**FY 2017 - 2018 AGREEMENT FUNDING APPLICATION (AFA) CHECKLIST**

**Agency Name:** County of San Bernardino  
**Agreement #:** 201736  
**Program:** ☒ BIH   ☐ AFLP   ☐ CHVP  
*(Check one box only)*

Please check the box next to all submitted documents. 
All documents must be submitted by email using the required naming convention on page 2.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☒</td>
<td>1. <strong>AFA Checklist</strong></td>
</tr>
<tr>
<td>☒</td>
<td>2. <strong>Agency Information Form</strong> with signature (PDF)</td>
</tr>
<tr>
<td>☒</td>
<td>3. <strong>Attestation of Compliance with the Sexual Health Education Accountability Act of 2007</strong> (PDF)</td>
</tr>
<tr>
<td>☒</td>
<td>4. <strong>Community Profile</strong> submit only one profile including information about your MCAH, AFLP and/or BIH populations and programs as applicable (Word)</td>
</tr>
<tr>
<td>☒</td>
<td>5. <strong>Budget Template</strong> submit for the next two upcoming Fiscal Years (17/18 and 18/19) list all staff (by position) and costs (including projected salaries and benefits, operating and ICR). Multiple tabs for completion include Summary Page, Detail Pages, and Justifications. Personnel must be consistent with the Duty Statements and Organizational Charts (Excel)</td>
</tr>
<tr>
<td>☒</td>
<td>6. <strong>Indirect Cost Rate (ICR) Certification Form</strong> details methodology and components of the ICR</td>
</tr>
<tr>
<td>☒</td>
<td>7. <strong>Duty Statements (DS)</strong> for all staff (numbered according to the Personnel Detail Page and Organization Chart) listed on the budget</td>
</tr>
<tr>
<td>☒</td>
<td>8. <strong>Organization Chart(s)</strong> of the applicable programs, identifying all staff positions on the budget including their Line Item # and its relationship to other services for women and children, the local health officer and overall agency</td>
</tr>
<tr>
<td>☐</td>
<td>9. <strong>Approval Letters</strong> submit most recent letter on State letterhead with state staff signatures, including waivers for the following positions: ☐ MCAH Director; ☐ BIH Coordinator; ☐ AFLP Director; ☐ CHVP Coord./Nurse Sup.; ☐ Other</td>
</tr>
<tr>
<td>☒</td>
<td>10. <strong>Scope of Work (SOW)</strong> documents for all applicable programs (PDF/Word)</td>
</tr>
<tr>
<td>☒</td>
<td>11. <strong>Annual Inventory</strong> – Form CDPH 1204</td>
</tr>
<tr>
<td>☐</td>
<td>12. Local Health Officer Approval Letter to conduct FIMR [MCAH only]</td>
</tr>
<tr>
<td>☐</td>
<td>13. <strong>Subcontractor (SubK) Agreement Packages</strong> submit Subcontract Agreement Transmittal Form, brief explanation of the award process, subcontractor agreement or waiver letter, and budget with detailed Justifications (required for all SubKs $5,000 or more) (Word)</td>
</tr>
<tr>
<td>☐</td>
<td>14. <strong>Certification Statement for the Use of Certified Public Funds (CPE)</strong> [AFLP CBOs and/or SubKs with FFP]</td>
</tr>
<tr>
<td>☐</td>
<td>15. <strong>STD 204 Payee Data Record</strong> (if applicable) for new or updated information</td>
</tr>
</tbody>
</table>
File Naming Convention Example

Please save all electronic documents using the required naming convention below:

Agreement # (space) Program Abbreviation (space) Document # (space) Document Name (from Checklist Above) (space) (Month/Day/Year) XXXXXX

Example for MCAH Program:

2017XX MCAH 1 AFA Checklist 010517
2017XX MCAH 2 Agency Information Form 010517
2017XX MCAH 3 Attestation 010517
2017XX MCAH 4 Program Narrative 010517
2017XX MCAH 5 Budget Template 010517
2017XX MCAH 6 ICR Certification Form 010517
2017XX MCAH 7 Duty Statement 1 010517
2017XX MCAH 7 Duty Statement 2 010517
2017XX MCAH 7 Duty Statement 3 010517
2017XX MCAH 7 Duty Statement 4 010517
2017XX MCAH 8 Org Chart 010517
2017XX MCAH 9 Approval Letter 010517
2017XX MCAH 10 SOW 010517
2017XX MCAH 11 Annual Inventory 010517
2017XX MCAH 12 FIMR Approval Letter 010517
2017XX MCAH 13 SubK Package 010517
2017XX MCAH 14 CPE 010517

Please contact your Contract Manager (CM) if you have any questions.
CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
MATERNAL, CHILD AND ADOLESCENT HEALTH (MCAH) DIVISION

FUNDING AGREEMENT PERIOD
FY 2017-2018

AGENCY INFORMATION FORM

Agencies are required to submit an electronic and signed copy (original signatures only) of this form along with their Annual AFA Package.

Agencies are required to submit updated information when updates occur during the fiscal year. Updated submissions do not require certification signatures.

AGENCY IDENTIFICATION INFORMATION

Any program related information being sent from the CDPH MCAH Division will be directed to all Program Directors.

Please enter the agreement or contract number for each of the applicable programs

<table>
<thead>
<tr>
<th>Program</th>
<th>Agreement or Contract Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCAH</td>
<td>201736</td>
</tr>
<tr>
<td>BIH</td>
<td></td>
</tr>
<tr>
<td>FIMR/SIDS</td>
<td>#</td>
</tr>
<tr>
<td>AFLP</td>
<td>#</td>
</tr>
<tr>
<td>CHVP</td>
<td></td>
</tr>
</tbody>
</table>

Update Effective Date: ________________ (only required when submitting updates)

Federal Employer ID#: 95-6002748

Complete Official Agency Name: County of San Bernardino

Business Office Address: 351 North Mountain View Avenue, Third Floor, San Bernardino, CA 92415-0010

Agency Phone: 909-387-9146

Agency Fax: 909-387-6228

Agency Website: www.sbcounty.gov/dph/publichealth
Please enter the **agreement or contract** number for each of the applicable programs

<table>
<thead>
<tr>
<th></th>
<th>MCAH</th>
<th>201736</th>
<th>BIH</th>
<th>0</th>
<th>FIMR/SIDS</th>
<th>#</th>
<th>AFLP</th>
<th>#</th>
<th>CHVP</th>
</tr>
</thead>
</table>

The undersigned hereby affirms that the statements contained in the Agreement Funding Application (AFA) are true and complete to the best of the applicant's knowledge.

I certify that these Maternal, Child and Adolescent Health (MCAH) programs will comply with all applicable provisions of Article 1, Chapter 1, Part 2, Division 106 of the Health and Safety code (commencing with section 123225), Chapters 7 and 8 of the Welfare and Institutions Code (commencing with Sections 14000 and 142), and any applicable rules or regulations promulgated by CDPH pursuant to this article and these Chapters. I further certify that all MCAH related programs will comply with the most current MCAH Policies and Procedures Manual, including but not limited to, Administration, Federal Financial Participation (FFP) Section. I further certify that the MCAH related programs will comply with all federal laws and regulations governing and regulating recipients of funds granted to states for medical assistance pursuant to Title XIX of the Social Security Act (42 U.S.C. section 1396 et seq.) and recipients of funds allotted to states for the Maternal and Child Health Service Block Grant pursuant to Title V of the Social Security Act (42 U.S.C. section 701 et seq.). I further agree that the MCAH related programs may be subject to all sanctions, or other remedies applicable, if the MCAH related programs violate any of the above laws, regulations and policies with which it has certified it will comply.

---

**Chairman, Board of Supervisors**

Original signature of official authorized to commit the Agency to an MCAH Agreement

Robert A. Lovingood

Name (Print)

___

Date

---

**MCAH Co-Director/Public Health Mgr.**

Original signature of MCAH/AFLP Director

Vanessa Long

Name (Print)

___

Date
Exhibit K

Attestation of Compliance with the
Sexual Health Education Accountability Act of 2007

Agency Name: County of San Bernardino
Agreement/Grant Number: 201736
Compliance Attestation for Fiscal Year: 2017-18

The Sexual Health Education Accountability Act of 2007 (Health and Safety Code, Sections 151000 – 151003) requires sexual health education programs (programs) that are funded or administered, directly or indirectly, by the State, to be comprehensive and not abstinence-only. Specifically, these statutes require programs to provide information that is medically accurate, current, and objective, in a manner that is age, culturally, and linguistically appropriate for targeted audiences. Programs cannot promote or teach religious doctrine, nor promote or reflect bias (as defined in Section 422.56 of the Penal Code), and may be required to explain the effectiveness of one or more drugs and/or devices approved by the federal Food and Drug Administration for preventing pregnancy and sexually transmitted diseases. Programs directed at minors are additionally required to specify that abstinence is the only certain way to prevent pregnancy and sexually transmitted diseases.

In order to comply with the mandate of Health & Safety Code, Section 151002 (d), the California Department of Public Health (CDPH) Maternal, Child and Adolescent Health (MCAH) Program requires each applicable Agency or Community Based Organization (CBO) contracting with MCAH to submit a signed attestation as a condition of funding. The Attestation of Compliance must be submitted to CDPH/MCAH annually as a required component of the Agreement Funding Application (AFA) Package. By signing this letter the MCAH Director or Adolescent Family Life Program (AFLP) Director (CBOs only) is attesting or “is a witness to the fact that the programs comply with the requirements of the statute”. The signatory is responsible for ensuring compliance with the statute. Please note that based on program policies that define them, the Sexual Health Education Act inherently applies to the Black Infant Health Program, AFLP, and the California Home Visiting Program, and may apply to Local MCAH based on local activities.

The undersigned hereby attests that all local MCAH agencies and AFLP CBOs will comply with all applicable provisions of Health and Safety Code, Sections 151000 – 151003 (HS 151000–151003). The undersigned further acknowledges that this Agency is subject to monitoring of compliance with the provisions of HS 151000–151003 and may be subject to contract termination or other appropriate action if it violates any condition of funding, including those enumerated in HS 151000–151003.

Signed

County of San Bernardino 201736
Agency Name Agreement/Grant Number

Signature of MCAH Director Date
Signature of AFLP Director (CBOs only)

Vanessa Long
Printed Name of MCAH Director
Printed Name of AFLP Director (CBOs only)
CALIFORNIA CODES
HEALTH AND SAFETY CODE
SECTION 151000-151003

151000. This division shall be known, and may be cited, as the Sexual Health Education Accountability Act.

151001. For purposes of this division, the following definitions shall apply:

(a) "Age appropriate" means topics, messages, and teaching methods suitable to particular ages or age groups of children and adolescents, based on developing cognitive, emotional, and behavioral capacity typical for the age or age group.

(b) A "sexual health education program" means a program that provides instruction or information to prevent adolescent pregnancy, unintended pregnancy, or sexually transmitted diseases, including HIV, that is conducted, operated, or administered by any state agency, is funded directly or indirectly by the state, or receives any financial assistance from state funds or funds administered by a state agency, but does not include any program offered by a school district, a county superintendent of schools, or a community college district.

(c) "Medically accurate" means verified or supported by research conducted in compliance with scientific methods and published in peer review journals, where appropriate, and recognized as accurate and objective by professional organizations and agencies with expertise in the relevant field, including, but not limited to, the federal Centers for Disease Control and Prevention, the American Public Health Association, the Society for Adolescent Medicine, the American Academy of Pediatrics, and the American College of Obstetricians and Gynecologists.

