

**Request for Supplemental Information (RSI) Local Health Jurisdiction
(LHJ) Questions & Maternal Child and Adolescent Health-Black Infant
Health (MCAH-BIH) Answers
March 4, 2015**

Recruitment

- 1. Table for Part A Q1: Is the number of pregnant AA women served annually by the provider/agency an estimate? Is the anticipated number of referrals to BIH based on past referrals received from the provider/agency?**

In PART A, question number 1, the BIH site should provide the actual number of pregnant AA women served annually by each provider/agency from the past year. The anticipated number of referrals is based on past referrals from the providers/agencies that your BIH program has collaborated with in the past. A new referral site should provide the anticipated number of women that will be referred.

- 2. What are the ramifications if a program does not achieve program outcomes? (Table 2, page 10).**

The assigned MCAH BIH Program Consultant (PC) will provide Training and Technical Assistance (TA) on an ongoing basis to ensure program requirements are met and the BIH program is implemented in a standardized manner. The PC will provide the necessary support to ensure program outcomes are met. However, it is expected that the Community Outreach Liaison will recruit enough women to meet the requirement. The primary role of the Community Outreach Liaison is to recruit continuously throughout the year, to ensure that target numbers for women recruited, enrolled and served are met.

- 3. Based upon the last four and a half years of implementing the group model and analysis of data, our program has never reached the enrollment and completion goal required for Tier 3. We will put forth earnest efforts, however the numbers appear unrealistic. What was the methodology for outcome numbers?**

Prior BIH data shows that women who attend the group intervention have a high retention rate and tend to complete the program in its entirety. It is expected that the Community Outreach Liaison will recruit enough women to meet the requirement per the LHJ recruitment plan. The primary role of the Outreach Liaison is to recruit continuously throughout the year. The BIH team will provide the necessary training and TA to achieve these goals. The methodology used is the number of groups that LHJs can conduct annually based on the number of AA births per LHJ over a 3 year period.

- 4. Is one Outreach Liaison position sufficient to recruit twice as many women into the program to meet enrollment requirements?**

1FTE Community Outreach Liaison is required for all LHJs. LHJs that determine the need for additional support in this area can add additional FTE's with matching Title XIX and/or local funds.

- 5. We would like to concentrate our BIH program in the Vallejo zip codes and not Fairfield. Trying to reach out to these large zip codes will be challenging. We don't have the required staff resources to have the number of groups for prenatal and postpartum in both cities. We can reach the numbers by focusing in Vallejo.**

LHJs may provide services in designated high-density areas of the County as long as the required number of participants outlined in their designated tiers is served.

- 6. Do target areas selected by counties need to be identified by census tracts?**

Target areas selected by counties do not need to be identified by census tracts.

- 7. Should the target areas selected be based only upon the map provided by State, or can other data sources (e.g., demographic data, poverty level, etc.) be utilized by local program?**

LHJs may utilize other data sources in addition to the number of African-American births to determine LHJ BIH Program service delivery areas.

- 8. Does program need to target every red area identified on the map? (Part II - page 17 – Question 4).**

It is not necessary for LHJs to target every high density area on the designated maps. The maps were provided in order for LHJs to determine where high numbers of AA women are located for service delivery.

Enrollment/Eligibility

- 9. Can the enrollment process be conducted in a group setting?**

The enrollment consist of the following: 1) orientation, 2) consent, 3) assessment, and 4) VIA character strengths. Orientation can be done in a group setting. The consent, initial assessment and character strengths survey must be done individually with each participant.

- 10. What's the rationale of having the Mental Health Professional (MHP) complete the initial intake process? (Enrollment Process, page 7)**

To ensure that standardization of the enrollment and intake process occurs among all BIH sites.

- 11. What considerations will be made re: women who show up after having dropped out of the prenatal class? Will they be allowed to re-enroll even if they're beyond the 26 weeks or have already delivered?**

Eligibility criterion states that eligible participants must be no more than 26 weeks gestational age upon enrollment in order to participate in the BIH Program. Participants that drop out of BIH prenatal group sessions will be dis-enrolled from BIH and no longer eligible to re-enroll in BIH unless they become pregnant again. Women may not enroll in a postpartum group series unless they have completed the prenatal group series first.

12. Pregnant women must be no more than 26 weeks gestational age at time of prenatal entry into BIH (p. 9 E.1.). Question: Does the 26 weeks gestational age refer to the gestational age at the time the woman is first identified for referral (e.g. at the provider office) or does it refer to the gestational age at time of intake?

The BIH Policy & Procedures (P&P) states that all participants will be 26 weeks or less upon enrollment.

