementation period, along with its FY 2010/2011 Annual Report.
- Notes and summaries of discussions during telephone conference calls. In addition to regularly-scheduled conference calls of the BIH Workgroup and previously established subcommittees, CDPH/MCAH initiated a new series of regular monthly capacity-building calls. These calls were scheduled for BIH Coordinators, for FHAs, and for Group Facilitators as a forum for sharing their own experiences with the updated model, and for discussing and resolving program issues. The Evaluation Team also conducted additional site-specific conference calls with staff at each of the eight Group 1 BIH LHJs from in June 2011; each of these calls included the LHJ's BIH Coordinator and either the MCAH Director or another local staff person. Prior to these calls, information was requested from each LHJ to guide a discussion of the following items: (1) three successes and three challenges related to recruitment of BIH participants; (2) any First 5 funding received and non-core activities occurring as a result of outside funding; (3) clarification of enrollment and recruitment information previously collected by CDPH/MCAH on the Quarterly Progress Report; and (4) any additional services being provided to clients beyond the scope of core BIH Program activities. Each call ended with an open discussion of concerns, questions, or comments from BIH staff about implementing the updated BIH model.
- Staff training evaluations. General staff satisfaction with the updated program model trainings was measured using a survey of attendees. Surveys were distributed to participants at the conclusion of each training session.
- Staff survey. Using the online survey software SurveyMonkey, a brief 3-question survey of Group 1 BIH staff was conducted in December 2011. The survey covered a few key questions to gather BIH staff opinions on how involvement with the updated model affected themselves and their clients.

Quantitative data. While the new CDPH/MCAH MIS has not yet been available for routine data entry by BIH staff, a subset of quantitative data collected on hard-copy versions of the new Data Book was submitted to CDPH/MCAH in April 2011 and December 2011 and provides the basis for preliminary findings related to client caseload and demographics.