

California Department of Public Health (CDPH)
Maternal, Child and Adolescent Health (MCAH) Program
Scope of Work (SOW)

BACKGROUND:

In an effort to increase efficiency, simplify and allow for local flexibility, MCAH has consolidated four Title V programs into one scope of work (SOW). All Local Health Jurisdictions (LHJs) will be accountable for Part I, the Local MCAH SOW. Only those LHJs with the Fetal Infant Mortality Review (FIMR) Program funding are accountable for Objectives 3.5-3.7 and 3.8 within Part I of the Local MCAH SOW.

LHJs that receive funding for the Adolescent Family Life Program (AFLP) and/or the Black Infant Health (BIH) Program must adhere to their respective SOWs.

The SOW has three parts:

Part I. Local MCAH, which includes Title V and State required activities, the Comprehensive Perinatal Services Program (CPSP), the Sudden Infant Death Syndrome (SIDS) Program, and FIMR for those LHJs with FIMR funding.

Part II. AFLP

Part III. BIH

It is the responsibility of the LHJ to meet the goals and objectives of this SOW. The LHJ shall strive to develop systems that protect and improve the health of California's women of reproductive age, infants, children, adolescents, and their families.

The goals in this SOW incorporate local problems identified by LHJs 5-Year Needs Assessments and reflect the Title V priorities of the MCAH Division.

The development of this SOW was guided by several public health frameworks including the Ten Essential Services of Public Health and the three core functions of assessment, policy development, and assurance; the Spectrum of Prevention; the Life Course Perspective; the Social-Ecological Model, and the Social Determinants of Health. Please consider integrating these approaches when conceptualizing and organizing local program, policy, and evaluation efforts.

- The Ten Essential Services of Public Health: <http://www.cdc.gov/nphpsp/essentialServices.html>; <http://www.publichealth.lacounty.gov/qi/corefcns.htm>
- The Spectrum of Prevention: <http://www.preventioninstitute.org/component/taxonomy/term/list/94/127.html>
- Life Course Perspective: <http://mchb.hrsa.gov/lifecourseresources.htm>
- The Social-Ecological Model: <http://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html>
- Social Determinants of Health: <http://www.cdc.gov/socialdeterminants/>
- Strengthening Families: <http://www.cssp.org/reform/strengthening-families>

¹ 2001-2015 Title V State Priorities

² Title V Requirement

³ State Requirement

BUDGET:

All Title V programs must comply with the MCAH Fiscal Policies and Procedures Manual which is found on the CDPH/MCAH website at:
<http://www.cdph.ca.gov/services/funding/mcah/Pages/FiscalDocuments.aspx>

ACTION REQUIRED:

Part I. Local MCAH

All LHJs must perform the activities in the shaded areas in Goals 1-3 and monitor and report on the corresponding evaluation/performance measures. In addition, each LHJ is required to develop objectives to address one problem in each of Goals 1 and 2. LHJs are required to develop 2 objectives for Goal 3, a SIDS objective to promote infant safe sleep and risk reduction community health education and an objective to improve infant health outcomes. If resources allow, LHJs should also develop additional objectives, which they may place under any of the Goals 1-6. All activities in this SOW must take place within the fiscal year. Please see the MCAH Policies and Procedures Manual for further instructions on completing the SOW.

<http://www.cdph.ca.gov/services/funding/mcah/Pages/LocalMCAHProgramDocuments.aspx>

For LHJs that receive FIMR funding, perform the activities in the shaded area in Goal 3, Objectives 3.5-3.7 and 3.8. In the second shaded column, Intervention Activities to Meet Objectives, insert the number and percent of cases you will review for the fiscal year.

CDPH/MCAH Division expects each LHJ to make progress towards Title V State Performance Measures and Healthy People 2020 goals. These goals involve complex issues and are difficult to achieve, particularly in the short term. As such, in addition to the required activities to address Title V State Priorities, and Title V and State requirements, the MCAH SOW provides LHJs with the opportunity to develop locally determined objectives and activities that can be realistically achieved given the scope and resources of local MCAH programs.

Please review your data with key health department leadership at least annually.

LHJs are required to comply with requirements as stated in the MCAH Program Policies and Procedures Manual, such as attending statewide meetings, conducting a Needs Assessment every five years, submitting Agreement Funding Applications, and completing Annual Reports.

FIMR LHJs are required to comply with requirements as stated in the FIMR Policies and Procedures Manual:

<http://www.cdph.ca.gov/services/funding/mcah/Pages/FIMRDocuments.aspx>

¹ 2001-2015 Title V State Priorities

² Title V Requirement

³ State Requirement

Part I. Local MCAH

Goal 1: Improve Outreach and Access to Quality Health and Human Services

- Link the MCAH population to needed medical, mental, social, dental, and community services to promote equity in access to quality services, especially for those who are eligible for Medi-Cal or other publicly provided health care programs ¹.
- Outreach services will be targeted to identify pregnant women, women of reproductive age, infants, children and adolescents and their families who are eligible for Medi-Cal assistance or other publicly provided health care programs and assist them in applying for these benefits ².

The shaded area represents required activities. Nothing is entered in the shaded areas.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
1.1-1.6 All women, infants and children will have access to: <ul style="list-style-type: none"> • Medical, mental, dental care and available social support services • Early and comprehensive perinatal care and maternal medical, dental, and mental health care • An environment that maximizes their health 	Assessment 1.1 Identify and monitor trends, geographic areas and/or population groups, including disparities, social determinants and barriers to the provision of: <ol style="list-style-type: none"> 1. Health and human services to the MCAH population 2. Early and comprehensive perinatal care 3. Maternal medical, dental and mental health care 4. Fetal and infant health care Annually, share your data with your key health department leadership	Assessment 1.1 List and briefly describe trends, geographic areas and/or population groups, including disparities, social determinants and barriers to the provision of: <ol style="list-style-type: none"> 1. Health and human services to the MCAH population 2. Early and comprehensive perinatal care 3. Maternal medical, dental and mental health care 4. Fetal and infant health care. Date data shared with the key health department leadership. Briefly describe their response, if significant.	Assessment 1.1 Submit Long Term Outcome Objectives Data Table.
	1.2 Participate in collaboratives, coalitions, community organizations, etc., to review data and develop policies and products to address social determinants of health and disparities.	1.2 Report the total number of collaboratives with MCAH staff participation. Submit up to three Collaborative Surveys that document	1.2 List policies or products developed to improve infrastructure and address MCAH priorities.

¹ 2001-2015 Tittle V State Priorities

² Tittle V Requirement

³ State Requirement

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
		participation, objectives, activities and accomplishments of MCAH – related collaboratives.	
	<p>1.3 Policy Development</p> <p>Review, revise and enact policies that facilitate access to Medi-Cal, Covered CA, Child Health and Disability Prevention Program (CHDP), Women, Infants, and Children (WIC), Family Planning, Access, Care, and Treatment (Family PACT), and other relevant programs.</p>	<p>1.3 Policy Development</p> <p>Describe efforts to develop policy and systems changes that facilitate access to Medi-Cal, Covered CA, CHDP, WIC, Family PACT, and other relevant programs.</p> <p>List formal and informal agreements, including Memoranda of Understanding with Medi-Cal Managed Care (MCMC) plans or other organizations that address the needs of mothers and infants.</p>	<p>1.3 Policy Development</p> <p>Describe the impact of policy and systems changes that facilitate access to Medi-Cal, Covered CA, CHDP, WIC, Family PACT, and other relevant programs.</p>
	<p>1.4 Assurance</p> <p>Participate in and/or deliver trainings in MCAH and public health competencies and workforce development as resources allow.</p>	<p>1.4 Assurance</p> <p>List trainings attended or provided and numbers attending.</p>	<p>1.4 Assurance</p> <p>Describe outcomes of workforce development trainings in MCAH and public health competencies, including but not limited to, knowledge or skills gained, practice changes or partnerships developed.</p>
	<p>1.5</p> <p>Conduct activities to facilitate referrals to Covered CA, Medi-Cal, and other low cost/no-cost health insurance programs for health care coverage and local</p>	<p>1.5</p> <p>Describe activities to facilitate referrals to health insurance and programs.</p>	<p>1.5</p> <p>Report the number of referrals to Medi-Cal, CHDP, WIC, FamilyPACT, Text4Baby, or other low/no-cost health insurance or programs.</p>