151002. (a) Every sexual health education program shall satisfy all of the following requirements:

(1) All information shall be medically accurate, current, and objective.

(2) Individuals providing instruction or information shall know and use the most current scientific data on human sexuality, human development, pregnancy, and sexually transmitted diseases.

(3) The program content shall be age appropriate for its targeted population.

(4) The program shall be culturally and linguistically appropriate for its targeted populations.

(5) The program shall not teach or promote religious doctrine.

(6) The program shall not reflect or promote bias against any person on the basis of disability, gender, nationality, race or ethnicity, religion, or sexual orientation, as defined in Section 422.56 of the Penal Code.

(7) The program shall provide information about the effectiveness and safety of at least one or more drugs and/or devices approved by the federal Food and Drug Administration for preventing pregnancy and for reducing the risk of contracting sexually transmitted diseases.
(b) A sexual health education program that is directed at minors shall comply with all of the criteria in subdivision (a) and shall also comply with both the following requirements:

1. It shall include information that the only certain way to prevent pregnancy is to abstain from sexual intercourse, and that the only certain way to prevent sexually transmitted diseases is to abstain from activities that have been proven to transmit sexually transmitted diseases.

2. If the program is directed toward minors under the age of 12 years, it may, but is not required to, include information otherwise required pursuant to paragraph (7) of subdivision (a).

(c) A sexual health education program conducted by an outside agency at a publicly funded school shall comply with the requirements of Section 51934 of the Education Code if the program addresses HIV/AIDS and shall comply with Section 51933 of the Education Code if the program addresses pregnancy prevention and sexually transmitted diseases other than HIV/AIDS.

(d) An applicant for funds to administer a sexual health education program shall attest in writing that its program complies with all conditions of funding, including those enumerated in this section. A publicly funded school receiving only general funds to provide comprehensive sexual health instruction or HIV/AIDS prevention instruction shall not be deemed an applicant for the purposes of this subdivision.

(e) If the program is conducted by an outside agency at a publicly funded school, the applicant shall indicate in writing how the program fits in with the school's plan to comply fully with the requirements of the California Comprehensive Sexual Health and HIV/AIDS Prevention Education Act, Chapter 5.6 (commencing with Section 51930) of the Education Code. Notwithstanding Section 47610 of the Education Code, "publicly funded school" includes a charter school for the purposes of this subdivision.

(f) Monitoring of compliance with this division shall be integrated into the grant monitoring and compliance procedures. If the agency knows that a grantee is not in compliance with this section, the agency shall terminate the contract or take other appropriate action.

(g) This section shall not be construed to limit the requirements of the California Comprehensive Sexual Health and HIV/AIDS Prevention Education Act (Chapter 5.6 (commencing with Section 51930) of Part 28 of the Education Code).

(h) This section shall not apply to one-on-one interactions between a health practitioner and his or her patient in a clinical setting.

151003. This division shall apply only to grants that are funded pursuant to contracts entered into or amended on or after January 1, 2008.
Section 1 – Demographics

<table>
<thead>
<tr>
<th>Our Community</th>
<th>Local</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>2,096,123</td>
<td>38,202,269</td>
</tr>
<tr>
<td>Total Population, African American</td>
<td>183,262</td>
<td>2,215,348</td>
</tr>
<tr>
<td>Total Population, American Indian/Alaskan Natives</td>
<td>9,706</td>
<td>170,198</td>
</tr>
<tr>
<td>Total Population, Asian/Pacific Islander</td>
<td>137,788</td>
<td>5,135,515</td>
</tr>
<tr>
<td>Total Population, Hispanic</td>
<td>1,060,475</td>
<td>14,692,509</td>
</tr>
<tr>
<td>Total Population, White</td>
<td>704,893</td>
<td>14,994,349</td>
</tr>
<tr>
<td>Total Live Births</td>
<td>30,201</td>
<td>494,392</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Our Mothers and Babies</th>
<th>Local</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of women giving birth to a second child within 24 months of a previous pregnancy</td>
<td>39.2%</td>
<td>37.9%</td>
</tr>
<tr>
<td>% of women delivering a baby who received prenatal care beginning in the first trimester of their pregnancy</td>
<td>83.4%</td>
<td>83.7%</td>
</tr>
<tr>
<td>% of births covered by Medi-Cal</td>
<td>52.7%</td>
<td>46.2%</td>
</tr>
<tr>
<td>% of women ages 18-64 without health insurance</td>
<td>24.7%</td>
<td>22.1%</td>
</tr>
</tbody>
</table>


Section 2 – Our Community – Health Status Where We Live, Learn, Work, and Play

Describe the following using brief narratives or bullets: 1) Geography, 2) Major industries and employers (public/private), 3) Walkability, recreational areas

**Geography**

With an area of over 20,000 square miles, the County of San Bernardino is the largest county in the contiguous United States. The county is comprised of several distinct regions, including a wide strip of urban development (residential and commercial) along the Interstate 10 corridor, especially in its westernmost section; mountains and lakes; and vast desert expanses in the northern and eastern quadrants. The size of the county, distances between regions, and the physical/topographical features all contribute significantly to the challenge of providing services to residents. Many of the cities in the rapidly growing high desert region are greater than 40 miles from the county seat, San Bernardino, which is the largest city and the central location for most of the jurisdiction’s health and community services personnel. The size of the county similarly impacts access to infrastructure, especially public transportation, which is one of the indicated barriers to the county’s most in need populations. There are 37 incorporated cities/towns and unincorporated communities in the county.

**Major Industries and Employers (public/private)**

The major industries in the County are: trade/transportation/utilities, government, education and health, professional and business services, leisure and hospitality, manufacturing, construction, and financial services. The top ten employers in the County are the County of San Bernardino, Stater Bros. Markets, U.S. Army, Loma Linda University, U.S. Marine Corps, United Parcel Service, San Bernardino City Unified School District, Ontario International Airport, Loma Linda University Medical Center, and Kaiser Permanente (Fontana).

**Walkability, Recreational Areas**

- Approximately 2.5 million acres of recreational land and more than 470 bikeway miles throughout the County
- There are more than 30 wilderness areas within the County (in whole or part)
- National protected areas of note include: Angeles National Forest, Death Valley National Park, Havasu National Wildlife Refuge, Joshua Tree National Park, Mojave National Preserve, and San Bernardino National Forest
- Six (6) ski resorts: Bear Mountain, Lake Arrowhead, Mountain High, Mt. Baldy, Snow Summit, and Snow Valley Mountain Resort
- Eleven (11) regional parks and recreation areas, including Calico Ghost Town, Santa Ana River Trail, and Lake Gregory
- Ten (10) community theaters and/or concert venues, and eight (8) museums and/or historical societies
Section 3 – Health System – Health and Human Services for the MCAH Population

Describe the following using brief narratives or bullets: Strategies/initiatives that address the following: Maternal/Women’s Health, Perinatal/Infant Health, Child Health, Adolescent Health, Children with Special Health Care Needs and cross cutting or life course issues (public health issues that impact multiple MCAH population groups).

Healthy Babies are Worth the Wait

Healthy Babies are Worth the Wait (HBWW) is a March of Dimes-led, community program aimed at reducing preterm birth. The program convenes the key perinatal stakeholders in a selected community to identify where improvements might be made in areas that impact preterm birth. Model programs have been implemented in Kentucky and Texas, and San Bernardino County (High Desert region) was selected for implementation of this model. The local MCAH Program is an active member of the HBWW steering committee and workgroups. HBWW have identified three major risk factors to address: 1) tobacco and substance use, 2) access to services/remote communities, and 3) birth spacing and access to family planning services.

Community Vital Signs

Community Vital Signs (CVS) is a community-driven enterprise in partnership with multiple departments within the County to establish and promote a health improvement framework. It is intended to develop evidence-based goals and priorities to align with national and statewide efforts through Healthy People 2020 and Healthy California 2020. CVS focuses on several components of community health and wellness, including access to care, prenatal care, leading causes of death for infants and children under five-years-old, obesity, and chronic disease in children and adults.

Section 4 – Health Status and Disparities for the MCAH Population

Describe the following using brief narratives or bullets: Key health disparities and how health behaviors, the physical environment and social determinants of health (social/economic factors) contribute to these disparities for specific populations. Highlight areas where progress has been made in improving health outcomes.

Many factors contribute to the existence of health disparities among San Bernardino County’s population, including (but not limited to) widely varying socio-demographics, economic characteristics, and geographic features across the county’s 2.1 million residents and 20,105 square miles. San Bernardino County is ethnically and culturally diverse, with Hispanics comprising the majority of the population (52%), Whites accounting for 30%, and Black and Asian residents accounting for eight and seven percent, respectively. Almost 21% of the county’s population lives below the federal poverty level, and median income is 16% less than it is in California. Like income, educational attainment is lower in the county than in the state, with just 19% of the county’s population age 25 years and older having a bachelor’s degree compared to 32% in California.

Disparities exist for a variety of common MCAH indicators, both between San Bernardino County and California, and between different segments of the population within the county. The infant mortality rate (IMR) was 6.5 infant deaths per 1,000 live births in San Bernardino County from 2012-2014 (41% higher than California’s rate of 4.6), and ranged from 14.0 among Blacks, to 5.9 among Whites, to 4.6 among Asian/Pacific Islanders. IMR was higher in the High Desert among all racial/ethnic groups, at 12.8 among Blacks, 6.5 among Whites, and 3.9 among Asian/Pacific Islanders. The rate of low birthweight was also higher in the High Desert (7.9%) than it was in the county overall (7.3%) and California (6.8%), and was higher among Black residents in all locations (14% in the High Desert, 12.8% in the county overall, and 11.8% in California). The rate of prematurity (births at less than 37 weeks gestation) was 8.9% in San Bernardino County from 2011-2013, and varied by race/ethnicity (9.5% among Asian/Pacific Islanders, 12.8% among Blacks, 8.3% among Hispanics, and 8.4% among Whites). Prematurity rates were higher in the High Desert among all racial/ethnic groups (13% among Asian/Pacific Islanders, 13.9% among Blacks, 8.7% among Hispanics, and 9% among Whites). The rate of tobacco use during pregnancy was higher in San Bernardino County (3.5%) than it was in California (2%) from 2011-2013, and varied widely by race/ethnicity (1% among Asian/Pacific Islanders, 6% among Blacks, 1.8% among Hispanics, and 8.1% among Whites). The teen birth rate (percentage of births among teens less than 18 years of age) was also higher in San Bernardino County (2.3%) than it was in California (1.8%) in 2013, and ranged from 3.2% among Blacks to 1% among Whites.

Improvement in some of the above-referenced indicators has been realized in the county over time. The IMR decreased by 4% in San Bernardino County from 2009-2011 (6.39) to 2011-2013 (6.13), representing a slightly larger decrease than California’s during the same time (3.2% decline, from 4.81 to 4.66). San Bernardino County’s rate of smoking during pregnancy also decreased over this time for all races/ethnicities, from 3.87% in 2009-2011 to 3.54% in 2011-2013, but most significantly among Blacks (6.54% to 5.93%) and Asian/Pacific Islanders (1.25% to 0.95%). Teen birth rates declined in San Bernardino County at the same rate they declined in California from 2009 to 2013 (40% decline), from 3.8% to 2.3%. The decline in teen birth rates was observed across all racial/ethnic groups in the county (5.2% to 3.2% among Blacks, 4.6% to 2.9% among Hispanics, and 1.8% to 1% among Whites). The prematurity rate declined in San Bernardino County (9.3% to 8.9%) and California (8.8% to 8.4%) from 2009 to 2013, as it did in the High Desert (9.9% to 9.6%), although the rate of decline was slowest in the High Desert. In mid-2015, the Healthy Babies are Worth the Wait program, a community collaborative effort spearheaded by the March of Dimes intended to reduce preterm birth, was implemented in the High Desert; San Bernardino County is an active participant in this effort.