13. Prenatal entry only – women must be pregnant and no more than 26 weeks gestational age. Is the 26 week gestation for 100% of all clients, or is it 80% of clients enrolled as in FY 14-15? Can program enroll woman after 26 weeks if there is enough time to complete the entire prenatal group session? (Program Requirements E, page 9)

The revised P&P will state that 100% of all participants will be 26 weeks or less gestation upon enrollment.

14. Can the mental health assessment be administered by a FHA (if the site does not have a mental health staff) or one is not hired yet, or not available at the time?

Sites may not utilize the FHA to conduct the mental health assessment. It is expected that sites should have plenty of time to hire the MHP before the July 1, 2015 start date. The purpose of having the MHP available as participants enroll in the program is to ensure that each participant receives BIH Program information and the assessment in a standardized manner.

Case Management

15. What about clients who become pregnant before completing the program (it happens...) – are we limited to just providing them with the 60 days of case management and then closing them?

The response to this question may vary depending on the phase of the program the participant is in. All the sites should contact their program consultant for TA for unique circumstances.

Group

16. If we think we can serve more than the minimum # of clients listed in table 2 for our tier by conducting fewer than the # of sessions listed in table 2, is this allowable?

LHJs must ensure that sites meet the number of women that are to be served in their tier and that participants have the opportunity to enroll in a group within 30 days of initial contact. Conducting fewer group series per year may prevent participants near the eligibility cut-off of 26 weeks gestation the opportunity to enroll in BIH.

17. For each tier there is a stated range of clients for group (e.g. Tier 2 8-12 participants). Does this mean that we cannot begin a group unless we have a minimum of 8 participants?

LHJs must not conduct group sessions unless there are at least 8 participants in attendance. It is expected that the Community Outreach Liaison will recruit enough women to meet this requirement. The primary role of the Community Outreach Liaison is to continuously recruit throughout the year.

18. In the #women/group column in table 2 on page 10 – is this a range of the number of women the program is to enroll in each group series?

Yes, each group series must have no less than 8 women and no more than 12 women per group series.

19. Are there a set number of women per group? Table 2 on page 10 has a range from 8 to 12 women per group, however in order to comply with the requirement of women enrolling into group within 30 days there may be an instance when the group size may be smaller.

Group series' are to consist of no less than 8 women and no more than 12 women per group series. It is expected that the Community Outreach Liaison will recruit enough women to meet this requirement. The primary role of the Community Outreach Liaison is to continuously recruit throughout the year.

20. What is the purpose of the #women/group, as long as program reaches the minimum Tier requirement? (Table 2, page 10).

Additional literature review shows that 8-12 women is the optimal size for a grouped-based intervention in order for women to receive social support and empowerment to make good choices leading to a healthier life.

Case Closure

21. Will there be guidelines re: the number of efforts for the purpose of re-engaging clients?

Yes, the BIH "Case Closure" P&P will address participant re-engagement activities.

22. The RSI states that the participant's cases are expected to close within 60 days of the last postpartum group. (p. 9—Case Closure). The Policies and Procedures Guidance for Implementation of the BIH Program states that a participant may

**continue in BIH for up to 18 months postpartum. (p.20—Program Completion).
Please clarify length of time a participant can receive BIH services.**

The updated P&P states that participant cases are to be closed within 60 days when the last postpartum group session has ended. The FY 2015-16 BIH Scope of Work (SOW) will also reflect this change.

23. BIH participants' cases are expected to be closed within 60 days of the last postpartum group. Previously clients could remain in the program until the infant reached 9 months of age, what is the rationale for closing cases 60 days after the last postpartum session? The infant mortality rate for African Americans is still two and half times the rate of other ethnic groups, is this adequate time in the programs to have an impact on the infant mortality rate for clients enrolled in the program? (Case Closure, page 9)

Participants can enroll in postpartum sessions up to the time their child is 6 months of age. At the end of the postpartum session LHJs have 60 days to close out a case and refer out to other community resources if necessary. The rationale for closing cases sooner than later allows LHJs to enroll and provide BIH services to a greater number of women with the goal of impacting AA infant mortality rates. Serving fewer women will have less of an impact on AA infant mortality rates.

24. Why are we closing cases 60 days after the last postpartum session, when the infant mortality rate for AA still disparate in comparison to other ethnic groups. (Case Closure, page 9)

Participants can enroll in postpartum sessions up to the time their child is 6 months of age. At the end of the postpartum session LHJs have 60 days to close out a case and refer out to other community resources if necessary. The rationale for closing cases sooner than later allows LHJs to enroll and provide BIH services to a greater number of women with the goal of impacting AA infant mortality rates. Serving fewer women will have less of an impact on AA infant mortality rates.

Staffing

25. If our program has additional funding can we increase the number of FHA/Facilitator positions?

Yes. LHJs may increase the number of FHA/GF positions if additional funding is available.