¹ 2001-2015 Tittle V State Priorities

² Tittle V Requirement

³ State Requirement

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	MCAH programs, CHDP, WIC, and other relevant programs ² , such as Text4baby.		
	1.6 Provide a toll-free or “no-cost to the calling party” telephone information service and other appropriate methods of communication, e.g. local MCAH Program web page to the local community ² to facilitate linkage of MCAH population to services.	1.6 Describe the methods of communication, including the, cultural and linguistic challenges and solutions to linking the MCAH population to services.	1.6 Report the following: 1. Number of calls to the toll-free or “no-cost to the calling party” telephone information service 2. The number of web hits to the appropriate local MCAH Program webpage
Insert Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below.			
1.7 At least one specific short and/or intermediate SMART outcome objective(s) to address access to health and human services is required here. Consider addressing problems related to: <ul style="list-style-type: none"> • Access to health care • Access to dental care • Access to mental health care 	1.7 List activities to address health disparities, social determinants and barriers to increased access to health and human services here. Organize intervention activities and performance measures using the three core functions of public health: Assessment, Policy Development, and Assurance. http://www.publichealth.lacounty.gov/qj/corefcns.htm	1.7 Develop process measures for applicable intervention activities here.	1.7 Develop short and/or intermediate outcome related performance measures for the objectives and activities here.

¹ 2001-2015 Tittle V State Priorities

² Tittle V Requirement

³ State Requirement

Goal 2: Improve Maternal and Women's Health

- Improve maternal health by optimizing the health and well-being of girls and women across the lifecycle ¹
- Reduce maternal morbidity and mortality and the increasing disparity in maternal health outcomes ¹
- Assure that all pregnant women will have access to early, adequate and high quality perinatal care with a special emphasis on low-income and Medi-Cal eligible women ²

The shaded area represents required activities. Nothing is entered in the shaded areas.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
2.1-2.3 All women will have access to quality maternal and early perinatal care, including CPSP services for Medi-Cal eligible women.	2.1 Assurance Develop MCAH staff knowledge of the system of maternal and perinatal care and CPSP. Recruit and assist Medi-Cal providers to become CPSP providers and implement CPSP according to MCAH Policies and Procedures.	2.1 Assurance Report the following: 1. Number of current and newly enrolled CPSP providers 2. Number of Medi-Cal Obstetric (OB) providers 3. Barriers and opportunities for successful recruitment and retention of CPSP providers 4. Barriers and opportunities to improve access to quality maternal and perinatal care	2.1 Assurance Describe the impact on access to and quality of maternal and perinatal care and CPSP services.
	2.2 Provide technical assistance to CPSP providers and MCMC Plans related to the provision of CPSP services.	2.2 List technical assistance provided to CPSP providers and MCMC plans.	2.2 Describe outcomes of technical assistance provided to CPSP providers and MCMC plans.
	2.3 At a minimum, conduct annual quality improvement quality assurance (QI/QA) activities, reviewing CPSP prenatal and postpartum services, for CPSP providers. Conduct QI/QA in collaboration with MCMC plan staff, if applicable.	2.3 List CPSP provider QI/QA activities that were conducted. Report the number of site visits and face to face contacts with current and potential CPSP providers and MCMC providers and plans.	2.3 Describe the results of QI/QA activities that were conducted.

¹ 2001-2015 Tittle V State Priorities

² Tittle V Requirement

³ State Requirement

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
		Report the percentage of CPSP providers receiving a QI/QA site visit.	
Insert Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below.			
<p>2.4 At least one specific short and/or intermediate SMART outcome objective(s) to address maternal and women’s health is required here.</p> <p>Consider addressing local problems related to:</p> <ul style="list-style-type: none"> • Late initiation of prenatal care and/or inadequate prenatal care • Perinatal mood and anxiety disorders • Partner/family violence 	<p>2.4 List activities to improve access to early, adequate and high quality perinatal care and maternal health here.</p> <p>Organize intervention activities and performance measures using the three core functions of public health: Assessment, Policy Development, and Assurance. http://www.publichealth.lacounty.gov/qi/corefcns.htm</p>	<p>2.4 Develop process measures for applicable intervention activities here.</p>	<p>2.4 Develop short and/or intermediate outcome related performance measures for the objectives and activities here.</p>

¹ 2001-2015 Tittle V State Priorities

² Tittle V Requirement

³ State Requirement

Goal 3: Improve Infant Health

- Reduce infant mortality and address disparities by promoting preconception health and health care and by preventing causes such as birth defects, low birth weight/prematurity, SIDS, and maternal complications in pregnancy¹

The shaded area represents required activities. Nothing is entered in the shaded areas, except for FIMR LHJs.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
3.1-3.2 All infants are provided a safe sleep environment	3.1 Assurance Establish contact with parents/caregivers of infants with presumed SIDS death to provide grief and bereavement support services ³ .	3.1 Assurance (Insert number) of parents/caregivers who experience a presumed SIDS death and the number who are contacted for grief and bereavement support services.	
	3.2 Attend the SIDS Annual Conference/ SIDS training(s) and other conferences/trainings related to infant health ³ .	3.2 Provide staff member name and date of attendance at SIDS Annual Conference/training(s) and other conferences/trainings related to infant health.	3.2 Describe results of staff trainings related to infant health.
Insert Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below.			
3.3 At least one specific objective(s) addressing infant safe sleep practices and SIDS risk reduction community health education is required here.	3.3 List activities to promote infant safe sleep and SIDS risk reduction education activities to the community here. Organize intervention activities and performance measures using the three core functions of public health: Assessment, Policy Development, and Assurance. http://www.publichealth.lacounty.gov/qj/corefcns.htm	3.3 Develop process measures for applicable intervention activities here.	3.3 Develop short and/or intermediate outcome related performance measures for the objectives and activities here.

¹ 2001-2015 Tittle V State Priorities

² Tittle V Requirement

³ State Requirement

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
<p>3.4 At least one specific short and/or intermediate SMART outcome objective(s) to address infant health is required here.</p> <p>Objectives that improve infant health may address local problems related to:</p> <ul style="list-style-type: none"> • Prematurity/Low birth weight • Perinatal substance use 	<p>3.4 List activities to improve infant health here.</p> <p>Organize intervention activities and performance measures using the three core functions of public health: Assessment, Policy Development, and Assurance. http://www.publichealth.lacounty.gov/qj/corefcns.htm</p>	<p>3.4 Develop process measures for applicable intervention activities here.</p>	<p>3.4 Develop short and/or intermediate outcome related performance measures for the objectives and activities here.</p>
<p>For FIMR LHJs Only: 3.5-3.7 Preventable fetal, neonatal and postneonatal deaths will be reduced.</p>	<p>For FIMR LHJs Only: Assessment 3.5 Complete the review of at least ___ cases, which is approximately ___% of all fetal, neonatal, and postneonatal deaths.</p>	<p>For FIMR LHJs Only: Assessment 3.5 Submit number of cases reviewed as specified in the Annual Report table.</p>	<p>For FIMR LHJs Only: Assessment 3.5 Submit periodic local summary report of findings and recommendations (periodicity to be determined by consulting with MCAH).</p>
	<p>Assurance 3.6 Establish, facilitate, and maintain a Case Review Team (CRT) to review selected cases, identify contributing factors to fetal, neonatal, and postneonatal deaths, and make recommendations to address these factors.</p>	<p>Assurance 3.6-3.7 Submit FIMR Tracking Log and FIMR Committee Membership forms for CRT and CAT with the Annual Report.</p>	

¹ 2001-2015 Tittle V State Priorities

² Tittle V Requirement

³ State Requirement

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	<p>3.7 Establish, facilitate, and maintain a Community Action Team (CAT) to recommend and implement community, policy, and/or systems changes that address review findings.</p>		
<p>Insert Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below.</p>			
<p>For FIMR LHJs Only: 3.8 One objective addressing the development of interventions to prevent fetal, neonatal, and postneonatal deaths is required here.</p>	<p>For FIMR LHJs Only: 3.8 Based on CRT recommendations, identify and implement at least one intervention involving policy, systems, or community norm changes here.</p>	<p>For FIMR LHJs Only: 3.8 Develop process measures for applicable intervention activities here:</p>	<p>For FIMR LHJs Only: 3.8 Develop short and/or intermediate outcome- related performance measures for the objectives and activities here:</p>