IMPORTANT: By clicking this box, I agree to allow the state MCAH Program to post my LHJ’s Community Profile on the CDPH/MCAH website.
### BUDGET SUMMARY

<table>
<thead>
<tr>
<th>Program:</th>
<th>Black Infant Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency:</td>
<td>201736 San Bernardino</td>
</tr>
<tr>
<td>SubK:</td>
<td>2017-18 BR1</td>
</tr>
</tbody>
</table>

#### UNMATCHED FUNDING

<table>
<thead>
<tr>
<th>EXPENSE CATEGORY</th>
<th>TITLE V</th>
<th>BrH - SGF</th>
<th>AGENCY FUNDS</th>
<th>Title V</th>
<th>BrH - N</th>
<th>BrH Cnty - N</th>
<th>BrH - E</th>
<th>BrH Cnty - E</th>
</tr>
</thead>
<tbody>
<tr>
<td>(I) PERSONNEL</td>
<td>716,966</td>
<td>265,086</td>
<td>331,936</td>
<td>98,593</td>
<td>5,714</td>
<td>15,638</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(II) OPERATING EXPENSES</td>
<td>66,202</td>
<td>40,607</td>
<td>15,722</td>
<td>8,524</td>
<td>1,349</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(III) CAPITAL EXPENSES</td>
<td>13,695</td>
<td>11,684</td>
<td>1,012</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(IV) OTHER COSTS</td>
<td>189,748</td>
<td>72,677</td>
<td>16,805</td>
<td>16,805</td>
<td>3,480</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(V) INDIRECT COSTS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BUDGET TOTALS**

| TOTAL TITLE V     | 805,631 | 390,054   | 364,464      | 10,543  | 1.73%   | 15,638      |
| TOTAL SGF         | 373,645 | 390,054   |              |         |         |             |
| TOTAL TITLE XIX   | 17,000  | 364,464   |              |         |         |             |
| TOTAL AGENCY FUNDS| 124,934 | 124,934   |              |         |         |             |

#### BALANCE(S)

| TOTAL TITLE V | 390,054 | 390,054   | 364,464      | 10,543  | 1.73%   | 15,638      |
| TOTAL SGF    | 373,645 | 390,054   |              |         |         |             |
| TOTAL TITLE XIX | 17,000  | 364,464   |              |         |         |             |
| TOTAL AGENCY FUNDS | 124,934 | 124,934   |              |         |         |             |

---

**$ 780,699 Maximum Amount Payable from State and Federal resources**

---

**WE CERTIFY THAT THIS BUDGET HAS BEEN CONSTRUCTED IN COMPLIANCE WITH ALL MCAH ADMINISTRATIVE AND PROGRAM POLICIES.**

---

**STATE USE ONLY - TOTAL STATE AND FEDERAL REIMBURSEMENT**

<table>
<thead>
<tr>
<th>PCA Codes</th>
<th>TITLE V</th>
<th>BIH - SGF</th>
<th>AGENCY FUNDS</th>
<th>BIH - N</th>
<th>BIH Cnty - N</th>
<th>BIH - E</th>
<th>BIH Cnty - E</th>
</tr>
</thead>
<tbody>
<tr>
<td>(I) PERSONNEL</td>
<td>265,086</td>
<td>331,936</td>
<td>5,714</td>
<td>15,638</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(II) OPERATING EXPENSES</td>
<td>40,607</td>
<td>15,722</td>
<td>3,480</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(III) CAPITAL EXPENSES</td>
<td>11,684</td>
<td>16,805</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(IV) OTHER COSTS</td>
<td>72,677</td>
<td>16,805</td>
<td>10,543</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Totals for PCA Codes**

| 780,699 | 390,054 | 364,464   | 10,543       | 15,638  |
### Program: Black Infant Health
### Agency: 201736 San Bernardino

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL FUNDING %</td>
<td>TITLE V %</td>
<td>SGF %</td>
<td>Agency Funds %</td>
<td>Combined Fed/State %</td>
<td>Combined Fed/Agency %</td>
<td>Combined Fed/State %</td>
<td>Combined Fed/Agency %</td>
<td>Combined Fed/State %</td>
<td>Combined Fed/Agency %</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TITLE V</td>
<td>BIH - SGF</td>
<td>BIH - N</td>
<td>BIH Corp. - N</td>
<td>BIH - E</td>
<td>BIH Corp. - E</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
</tr>
</tbody>
</table>

**UNMATCHED FUNDING**

- **-match Available**: Title V matches are available for the unmatched portion of the agency's funds.

#### (II) OPERATING EXPENSES DETAIL

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td></td>
</tr>
</tbody>
</table>

**TRAVEL**

- **Result**: 33,200

<table>
<thead>
<tr>
<th>Item</th>
<th>100.00%</th>
<th>100.00%</th>
<th>100.00%</th>
<th>100.00%</th>
<th>100.00%</th>
<th>100.00%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>13,200</td>
<td>54.00%</td>
<td>2,760</td>
<td>10.00%</td>
<td>1,040</td>
<td>34.00%</td>
</tr>
<tr>
<td>2</td>
<td>500</td>
<td>0.50%</td>
<td>343</td>
<td>21.44%</td>
<td>107</td>
<td>10.00%</td>
</tr>
</tbody>
</table>

**UNMATCHED**

#### (III) CAPITAL EXPENDITURE DETAIL

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Title V**

- **Result**: 66,202

<table>
<thead>
<tr>
<th>Item</th>
<th>100.00%</th>
<th>100.00%</th>
<th>100.00%</th>
<th>100.00%</th>
<th>100.00%</th>
<th>100.00%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>16,150</td>
<td>24.55%</td>
<td>4,073</td>
<td>23.03%</td>
<td>2,724</td>
<td>93.31%</td>
</tr>
<tr>
<td>2</td>
<td>11,684</td>
<td>13.51%</td>
<td>1,012</td>
<td>26.33%</td>
<td>671</td>
<td>23.23%</td>
</tr>
</tbody>
</table>

**Enhanced Matching (75/25)**

- **Result**: 1,012

<table>
<thead>
<tr>
<th>Item</th>
<th>100.00%</th>
<th>100.00%</th>
<th>100.00%</th>
<th>100.00%</th>
<th>100.00%</th>
<th>100.00%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>16,150</td>
<td>24.55%</td>
<td>4,073</td>
<td>23.03%</td>
<td>2,724</td>
<td>93.31%</td>
</tr>
<tr>
<td>2</td>
<td>11,684</td>
<td>13.51%</td>
<td>1,012</td>
<td>26.33%</td>
<td>671</td>
<td>23.23%</td>
</tr>
</tbody>
</table>

**Unmatched Operating Expenses are not eligible for Federal matching funds (Title XIX). Expenses may only be charged to Unmatched Title V (Col. 3), State General Funds (Col. 5), and/or Agency (Col. 7) funds.**

#### (IV) OTHER COSTS DETAIL

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Title V**

- **Result**: 12,695

<table>
<thead>
<tr>
<th>Item</th>
<th>100.00%</th>
<th>100.00%</th>
<th>100.00%</th>
<th>100.00%</th>
<th>100.00%</th>
<th>100.00%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>500</td>
<td>62.43%</td>
<td>312</td>
<td>20.00%</td>
<td>100</td>
<td>15.00%</td>
</tr>
<tr>
<td>2</td>
<td>10,249</td>
<td>100.00%</td>
<td>10,249</td>
<td>100.00%</td>
<td>10,249</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

**Title V**

- **Result**: 1,012

<table>
<thead>
<tr>
<th>Item</th>
<th>100.00%</th>
<th>100.00%</th>
<th>100.00%</th>
<th>100.00%</th>
<th>100.00%</th>
<th>100.00%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>16,150</td>
<td>24.55%</td>
<td>4,073</td>
<td>23.03%</td>
<td>2,724</td>
<td>93.31%</td>
</tr>
<tr>
<td>2</td>
<td>11,684</td>
<td>13.51%</td>
<td>1,012</td>
<td>26.33%</td>
<td>671</td>
<td>23.23%</td>
</tr>
</tbody>
</table>

**Match Available**

- **Result**: 2,58%
### (V) INDIRECT COSTS DETAIL

<table>
<thead>
<tr>
<th>TITLE OR CLASSIFICATION</th>
<th>FTE</th>
<th>BASE SALARY</th>
<th>TOTAL WAGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>...</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TOTAL INDIRECT COSTS</th>
<th>109,768</th>
</tr>
</thead>
<tbody>
<tr>
<td>BIH - SGF</td>
<td>72,677</td>
</tr>
<tr>
<td>15.31% of Total Wages + Fringe Benefits</td>
<td>80,271</td>
</tr>
</tbody>
</table>

### (I) PERSONNEL DETAIL

<table>
<thead>
<tr>
<th>TITLE OR CLASSIFICATION</th>
<th>% FTE</th>
<th>BASE SALARY</th>
<th>TOTAL WAGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>...</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TOTAL PERSONNEL COSTS</th>
<th>716,960</th>
</tr>
</thead>
<tbody>
<tr>
<td>BIH - SGF</td>
<td>56,640</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RECONCILIATION SECTION (Remaining Funds)</th>
<th>TOTAL INDIRECT COSTS</th>
<th>109,768</th>
</tr>
</thead>
<tbody>
<tr>
<td>BIH - SGF</td>
<td>72,677</td>
<td></td>
</tr>
<tr>
<td>15.31% of Total Wages + Fringe Benefits</td>
<td>80,271</td>
<td></td>
</tr>
</tbody>
</table>

| BIH - SGF | 72,677 |
| 15.31% of Total Wages + Fringe Benefits | 80,271 |
CERTIFICATION OF INDIRECT COST RATE METHODOLOGY

Please list the Indirect Cost Rate (ICR) Percentage and supporting methodology for the contract or allocation with the California Department of Public Health, Maternal Child and Adolescent Health Division (CDPH/MCAH Division).

Date:  March 28, 2017

Agency Name:  County of San Bernardino

Contract/Agreement Number:  201736  Contract Term/Allocation Fiscal Year:  2017-18

1. NON-PROFIT AGENCIES/ COMMUNITY BASED ORGANIZATIONS (CBO)
   Non-profit agencies or CBOs that have an approved ICR from their Federal cognizant agency are allowed to charge their approved ICR or may elect to charge less than the agency’s approved ICR percentage rate.
   Private non-profits local agencies that do not have an approved ICR from their Federal cognizant agency are allowed a maximum ICR percentage of 15.0 percent of the Total Personnel Costs.
   The ICR percentage rate listed below must match the percentage listed on the Contract/Allocation Budget.

   %  Fixed Percent of:
   ☑  Total Personnel Costs:

2. LOCAL HEALTH JURISDICTIONS (LHJ)
   LHJs are allowed up to the maximum ICR percentage rate that was approved by the CDPH Financial Management Branch ICR or may elect to charge less than the agency’s approved ICR percentage rate. The ICR rate may not exceed 25.0 percent of Total Personnel Costs or 15.0 percent of Total Direct Costs. The ICR application (i.e. Total Personnel Costs or Total Allowable Direct Costs) may not differ from the approved ICR percentage rate.
   The ICR percentage rate listed below must match the percentage listed on the Allocation/Contracted Budget.

