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Black Infant Health Scope of Work

The Agency agrees to provide to the Department of Public Health the services in this Scope of Work (SOW). The California Department of Public Health Maternal, Child and Adolescent Health (MCAH) Division places a high priority on the poor outcomes that disproportionately impact the African American community in California. Central to the efforts in reducing these disparities is the Black Infant Health (BIH) Program. The goal of the BIH Program is to improve African American infant and maternal health and decrease Black-White health disparities and social inequities for women and infants. To achieve this goal, the BIH Program is a client-centered, strength-based group intervention with complimentary 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 maintain a data base to measure outcomes.

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

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

All BIH sites are required to comply with the [BIH Policy and Procedure \(P&P\) Manual](#) and the [MCAH Fiscal Policies and Procedures Manual](#). In addition, all BIH sites shall work toward meeting the BIH Program Standards that maximize program fidelity. The SOW is intended to document process and document outcome measures as data is available.

All activities in this Scope of Work shall take place within the fiscal year.

Under the Measures (Process and Outcome) cells there are Source Keys that designed to provide a reference for reporting purposes. The "M" Source Key is data that is in the MIS and can be generated through a report. The "N" Source Key is narrative to explain the measure

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

Outcome Objective(s)	Intervention Activities to Meet Objectives	Evaluation/Performance Measures Measures to be Reported in the Annual Report, semi-annually or quarterly where indicated)	
		Process Measures	Outcome Measures
1.1 Increase social support and decrease social isolation among women in the BIH Program.	1.1 <ul style="list-style-type: none"> Implement the prenatal and postpartum group intervention. Encourage attendance and participation at all group sessions Support clients in fostering healthy interpersonal and familial relationships. 	1.1 <ul style="list-style-type: none"> Provide FY 11-12 group intervention schedules.(N) Describe decision-making process used to determine group intervention timing and frequency. (N) Complete group facilitator feedback forms, including description of women's engagement in group activities. (N) Number and percent of enrolled clients who participate in group intervention. (M) 	1.1 <ul style="list-style-type: none"> Number and percent of clients who report an increase in having someone to talk to regularly (M) Number and percent of clients who report an increase in practical help (M). Number and percent of clients who report receiving emotional support from the father of the baby (M) Number and percent of clients who report receiving financial support from the father of the baby (M) Provide anecdotes/client stories of increases in social support (N)

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		Process Measures	Outcome Measures
1.2 Increase self-esteem, mastery, coping and resiliency by empowering women in the BIH Program.	1.2.1 All activities are delivered with an understanding of African American culture and history. <ul style="list-style-type: none"> • Assist clients in identifying and utilizing their personal strengths. • Develop and implement an Individual Client Plan (ICP) with each client. • Teach and support clients in developing goal setting skills and creating a Life Plan. • Teach clients the importance of stress reduction and guide them in applying stress reduction techniques. • Empower clients to get their needs met. • Teach clients how to express their feelings in constructive ways. • Help clients to understand societal influences and their impact on African American health and wellness. • Assist client in understanding the connection between financial literacy and empowerment. 	1.2 <ul style="list-style-type: none"> • Number and percent of clients who completed a Life Plan.(M) • Number and percent of clients who complete ICP. (M) 	1.2.1 <ul style="list-style-type: none"> • Number and percent of clients who have increased self-esteem based on responses to the Rosenberg Self-Esteem Scale. (M) • Number and percent of clients who have increased mastery based on responses to the Pearl in Mastery Scale. (M) • Number and percent of clients who have increased coping and resiliency based on responses to the Brief Resilience Scale. (M) • Provide anecdotes/client stories of increases in coping/resiliency (N)

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

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

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	they complete their Life Plan. <ul style="list-style-type: none"> Assist clients to understand the characteristics of healthy relationships and provide resources to assist in dealing with abuse, reproductive coercion or birth control sabotage. Provide referrals and promote linkages to family planning providers including FPACT. 		stories about improved planning for future pregnancies. (N)
2.3 Improve the mental health of women in the BIH program.	2.3 <ul style="list-style-type: none"> Assist clients in understanding contribution of mental health to overall health and wellness. Assist clients in recognizing the connection between stress and mental health, and practice stress reduction techniques. Help clients understand the connection between physical activity and mental health. Administer Edinburgh Postpartum Depression Screen (EPDS) to every postpartum client at 6-8 weeks after delivery. Help clients understand the symptoms of postpartum depression. Provide referrals and follow-up to mental health services. 	2.3 <ul style="list-style-type: none"> Describe successes and challenges in addressing mental health issues including mental health referrals. (N) Number and percent of clients who received EPDS 6-8 weeks postpartum. (M) 	2.3 <ul style="list-style-type: none"> Number and percent of clients who report a decrease in feeling sad, empty or depressed. (M) Provide anecdotes/client stories about stress reduction related to improved mental health. (N) Number and percent of EPDS positive screens successfully referred to community mental health provider. (M)

