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Black Infant Health Scope of Work

The Agency agrees to provide to the Department of Public Health the services in this Scope of Work (SOW). The California Department of Public Health Maternal, Child and Adolescent Health (MCAH) Division places a high priority on the poor outcomes that disproportionately impact the African American community in California. Central to the efforts in reducing these disparities is the Black Infant Health (BIH) Program. The goal of the BIH Program is to improve African American infant and maternal health and decrease Black-White health disparities and social inequities for women and infants. To achieve this goal, the BIH Program is a client-centered, strength-based group intervention with complementary case management that embraces the lifecourse perspective and promotes skill building, stress reduction and life goal setting. Each BIH Site shall also assure program fidelity and collect and enter client and program data into the electronic MCAH-BIH-MIS.

Development of this SOW was also guided by the three core public health functions of assessment, policy development, and assurance, and the following public health frameworks:

- The 10 Essential Services of Public Health <http://www.cdc.gov/nphpsp/essentialServices.html>
- The Spectrum of Prevention http://www.preventioninstitute.org/index.php?option=com_jlibrary&view=article&id=105&Itemid=127
- Life Course Perspective <http://mchb.hrsa.gov/lifecourseresources.htm>
- The Socioecological Model http://www.cdc.gov/ncipc/dvp/social-ecological-model_dvp.htm
- Social Determinants of Health <http://www.cdc.gov/socialdeterminants/>

All BIH Sites are required to comply with the [BIH Policy and Procedure \(P&P\) Manual](#) and the [MCAH Fiscal Policies and Procedures Manual](#). In addition, all BIH Sites shall work toward meeting the BIH Program Standards and to maximize fidelity in implementing Program services. All activities in this Scope of Work shall take place within the fiscal year.

Under the Measures (Process and Outcome) cells below, there are Source Keys that are designed to provide a reference for reporting purposes. The “M” Source Key refers to information that is based on data included in the MCAH-BIH-MIS and can be generated through standard reports and “analyzer” function in the MCAH-BIH-MIS. The “N” Source Key refers to narrative information.

Goal 1: Increase the ability of African American women to manage chronic stress.

Outcome Objective(s)	Intervention Activities to Meet Objectives	Evaluation/Performance Measures Measures to be Reported in the Annual Report, semi-annually or quarterly where indicated)	
		Process Measures	Outcome Measures
1.1 Increase social support and decrease social isolation among women in the BIH Program.	1.1 <ul style="list-style-type: none"> Implement the prenatal and postpartum group intervention with fidelity to the P&P and Program Standards. Encourage clients to attend and participate in group sessions. Support clients in fostering healthy interpersonal and familial relationships. 	1.1 <ul style="list-style-type: none"> Provide FY 12-13 group intervention schedules.(N) Describe decision-making process used to determine group intervention timing and frequency. (N) Complete a group facilitator feedback form, including description of women’s engagement in group activities, for each group session. (N) Number and percent of enrolled clients who participate in group intervention. (M) 	1.1 <ul style="list-style-type: none"> Number and percent of clients who report an increase in having someone to talk to regularly. (M) Number and percent of clients who report an increase in practical help. (M) Number and percent of clients who report receiving emotional support from the father of the baby. (M) Number and percent of clients who report receiving financial support from the father of the baby/partner. (M) Provide anecdotes/client stories of increases in social support. (N) Provide anecdotes/client stories of decreases in social isolation. (N)

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1.2 Increase self-esteem, mastery, coping and resiliency by empowering women in the BIH Program.	1.2 All activities are delivered with an understanding of African American culture and history. <ul style="list-style-type: none"> • Assist clients in identifying and utilizing their personal strengths. • Develop and implement an Individual Client Plan (ICP) with each client. • Teach and provide support to clients as they develop goal-setting skills and create their Life Plans. • Teach clients about the importance of stress reduction and guide them in applying stress reduction techniques. • Support clients as they become empowered to take actions toward meeting their needs. • Teach clients how to express their feelings in constructive ways. • Help clients to understand societal influences and their impact on African American health and wellness. • 	1.2 <ul style="list-style-type: none"> • Number and percent of clients who complete a Life Plan.(M) • Number and percent of clients who complete ICP. (M) 	1.2.1 <ul style="list-style-type: none"> • Number and percent of clients who have increased self-esteem based on responses to the Rosenberg Self-Esteem Scale. (M) • Number and percent of clients who have increased mastery based on responses to the Pearlin Mastery Scale. (M) • Number and percent of clients who have increased coping and resiliency based on responses to the Brief Resilience Scale. (M) • Provide anecdotes/client stories about increases in coping/resiliency (N)