   15.623%  Fixed Percent of:
   ☑  Total Personnel Costs:
   ☐  Total Allowable Direct Costs:

3. OTHER GOVERNMENTAL AGENCIES AND PUBLIC UNIVERSITIES
   University Agencies are allowed up to the maximum ICR percentage approved by the agency’s Federal cognizant agency ICR or may elect to charge less than the agency’s approved ICR percentage rate. Total Personnel Costs or Total Direct Costs cannot change.

   %  Fixed Percent of:
   ☐  Total Personnel Costs (Includes Fringe Benefits)
   ☐  Total Personnel Costs (Excludes Fringe Benefits)
   ☐  Total Allowable Direct Costs
CERTIFICATION OF INDIRECT COST RATE METHODOLOGY

Please provide you agency's detailed methodology that includes all indirect costs, fees and percentages in the box below.

ICR percentage rate was certified as to form and methodology by San Bernardino County, Auditor Controller. The costs and cost categories contained in the Indirect Cost Rate of 15.623% of Total Personnel Costs are accurate and consistent with generally accepted accounting principles and prepared in conformance with Office of management and Budget 2 CFR Part 200 Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards Final Guidance (78 FR 78589). No costs other than those incurred by the Grantee/Contractor, or allocated to the Grantee/Contractor via an approved central service cost plan, were included in indirect cost pool as finally accepted, and that such incurred costs are legal obligations of the Grantee/Contractor and allowable under the governing cost principles. The same costs that have been treated as indirect costs have not been claimed as direct costs and similar types of costs have been accorded consistent accounting treatment.

Please submit this form via email to your assigned Contract Manager.

The undersigned certifies that the costs used to calculate the ICR are based on the most recent, available and independently audited actual financials and are the same costs approved by the CDPH to determine the Department approved ICR.

Signature: [Signature]

Printed First & Last Name: Melanie Reneau
Title/Position: Administrative Manager
Date: March 28, 2017
January 31, 2017

Kelly Welty
Chief Financial Officer
San Bernardino County
351 N. Mountain View Avenue
San Bernardino, CA 92415-0010

Dear Kelly Welty:

Thank you for submitting your Indirect Cost Rate (ICR) documentation to the California Department of Public Health (CDPH). CDPH is excited to have a standardized process that allows each Local Health Department (LHD) to use the negotiated ICR for all contracts, unless the IRC is otherwise designated by state or federal statutes, regulations, or specific grant guidelines, with CDPH.

For Fiscal Year (FY) 2017-2018, CDPH has accepted the documentation you have provided and, on a one-year basis, will approve your ICR proposal as follows:

15.623% calculated based on Salaries, Wages and Fringe Benefits

Please note, the rate you provided was approved up to the maximum allowed by CDPH policy (up to 25% for ICR calculated based on Salaries, Wages and Fringe Benefits and up to 15% for ICR calculated based on Allowable Total Direct Costs).

We look forward to working with you to document your approved ICR in CDPH contracts with a start date of July 1, 2017 or later.

If you have any questions, contact CDPH at CDPH-ICR-Mailbox@cdph.ca.gov

Thank you,

[Signature]

Jaana H. Brown, FMB-Accounting Services Section Chief
California Department of Public Health
SCOPE OF RESPONSIBILITY: The Social Service Practitioner (SSP) provides culturally relevant, client-centered, strength-based and cognitive skill-building services to eligible African-American participants with complex needs. The SSP provides social service case management and mental health interventions that focus on identifying and triaging participant needs and facilitating access to prenatal and postnatal supportive services; working with the participant to identify and build upon strengths and resources to problem-solve and obtain the needed services, and assessing mental health issues, providing interventions and/or referring to higher level mental health services. Services are primarily office-based, with some home visiting.

SUPERVISION: The Social Service Practitioner (FHA) reports directly to the BIH Coordinator.

DUTY STATEMENT:

1. Serves as the case manager who coordinates the interdisciplinary team in providing program services to participants.
2. Coordinates and conducts intake and orientation for program participants within established timelines.
3. Ensures ongoing participant client retention for individual case management and group interventions per established standards, including monitoring and tracking participant enrollment into prenatal and postnatal sessions and working with participants to address barriers to services.
4. Provides social service case management that includes:
   a. Interviewing participants and conducting health, social and psychological assessments; developing, individual care plans, life course plans and birth plans with participants and a trans-disciplinary team.
   b. Referring and linking participants to health and behavioral health care and other identified resources, including monitoring compliance to ensure that care is accessed.
   c. Acting as a liaison between participants, their families and health care providers.
   d. Making appointments, facilitating transportation to services, and maintaining a client incentive process.
5. Works collaboratively with participant to identify and prioritize concerns and to set goals and create an individual care plan of action for addressing their concerns.
6. Provides mental health assessment and intervention support for individuals and groups with health, psychosocial and/or economic problems, and refers to mental health services, as appropriate.
7. Conducts prenatal and postnatal sessions (group interventions) using a Black Infant Health-approved curriculum. Co-facilitates group intervention and manages group dynamics, leads exercises to reduce stress, and gives opportunities for participants to set personal goals and to gain self-empowerment to improve health.
8. Provides education on basic health information including child development, nutrition, the birthing process and reproductive health.

9. Leads interdisciplinary case conferences for new participants and established high acuity participants to develop, coordinate and implement a case management plan.

10. Collects participant specific data using a series of Black Infant Health forms and tools for client management and program evaluation, ensures accuracy of information, and prepares statistical and progress reports.

11. Adheres to program performance standards including applying skills and knowledge to assure that participants attend at least 70 percent of the 10 prenatal sessions and at least 70 percent of the 10 postnatal sessions.

12. Assists the Black Infant Health Coordinator in quality assurance and quality improvement plans for improving program services.

13. Drafts and/or updates policies and procedures as part of an interdisciplinary team.

SCOPE OF RESPONSIBILITY: The Social Service Practitioner (SSP) provides culturally relevant, client-centered, strength-based and cognitive skill-building services to eligible African-American participants. The SSP provides assessment, intervention and case management support to program participants with complex health, psychosocial or economic problems through case conferences, individual and group interventions and in coordination with mental and behavioral health services. Services are primarily office-based, with some home visiting.

SUPERVISION: The Social Service Practitioner (Mental Health Professional) reports directly to the BIH Coordinator.

DUTY STATEMENT:

1. Provides social service case management to participants with high complex needs that include:
   a. Conducting intake and orientation.
   b. Interviewing participants and conducting health, social and psychological assessments; developing, individual care plans, life course plans and birth plans with participants and a trans-disciplinary team.
   c. Referring and linking participants to health and behavioral health care and other identified resources, including monitoring compliance.
   d. Makes appointments, facilitates transportation to services, and maintains a client incentive process.
   e. Ensures ongoing participant client retention for individual case management and group interventions per established standards, including monitoring and tracking participant enrollment into prenatal and postnatal sessions and working with participants to address barriers to services.

2. Works collaboratively with participant to identify and prioritize concerns and to set goals and create a plan of action for addressing their concerns.

3. Develops and maintains a trusting, professional relationship with participants, provides in-depth counseling as needed to assist participants in improving social functioning, which may include advocacy, educating, counseling and mediation and crisis intervention and stabilization.

4. Conducts Black Infant Health risk and diagnostic assessment of bio-psychosocial conditions and determines conditions such as abuse, isolation, abandonment, physical abuse, sexual abuse, emotional abuse, neglect, domestic violence, suicidal ideation/intent, medical/mental impairment, and attachment issues. Formal assessments include but are not limited to appraisal of baseline, depression, interaction and risk, behavior, growth and development.

5. Provides mental health assessment and intervention support for individuals and groups with complex health, psychosocial and/or economic problems, and refers to community mental health services as appropriate.
6. Participates in interdisciplinary case conferences for new participants and established participants with high complex needs to develop, coordinate and implement a case management plan.

7. Collects participant specific data using a series of Black Infant Health forms and tools for client management and program evaluation, ensures accuracy of information, and prepares statistical and progress reports.

8. Serves as a consultant for other staff and community members on complex social work issues, including managing group dynamics, improving participant social empowerment, and stress reduction interventions.

9. Assists the Black Infant Health Coordinator in quality assurance and quality improvement plans for improving program services, especially for higher acuity participants.

10. Adheres to program productivity standards including applying skills and knowledge to assure that participants attend at least 70 percent of the 10 prenatal sessions and at least 70 percent of the 10 postnatal sessions.

11. Establishes and maintains a functional referral process with community mental and behavioral health providers, and collaborates and coordinates the provision of mental and behavioral health services, including treatment, care, transition or service plans.

12. Conducts and facilitates as needed, prenatal and postnatal group sessions/interventions using a California Department of Public Health-approved curriculum.

13. Drafts and/or updates policies and procedures as part of an interdisciplinary team.
DEPARTMENT OF PUBLIC HEALTH  
COUNTY OF SAN BERNARDINO

Public Health Program Coordinator-Black Infant Health Program  
(Black Infant Health Coordinator)

Duty Statement  
Budget Row 4

SCOPE OF RESPONSIBILITY: The Public Health Program Coordinator (PHPC) provides culturally relevant, client-centered, strength-based and cognitive skill-building services to eligible African-American participants with complex needs. The PHPC oversees and coordinates the operations of the Black Infant Health Program, including developing, implementing, monitoring and evaluating Program services, and supervising Program staff.

SUPERVISION: The Public Health Program Coordinator reports directly to the Family Health Services Public Health Program Manager, who also serves as the MCAH Co-Director.

DUTY STATEMENT:

1. Oversees and operationalizes the Black Infant Health Program that includes partnering and collaborating with public and private community agencies; managing participant recruitment and retention plans, group interventions, case management, case conferences and data collection functions.
2. Ensures compliance with all BIH Program fiscal allocation, administrative and program requirements.
3. Assesses the health status of the African-American population and Program participants and their related determinates of health and illness by using methods and instruments for collecting valid and reliable quantitative and qualitative data. Based on data and analysis, recommends modifications to service delivery.
4. Develops and manages a quality assurance and quality improvement process that features performance standards and measures for ensuring client confidentiality, staff productivity, Program compliance and service delivery effectiveness in accordance with County of San Bernardino and Black Infant Health Program standards.
5. Leads and coordinates a team in developing formal collaborative agreements with public and private agencies, faith-based organizations and health care providers for participant recruitment and referral.
6. Produces and/or oversees developing protocols and procedures for program administrative and service delivery operations, including participant enrollment, work flow and staff deployment, case management and quality assurance.
7. Leads and coordinates the team utilizing the Efforts to Outcomes (ETO) and/or other MIS systems for tracking, monitoring and evaluating scope of work deliverables, and developing/implementing plans to improve program outcomes.
8. Assists with developing and monitoring budgets and implementing corrective plans as needed.
9. Assesses community linkages and relationships among multiple determinates affecting health and facilitates collaboration among public and private agencies and negotiates the use of community assets and resources.

10. Promotes public health practices and policies and resources to address the determinates of health for improving health outcomes.

11. Supervises, directly and indirectly, professional and para-professional staff, including conducting work performance evaluations, creating duty statements and developing work performance standards.

12. Attends California DPH trainings, conferences and teleconferences.
SCOPE OF RESPONSIBILITY: The Health Education Specialist II (HES II) provides culturally relevant, client-centered, strength-based and cognitive skill-building support services to eligible African-American participants. The HES II coordinates and manages the Black Infant Health recruitment plan to enroll and retain participants in program services.

SUPERVISION: The Health Education Specialist II reports directly to the Public Health Program Coordinator (BIH Program Coordinator).