26. Are the FHA and Group Facilitators interchangeable? Can we have one or the other?

Yes. FHA and Group Facilitators may perform the same job duties as long as they have participated in MCAH-BIH required trainings for the specific position.

27. Can the data entry staff person also serve in the administrative capacity increasing the position to 1.0 FTE?

If sites have additional funds to support a 1.0 FTE Data Entry person after fulfilling the required staffing positions, the Data Entry person can take on administrative duties at 0.5 FTE.

28. If the Family Health Advocate performs their own data entry, can program remove the data entry position?

No. All LHJs have been provided with sufficient funding to support a 0.5 FTE data entry person.

29. Will consideration of a “hybrid” type staffing model be made (i.e. when the coordinator and/or mental health professional also act as facilitators)?

The 0.5 BIH Coordinator and Mental Health Worker can be trained as facilitators in order to support group sessions on a short-term temporary basis (not on-going) in the event designated GF's are not available. The RSI required FTE for BIH Coordinator and MHP must be met.

30. I finally got the 2 positions approved by our Board of Supervisors to hire the PHN and CHOW for the BIH program. My concern is now that after reviewing the documents and the requirements, I'm not sure if I should hire them at this point. For one reason, the CHOW position does not require a bachelor's degree and now the PHN is not a requirement it's optional. Will you be grandfathering any staff in? For instance, currently one of my CHOW/FHA does not have a Bachelor's Degree, so am I going to have to let her go and not be a part of the BIH program anymore?

The Public Health Nurse (PHN) remains a critical component of BIH (if LHJs already have a PHN in place and additional funding is available LHJs may budget for a PHN). Educational requirements for core BIH positions are located in Appendix III of the BIH RSI. LHJs with existing BIH Program staff not meeting educational requirements must submit a waiver to their designated BIH PC. Waivers must clearly document BIH staff experience and skills necessary to fulfill designated roles. LHJs must also ensure that trainings and staff development plans are in place to enhance skill levels. LHJs that hire new BIH Program staff must adhere to LHJ staffing requirements outlined in Appendix III of the BIH RSI.

31. In order to hire the required staff, instead of going through a treacherous process of developing new civil service positions and having to go to the BOS and civil service board, will you be letting us hire other classifications that fit into the requirements you are asking. For example, a Public Health Educator Assistant in our County fills the qualifications of a FHA/Group Facilitator and an Office Assistant fills the qualifications of a data entry person.

LHJs must ensure that all “core” BIH Program staff has the necessary qualifications and skills to implement the program, despite county classifications titles. LHJ BIH budgets must reflect designated MCAH-BIH Program titles as outlined in the BIH RSI, SOW and P&P.

32. In the staff requirement standards for the FHA, it requires a Bachelor's degree. If existing staff do not have a degree, but have completed the state-required training and have several years of experience working in the position in the BIH program, can they be exempt from this requirement?

LHJs with existing BIH Program staff not meeting educational requirements must submit a waiver to their designated BIH PC. Waivers must clearly document BIH staff experience and skills necessary to fulfill designated roles. LHJs must also ensure that trainings and staff development plans are in place to enhance skill levels. LHJs that hire new BIH Program staff must adhere to LHJ staffing requirements outlined in Appendix III of the BIH RSI.

33. Why is the Public Health Nurse position optional now versus being required for FY 14-15?

The Public Health Nurse (PHN) remains a critical component of BIH (if LHJs already have a PHN in place and additional funding is available LHJs may budget for a PHN). BIH PHN activities are outlined in Appendix III of the BIH RSI. The revised allocation requires the LHJ to have a MHP in place to conduct vital enrollment activities. MCAH-BIH recognizes that LHJs do not have mental health providers readily available to assist with participant concerns. However, PHN field nursing units are available in LHJs for health-related BIH participant concerns.

34. BIH County Coordinator vs Subcontract Project Director: Does the BIH Coordinator at the County level need to be included in the BIH budget?

Yes. The BIH County Coordinator must be included on the BIH budget to assist with oversight of the Subcontractor program activities.

35. Will the answers for #6 on page 17 be similar to what was included in the duty statements submitted for this year?

LHJs must list all core staff positions and include BIH role. Any additional staff on the budget must include major job duties specific to BIH and rationale for supporting the BIH program.

RSI Submission

36. Will there be a fill-in Part A sent to us or do we have to create our own questions and answer response form?

Page 15, PART A: Local Health Jurisdiction Information of the RSI contains the questions that require responses within the RSI.

Training

37. Will there be a formal curriculum training prior to implementation?

Yes. MCAH-BIH will conduct a formal training for all BIH LHJs that will include BIH Program implementation requirements June 23-26, 2015 in Sacramento, CA.