¹ 2001-2015 Tittle V State Priorities

² Tittle V Requirement

³ State Requirement

Goal 4: Improve Nutrition and Physical Activity

- **Promote healthy nutrition and physical activity among MCAH populations throughout the lifespan beginning with exclusive breastfeeding of infants to six months of age¹**

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
<p>4.1 Add specific short and/or intermediate SMART outcome objective(s) here.</p> <p>Consider addressing local problems related to:</p> <ul style="list-style-type: none"> • Exclusive breastfeeding initiation and duration. • Overweight/obesity – children, adolescents, or women. 	<p>4.1 List activities to meet the Outcome Objective(s) here.</p> <p>Organize intervention activities and performance measures using the three core functions of public health: Assessment, Policy Development, and Assurance. http://www.publichealth.lacounty.gov/qi/corefcns.htm</p>	<p>4.1 Develop process measures for applicable intervention activities here.</p>	<p>4.1 Develop short and/or intermediate outcome related performance measures for the objectives and activities here.</p>

¹ 2001-2015 Tittle V State Priorities

² Tittle V Requirement

³ State Requirement

Goal 5: Improve Child Health

- **Support the physical, socio-emotional, and cognitive development of children, including the prevention of injuries, through the implementation of prevention, early identification and intervention strategies¹**

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
<p>5.1 Add specific short and/or intermediate SMART outcome objective(s) here.</p> <p>Consider addressing local problems related to:</p> <ul style="list-style-type: none"> • Childhood injury • Child abuse • Oral health 	<p>5.1</p> <p>List activities to meet the Outcome Objective(s) here.</p> <p>Organize intervention activities and performance measures using the three core functions of public health: Assessment, Policy Development, and Assurance. http://www.publichealth.lacounty.gov/qi/corefcns.htm</p>	<p>5.1</p> <p>Develop process measures for applicable intervention activities here.</p>	<p>5.1</p> <p>Develop short and/or intermediate outcome related performance measures for the objectives and activities here.</p>

¹ 2001-2015 Tittle V State Priorities

² Tittle V Requirement

³ State Requirement

Goal 6: Improve Adolescent Health

- Promote positive youth development strategies to support the physical, mental, sexual and reproductive health of adolescents¹

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
<p>6.1 Add specific short and/or intermediate SMART outcome objective(s) here.</p> <p>Consider addressing local problems related to:</p> <ul style="list-style-type: none"> • Adolescent sexual health • Adolescent pregnancy • Adolescent injuries • Adolescent violence • Adolescent mental health 	<p>6.1</p> <p>List activities to meet the Outcome Objective(s) here.</p> <p>Organize intervention activities and performance measures using the three core functions of public health: Assessment, Policy Development, and Assurance. http://www.publichealth.lacounty.gov/qi/corefcns.htm</p>	<p>6.1</p> <p>Develop process measures for applicable intervention activities here.</p>	<p>6.1</p> <p>Develop short and/or intermediate outcome related performance measures for the objectives and activities here.</p>

¹ 2001-2015 Tittle V State Priorities

² Tittle V Requirement

³ State Requirement

Part II. Adolescent Family Life Program

LHJs that receive AFLP funding are required to adhere to Part II of this SOW, in addition to complying with requirements stated in the AFLP Program Policies and Procedures Manual, <http://www.cdph.ca.gov/programs/AFLP/Pages/default.aspx>. These requirements include, but are not limited to attending statewide meetings, submitting Agreement Funding Applications, submitting timely invoices and Lodestar data, and completing annual and quarterly reports.

As defined in the implementing statute in Health and Safety Code Sections 124175, 124180, and 124185, the purpose of AFLP is to address the social, health, educational, and economic consequences of adolescent pregnancy by (1) establishing local networks to provide necessary services to pregnant and parenting teens and their children, and (2) providing comprehensive case management services focused on achieving the following goals: improve the health of the teen, thus supporting the health of the baby; improve high school graduation rates; reduce repeat pregnancies; and improve linkages and create networks. To positively impact the goals of the AFLP program, AFLP emphasizes strengths-based case management based on positive youth development principles with integrated life planning.

The statute also requires the AFLP to assess client needs and refer clients to services including comprehensive prenatal care; medical care; psychological and nutritional counseling; maternity counseling; adoption counseling; academic and vocational programs; day care; and substance abuse prevention, intervention, and counseling. Each AFLP shall also assure program integrity and maintain a data base to measure outcomes

All activities in this SOW must take place within the fiscal year. The measures marked with an asterisk will be calculated by Branaugh Information Group from Lodestar data in a Scope of Work report from data in Lodestar data forms, which include Intake, Status Change, Follow Up Form, Service Matrix, Additional Outcomes, Pregnancy Outcome, Freecode Forms. It is essential that local agency staff complete these forms accurately and completely.

The Adolescent Family Life Program is a specialized CDPH MCAH program under the local MCAH system and helps to address MCAH SOW Goal 6- Improve Adolescent Health.

In accordance with AFLP Standards, AFLP Local Agency will provide, at a minimum, the following case management Months of Service (MOS) to eligible adolescents and their children for fiscal year(s):_____ AFLP MOS (___ clients) for the budget period of 07/01/14 through 06/30/15

PART II: ADOLESCENT FAMILY LIFE PROGRAM

Goal 1: Improve linkages and create networks for pregnant and parenting teens and their children

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
1.1 AFLP will assess local needs, and develop and maintain a comprehensive, culturally appropriate local network of teen friendly supportive services.	1.1.1 Identify and monitor local trends in teen pregnancy and parenting outcomes, including disparities, and social determinants.	1.1.1 List and briefly describe local trends in teen pregnancy and parenting outcomes, including disparities and social determinants.	Not Applicable
	1.1.2 Identify and monitor local geographic areas or population groups that have insufficient access to health and human services for pregnant and parenting teens. Identify high risk groups and areas.	1.1.2 List and briefly describe: <ul style="list-style-type: none"> • Geographic areas or population groups that have insufficient access to health and human services for pregnant and parenting teens. • Any activities that have specifically addressed these gaps and the associated outcomes. 	Not Applicable
	1.1.3 Identify community agencies and other service providers for pregnant and parenting teens and work toward developing documented agreements (e.g., MOUs, letters of support or agreement) for referral with at least the following: <ul style="list-style-type: none"> • Local MCAH Program (for CBOs) • Family PACT providers • CPSP providers • WIC • Cal Learn 	1.1.3 <ol style="list-style-type: none"> a. Complete the table in the Annual Report to describe services available to clients and type of agreement for referral b. Describe the relationship with the local MCAH program c. Describe venues where case management services are delivered to clients, address of offices, and d. model of service delivery (group, individual, face to face, telephone, combination) 	1.1.3 Summarize: <ol style="list-style-type: none"> a. Service gaps and changes in the provider network during the reporting period. b. the impact on the AFLP population c. key challenges and strategies to address the gaps and challenges

* MIS Scope of Work Report

** Service Referral Analysis Report

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	<ul style="list-style-type: none"> • Cal SAFE • Primary care providers • Child care and development services • Local schools or education services, including migrant education where appropriate <p>Other resources could include:</p> <ul style="list-style-type: none"> • Psychological counseling • Social services • Vocational programs • Emergency support • Housing • Legal Assistance • Substance Abuse Prevention • Adoption Counseling • Parenting Classes • Home Visiting Programs 	(500 word limit)	
1.2 Improve local systems of care through collaboration designed to establish, sustain and enhance comprehensive systems of care for pregnant and parenting teens and their children.	1.2 Participate in at least one collaborative, coalition, network, etc., that develops products or strategies that address unmet needs and promote increased local access to health and human services for pregnant and parenting teens and their children.	1.2 Submit Collaborative Form to document participation in at least one and not more than 3 AFLP collaboratives or coalitions that address unmet needs and improve access to health and human services: Maintain records of collaboration in AFLP Agency (i.e. network coordination documentation, summaries, and/or minutes of meetings attended).	1.2 Collaborative Form submitted in Process will <ol style="list-style-type: none"> a. Document objectives and accomplishments and include a description of the collaborative's impact on the local system of care for pregnant and parenting teens. b. List products developed and outcomes of dissemination on Collaborative Form.
1.3 Improve community knowledge of AFLP services and identify potential clients by conducting	1.3 AFLP will conduct outreach activities to high risk groups, areas, and community agencies	1.3 Describe: <ol style="list-style-type: none"> a. Top three outreach activities. b. State number of clients on 	1.3 State the number and percent of clients completing intake by source of referral in MIS Scope of