DUTY STATEMENT:

1. Develops and implements a strategic recruitment plan with evidence and best practice strategies for working with public and private agencies and health care providers for recruiting and enrolling eligible women into program services.
2. Develops and implements performance measures for recruitment and enrollment, and tracks and monitors outcomes.
3. Fosters collaborative relationships with referring public and private agencies and health care providers.
4. Develops and maintains functional referral systems between the program and referral sources.
5. Assists with developing collaborative agreements with public and private agencies and health care providers to ensure that each referring source has a clear understanding of the BIH vision, along with roles and responsibilities.
6. Conducts presentations at public and private agencies to promote program services and collaborative efforts.
7. Provides consultation to community groups and agencies in defining health problems, setting priorities and evaluating health projects related to improving the health of African-American women and their families.
8. Collects program data using a series of Black Infant Health forms and tools for client management and program evaluation, ensures accuracy of information, and prepares statistical and progress reports.
9. Adheres to program performance standards such as assuring the target number of participants recruited and the number of participants with appointments for program intake.
10. Oversees the recruitment process that includes identifying the clients and scheduling the first appointment.
11. Plans and designs educational and promotional materials and training aids to support program scope of work activities.
12. Leads team of staff responsible for scheduling intake appointments.
13. Develops operational policies and procedures in conjunction with specific program scope of work activities.
14. Participates as an interdisciplinary team member and performs other duties as required, including acting as a group facilitator as needed.
15. Attends San Bernardino County Public Health Department Health Education staff meetings.
16. Attends California DPH required trainings
SCOPE OF RESPONSIBILITY: The Health Services Assistant I (HSA) provides culturally relevant, client-centered, strength-based and cognitive skill-building support services to eligible African-American participants. The HSA assists with client recruitment and facilitates participant intake, and provides enabling support services. Services are primarily office-based with some home visiting.

SUPERVISION: The Health Services Assistant I reports directly to the Black Infant Health Coordinator.

DUTY STATEMENT:

1. Assists the Community Liaison in maintaining a referral system to enroll participants into program services, including networking with community agencies and providers and providing presentations to promote the program.
2. Contacts referred women to determine eligibility and facilitate participant intake visits.
3. Adheres to program performance standards including contacting women within 72 hours of the referral and scheduling an intake appointment within 30 days. Collects participant specific data using a series of standard forms and tools and ensures accuracy of information, and prepares productivity reports.
4. Assists with participant intake as directed.
5. Assists with the distribution and tracking of program incentives and transportation vouchers.
6. Assists the Case Manager in facilitating transportation for the participant to group interventions and individual case management sessions.
7. Assists the Case Manager in care coordination activities such as confirming participant appointment compliance and enrolling into and maintaining Medi-Cal coverage.
8. Provides babysitting to participant children during group interventions and as necessary, including providing age-appropriate educational activities.
9. Assists the Black Infant Health Coordinator in quality assurance and quality improvement plans for improving program services.
10. Participates in case conferences as requested.
11. Attends California DPH required trainings.
12. Participates as an interdisciplinary team member and performs other duties as required.
SCOPE OF RESPONSIBILITY: The Office Assistant III (OAIII) provides culturally relevant, client-centered, strength-based and cognitive skill-building support services to eligible African-American participants. Responsible for complex clerical activities requiring through knowledge of the BIH project’s policies and procedures.

SUPERVISION: Reports directly to the Public Health Program Coordinator.

DUTY STATEMENT:

1. Prepares and assists with various projects including compiling and entering data on an on-going basis.
2. Types a variety of documents in draft and final form, including correspondence, contracts, and reports from handwritten or printed sources; proofreads materials for completeness, correcting grammar, spelling and punctuation.
3. Performs data entry into databases and automated systems. Adheres to program performance standards including completion of data entry assignments within the timeframes established by the BIH Coordinator.
4. Answer calls and provides information to the public about services available in the Black Infant Health Project (BIH) and Department of Public Health.
5. Problem solves with staff members to ensure optimum service delivery to BIH clients.
6. Participates in required/conducted training and educational sessions relating to the scope of BIH project services and/or operations.
7. Orders supplies, resources, and materials for use and distribution by project staff.
8. Assists the Community Liaison in maintaining a referral system to enroll participants into program services, including networking with community agencies, providers and providing presentations to promote the program.
9. Collects participant specific data using a series of Black Infant Health forms and tools and ensures accuracy of information, and prepares productivity or operational reports.
10. Assists with the distribution and tracking of program incentives and transportation vouchers.
11. Assists in the procurement process for food, beverages, and refreshments for group sessions, retention activities, and/or other BIH events.
12. Assists the Case Manager in facilitating transportation for the participant to group interventions and individual case management sessions.
13. Assists the Black Infant Health Coordinator in quality assurance and quality improvement plans for improving program services.
14. Participates as an interdisciplinary team member and performs other duties as required.
SCOPE OF RESPONSIBILITY: The Public Health Nurse II (PHN) provides culturally relevant, client-centered, strength-based and cognitive skill-building nursing services to eligible African-American participants. The scope of services ranges from providing medical consultation at case conferences to limited physical assessments, with service delivery being primarily office-based with some home visiting.


DUTY STATEMENT:

1. Provides consultation on health issues during case conferences, including reporting on participants’ health condition, explaining medical procedures and tests, recommending community resources and participating in developing an individual client plan.
2. Presents health information as a subject matter expert at group interventions.
3. Provides limited physical assessments on program participants, along with a recommended service plan for the case manager to coordinate.
4. Uses nursing expertise and judgment to identify potential medically at-risk women for referral to the appropriate level of care.
5. Collaborates with the case manager to coordinate and link participants with community health care providers, including obtaining medical information and assuring compliance of medical care plan.
6. Assesses the medical provider system capacity and availability for barriers to care and collaborates to link participants with the appropriate level of care.
7. Provides home assessments as recommended by the case conference process and program guidelines to enhance the Individual Client Plan.
8. Provides health-related consultation to participants to assist them in understanding and identifying health problems or conditions and in recognizing the value of preventative and remedial health care as it relates to their medical condition.
9. Participates as an interdisciplinary team member and performs other duties as required, including acting as a group facilitator and/or case manager as needed.
10. Collects participant specific data using a series of Black Infant Health forms and tools for client management and program evaluation, ensures accuracy of information, and prepares statistical and progress reports.
11. Assists the Black Infant Health Coordinator in quality assurance and quality improvement plans for improving program services.
12. Adheres to program performance standards including applying skills and knowledge to assure that participants attend at least 70 percent of the 10 prenatal sessions and at least 70 percent of the 10 postnatal sessions.
13. Drafts and/or updates policies and procedures as part of an interdisciplinary team.
14. Attends CDPH required training
SCOPE OF RESPONSIBILITY: The Secretary I provides culturally relevant, client-centered, strength-based and cognitive skill-building support services to eligible African-American participants. The Secretary I works directly with the Program Manager (MCAH Co-Director) to assist with efficient implementation of directives and assigned responsibilities of the BIH Program on a daily basis.

SUPERVISION: The Secretary I reports directly to the Program Manager (MCAH Co-Director) for daily assignments.

DUTY STATEMENT:

1. Provides direct support to the Program Manager, including opening and review incoming mail, processing outgoing correspondence, placing and screening telephone calls, and copying and distributing critical documents and materials on behalf of the Program Manager.

2. Composes, edits, and proofreads Program Manager’s correspondence, interoffice memoranda, and policies and procedures. Types Work Performance Evaluations and other confidential documents. Takes minutes during staff meetings or meetings with community partners and collaborators.

3. Maintains Program Manager’s calendar, schedules appointments, reserves conference rooms and confirms arrangements with attendees, sets up and modifies a schedule of meetings with key program staff (including BIH Program and/or community collaborators and stakeholders), and maintains record of prospective staff leave time and work schedules for Program Manager’s reference.

4. Maintains, updates, and accesses a filing system, including Program Manager’s correspondence, personnel records; grant, contract, and memorandum of understanding documents; program productivity and outcome measures; and program scopes of work. Retrieves and replaces documentation used by Program Manager and other staff.

5. Makes travel and meeting arrangements for Program Manager, including transportation, lodging, and registration for conferences and training sessions. Processes all documentation and request forms for County approval by required timelines.
SCOPE OF RESPONSIBILITY: The Supervising Public Health Nurse (SPHN) provides culturally relevant, client-centered, strength-based and cognitive skill-building services to eligible African-American participants with complex needs. The SPHN supervises the nursing practice of the Public Health Nurse.

SUPERVISION: The Supervising Public Health Nurse reports directly to the Family Health Services Public Health Program Manager who also serves as the MCAH Co-Director.

DUTY STATEMENT:

1. Provides consultation to the Black Infant Health Coordinator on best nursing practices for eligible Black Infant Health Program clients.
2. Supervises and reviews the nursing practice of the program Public Health Nurse, including conducting office and home-based observations.
3. Develops a quality assurance and quality improvement plan for nursing services.
4. Produces nursing protocols and procedures based on best nursing practices and standards.
5. Provides consultation to the Black Infant Health Coordinator on nursing performance and productivity and implements as directed.
6. Participates as an interdisciplinary team member and performs other duties, as required.
SCOPE OF RESPONSIBILITY:

The Administrative Supervisor I oversees the Supervising Office Assistant who provides support services to the BIH Program primarily in the areas of purchasing materials/equipment and time study validation; Conducts special studies and prepares and monitors program budgets; Performs related duties as required.

SUPERVISION:

The Administrative Supervisor reports directly to the Program Manager.

DUTY STATEMENT:

1. Supervises a staff providing support services, assigns and reviews work; evaluates work performance; and participates in selection and discipline of staff.
2. Recommends and establishes an external and internal contract compliance system, including interpretation of contract terms and monitoring adherence to same. Recommends solutions to contractual problems.
3. Recommends and monitors procedures for grant implementation.
4. Prepares initial BIH budgets; develops justifications for budget recommendations; monitors budget performance to ensure objectives are met; recommends corrective action on budget variances in the context of state policies and guidelines.
5. Develops and recommends various fiscal and operational policies and procedures for BIH upon request; develops written procedures to implement adopted polices or to clarify and describe standard practices; designs or improves forms to expedite procedures and coordinates the production and dissemination of same.
6. Prepares or coordinates reports and analyses in support of BIH Program operations and service delivery models.
7. Reviews present and pending legislation to determine effect on departmental organizations and presents recommendations in verbal or written form.
SCOPE OF RESPONSIBILITY: The Accountant II/III / Staff Analyst II provides culturally relevant, client-centered, strength-based and cognitive skill-building support services to eligible African-American participants. The assigned staff member prepares budgets and invoices in support of the BIH Program and performs related duties, as requested.

SUPERVISION: The Accountant II/III / Staff Analyst II reports to a centralized support unit within the County of San Bernardino Department of Public Health, but coordinates all work through the Program Manager or Administrative Supervisor I, as applicable.

DUTY STATEMENT:

1. Prepares budgets and invoices for the BIH Program, including collection and collation of documentation to support all claims for reimbursement.
2. Prepares and maintains regular reports of expenditures and revenues compared to budgeted levels. Identifies significant variations to budget levels and notifies the BIH Program Manager or key supervisory staff. Recommends strategies to resolve budget shortages or under expenditure.
3. As requested, prepares a variety of reports, summaries, and analyses for BIH Program staff reference.
SCOPE OF RESPONSIBILITY:

The Supervising Office Assistant provides administrative support to the BIH Program, primarily in the areas of purchasing materials/equipment and time study validation.

SUPERVISION:

Reports directly to the Administrative Supervisor I.