Contracts

- 38. Is it possible to get a break down of the Title V & SGF amounts for each tier (Pg. 6)? So, for Tier 1 how much of the \$315.00 is Title V funds and how much is SGF?**

The funding breakdown as shown in Addendum 2 is 51% Title V funds and 49% State General Funds (SGF).

- 39. When working on the budget, do you want us to use 30% MCF or should we use a different base rate?**

To complete your budget template please follow the same guidance as completing your AFA budget and use the Medi-Cal Factor from the Black Infant Health Program Medi-Cal Factor Table Effective FY 2014-15 within the MCAH Business Partners section of the BIH website. (<http://www.cdph.ca.gov/services/funding/mcah/Pages/Default.aspx>)

- 40. On page 6 in the RSI document, we request the discrete amounts for the Title V and State General Funds in Table 1 (Tier 4, fourth column; \$595,000).**

The funding breakdown as shown in Addendum 2 is 51% Title V funds and 49% State General Funds (SGF).

- 41. Also in Table 1, does the estimated amount in the fifth column (Tier 4; \$850,000) include Title XIX matching from both State General Funds and local funds?**

The funding breakdown as shown in Addendum 2 is Title V and State General Funds only, this table does not include any Title XIX. MCAH is not requiring BIH LHJs to include any local funds.

- 42. Does the 30% minimum Title XIX matching mean that at least 30% of all Title XIX matching must be drawn by local funds? Or, is it 30% applied (in addition) to some other amount to yield the local funds that must be budgeted?**

We expect the BIH LHJs to draw down at least 30% Title XIX based on State General Funds only. Local funds may also be used for additional Title XIX draw down. Please contact your assigned contract manager if you have additional questions.

- 43. Is there a limitation on the percentage of matching (i.e., 30%) that individual staff members are permitted to match: either a combination of enhanced and non-enhanced matching, or a limit in enhanced or non-enhanced separately?**

There is no limitation on the amount of Title XIX you can match. If your activities support higher match percentages, you should take advantage of all matching funds.

Additionally you are allowed and encouraged to add local funds that can be matched to increase your Title XIX funds.

44. For preparation of the budget, please provide the BIH Program Medi-Cal factor for the County of San Bernardino.

BIH LHJ sites not listed on the Medi-Cal Factor (MCF) table should use the statewide average MCF of 85.14%.

45. What is the total State General dollar amount for Solano? see Page 6

SGF for tier 2 (including Solano) is \$236,311 or 49% of the total allocation of \$483,000.

46. What is the percentage breakdown of the SGF and Title V amounts listed in Table 1 – Funding Tiers?

The funding breakdown as shown in Addendum 2 is 51% Title V funds and 49% State General Funds (SGF).

47. How was funding distribution determined in comparison to the required number of clients to be served?

The funding is based on the required personnel necessary to implement the intervention for each tier. For example, the minimum number of women to be served for tier 1 is 64. To accomplish this we expect the site to provide 8 group series in one year. The staffing required to provide at least 8 group series is 2 FTE facilitators, 1 FTE outreach liaison, .50 FTE mental health professional, .50 FTE BIH Coordinator and .50 FTE data entry person. Staff costs were determined by averaging salaries from the 2014 AFA budgets.

48. Besides using our funds on Personnel, training and travelling, can we use any funds for food and incentives/give-a-ways for the clients at the sessions?

95% of Tiered funding amounts are based on Personnel. The additional 5% should be dedicated to Travel and Training. We expect the BIH LHJs to draw down at least 30% Title XIX based on State General Funds only. Local funds may also be used for additional Title XIX draw down. Please contact your assigned contract manager if you have additional questions.

49. Page 6 of the RSI – Table 1: Funding Tiers – The column “Eligible LHJ’s” list various counties under each Tier, is this the Tier that counties must request funding for? Example – Sacramento County is listed under Tier 4, is Sacramento County able to requesting funding under Tier 3 instead of Tier 4?

All LHJs must adhere to the tier your county falls in and develop a budget for the allocated funding amount. Tiered funding is based on number of African-American births in each LHJ in order to conduct outreach activities to reach potential participants.

Epi

50. Clients who began prenatal group session in FY 14-15, but completed the remaining prenatal group sessions and postpartum sessions in FY 15-16 , are they counted towards FY 15-16 completion numbers or FY 14-15?

Our current reporting method for Program Completion is to count any participants relative to the fiscal year that they enrolled. For example, if a participant enrolls on May 20, 2014 and begins prenatal group on June 8, 2014 and finishes her postpartum group in FY 15-16, her program completion would be attributed to FY 14-15. We must also account for appropriate “lag time” when reporting to assess program completion as a participant has to be in the program long enough to complete all the group sessions and life planning meetings.

When tracking activities completed within a Fiscal Year, we use methods such as “Active Caseload” that looks at any participants that received a list of service(s) from BIH during that Fiscal Year.