* MIS Scope of Work Report

** Service Referral Analysis Report

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
outreach activities.	and other service providers to ensure that appropriate and eligible clients are identified, referred to the program and enrolled or placed on a waiting list, or referred to other community services.	<ul style="list-style-type: none"> c. Describe the process of referrals for clients that are not appropriate for AFLP. d. Three challenges. 	Work Report.
1.4 Clients will obtain health insurance.	1.4 Make referrals and assist clients to enroll in Medi-Cal, Access for Infants and Mothers (AIM) and other low cost/no cost health insurance programs for health care coverage.	1.4 Provide the number of clients and their children receiving referrals to Medi-Cal.**	1.4 Report the following: <ul style="list-style-type: none"> a. Number and percent of adolescent clients with health insurance at intake* b. Number and percent of adolescent clients with health insurance at last follow up* c. Number and percent of index children with Medi-Cal *
1.5 Client will access needed services for herself and her child.	1.5 Case Managers (CMs) will work with clients to assure that clients and children receive linkages to services. CMs will educate client to understand the importance of well child visits and immunizations.	Not Available	1.5 Report the following: <ul style="list-style-type: none"> a. Percent of clients and index children who needed and received services** b. Attach the Service Referral Analysis Report**
1.6 Client will develop a supportive relationship with a stable, caring adult outside of AFLP.	1.6 CMs will encourage clients to identify a stable, caring adult outside of AFLP. This could include improving relationships with parents, involvement with community groups or faith communities, or educational institutions.	1.6 <ul style="list-style-type: none"> a. Describe the process to incorporate this objective into case management activities and b. List three challenges and successes in achieving this objective. 	1.6 Report the number and percent of clients who self-report that they have a supportive relationship with a caring adult outside of AFLP. (In development for future reporting)

* MIS Scope of Work Report

** Service Referral Analysis Report

Goal 2: Improve the health of the pregnant or parenting teen, thus also supporting the health of the index child

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
<p>2.1 Clients will have healthy nutrition and healthy weight.</p>	<p>2.1 Refer to WIC and follow up to encourage linkage. Refer to CPSP provider if pregnant and reinforce healthy diet/weight gain. Assist client to develop a goal to achieve or maintain a healthy weight. Program policies and activities, including case management activities, will promote and model healthy diet and reinforce healthy nutrition.</p>	<p>2.1 List three key activities used to promote healthy nutrition and healthy weight.</p>	<p>2.1 Report number and percent of clients receiving WIC.*</p>
<p>2.2 Clients will engage in daily physical activity.</p>	<p>2.2 Encourage physical activity daily, at least one hour four times a week, or as allowed by MD if pregnant. Program policies and activities, including case management activities, will promote and model regular and frequent physical activity.</p>	<p>2.2 List three key activities used to promote physical activity.</p>	<p>2.2 Report the number and percent of: a. clients with any physical activity b. for those clients that report any physical activity, report the average days of physical activity per week.</p>

* MIS Scope of Work Report

** Service Referral Analysis Report

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
2.3 Pregnant clients will receive timely prenatal care in order to maximize their health and deliver a healthy baby.	2.3 Refer to prenatal provider, use CPSP provider when available. Identify and address barriers to keeping appointments.	2.3 Describe three successes/challenges in linking to CPSP and other prenatal providers.	2.3 Report the number and percent of clients pregnant at enrollment who: a. Received prenatal care* b. Had a LBW baby (<2500g)* c. Had a pre-term baby (<37 wks.)* d. Had an LGA baby (>4000g or 8#-13oz.)*
2.4 Clients will initiate and continue breastfeeding.	2.4 Encourage breastfeeding.	2.4 List three activities used to promote breastfeeding.	2.4 a. Report number and percent of clients who did any breastfeeding*. b. Report number and percent of clients planning to breastfeed if pregnant at intake*.
2.5 Clients will not use tobacco.	2.5 Assess each client for tobacco use using self-report and/or validated screening tool. Advise to quit or decrease tobacco use. Refer to tobacco quit line, other treatment as appropriate.	2.5 Briefly describe three activities to screen and refer clients to tobacco cessation.	2.5 a. Report number and percent of clients who were smoking at intake.* b. Report the number and percent of clients who were smoking at last follow up.*
2.6 Clients will not use alcohol or other drugs.	2.6 Assess each client for alcohol or other drug use using self-report and/or validated screening tool. Advise to quit or decrease alcohol or other drug use. Refer to treatment for alcohol or other drug use.	2.6 Describe three key challenges related to alcohol or other drug use among clients.	2.6 Report number and percent of clients who: a. Admit use of alcohol in the 6 months before intake* b. Admit use of alcohol in the 6 months before last follow up* c. Admit use of drugs in the 6 months before intake* d. Admit use of drugs in the 6 months before last follow up*

* MIS Scope of Work Report

** Service Referral Analysis Report

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
<p>2.7 Non pregnant clients will receive primary preventive health care.</p>	<p>2.7 Discuss with each client the importance of receiving primary preventive health care to prevent illness and identify and address health conditions early (for example, STIs, chronic conditions, pregnancy related conditions).</p> <p>Educate clients about importance of chlamydia screening (per CDC rec to annually screen all youth < 25) and encourage to request testing by provider.</p> <p>Identify and address barriers to clients receiving primary preventive health care.</p>	<p>2.7 Briefly describe three successes and challenges in clients obtaining primary preventive care.</p>	<p>2.7 Report the number and percent of clients who received primary preventive health care.*</p>
<p>2.8 Clients will demonstrate knowledge of normal child development and appropriate parenting skills.</p>	<p>2.8 Observe client/child interactions. Provide child development and parenting education. This could include use of validated early childhood developmental screening tools (e.g. ASQ, ASQ SE) and must include identification of a source of preventive and primary care for the client and her child. Provide anticipatory guidance and education regarding importance of developmental screening and well child visits.</p> <p>Model appropriate parenting skills and refer to parenting classes or other resources.</p>	<p>2.8 State how AFLP agency implements objective. Identify assessments or other curricula used and usual types of referrals. Discuss referrals made to improve knowledge of child development and appropriate parenting skills.**</p>	<p>2.8 Attach the Service Referral Analysis Report. **</p>

* MIS Scope of Work Report

** Service Referral Analysis Report

Goal 3: Improve high school graduation rates for pregnant and parenting teens

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
<p>3.1 All clients will set and achieve a goal to complete high school or equivalent.</p>	<p>3.1 Case managers will work with all clients to develop and execute a plan for the client to complete high school or the equivalent.</p> <p>CM will communicate with school staff responsible for tracking the client's academic progress (e.g. high school counselor, special education teacher, or migrant education program) routinely, at least biannually and note in Individual Service Plan (ISP). Identify and address barriers to attending and completing high school.</p>	<p>3.1 List and briefly describe the top three barriers to clients completing high school and strategies to address barriers.</p>	<p>3.1 Report the number, percent and total clients who:</p> <ul style="list-style-type: none"> a. Are attending school or have graduated or the equivalent* b. Have an educational goal. *
<p>3.2 Parenting Clients will have a reliable source of quality child care to enable them to attend school.</p>	<p>3.2 CM will help client identify and address barriers to obtaining reliable, high quality child care.</p>	<p>3.2 List and briefly describe the top three barriers to clients obtaining child care and strategies to address.</p>	<p>3.2 Report number and percent of clients not in school because of child care barrier.*</p>
<p>3.3 Clients will have reliable transportation to school.</p>	<p>3.3 CM will help client to identify and address barriers to obtaining reliable transportation to school.</p>	<p>3.3 List and describe the top three barriers to clients having transportation to school and strategies to address these barriers.</p>	<p>3.3 Report number and percent of clients not attending school because of transportation barrier.*</p>