DUTY STATEMENT:

1. Performs secondary/quality assurance review of quarterly time studies in support of Federal Financial Participation (FFP) claims for reimbursement.
2. Assists in the procurement process for BIH operating expenses and other costs (e.g., educational materials, client support materials) and/or equipment and internal services (e.g., furniture, telecommunications items).
3. As requested, prepares various summaries or reports related to the aforementioned areas of focus.
4. Recommends office procedures to the BIH Coordinator that will enhance implementation of BIH Program services.
SCOPE OF RESPONSIBILITY:

Provides automated systems support, including installation and maintenance of computers, printers, and peripherals; ensure network security; and troubleshooting functions (diagnosis and resolution). Performs related duties, as required.

SUPERVISION:

The Automated Systems Analyst reports to a centralized support unit within the County of San Bernardino Department of Public Health, but coordinates all work through the Program Manager, BIH Coordinator, or Administrative Supervisor I, as applicable.

DUTY STATEMENT:

1. Oversees local computer operations; proposes and coordinates systems’ configuration, which may include networking systems; develops systems edits and determines the number of fields and screens; develops access codes; determines information required of each screen; supervises or writes and modifies local application programs.

2. Interacts with County Information Services Department (ISD) staff and hardware/software vendors regarding office automation technology and the department’s needs; writes detailed specifications; evaluates equipment and software capabilities; performs cost/benefit analysis; makes recommendations to management.

3. Serves as resource consultant for an organization on data analysis and processing, research methodology, and systems development; may document technical data descriptions; analyze program coding requirements, operator instructions, and organizational procedures.

4. Instructs and trains organizational personnel on data processing operations, including distributed and networking computer systems; establishes local procedures for adhering to computer and data security systems; resolves data processing service complaints between organizational users and ISD.
SCOPE OF RESPONSIBILITY: The Program Manager provides culturally relevant, client-centered, strength-based and cognitive skill-building support services to eligible African-American participants. The Program Manager manages all aspects of the BIH Program, including program planning and development, fiscal administration, service delivery standards and compliance, and community relations. Also serves as the MCAH Co-Director.

SUPERVISION: The Program Manager reports to the Chief of Community Health/Director of Nursing for the County of San Bernardino Department of Public Health.

DUTY STATEMENT:

1. Develops implements, and evaluates BIH Program goals, objectives, and scope of work elements. Manages and directs staff toward the successful achievement of same.
2. Develops, manages, and monitors the BIH Program budget to ensure compliance with state and local policies and procedures, allowability of expenditures, and Federal Financial Participation (FFP) matching fund requirements.
3. Manages and ensures adherence to BIH Program service delivery standards and quality assurance targets, including program process and outcome measures.
4. Collaborates with key stakeholders and community partners to inform program planning and evaluation strategies.
SCOPE OF RESPONSIBILITY: The Public Health Epidemiologist conducts studies and analyses of data related to the population eligible for BIH Program service delivery, for the purpose of expanding/improving access to care and BIH Program services.

SUPERVISION: Reports directly to the MCAH Co-Director/Public Health Manager.

DUTY STATEMENT:

1. Serves as the data quality expert for Black Infant Health (BIH) to monitor and evaluate the accuracy and quality of program data, including service as a local resource to program staff related to use of the Efforts to Outcomes (ETO) database.

2. Collaborates with Information Technology and affiliated staff to create data sets of African American live births in the County for the purposes of identification of and outreach to potential participants to increase program enrollment.

3. Analyzes population-based primary, secondary, and related maternal, child, and adolescent health data sets (e.g., live births, morbidities and co-morbidities, infant mortality) to identify and prioritize health needs and adverse findings within the population eligible for BIH Program services.

4. Plans, develops, and assists with the development of strategies to address identified health needs, access to care, linkage to health care and related services, and availability of services for BIH Program participants.

5. Evaluates and analyzes health trends and health hazards that contribute to poor pregnancy, child, and maternal health outcomes, and recommends epidemiological-based strategies and interventions to address health care needs of the BIH service delivery population.
SCOPE OF RESPONSIBILITY: The Office Assistant II (OAI) provides occasional clerical support for the BIH Program, typically in a coverage or back-up role to the Data Entry Clerk.

SUPERVISION: Reports directly to the Supervising Office Assistant.

DUTY STATEMENT:

1. Types a variety of documents in draft and final form, including correspondence, contracts, and reports from handwritten or printed sources; proofreads materials for completeness, correcting grammar, spelling and punctuation.
2. Problem solves with staff members to ensure optimum service delivery to BIH clients.
3. Orders supplies, resources, and materials for use and distribution by project staff.
4. Assists in the procurement process for food, beverages, and refreshments for group sessions, retention activities, and/or other BIH events.
SCOPE OF RESPONSIBILITY: The Supervising Health Education Specialist (SHES) performs in a coverage or back-up role in support of the culturally relevant, client-centered, strength-based and cognitive skill-building services to eligible African-American participants. The SHES coordinates, facilitates and organizes the antepartum and postpartum series of sessions (group interventions) based on a California Department of Public Health approved curriculum and provides health education in a group setting.

SUPERVISION: The Supervising Health Education Specialist reports to a centralized support unit within the County of San Bernardino Department of Public Health, but coordinates all work through the Public Health Program Coordinator, as applicable.

DUTY STATEMENT:

1. Coordinates all aspects of preparing for the group interventions, including ensuring that all supplies, equipment and logistics are in place, and all required forms are prepared and completed.
2. Develops and maintains an incentive and transportation plan for program participants to attend group intervention and individual case management.
3. Develops and maintains a plan for babysitting, including age-appropriate educational activities for children.
4. Plans and designs educational and promotional materials and training aids to support program scope of work activities.
5. Conducts a cohort series of culturally relevant antepartum and postpartum sessions with a CHDP-approved curriculum that
   a. focuses on building each participant’s knowledge and skills, while enhancing participant self-esteem and confidence, with the goal of empowering her to take active responsibility for her own health and that of her family, and
   b. incorporates opportunities to build participant awareness of how health is shaped by social determinates including economic and social factors like income, education, interpersonal relationships and discrimination.
6. Co-facilitates and manages group intervention dynamics, leads exercises to reduce stress, and provides opportunities for participants to set personal goals and to gain self-empowerment to improve health.
7. Provides education on health topics that include child development, nutrition, birthing process and birth spacing.
8. Develops and implements Black Infant Health pre and post tests to measure participant knowledge change.
California Department of Public Health (CDPH)
Maternal, Child and Adolescent Health (MCAH)
Black Infant Health (BIH) Scope of Work (SOW)

Black Infant Health Program

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

All BIH Sites are required to comply with BIH Policy and Procedures (P&P) and the Fiscal Policies and Procedures Manual in their entirety. In addition, all BIH Sites shall work towards maximizing fidelity in the following four domains (adherence, dose, participant engagement and quality of service delivery) by implementing Program services, fulfilling all deliverables associated with benchmarks, attending required meetings and trainings and completing other MCAH-BIH reports as required. A list of the fidelity indicators for each domain is linked here: BIH Fidelity Indicator Listing (rev. 3/11/16).

The CDPH Maternal, Child and Adolescent Health (MCAH) Division places a high priority on the poor outcomes that disproportionately impact the African-American community in California. The BIH site agrees to implement all activities in this Scope of Work (SOW). Central to the efforts in reducing these disparities, listed below are the four (4) goals that are the hallmark of the program:

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, collect and enter participant and program data into the electronic Efforts to Outcomes (ETO) data system and engage community partner agencies.

All BIH Sites are required to comply with the following tiered staffing matrix per the BIH 2015 Request For Supplemental Information (RSI) BIH RSI Instructions to ensure fidelity and standardization across all sites:

<table>
<thead>
<tr>
<th>Staffing Requirements</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
<th>Tier 4</th>
<th>Tier 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Health Jurisdiction</td>
<td>San Francisco, Santa Clara, Contra Costa, Long Beach, Fresno, San Joaquin, Solano, Kern</td>
<td>San Diego, Alameda, Riverside</td>
<td>Sacramento, San Bernardino</td>
<td>Los Angeles</td>
<td></td>
</tr>
<tr>
<td>BIH Coordinator</td>
<td>0.5 FTE</td>
<td>0.5 FTE</td>
<td>0.5 FTE</td>
<td>0.5 FTE</td>
<td>0.5 FTE</td>
</tr>
<tr>
<td>FHA/Group Facilitator</td>
<td>2.0 FTE</td>
<td>3.0 FTE</td>
<td>4.0 FTE</td>
<td>6.0 FTE</td>
<td>8.0 FTE</td>
</tr>
<tr>
<td>Mental Health Professional</td>
<td>0.5 FTE</td>
<td>0.5 FTE</td>
<td>0.5 FTE</td>
<td>0.5 FTE</td>
<td>0.5 FTE</td>
</tr>
<tr>
<td>Outreach Liaison</td>
<td>1.0 FTE</td>
<td>1.0 FTE</td>
<td>1.0 FTE</td>
<td>1.0 FTE</td>
<td>1.0 FTE</td>
</tr>
<tr>
<td>Data Entry</td>
<td>0.5 FTE</td>
<td>0.5 FTE</td>
<td>0.5 FTE</td>
<td>0.5 FTE</td>
<td>0.5 FTE</td>
</tr>
</tbody>
</table>
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 “E” Source Key refers to information that is based on participant-level program data included and maintained in ETO. The “N” Source Key refers to narrative information provided in quarterly reports or site surveys.

It is the responsibility of the Local Health Jurisdiction (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. It is the responsibility of an LHJ to solicit technical assistance and guidance from MCAH if performance issues arise. If a program does not meet the goals and objectives outlined in this SOW, the LHJ may be placed on a corrective action plan (CAP) status. After implementation of the CAP, if the LHJ does not demonstrate substantial growth or fails to successfully meet the goals and objectives of this SOW, MCAH will either cancel the Agreement or amend it to reflect reduced funding. Continued participation in the BIH program beyond the current fiscal year is also subject to successful performance of agreed upon activities.

The development of this SOW was guided by several public health frameworks including the Ten Essential Services of Public Health and the three (3) 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 integrate these approaches when conceptualizing and organizing local program, policy, and evaluation efforts.

- The Ten Essential Services of Public Health: CDC - Public Health System and the 10 Essential Public Health Services - NPHPSP
  [http://www.publichealth.lacounty.gov/qi/corefcns.htm](http://www.publichealth.lacounty.gov/qi/corefcns.htm)
- The Spectrum of Prevention: The Spectrum of Prevention | Prevention Institute
- Life Course Perspective: Life Course Approach in MCH
- Social Determinants of Health: [http://www.cdc.gov/socialdeterminants/](http://www.cdc.gov/socialdeterminants/)
- Strengthening Families: Center for the Study of Social Policy / Young Children & Their Families / Strengthening Families

All activities in this SOW shall take place within the fiscal year.
For each fiscal year of the contract period, the LHJ shall submit the deliverables identified below. All deliverables shall be submitted to the MCAH Division to your designated Program Consultant in accordance with the BIH P&P Manual and postmarked or emailed no later than the due date.

**Deliverables for each FY**

- Annual Progress Report

**Due Date for each FY**

August 15

**Coordinator Quarterly Report:**

<table>
<thead>
<tr>
<th>Reporting Period</th>
<th>From</th>
<th>To</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2) Second Report</td>
<td>October 1, 2017</td>
<td>December 31, 2017</td>
<td>January 31, 2018</td>
</tr>
<tr>
<td>3) Third Report</td>
<td>January 1, 2018</td>
<td>March 31, 2018</td>
<td>April 30, 2018</td>
</tr>
<tr>
<td>4) Fourth Report (WAIVED)</td>
<td>April 1, 2018</td>
<td>June 30, 2018</td>
<td>July 31, 2018</td>
</tr>
</tbody>
</table>

*Information during this reporting period will be included in the Annual Progress Report*

See the following pages for a detailed description of the services to be performed.
**Part II: Black Infant Heath (BIH) Program**

**Goal 1:** BIH will maintain program fidelity and fiscal management to administer the program as required by the BIH Program P&Ps and SOW and will assure program implementation, staff competency, and data management.