Goal 2: Improve the health of pregnant and parenting women, thus also promoting the health of their infants.

Outcome Objective(s)	Intervention Activities to Meet Objectives	Evaluation/Performance Measures Measures to be Reported in the Annual Report, semi-annually or quarterly when indicated	
		Process Measures	Outcome Measures
2.1 Promote behaviors (including obtaining needed health care and other services outside of BIH) to support health and wellness among women in the BIH Program.	<p>2.1</p> <ul style="list-style-type: none"> Assist clients in understanding behaviors that contribute to overall good health, including: <ol style="list-style-type: none"> Stress management Sexual health Nutrition Physical activity Ensure that clients are receiving prenatal care. Provide clients with health information that supports a healthy pregnancy. Ensure that clients have access to health insurance. Identify clients' health and social needs and provide referrals and follow-up as needed to health and community services. Provide information and health counseling to clients who report drug, alcohol and/or tobacco use. Help clients complete their birth plans 	<p>2.1</p> <ul style="list-style-type: none"> List and describe additional activities (e.g., Champions for Change cooking demonstrations) conducted that promote health and wellness of BIH clients.(N) Number and percent of clients reporting drug, alcohol and/or tobacco use who are provided information and health counseling. (M) Number and percent of prenatal clients who complete a birth plan. (M) Number and percent of clients receiving prenatal care, by trimester of initiation (M) Describe barriers, challenges, and solutions to linkages to WIC. Number and percent of previously uninsured clients who obtained needed health insurance while enrolled in BIH. (M) Number and percent of prenatal clients who complete a birth plan. (M) 	<p>2.1</p> <ul style="list-style-type: none"> Number and percent of clients whose health status improves over the course of their participation in BIH. (M) Number and percent of clients and infants who obtained needed health and community services while enrolled in BIH. (M) Number and percent of clients whose healthy eating behaviors improve over the course of their participation in BIH. (M) Number and percent of clients whose physical activity increased over the course of their participation in BIH. (M) Provide anecdotes/client stories about improved health and wellness. (N)
2.2 Promote reproductive life planning and access to family planning services.	<p>2.2</p> <ul style="list-style-type: none"> Promote and support family planning by providing information and counseling. Promote and support 	<p>2.2</p> <ul style="list-style-type: none"> Number and percent of clients who complete a Life Plan. (M) 	<p>2.2</p> <ul style="list-style-type: none"> Number and percent of clients who attend a timely postpartum checkup. (M) Number and percent of clients

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	<p>interconception health.</p> <ul style="list-style-type: none"> • Help clients understand and value the concept of reproductive life planning as they complete their Life Plans. • Help clients understand the characteristics of healthy relationships and provide resources that can help clients deal with abuse, reproductive coercion or birth control sabotage. • Provide referrals and promote linkages to family planning providers including FPACT. 		<p>who use any method of birth control to prevent pregnancy after their babies are born. (M)</p> <ul style="list-style-type: none"> • Provide anecdotes/client stories about improved planning for future pregnancies. (N)
2.3 Improve the mental health of women in the BIH Program.	<p>2.3</p> <ul style="list-style-type: none"> • Help clients understand how mental health contributes to overall health and wellness. • Help clients recognize the connection between stress and mental health and practice stress reduction techniques. • Help clients understand the connection between physical activity and mental health. • Administer the Edinburgh Postpartum Depression Screen (EPDS) to every client 6-8 weeks after she gives birth. • Help clients understand the symptoms of postpartum depression. • Provide referrals and follow-up to mental health services when appropriate. 	<p>2.3</p> <ul style="list-style-type: none"> • Describe successes and challenges in addressing mental health issues, including mental health referrals. (N) • Number and percent of clients who completed the EPDS 6-8 weeks postpartum. (M) 	<p>2.3</p> <ul style="list-style-type: none"> • Number and percent of clients who are less likely to report feeling sad, empty or depressed after participating in BIH. (M) • Provide anecdotes/client stories about stress reduction related to improved mental health. (N) • Number and percent of clients with “positive” EPDS screens who are successfully referred to a community mental health provider. (M)