* MIS Scope of Work Report

** Service Referral Analysis Report

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
3.4 Clients who have graduated from high school will enroll in postsecondary education or vocational training or will be employed.	3.4 CM will assist clients to develop and execute a plan for postsecondary education or training or employment (see next objective) after high school completion.	3.4 List and describe the top three barriers to clients enrolling in postsecondary education or training and strategies to address these barriers. Identify opportunities for policy development, program planning and collaboration.	3.4 Report the number and percent of clients who have graduated high school that are enrolled in postsecondary education or vocational training.*
3.5 Clients who have graduated from high school and are not enrolled in postsecondary education training will be employed.	3.5 CM will assist clients who do not wish to pursue postsecondary education or training to develop and execute a plan to obtain employment after high school completion.	3.5 List and describe the top three barriers to clients obtaining employment and strategies to address these barriers. Identify opportunities for policy development, program planning and collaboration.	3.5 Report the number and percent of clients who have graduated high school and are employed.*

* MIS Scope of Work Report

** Service Referral Analysis Report

Goal 4: Reduce repeat pregnancies in pregnant and parenting teens

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
<p>4.1 Clients who are not pregnant and are sexually active will:</p> <ul style="list-style-type: none"> • Always use contraception, • Use long acting contraceptives • Not have a repeat pregnancy while in the program. • Use condoms to prevent STIs 	<p>4.1</p> <p>Refer to Family PACT/ primary care provider.</p> <p>Identify and address barriers to correct and consistent use of contraception.</p> <p>Encourage clients to use long acting contraceptives.</p> <p>Document client pregnancies Encourage clients to use condoms to prevent STIs.</p> <p>Educate on family planning as possible within the scope of training and licensure of the CM.</p>	<p>4.1</p> <p>Describe the top three barriers to clients using contraception and strategies to address these barriers.</p>	<p>4.2</p> <p>Report Number and Percent of sexually active non-pregnant clients who:</p> <ol style="list-style-type: none"> a. are always using contraception* b. are using long acting contraceptives (6- IUD,7-implant)* <p>Report number and percent of sexually active clients who:</p> <ol style="list-style-type: none"> c. had a repeat birth while in the program (all female clients)* d. are using condoms* e. are using condoms with another contraceptive method.
<p>4.2 Clients will verbalize characteristics of healthy relationships and how to recognize and respond to reproductive coercion and birth control sabotage (RC/BCS).</p>	<p>4.2</p> <p>AFLP will integrate information about RC/BCS into the SID and train CMs to provide information to clients.</p> <p>Screen clients for RC/BCS.</p> <p>Provide resources (Safety cards, Web sites) on recognizing and addressing this.</p> <p>Refer clients to providers to obtain coercion resistant birth control methods and counseling.</p> <ul style="list-style-type: none"> • Provide emotional support. 	<p>4.2</p> <ol style="list-style-type: none"> a. Report number and percent of clients who received information on reproductive coercion and birth control sabotage. * <p>Describe process to integrate information on reproductive coercion and birth control sabotage into case management.</p> <ol style="list-style-type: none"> b. Report number and percent of clients referred for "coercion resistant" birth control methods and counseling.* <p>Provide compelling anecdotal</p>	<p>4.2</p> <ol style="list-style-type: none"> a. Report number and percent of clients who state they feel safe in their relationship with their partner/other parent at intake.* b. Report number and percent of clients who state they feel safe in their relationship with their partner/other parent at last follow up.*

* MIS Scope of Work Report

** Service Referral Analysis Report

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	<ul style="list-style-type: none"> Maintain and train on local policy and procedure for mandatory reporters. 	stories when available.	

* MIS Scope of Work Report
 ** Service Referral Analysis Report

Goal 5: AFLP will maintain program and fiscal management capability to administer the program as required by the AFLP Program Policies, Procedures and Scope of Work and will assure staff competency, program integrity, and data completeness

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
<p>5.1 AFLP will maintain program and fiscal management capability and will demonstrate that it is conducting AFLP activities as required in the AFLP Policies and Procedures, SOW and Program and Fiscal Policies and Procedures.</p>	<p>5.1</p> <ul style="list-style-type: none"> • Annually review, revise and enhance internal policies and procedures for delivering services to clients to prioritize the highest risk clients (Entry Criteria). • Meet the MOS. • AFLP will maintain a client to case manager ratio of no more than 50 clients per case manager. • Submit AFA and Annual Report timely. • Collect and input monthly Follow Up, Service Matrix and Additional Outcomes forms that are due. 	<p>5.1</p> <ul style="list-style-type: none"> a. Submit Entry Criteria. b. Discuss risk rating factors used. c. Discuss successes and challenges in meeting or exceeding MOS. d. Complete the staffing profile in Annual Report. e. Complete the client profile in the Annual Report. f. State criteria for program completion/exit. g. State top three reasons for client exit. h. State common linkages to other programs or services for clients exiting the program. 	<p>5.1</p> <ul style="list-style-type: none"> a. Report number of clients and MOS for the year along with percent of allocation delivered (MOS and Caseload Analysis Report).* b. Submit the MOS and Caseload Analysis Report and AFLP Personnel List quarterly. * c. Report the percent of clients who have completed Follow Up Forms by the time the index child is six months old* d. Report the percent of clients who have Service Matrix and Additional Outcome forms with the most recent Follow Up Form. * <p>Annual Report (to MCAH Program Consultant and postmarked by due date of August 15) by electronic submission.</p> <p>Quarterly Reports (to MCAH Program Consultant and postmarked by due dates of January 31, April 30, July 31, and October 31) by electronic submission.</p> <p>Quarterly reports to include: Cover Sheet, MOS Report,</p>

* MIS Scope of Work Report

** Service Referral Analysis Report

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
			Caseload Analysis, & Personnel List Bi-monthly MIS Data (to MIS contractor) due: 7th and/or 17th of each month by electronic submission.
5.2 AFLP will maintain and increase staff competency.	5.2 <ul style="list-style-type: none"> • Identify staff training needs • Provide or support staff training • AFLP Director will attend statewide meetings. • If they have not done so already, AFLP Director will conduct self-assessment of Core Competencies for Providers of Adolescent Sexual and Reproductive Health using the ASHWG (CA Adolescent Sexual Health Workgroup) tools and require supervisory staff and case managers to do so. • Staff who have completed the self-assessment will develop and implement a plan to improve their skills and document progress annually. • Develop training for CM. 	5.2 <ol style="list-style-type: none"> a. List gaps in core competencies identified and trainings and professional development for AFLP staff to address these gaps and other training needs. b. Describe the plan for conducting ASHWG core competency assessment for case managers. 	5.2 Describe the outcome of the training evaluation.
5.3 AFLP Director will assure that CMs conduct intake, comprehensive baseline assessment, develop an Individual Service plan, provide appropriate referrals, and conduct other elements of case management defined in the	5.3 AFLP will conduct monitoring and evaluation of client documentation for: <ul style="list-style-type: none"> • Comprehensive Baseline Assessment (CBA) within 60 days of consent-includes home visit • Individual Service Plan (ISP) 	5.3 State number and percent of clients that: <ol style="list-style-type: none"> a. received a Comprehensive Baseline Assessment (CBA) within 60 days of enrollment* b. received a Home Visit within 60 days of enrollment* c. received monthly face to face 	5.3 Describe the outcome of the QI plan.