<table>
<thead>
<tr>
<th>Short and/or Intermediate Objective(s)</th>
<th>Intervention Activities to Meet Objectives (Describe the steps of the intervention)</th>
<th>Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Implement the program activities as designed.</td>
<td>Process Description and Measures</td>
</tr>
<tr>
<td></td>
<td>• Annually review and revise internal policies and procedures for delivering services to eligible BIH participants.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Submit Agreement Funding Application (AFA) timely.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Ensure that BIH Coordinator is involved in the BIH budget process prior to submission of AFA to MCAH.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Submit BIH Annual report by August 15.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Submit BIH Quarterly Reports as directed by MCAH.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2</td>
<td>Maintain culturally competent staff to perform program services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• At a minimum, the following key staffing roles are required:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o 0.5 FTE BIH Coordinator</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Family Health Advocates (FHA)/Group Facilitators (GF) based on MCAH-BIH designated tier level.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o 1 FTE Community Outreach Liaison (COL)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o 0.5 FTE Data Entry</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o 0.5 FTE Mental Health</td>
<td></td>
</tr>
<tr>
<td>1.2</td>
<td>Describe process of hiring staff at each site that are filled by personnel meeting qualifications in the P&amp;P.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Include duty statements of all staff with submission of AFA packet.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Submission of all staff changes per guidelines outlined in BIH P&amp;P.</td>
<td></td>
</tr>
<tr>
<td>1.2</td>
<td>Percent of key staffing roles at site filled by personnel who meet qualifications in the P&amp;P.</td>
<td></td>
</tr>
<tr>
<td>Short and/or Intermediate Objective(s)</td>
<td>Intervention Activities to Meet Objectives (Describe the steps of the intervention)</td>
<td>Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>TRAINING</strong></td>
<td>1.3 Develop a plan to assess the ability of staff to effectively perform their assigned tasks, including regular observations of group facilitators.</td>
<td><strong>1.3</strong> Maintain records of staff attendance at trainings. (N)</td>
</tr>
<tr>
<td></td>
<td>• Identify staff training needs and ensure those needs are met, notifying MCAH of any training needs.</td>
<td>• Number of trainings (both state and local) attended by staff during FY 2017-18. (E)</td>
</tr>
<tr>
<td></td>
<td>• Ensure that all key BIH staff participates in training or educational opportunities designed to enhance cultural sensitivity.</td>
<td>• Completion of at least 2 group observation feedback forms by the BIH Coordinator for every group facilitator during FY 2017-18. (E)</td>
</tr>
<tr>
<td></td>
<td>• Require that all key BIH staff (i.e. MCAH Director, BIH Coordinator, and ALL direct service staff) attend mandatory MCAH Division-sponsored trainings, conference calls, meetings and/or conferences as scheduled by MCAH Division.</td>
<td>• Number and percent of key staff that completed BIH ETO Training. (E)</td>
</tr>
<tr>
<td></td>
<td>• Ensure that the BIH Coordinator and all direct service staff attend mandatory MCAH Division-sponsored training(s) prior to implementing the BIH Program.</td>
<td></td>
</tr>
<tr>
<td>Short and/or Intermediate Objective(s)</td>
<td>Intervention Activities to Meet Objectives (Describe the steps of the intervention)</td>
<td>Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>DATA COLLECTION AND ENTRY</td>
<td>1.4 • 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 ETO as determined by MCAH. • Ensure accuracy and completeness of data input into ETO system. • Ensure that all staff receives updates about changes in ETO and data book forms. • Ensure that a selected staff member with advanced knowledge of the BIH Program, data collection, and ETO is selected as the BIH Site’s Data Entry lead and participates in all Data and Evaluation calls. • Accurately and completely collect required participant information, with timely data input into the appropriate data system(s). • Work with MCAH to ensure proper and continuous operation of the MCAH-BIH-ETO.</td>
<td>1.4 • Review ETO and fidelity snapshot reports and discuss during calls with BIH State Team. • Review ETO Utilization Reports for all staff at BIH Sites. • Enter all data into ETO within seven (7) working days of collection. • Review of the BIH Data Collection Manual by all staff. • Completion of ETO training by all staff. • Participation in periodic MCAH-Data calls. • Participation in role-specific trainings by the Data Entry Lead. • Review of ETO data quality reports by the BIH Coordinator and Data Entry staff on at least a monthly basis. • Conduct and report on audits of recruitment, enrollment, and service delivery paper forms against ETO reports; audit sample must include at least 10% of recruitment records and 10% of enrollment records.</td>
</tr>
<tr>
<td></td>
<td>All BIH participant program information and outcome data will be collected and entered timely and accurately using BIH required forms at required intervals.</td>
<td></td>
</tr>
</tbody>
</table>

**DATA COLLECTION AND ENTRY**

All BIH participant program information and outcome data will be collected and entered timely and accurately using BIH required forms at required intervals.
<table>
<thead>
<tr>
<th>Short and/or Intermediate Objective(s)</th>
<th>Intervention Activities to Meet Objectives (Describe the steps of the intervention)</th>
<th>Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Store Participant level Data forms on paper per guidelines in P&amp;P.</td>
<td>Process Description and Measures</td>
</tr>
<tr>
<td></td>
<td>• Define a data entry schedule for staff and monitor for adherence.</td>
<td></td>
</tr>
<tr>
<td>OUTREACH 1.5</td>
<td>• All BIH LHJs will conduct outreach activities and build collaborative relationships with local social service providers, health care providers, community agency partners and individuals to maximize awareness and ensure that eligible women are referred to BIH.</td>
<td>1.5 • Describe the types of community partner agencies contacted by LHJ staff. (N)</td>
</tr>
<tr>
<td></td>
<td>• All BIH LHJs will establish referral mechanisms that will facilitate reciprocity with partner agencies.</td>
<td>1.5 • Describe outreach activities performed in order to reach target population. (N)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.5 • Describe deviations in outreach activities, noting changes from local recruitment plan. (N)</td>
</tr>
<tr>
<td>PARTICIPANT RECRUITMENT 1.6</td>
<td>• Develop and implement a Participant Recruitment Plan (standardized intake process) according to the target population and eligibility guidelines in MCAH-BIH P&amp;P.</td>
<td>1.6 • Submit participant triage algorithm with submission of AFA packet.</td>
</tr>
<tr>
<td></td>
<td>• Review Recruitment plan annually and update as needed.</td>
<td>1.6 • Participant Recruitment Plan will be reviewed annually and updated as needed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short and/or Intermediate Objective(s)</td>
<td>Intervention Activities to Meet Objectives (Describe the steps of the intervention)</td>
<td>Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>PARTICIPANT REFERRAL</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 1.7 All BIH LHJs will establish a network of referral partners. | - Collaborate with community agencies to develop a network of referral partners who will refer eligible women to BIH.  
- Provide referrals to other MCAH programs for women who cannot participate in group intervention sessions. | - Describe process for ensuring that referral partner agencies are referring eligible women to BIH in quarterly reports and during technical assistance calls. (N)  
- Total number of service providers that made referrals to the BIH Program in FY 2017-18. (E) |
| **ENROLLMENT**                        |                                                                                  |                                                                                  |
| 1.8 All participants enrolled in BIH will be African-American.  
All participants will be 18 years or older when enrolled in BIH.  
All participants will be enrolled during pregnancy.  
- All participants will be enrolled at or before 26 weeks of pregnancy.  
- All women will participate in group intervention. | - Enroll women that are African-American.  
- Enroll women at or before 26 weeks of pregnancy.  
- Enroll women that will participate in group intervention. | - Visual inspection of all recruitment eligibility fields on incoming referral forms for completeness.  
- Inclusion of eligibility criteria with materials used for referral and recruitment.  
- Number and percent of enrolled women who meet eligibility criteria defined by age and timing of pregnancy. (E) – *Fidelity Indicator A1b* |
| **PROGRAM PARTICIPATION**            |                                                                                  |                                                                                  |
| 1.9.1 All women will participate in a prenatal group.  
All women will participate in a group within 30 days of enrollment. | - Assign participants to a prenatal group as part of enrollment process.  
- Schedule prenatal groups to allow participants to attend within 30 days of enrollment.  
- Enroll participants in a prenatal group within 30 days of first successful contact. | - Describe barriers, challenges and successes of enrolling women in a prenatal group within 30 days of first successful contact during technical assistance calls. (N)  
- Number and percent of enrolled women who attended a prenatal group session within 45 days of enrollment. (E) – *Fidelity Indicator A3a*  
Number and percent of enrolled women assigned to a prenatal group. (E)  
Percent of group sessions that were conducted in the prescribed sequence and at...
<table>
<thead>
<tr>
<th>Short and/or Intermediate Objective(s)</th>
<th>Intervention Activities to Meet Objectives (Describe the steps of the intervention)</th>
<th>Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.9.2</td>
<td>• Assign participants to a FHA as part of enrollment process.</td>
<td>the prescribed time intervals. (E) – Fidelity Indicator A3c</td>
</tr>
<tr>
<td></td>
<td>• Conduct case management services that align with Life Plan activities (goal setting).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Collect completed self-administered scaled questions as described in P&amp;P.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Collect the required number of assessments per timeframe outlined in P&amp;P.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Develop and implement a Life Plan based on goal setting during Life Planning meetings 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 Life Planning meetings.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Ensure participant referrals are generated and completed for all services identified.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Conduct participant dismissal activities.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Conduct participant satisfaction surveys.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Submit complete and accurate reports in the timeframe specified by MCAH.</td>
<td></td>
</tr>
<tr>
<td>1.9.2</td>
<td>• Collect and record service delivery activities for enrolled women into ETO. (E)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Report number and percent of enrolled women for whom the following actions are completed (E):</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Assigned to an FHA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Intake procedures, including completion of an initial assessment and assigned date of initial prenatal group.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Initial case conferencing.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Life Planning meetings.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Prenatal and Postpartum assessments.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Birth Plan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Referrals</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Participant dismissal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Describe successes and/or challenges in assisting participants with setting short and long-term goals during Life Planning meetings. (N)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Describe program improvements resulting from participant satisfaction survey findings at least quarterly. (N)</td>
<td></td>
</tr>
<tr>
<td>1.9.2</td>
<td>• Number and percent of enrolled women assigned to an FHA. (E)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number and percent of enrolled women who complete prenatal and postpartum assessments at the P&amp;P-designated time intervals. (E)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number and percent of enrolled women who are assigned to a prenatal group upon enrollment.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number and percent of enrolled women who received at least one (1) case conference attended by a FHA or GF, and either the MHP or Public Health Nurse (PHN). (E) – Fidelity Indicator A2a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Percent of enrolled women who have (a) a long term goal and (b) one (1) or more short-term goals documented in one (1) of the three (3) focus areas (health, relationship, and finances) (among women enrolled 30 days or longer) during Life Planning meetings. (E) – Fidelity Indicator P1a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number and percent of enrolled women with a Birth Plan collected before the expected date of delivery (among women past due). (E) – Fidelity Indicator</td>
<td></td>
</tr>
<tr>
<td>Short and/or Intermediate Objective(s)</td>
<td>Intervention Activities to Meet Objectives (Describe the steps of the intervention)</td>
<td>Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 1.9.3  All BIH participants will participate in Group Intervention Sessions. | 1.9.3  - Schedule Group Intervention Sessions with guidance from State BIH Team.  
- All participants will have the opportunity to enroll in Group Intervention Sessions within 30 days of the first successful contact.  
- Conduct and adhere to the 20-group intervention model as specified in the P&P. | 1.9.3  - Collect and record Group Intervention Session attendance records for all enrolled women into ETO. (E)  
- Submit FY 2017-18 Group Intervention Sessions Calendar to MCAH-BIH Program with submission of AFA and upon request.  
- Describe participant successes or challenges with completing seven (7) of ten (10) prenatal and/or postpartum Group Intervention Sessions. |
| | 1.9.3  - Number of Group Intervention Sessions entered into ETO that began during FY 2017-18. (E)  
- Number and percent of enrolled women who attend at least one (1) prenatal Group Intervention Session. (E)  
- Number and percent of enrolled women who attended the expected number of Group Intervention Sessions based upon the number of days in program (E) – Fidelity Indicators D1a and D1b. | (supplemental) A4ai.  
- Number and percent of enrolled women who have a known referral status for every documented referral at time of exit from the program (among women dismissed from BIH). (E) – Fidelity Indicator Q4a  
- Number and percent of enrolled women who have not been dismissed from BIH two (2) or more months after completion of their last postpartum group. (E)  
- Number and percent of enrolled women who have been dismissed from BIH with a completed participant satisfaction survey. (E) |
Goal 2: Engage the community to support African-American families’ health and well-being with education and outreach efforts