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2.4 Enhance women's parenting skills and bonding with their infants and other family members.	2.4 <ul style="list-style-type: none"> • Assist clients in understanding and applying effective parenting techniques. • Assist women with completing home safety checklist. • Assist women with increasing knowledge of infant safe sleep practices/sudden infant death syndrome (SIDS) risk reduction • Assist women with completing birth plan. • Assist clients with identifying and using bonding strategies, including breastfeeding, with their newborns. 	2.4 <ul style="list-style-type: none"> • List and describe additional activities that enhance parenting and bonding. (N) • Number and percent of clients who complete the safety checklist. (M) • List and describe additional activities on infant safe sleep practices/SIDS risk reduction. • Number and percent of prenatal clients who complete a birth plan. (M) 	2.4 <ul style="list-style-type: none"> • Provide anecdotes/client stories about improved parenting/bonding. (N) • Provide anecdotes/client stories about the infant safe sleep practices and SIDS risk reduction

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Goal 3: Engage the community to support African American families' health and well-being.

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3.1 Elevate community awareness of African American birth outcomes and the impact on society.	3.1 <ul style="list-style-type: none"> Educate the community about the BIH Program by delivering standardized messages about poorer birth outcomes among African American women and about how the BIH Program addresses these issues. Create partnerships with community agencies that support the broad goal of the BIH Program, through formal and informal agreements. 	3.1 <ul style="list-style-type: none"> Briefly describe community education activities or events. (N) List and describe formal and informal partnerships with community agencies. (N) Briefly describe community efforts such as advisory board involvement, community collaboration to address maternal and infant health disparities, or other similar formal or informal partnerships.(N) 	

Goal 4: Assure BIH Program fidelity in program implementation, data management, staff competency, and fiscal management.

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		Process Measures	Outcome Measures
<p>4.1 Maintain program fidelity by implementing the program as specified in the:</p> <ul style="list-style-type: none"> • BIH Policy & Procedure Manual • BIH Program Standards • BIH Group Curriculum • BIH Client Data Book • BIH SOW • MCAH Fiscal Policies & Procedures Manual 	<p>4.1 Maintain BIH Program fidelity by:</p> <ul style="list-style-type: none"> • Implementing the program activities as designed. • Developing and monitoring a local continuous quality improvement (CQI)* plan. • Developing and implementing a recruitment plan that is reviewed on a quarterly basis and updated as needed. • Conducting a standardized intake process. • Conducting case conferencing on all clients following intake and as needed. • Conducting enhanced case management services that align with the Individualized Client Plan. • Conducting and adhering to the 20-session (for clients who enroll prenatally) or 10-session (for clients who enroll postpartum) group intervention model as specified in the group. • Conducting case closure activities. • Regularly conducting client satisfaction surveys. • Developing a plan for community linkages and 	<p>4.1</p> <ul style="list-style-type: none"> • Report number of prenatal and postpartum clients served (caseload) in the revised model. (M/N) • Report number and percent of women included in outreach but do not enroll.(M) • Report number and percent of enrolled clients for whom the following actions are completed (M): <ul style="list-style-type: none"> ○ Intake procedures, including completion of an initial assessment. ○ Initial case conferencing. ○ ICP. ○ 7 of 10 Prenatal Group Sessions. ○ 7 of 10 Postpartum Group Sessions. ○ 4 of 6 assessments (prenatal clients) or 2 of 3 assessment (postpartum clients) ○ Case closure, including Life Plan, ICP, and Assessments. • Describe activities that link and integrate the group sessions with individual case management. (N) • Generate standard reports at least quarterly as a management tool to assess status and identify areas for 	<p>4.1</p> <ul style="list-style-type: none"> • Describe aspects of current program implementation that differ from the model guidelines including the BIH P&P, Standards, Client Data Book, and Group Curriculum. (N) • Describe outcome of CQI efforts to address/remedy suboptimal program activities. (N) • Describe deviations in outreach activities, noting changes from local recruitment plan. (N) • Describe any program improvements resulting from client satisfaction survey findings. (N)