* MIS Scope of Work Report

** Service Referral Analysis Report

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
Standards, Policies and Procedures.	<ul style="list-style-type: none"> • within 60 days of consent • Monthly face to face client contact • Quarterly Home Visit • Quarterly contact with collaterals (i.e. parents, teachers, counselors) and service providers; • identification of barriers to services and emerging or changing client needs • evaluation of client use of services using feedback from client, collateral, and service providers. • Quarterly client reassessment and update and revision, if needed, of service plans <p>Monitor above measures in a quarterly random sample of 25 charts or 10%, whichever is lower, and routinely implement QI activities to address measures not meeting the standard. Consider addressing one deficient measure per quarter.</p>	<ul style="list-style-type: none"> d. contact* d. had an Individual Service Plan (ISP) within sixty days of enrollment* e. case manager made quarterly contact with collaterals or service providers.* f. received a reassessment subsequent to the initial assessment.* g. received a case review to assure compliance with AFLP Standards, Policies and Procedures (narrative). h. state what opportunities are currently available for staff to meet and share successes, identify challenges and strategize around solutions. i. state how frequently opportunities identified in i. are available. <p>Refer to the MIS SOW Report or the MIS Client Contact Summary Report</p> <p>Briefly describe QI activities and which standard(s) have been addressed.</p>	

* MIS Scope of Work Report

** Service Referral Analysis Report

Goal 6: To support pregnant and parenting teens at high schools and community service centers to implement the AFLP Positive Youth Development intervention. (Only for AFLP-PYD agencies)

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
6.1 Address internal agency conditions and external factors that affect youth-serving partnerships with schools and community.	6.1 Continue to update strategic plan based on guidelines provided by State MCAH. The strategic plan will address the youth serving programs and systems that provide client linkages to community support.	6.1 Strategic plan updated by agencies.	6.1 Submit a progress report related to activities and goals identified in the strategic plan.
6.2 Assure baseline knowledge and skills necessary to work with pregnant and parenting teens and support the implementation of the standardized case management intervention with integrated life planning.	6.2 AFLP managers, supervisors, and CMs will participate in trainings that support the key concepts and content areas of the AFLP PYD intervention.	6.2 Training attendance list.	6.2 Following each training, 80% of the AFLP managers, supervisors and CMs will demonstrate increased knowledge related to training topics based on a retrospective pre/post evaluation.
6.3 Inform the development and effective implementation of the standardized case management intervention with integrated life planning.	6.3 Participate in state sponsored site visits.	6.3 Submit information to State MCAH as appropriate and assist State MCAH staff to summarize and integrate findings. Maintain documentation onsite.	6.3 Pilot and implement the revised, standardized intervention.
	6.3.1 Participate in conference calls, focus groups, regional meetings, surveys and work groups to inform the development, implementation, and resolution of challenges of the AFLP intervention. Participate in development of AFLP program standards.	6.3.1 Submit information to State MCAH as appropriate and assist State MCAH staff to summarize and integrate findings.	6.3.1 Submit information to State MCAH as appropriate and assist State MCAH staff to summarize and integrate findings.

* MIS Scope of Work Report

** Service Referral Analysis Report

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
6.4 Ensure a quality intervention with program fidelity and Continuous Quality Improvement (CQI) as the standards for the intervention are developed.	6.4 Work with State MCAH to develop a CQI plan to evaluate and monitor the implementation of the standardized case management intervention with integrated life planning. These activities may include participating in focus groups, site visits, and use of CQI tools developed by State MCAH.	6.4 CQI plan will be developed and implemented.	6.4 Agencies will report on the outcomes of CQI activities and indicate how gaps will be addressed.
6.5 To comply with required reporting requirements.	6.5 Complete annual report using format provided by state MCAH.	6.5 Develop plan to maintain records for reporting on SOW.	6.5 Complete annual report. (to MCAH Program Consultant and postmarked by due date of August 15) by electronic submission.

Part III. Black Infant Health Program

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 four goals of the BIH Program are to:

1. Improve African American infant and maternal health.
2. Increase the ability of African American women to manage chronic stress.
3. Decrease Black-White health disparities and social inequities for women and infants.
4. Engage the community to support African American families' health and well-being with education and outreach efforts.

To achieve these goals, 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 participant and program data into the electronic MCAH-BIH-MIS and engage community partner agencies.

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 their entirety](#). In addition, all BIH Sites shall work toward meeting the BIH Program Standards and to maximize fidelity in implementing Program services, fulfilling all deliverables associated with benchmarks, attending required meetings and trainings and completing other MCAH-BIH reports as required. All activities in this SOW shall take place within the fiscal year.

The Black Infant Health program is a specialized CDPH MCAH program under the local MCAH system and helps to address MCAH SOW Goal 2 – Improve Maternal and Women's Health.

Contained within the BIH SOW, under the Measures (Process and Outcome) cells, 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 client-level program data maintained in the MCAH BIH Management Information System (MIS) included in the MCAH-BIH-MIS. The "N" Source Key refers to narrative information provided in quarterly reports or site surveys.

Part III: Black Infant Health Program

Goal 1: BIH will maintain program fidelity and fiscal management to administer the program as required by the BIH Program Policies and Procedures and Scope of Work and will assure program implementation, staff competency and data management

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
<p>1.1 LHJ Maternal, Child and Adolescent Health (MCAH) Director and/or designee (BIH Coordinator) will provide oversight, maintain program fidelity, fiscal management and demonstrate that it is conducting BIH activities as required in the BIH Policies and Procedures, SOW, Client Data Book, Group Curriculum, and MCAH Fiscal Policies and Procedures.</p>	<p>1.1</p> <ul style="list-style-type: none"> Annually review and revise internal policies and procedures for delivering services to eligible BIH participants. Submit Agreement Funding Application timely. Submit BIH Annual report by August 15, 2015. Submit BIH Quarterly Reports as directed by MCAH. 	<p>1.1</p> <ul style="list-style-type: none"> Briefly describe MCAH Director and/or BIH Coordinator responsibilities as they relate to BIH. Provide organizational chart that outlines delineation of responsibilities from MCAH to the BIH Program. 	<p>1.1 Not Applicable</p>
<p>1.2 Each LHJ must have in place qualified personnel as outlined in the P&P.</p>	<p>1.2</p> <ul style="list-style-type: none"> At a minimum, the following key staffing roles are required: <ul style="list-style-type: none"> 1 FTE BIH Coordinator 3 FTE FHA/Group Facilitators .50 FTE PHN 1 FTE Community Outreach Liaison 1 FTE Data Entry Staff 1 FTE Mental Health Clinician Utilization of a staff hiring plan. 	<p>1.2</p> <ul style="list-style-type: none"> Describe process of hiring staff at each site that are filled by personnel who meet recommended qualifications in the P&P. Include duty statements of all staff with submission of AFA Packet. Submission of all staff changes per guidelines outlined in BIH P&P guidelines. 	<p>1.2 Percent of key staffing roles at site filled by personnel who meet recommended qualifications in the P&P. (N)</p>

* MIS Scope of Work Report

** Service Referral Analysis Report

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
<p>TRAINING</p> <p>1.3</p> <p>All BIH staff will maintain and increase staff competency.</p>	<p>1.3</p> <ul style="list-style-type: none"> • Develop a plan to assess staff's ability to effectively perform their assigned tasks, including regular observations of group facilitators. • Identify staff training needs and ensure those needs are met, and notifying MCAH of any training needs. • Ensure that all key BIH staff participates in training or educational opportunities designed to enhance cultural sensitivity. • Require that all key BIH staff (i.e. MCAH Director, BIH Coordinator, and ALL direct service staff) attend mandatory MCAH Division-sponsored trainings, meetings and/or conferences as scheduled by MCAH Division. • Ensure that the BIH Coordinator and all direct service staff attend mandatory MCAH Division-sponsored training(s) prior to implementing the BIH Program. • Ensure that the BIH Coordinator and/or MCAH Director perform regular observations of group facilitators and assessments of FHAs' case management activities. 	<p>1.3</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) • Describe how staff has improved their performance and confidence in implementing the program model. (N) • List gaps in staff development and training. (N) • Describe plan to ensure that staff development needs are met. (N) • Describe how cultural sensitivity training has enhanced LHJ staff knowledge and how that knowledge is being applied. (N) • Recommend training topics that could be addressed at statewide meetings. (N) • Completion of group observation form. 	<p>1.3</p> <ul style="list-style-type: none"> • MCAH-BI H-MIS Utilization Reports for all staff at BIH Sites. (M)