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2.4 Enhance women's parenting skills and bonding with their infants and other family members.	2.4 <ul style="list-style-type: none"> • Assist clients in understanding and applying effective parenting techniques. • Assist women with completing home safety checklist. • Assist women with completing birth plan. • Assist clients with identifying and using bonding strategies, including breastfeeding, with their newborns. 	2.4 <ul style="list-style-type: none"> • List and describe additional activities that enhance parenting and bonding. (N) • Number and percent of clients who complete the safety checklist. (M) • Number and percent of prenatal clients who complete a birth plan. (M) 	2.4 <ul style="list-style-type: none"> • Number and percent of prenatal clients intending to breastfeed.(M) • Number and percent of women breastfeeding exclusively at 6 months postpartum. (M) • Provide anecdotes/client stories about improved parenting/bonding. (N)

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

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

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

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

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	<p>community linkages and effective referrals that is reviewed and updated annually.</p> <ul style="list-style-type: none"> • Submitting complete and accurate reports in the time specified by MCAH Program. <p>*MCAH Division will provide guidance on the development of local CQI plans.</p>	<p>assess status and identify areas for quality improvement. (M)</p> <ul style="list-style-type: none"> • Describe local CQI activities conducted. (N) • Report number of clients served (caseload) in the old model. (M) • Submit quarterly progress reports as defined by the MCAH Division • Submit Annual Report by August 15th. (N) • Maintain log of group records. (N) • Submit community linkages and referrals plan and note any annual changes. (N) 	
4.2 Maintain effective data management.	<p>4.2</p> <ul style="list-style-type: none"> • Accurately and completely collecting required client information, with timely data input into the appropriate data system(s). • Responding to MCAH Division data requests in a timely manner. • Working with MCAH Division to ensure proper and continuous operation of the BIH MIS and the MCAH MIS. • Storing Client Data Book forms on paper until staff has been trained to use the MCAH MIS and can access the system. 	<p>4.2</p> <ul style="list-style-type: none"> • Briefly describe the LHJ data management process. (N) • Number and percent of client records entered into the MIS within 30 days of collection on paper forms. (M) • Generate standard reports at least quarterly as a management tool to assess data accuracy and completeness. (M) • Describe aspects of data management activities that did not meet or differed from program guidelines.(N) 	

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4.3 Maintain and increase staff competency.	<p>4.3</p> <ul style="list-style-type: none"> Identifying staff training needs and ensure those needs are met, and notify MCAH Division of any training needs. Developing a plan to assess staffs' ability to effectively perform their assigned tasks including regular observations of group facilitators. Requiring that all key BIH staff (i.e. MCAH Director, BIH Coordinator, Group Facilitators, FHAs attend the 2-day annual BIH Meeting. In addition, other staff (i.e. public health nurses, mental health professionals and social workers) are encouraged to attend the 2-day annual meeting Requiring that the BIH Coordinator, FHAs, and Group Facilitators attend a 3-day MCAH Division-sponsored training prior to implementing the BIH Program. Ensuring that selected staff participate in training for data collection, data quality improvement, and data collection software use as determined by MCAH Division. Ensuring that the BIH Coordinator and/or MCAH director perform regular observations of group facilitators and audits of FHA case 	<p>4.3</p> <ul style="list-style-type: none"> Describe training activities in which staff participated (N) List gaps in staff development and training. (N) Describe plan to ensure staff development needs are met. (N) Describe training recommendations for consideration at statewide meetings. (N) Maintain records of staff participation in development activities and staff attendance at trainings. (N) 	<p>4.3</p> <ul style="list-style-type: none"> Describe ways in which training activities have improved staff performance in implementing the program model. (N)

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	management process.		