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	<p>effective referrals that is reviewed and updated annually.</p> <ul style="list-style-type: none"> • Submitting complete and accurate reports in the time specified by MCAH. <p>*MCAH Division will provide guidance on the development of local CQI plans.</p>	<p>quality improvement. (M)</p> <ul style="list-style-type: none"> • Describe local CQI activities conducted. (N) • Report number of clients currently being served (caseload) in the old model. (M) • Submit quarterly progress reports as requested by MCAH. • Submit Annual Report to MCAH by August 15th. (N) • Submit community linkages and referrals plan and note any annual changes. (N) 	
4.2 Maintain effective data management.	<p>4.2</p> <ul style="list-style-type: none"> • Accurately and completely collect required client information, with timely data input into the appropriate data system(s). • Respond to MCAH Division data requests in a timely manner. • Work with MCAH to ensure proper and continuous operation of the MCAH-BIH-MIS. • Store Client Data Book forms on paper until staff has been trained to use the MCAH-BIH-MIS and can access the system. • Define a data entry schedule for staff. 	<p>4.2</p> <ul style="list-style-type: none"> • Number and percent of client records entered into the MCAH-BIH-MIS within 7 days of collection on paper forms. (M) • Generate <i>Standard Reports</i> at least quarterly as a management tool to assess data accuracy and completeness. (M) • Describe aspects of data management activities that did not meet or differed from program guidelines.(N) 	<p>4.2</p> <ul style="list-style-type: none"> • Number and percent of <i>Enrolled</i> cases that have not had any information/action entered into the MIS in two weeks. (M) • Number and percent of cases with missing client recruitment forms. (M) • Number and percent of open cases more than 18 months after enrollment date. (M)

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4.3 Maintain and increase staff competency.	<p>4.3</p> <ul style="list-style-type: none"> Identify staff training needs and ensure those needs are met, and notifying MCAH of any training needs. Develop a plan to assess staff's ability to effectively perform their assigned tasks, including through regular observations of group facilitators. Require that all key BIH staff (i.e. MCAH Director, BIH Coordinator, and ALL direct service staff) attend the 2-day annual statewide BIH Meeting. Ensure that the BIH Coordinator and all direct service staff attend a mandatory 3-day MCAH Division-sponsored training prior to implementing the BIH Program. Ensure that BIH Coordinators and all direct service staff attend any mandatory 2-day MCAH Division-sponsored training. Ensure that all direct service staff participate in data collection, data entry, data quality improvement, and data collection software use as determined by MCAH. Ensure that all subcontractor agencies providing direct service enter data in the MCAH-BIH-MIS. Ensure that the BIH Coordinator and/or MCAH Director perform 	<p>4.3</p> <ul style="list-style-type: none"> Describe training activities in which staff participated. (N) Maintain records of staff participation in development activities and staff attendance at trainings. (N) List gaps in staff development and training. (N) Describe plan to ensure that staff development needs are met. (N) Recommend training topics that could be addressed at statewide meetings. (N) 	<p>4.3</p> <ul style="list-style-type: none"> Describe ways in which training activities have improved staff performance in implementing the program model. (N) MCAH-BIGH-MIS Utilization Reports for all staff at BIH Sites. (M)

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	regular observations of group facilitators and audits of FHAs' case management activities. <ul style="list-style-type: none"> • Ensure that all staff receive updates about changes in the MCAH-BIH-MIS and data book forms. • Ensure that a selected staff member with advanced knowledge of the BIH Program, data collection, and the MCAH-BIH-MIS is selected as the BIH Site MIS lead and participates in all monthly Data and Evaluation Committee calls. 		