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
<p>DATA ENTRY</p> <p>1.4 All BIH participant information and outcome data will be collected timely and accurately using BIH required forms at required intervals.</p>	<p>1.4</p> <ul style="list-style-type: none"> Ensure that all direct service staff participate in data collection, data entry, data quality improvement, and use of data collection software determined by MCAH. Ensure that all subcontractor agencies providing direct service enter data in the MCAH-BIH-MIS as determined by MCAH. Ensure accuracy and completeness of data input into MCAH-BIH-MIS system. Ensure that all staff receives 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 Data and Evaluation Committee calls. 	<p>1.4</p> <ul style="list-style-type: none"> Review data systems reports and discuss during calls with BIH State Team. Enter All data into the MCAH-BIH-MIS within 7 working days of collection 	<p>1.4</p> <ul style="list-style-type: none"> Number and percent of enrolled cases that have not had any information/action entered into the MIS within two weeks of enrollment. (M) Number and percent of participants with completed client recruitment forms. (M) Number and percent of open cases more than 12 months after delivery date. (M)
<p>PARTICIPANT RECRUITMENT/OUTREACH</p> <p>1.5 All BIH LHJs will recruit, outreach and enroll African American women 18 years of age early in pregnancy.</p>	<p>1.5</p> <ul style="list-style-type: none"> Implement the program activities as designed. Develop a Participant Recruitment Plan (standardized intake process) according to the target population and eligibility guidelines in CDPH/MCAH BIH P&P. Recruitment plan is reviewed 	<p>1.5</p> <ul style="list-style-type: none"> Submit participant triage algorithm with submission of AFA packet. Participant Recruitment Plan will be reviewed annually and updated as needed. Describe outreach activities performed in order to reach target population. 	<p>1.5</p> <ul style="list-style-type: none"> Describe deviations in outreach activities, noting changes from local recruitment plan. (N) Describe any program improvements resulting from client satisfaction survey findings. (N)

* MIS Scope of Work Report

** Service Referral Analysis Report

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	annually and updated as needed.		
ENROLLMENT 1.6 <ul style="list-style-type: none"> 100% of participants enrolled in BIH will be African American. 95% of participants will be 18 years or older when enrolled in BIH. 100% of participants will be enrolled during pregnancy. <ul style="list-style-type: none"> 80% of participants will be enrolled at or before 26 weeks of pregnancy. 100% of women will participate in group intervention. 	1.6 <ul style="list-style-type: none"> Enroll participants that are African American. Enroll participants during pregnancy. Enroll participants at or before 26 weeks of pregnancy. Enroll women that will participate in group intervention. Provide referrals to other MCAH programs for women who cannot participate in group intervention sessions. 	1.6 Not Applicable	1.6 <ul style="list-style-type: none"> Number and percent of participants who are 18 years of age and older.(M) Number and percent of participants enrolled at or before 26 weeks of pregnancy. (M)
PROGRAM PARTICIPATION 1.7.1 <ul style="list-style-type: none"> 100% of women will participate in prenatal group. <ul style="list-style-type: none"> 80% of women will participate in group within 30 days of signing consent. 	1.7.1 Schedule participants in a prenatal group within 30 days of signing consent form.	1.7.1 Describe barriers, challenges and successes of enrolling participants in prenatal group within 30 days of signing consent form. (N)	1.7.1 Number and percent of enrolled participants who attend a prenatal group session within 30 days of signing consent form. (M)
1.7.2 <ul style="list-style-type: none"> All BIH participants will receive complementary case management support as defined in the P&P. At least 65% of all participants will complete all prenatal and postpartum assessments within the recommended time 	1.7.2 <ul style="list-style-type: none"> Conduct complementary case management services that align with the Individualized Client Plan. Collect completed self-administered scaled questions as described in P&P. Collect the required number of assessments per timeframe 	1.7.2 <ul style="list-style-type: none"> Report number of prenatal and postpartum participants served. (M/N) Report number and percent of participants included in outreach but do not enroll.(M) Report number and percent of enrolled participants for whom the following actions are 	1.7.2 <ul style="list-style-type: none"> Number and percent of participants with completed prenatal and postpartum assessments, including Birth Plans at appropriate time intervals. (M) Number and percent of new participants with completed initial case conferencing. (M)

* MIS Scope of Work Report

** Service Referral Analysis Report

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		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
<p>intervals.</p> <ul style="list-style-type: none"> 100% of BIH participants will receive referrals to services outside of BIH based on her ICP. 	<p>outlined in P&P.</p> <ul style="list-style-type: none"> Develop and implement an ICP for each BIH participant; complete all prenatal and postpartum assessments; provide ongoing identification of her specific concerns/needs, and referral to services outside of BIH as needed based on her ICP Conduct case closure activities. Regularly conducting client satisfaction surveys. Submit complete and accurate reports in the time specified by MCAH. 	<p>completed (M):</p> <ul style="list-style-type: none"> Intake procedures, including completion of an initial assessment and date of initial prenatal group. Initial case conferencing ICP/Life Plan 4 of 6 assessments (prenatal clients) Case closure, including Life Plan, ICP, and Assessments. 	<ul style="list-style-type: none"> Number and percent of participants with documented disposition of referral services. (M)
<p>1.7.3 All BIH participants will participate in Group Intervention Sessions.</p>	<p>1.7.3</p> <ul style="list-style-type: none"> Schedule group sessions with guidance from State BIH Team. Conduct and adhere to the 20-group intervention model as specified in the P&P. 	<p>1.7.3</p> <p>Percentage of enrolled participants who participated in group intervention. (M)</p> <ul style="list-style-type: none"> Submit FY 2014-15 Group Session Calendar to MCAH-BIH Program upon request. Number and percent of enrolled clients for whom the following actions are completed (M): <ul style="list-style-type: none"> 7 of 10 Prenatal Group Sessions. 7 of 10 Postpartum Group Sessions. 	<p>1.7.3</p> <p>Number and Percent of participants who complete both the prenatal and postpartum group intervention. (M)</p>
<p>1.8 All participant and program data will be entered in the MCAH-BIH- MIS timely and accurately.</p>	<p>1.8</p> <ul style="list-style-type: none"> Accurately and completely collect required participant information, with timely data input into the appropriate data system(s). 	<p>1.8</p> <ul style="list-style-type: none"> Number and percent of participant records entered into the MCAH- BIH-MIS within 7 working days of collection on paper forms. (M) 	<p>1.8</p> <ul style="list-style-type: none"> Number and percent of enrolled participants that have information/action entered into the MIS within two weeks of collection. (M)

* MIS Scope of Work Report

** Service Referral Analysis Report

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	<ul style="list-style-type: none"> • Work with MCAH to ensure proper and continuous operation of the MCAH-BIH-MIS. • Store Client Data Book forms on paper per guidelines in P&P. • Define a data entry schedule for staff. 	<ul style="list-style-type: none"> • Generate Standard Reports at least quarterly as a management tool to assess data accuracy and completeness. (M) • BIH Coordinator and/or FHA/Data Entry Staff shall conduct periodic audits of participant records and report results and number reviewed (minimum 10%). 	<ul style="list-style-type: none"> • Number and percent of cases with completed recruitment forms. (M) • Number and percent of participating women with cases closed 12 months after delivery date. (M)

Goal 2: Engage the community to support African American families' health and well-being with education and outreach efforts

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
<p>2.1 BIH Coordinator and/or MCAH Director will elevate community awareness of African American birth outcomes and the impact on society.</p>	<p>2.1</p> <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 and referral agencies that support the broad goal of the BIH Program, through formal and informal agreements. Develop community awareness plan that outlines how community engagement will be conducted. 	<p>2.1</p> <ul style="list-style-type: none"> Describe the local plan for community linkages, including an effective referral process that will be reviewed on an annual basis and updated as needed. (N) Briefly describe successes and barriers to community education activities or events. (N) List and describe formal and informal partnerships with community and referral 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) 	<p>2.1</p> <ul style="list-style-type: none"> Describe community outreach activities conducted by BIH Coordinator and/or MCAH Director with submission of BIH Quarterly Reports. (N)
<p>2.2 BIH Outreach Liaison will increase information sharing with other local social services agencies in the community and establish a clear point of contact.</p>	<p>2.2</p> <ul style="list-style-type: none"> Develop collaborative relationships with local service agencies in the community to establish strong resource linkages for recruitment of potential participants and for referrals of active participants. Develop a clear point of contact (person/s) with collaborating community agencies on a regular basis as it relates to outreach, enrollment, referrals, care coordination, etc. 	<p>2.2</p> <ul style="list-style-type: none"> List the types of outreach performed along with materials used to educate community partners about BIH. (N) List and describe barriers, challenges and/or successes related to establishing community partnerships and points of contact. (N) 	<p>2.2</p> <ul style="list-style-type: none"> Number of agencies where the Outreach Liaison has a clear point of contact and with whom information is regularly exchanged. (M) Describe community outreach activities conducted by Outreach Liaison with submission of BIH Quarterly Reports. (N)

* MIS Scope of Work Report

** Service Referral Analysis Report

Goal 3: Increase the ability of African American women to manage chronic stress

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
<p>3.1 All BIH participants will report increased social support and decreased social isolation after attending prenatal and/or postpartum group intervention and completing ICP/Life Plan.</p>	<p>3.1</p> <ul style="list-style-type: none"> • Implement the prenatal and postpartum group intervention with fidelity to the P&P. • Encourage participants to attend and participate in group sessions. • Support clients in fostering healthy interpersonal and familial relationships. • Report results from group facilitator feedback form, including description of participant engagement in group activities, for each group session. 	<p>3.1</p> <ul style="list-style-type: none"> • Provide FY 2014- 2015 group intervention schedules upon request.(N) • Number and percent of enrolled participants who participate in group intervention. (M) 	<p>3.1</p> <ul style="list-style-type: none"> • Number and percent of participants who report an increase in social support as measured through the Social Provisions Scale – Short (SPS-S) (M) • Number and percent of completed group facilitator forms. (M)
<p>3.2 All BIH participants will report increased self-esteem, mastery, coping and resiliency after attending prenatal and/or postpartum group intervention and completing ICP/Life Plan.</p>	<p>3.2</p> <p>All activities are delivered with an understanding of African American culture and history.</p> <ul style="list-style-type: none"> • Assist participants in identifying and utilizing their personal strengths. • Develop and implement an Individual Client Plan (ICP)/Life Plan with each client. • Teach and provide support to participants as they develop goal- setting skills and create their Life Plans. • Teach participants about the importance of stress reduction 	<p>3.2</p> <ul style="list-style-type: none"> • Number and percent of participants who complete a Life Plan.(M) • Number and percent of participants who complete an ICP. (M) • Describe challenges/barriers why participants did not report an increase in self-esteem, mastery, coping and resiliency after attending prenatal and/or postpartum group intervention and completing ICP/Life Plan. (N) 	<p>3.2</p> <ul style="list-style-type: none"> • Number and percent of women who clearly articulate at least one short and long term goal as part of their ICP. (M) • Number and percent of women who report progress toward stated short term goals identified in their ICP. (M) • Number and percent of participants who maintain or increase self-esteem based on responses to the Rosenberg Self-Esteem Scale. (M) • Number and percent of participants who maintain or

* MIS Scope of Work Report

** Service Referral Analysis Report

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	<p>and guide them in applying stress reduction techniques.</p> <ul style="list-style-type: none"> • Support participants as they become empowered to take actions toward meeting their needs. • Teach participants how to express their feelings in constructive ways. • Help participants to understand societal influences and their impact on African American health and wellness. 		<p>increase mastery based on responses to the Pearlin Mastery Scale. (M)</p> <ul style="list-style-type: none"> • Number and percent of participants who maintain or increase coping and resiliency based on responses to the Brief Resilience Scale. (M)

Goal 4: Improve the health of pregnant and parenting women, thus also promoting the health of their infants

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
<p>4.1 All BIH participants will be linked to services that support health and wellness while enrolled in the BIH Program.</p>	<p>4.1</p> <ul style="list-style-type: none"> • Assist participants in understanding behaviors that contribute to overall good health, including: <ul style="list-style-type: none"> ○ Stress management ○ Sexual health ○ Nutrition ○ Physical activity • Ensure that participants are receiving prenatal care. • Ensure that healthy nutritious snacks are available during group sessions. • Provide participants with health information that supports a healthy pregnancy. • Ensure that participants have access to health insurance. • Identify participants' health and social needs and provide referrals and follow-up as needed to health and community services. • Provide information and health counseling to participants who report drug, alcohol and/or tobacco use. • Assist participants with completion of their birth plan. 	<p>4.1</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 participants. (N) • Number and percent of participants reporting drug, alcohol and/or tobacco use who are provided information and health counseling. (M) • Number and percent of prenatal participants who complete a birth plan. (M) • Number and percent of participants receiving prenatal care by trimester of program initiation. (M) • Number and percent of participants enrolled in WIC. (M) • Number and percent of previously uninsured participants who obtained needed health insurance while enrolled in BIH. (M) • Number and percent of prenatal participants who complete a birth plan. (M) 	<p>4.1</p> <ul style="list-style-type: none"> • Number and percent of participants whose health status improves over the course of their participation in BIH. (M) • Number and percent of participants and infants who obtained needed health and community services while enrolled in BIH. (M) • Number and percent of participants whose healthy eating behaviors improve over the course of their participation in BIH. (M) • Number and percent of participants whose physical activity increased over the course of their participation in BIH. (M)

* MIS Scope of Work Report

** Service Referral Analysis Report

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
<p>4.2</p> <p>All BIH participants will report an increase in knowledge and understanding of reproductive life planning and family planning services.</p>	<p>4.2</p> <ul style="list-style-type: none"> Promote and support family planning by providing information and counseling. Promote and support interconception health. Help participants understand and value the concept of reproductive life planning as they complete their Life Plans. Help participants understand the characteristics of healthy relationships and provide resources that can help participants deal with abuse, reproductive coercion or birth control sabotage. Provide referrals and promote linkages to family planning providers including FFACT. 	<p>4.2</p> <p>Number and percent of participants who complete a Life Plan. (M)</p>	<p>4.2</p> <ul style="list-style-type: none"> Number and percent of participants who attend a 4-6 week postpartum checkup with a medical provider. (M) Number and percent of participants who use any method of birth control to prevent pregnancy after their babies are born. (M)
<p>4.3</p> <p>All BIH participants will be screened for Perinatal Mood and Anxiety Disorders (PMAD) and those with positive screens will be given a referral to mental health services.</p>	<p>4.3</p> <ul style="list-style-type: none"> Help participants understand how mental health contributes to overall health and wellness. Help participants recognize the connection between stress and mental health and practice stress reduction techniques. Help participants understand the connection between physical activity and mental health. Administer the EPDS to every client 6-8 weeks after she gives birth. Help participants understand the symptoms of postpartum 	<p>4.3</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 participants who completed the Edinburgh Postpartum Depression Screen (EPDS) 6-8 weeks postpartum. (M) 	<p>4.3</p> <ul style="list-style-type: none"> Number and percent of participants with "positive" EPDS screens who are successfully referred to a community mental health provider. (M)

* MIS Scope of Work Report

** Service Referral Analysis Report

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		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	depression. <ul style="list-style-type: none"> • Provide referrals and follow-up to mental health services when appropriate. 		
4.4 All BIH participants will report an increase in parenting skills and bonding with their infants and other family members.	4.4 <ul style="list-style-type: none"> • Assist participants in understanding and applying effective parenting techniques. • Assist participants with completing home safety checklist. • Assist participants with increasing knowledge of infant safe sleep practices/sudden infant death syndrome (SIDS), sudden unexplained infant death (SUID) risk reduction. • Assist participants with completing birth plan. • Assist participants with identifying and using bonding strategies, including breastfeeding, with their newborns. 	4.4 <ul style="list-style-type: none"> • List and describe additional activities that enhance parenting and bonding. (N) • Number and percent of participants who complete the safety checklist. (M) • List and describe additional activities on infant safe sleep practices/SIDS/SUID risk reduction. (N) • Number and percent of postpartum participants who initiate breastfeeding. (N) • Number and percent of prenatal participants who complete a birth plan. (M) 	4.4 <ul style="list-style-type: none"> • Provide anecdotes/client success stories about improved parenting/bonding with submission of BIH Quarterly Reports. • Provide anecdotes/client success stories about infant safe sleep practices and SIDS/SUID risk reduction with submission of BIH Quarterly Reports. • Provide anecdotes/client success stories about breastfeeding practices with submission of BIH Quarterly Reports.

* MIS Scope of Work Report

** Service Referral Analysis Report