<table>
<thead>
<tr>
<th>Short and/or Intermediate Objective(s)</th>
<th>Intervention Activities to Meet Objectives (Describe the steps of the intervention)</th>
<th>Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)</th>
</tr>
</thead>
</table>
| 2.1 BirH Coordinator and/or MCAH Director will elevate community awareness of African-American birth outcomes. | • Inform the community about poorer birth outcomes among African-American women by delivering standardized messages describing how the BiH Program addresses these issues.  
• Create partnerships with community and referral agencies that support the broad goals of the BiH Program, through formal and informal agreements.  
• Develop and implement a community awareness plan that outlines how community engagement activities will be conducted.  
• Develop and implement activities related to multi-level community engagement and awareness with referral partners to identify service gaps in the LHJ target area.  
• Develop performance strategies with local organizations that provide services to AA women and infants to improve referrals and linkage to BiH services. | • Submit quarterly reports that describe outreach activities electronically using ETO in a timely manner. (N)  
• Document the local plan for community linkages, including an effective referral process that will be reviewed on an annual basis and updated as needed. (N)  
• Document successes and barriers to community education activities or events at least once per quarter in the ETO through quarterly reporting. (E/N)  
• List and maintain current documentation on the nature of formal and informal partnerships with community and referral agencies at least once a quarter; record MOUs and referral relationships in the ETO service provider details form. (E/N)  
• Document community efforts such as advisory board involvement and community collaborations to address maternal and infant health disparities, or other similar formal or informal partnerships at least once per quarter. (N)  
• Enter all outreach activities in the Community Contacts Log in ETO. | • Number, format, and outcomes associated with community outreach activities conducted by BiH Coordinator and/or MCAH Director during FY 2017-18. (E/N) |
<table>
<thead>
<tr>
<th>Short and/or Intermediate Objective(s)</th>
<th>Intervention Activities to Meet Objectives (Describe the steps of the intervention)</th>
<th>Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)</th>
</tr>
</thead>
</table>
| 2.2 BIH COL will increase information sharing with other local agencies providing services to African-American women and children in the community and establish a clear point of contact. | 2.2 - Develop collaborative relationships with local agencies in the community that provide services to African-American women and children, to establish strong resource linkages for recruitment of potential participants and for referrals of active participants.  
  - Develop a clear point(s) of contact with collaborating community agencies on a regular basis as it relates to outreach, enrollment, referrals, care coordination, etc.  
  - Assess referrals from partner agencies to determine enrollment points of entry quarterly. | 2.2 - Enter all outreach activities in the Community Contacts Log in ETO.  
  - Maintain current lists of community providers and Service Provider details in ETO.  
  - Describe materials used to inform community partners about BIH. (N)  
  - List and describe barriers, challenges and/or successes related to establishing community partnerships and point(s) of contact at least quarterly. (N)  
  - Number of agencies where the COL has a documented point(s) of contact and with whom information is regularly exchanged. (E)  
  - Total number of agencies with outreach records during FY 2017-18. (E) |
|                                                                                                                                      | 2.2 - Maintain current lists of community providers and Service Provider details in ETO.                                                                                       |                                                                                                           |
**Goal 3: Increase the ability of African-American women to manage chronic stress**

<table>
<thead>
<tr>
<th>Short and/or Intermediate Objective(s)</th>
<th>Intervention Activities to Meet Objectives (Describe the steps of the intervention)</th>
<th>Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 All BIH participants will have their social support measured at baseline and after attending the prenatal and/or postpartum group intervention and completing Life Planning activities.</td>
<td>3.1 • Implement the prenatal and postpartum group intervention with fidelity to the P&amp;P. • Encourage participants to attend and participate in group sessions. • Support clients in fostering healthy interpersonal and familial relationships. • Report results from group session information form, including description of participant engagement in group activities for each group session.</td>
<td>3.1 • Provide FY 2017-18 group intervention schedules upon request. (N) • Percent of participants who meet expected prenatal life planning session attendance (prenatal dose). (E) – Fidelity Indicator D2a • Percent of participants who meet expected prenatal group session attendance (prenatal dose). (E) – Fidelity Indicator D1a and D1b.</td>
</tr>
</tbody>
</table>

| 3.2 All BIH participants will have their self-esteem, mastery, coping and resiliency measured at baseline and after attending prenatal and/or postpartum group intervention and completing Life Planning activities. | 3.2 • All activities are delivered with an understanding of African-American culture and history. • Assist participants in identifying and utilizing their personal strengths. • Develop and implement a 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 and guide them in applying stress reduction techniques. | 3.2 • Describe challenges/barriers why participants did not have their self-esteem, mastery, coping and resiliency measured after attending prenatal and/or postpartum group intervention and completing Life Planning activities. (N) |

3.1 Number and percent of enrolled participants who have both a baseline and follow-up measurement in social support as measured through the Social Provisions Scale – Short (SPS-S). (E)

3.2 Number and percent of enrolled participants who have both a baseline and follow-up measurement in self-esteem as measured through the Rosenberg Self-Esteem Scale. (E) Number and percent of enrolled participants who have both a baseline and follow-up measurement in mastery as measured through the Pearlin Mastery Scale. (E) Number and percent of enrolled participants who have both a baseline and follow-up measurement in coping and...
<table>
<thead>
<tr>
<th>Short and/or Intermediate Objective(s)</th>
<th>Intervention Activities to Meet Objectives (Describe the steps of the intervention)</th>
<th>Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Support participants as they become empowered to take actions toward meeting their needs.</td>
<td>resiliency as measured through the Brief Resilience Scale. (E)</td>
</tr>
<tr>
<td></td>
<td>• Teach participants how to express their feelings in constructive ways.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Help participants to understand societal influences and their impact on African-American health and wellness.</td>
<td></td>
</tr>
</tbody>
</table>
**Goal 4: Improve the health of pregnant and parenting women, thus also promoting the health of their infants**

<table>
<thead>
<tr>
<th>Short and/or Intermediate Objective(s)</th>
<th>Intervention Activities to Meet Objectives (Describe the steps of the intervention)</th>
<th>Evaluation/Performance Measures (Process, Short and/or Intermediate Measures) (Report on these measures in the Annual Report)</th>
</tr>
</thead>
</table>
| 4.1                                   | Assist participants in understanding behaviors that contribute to overall good health, including:  
  - 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 education to participants who report drug, alcohol and/or tobacco use.  
  - Assist participants with completion of their birth plan. | 4.1  
  - List and document additional activities (e.g., Champions for Change cooking demonstrations) conducted that promote health and wellness of BIH participants and their infants at least once per quarter. (N/E) | 4.1  
  - Number and percent of participants and infants who obtained health and community services while enrolled in BIH. (E)  
  - Number and percent of participants whose healthy eating behaviors improve over the course of their participation in BIH. (E)  
  - Number and percent of participants whose physical activity increased over the course of their participation in BIH. (E)  
  - Number and percent of recruited and enrolled participants reporting drug, alcohol and/or tobacco use who are provided information and health education. (E)  
  - Number and percent of participants receiving prenatal care by trimester of program initiation. (E)  
  - Number and percent of participants uninsured at enrollment who received referral and follow-up for health insurance before delivery. (E)  
  - Number and percent of participants who complete a birth plan. (E) |
<table>
<thead>
<tr>
<th>Short and/or Intermediate Objective(s)</th>
<th>Intervention Activities to Meet Objectives (Describe the steps of the intervention)</th>
<th>Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)</th>
</tr>
</thead>
</table>
| 4.2 All BIH participants will report an increase in knowledge and understanding of reproductive life planning and family planning services. | 4.2  - Promote and support family planning by providing information and education.  
- 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 Family Planning, Access, Care, and Treatment (Family PACT). | 4.2  - Summarize challenges/barriers of birth control usage among enrolled women who have delivered. (N)  
4.3 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. | 4.2  - Number and percent of participants who attend a 4-6 week postpartum checkup with a medical provider. (E)  
- Number and percent of participants who use any method of birth control to prevent pregnancy after their babies are born. (E)  
4.3  - 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 Edinburgh Postpartum Depression Screen (EPDS) to every | 4.3  - Summarize successes and challenges in addressing mental health issues, including mental health referrals at least once per quarter. (N)  
4.3  - Number and percent of enrolled participants who completed the EPDS 6-8 weeks postpartum. (E)  
- Number and percent of participants with "positive" EPDS screens with a recorded referral to a community mental health provider within two (2) weeks after the EPDS collection date. (E)
<table>
<thead>
<tr>
<th>Short and/or Intermediate Objective(s)</th>
<th>Intervention Activities to Meet Objectives (Describe the steps of the intervention)</th>
<th>Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)</th>
</tr>
</thead>
</table>
| participant 6-8 weeks after she gives birth.  
- Help participants understand the symptoms of postpartum depression.  
- 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**  
- 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**  
- List and describe additional activities that enhance parenting and bonding. (N)  
- Provide anecdotes/participant success stories about improved parenting/bonding with submission of BIH Quarterly Reports.  
- List and describe additional activities on infant safe sleep practices/SIDS/SUID risk reduction. (N)  
- Provide anecdotes/participant success stories about infant safe sleep practices and SIDS/SUID risk reduction with submission of BIH Quarterly Reports.  
- Provide anecdotes/participant success stories about breastfeeding practices with submission of BIH Quarterly Reports. | **4.4**  
- Number and percent of participants who complete the safety checklist prior to delivery. (E)  
- Number and percent of postpartum participants who initiate breastfeeding. (E)  
- Number and percent of prenatal participants who complete a birth plan prior to delivery. (E) |
INVENTORY/DISPOSITION OF CDPH-FUNDED EQUIPMENT

Current Contract Number: 201736  Date Current Contract Expires: June 30, 2018
Previous Contract Number (if applicable): ____________________________
CDPH Program Name: Black Infant Health
Contractor's Name: County of San Bernardino  CDPH Program Contract Manager: Antwan Hornes
Department of Public Health  CDPH Program Address: California Department of Public Health
Contractor's Complete Address: 606 East Mill Street  1615 Capitol Ave., PO Box 997420, MS 8305, Sacramento, CA 95899-7420
San Bernardino, CA 92415-0011  Contractor's Contact Person: Vanessa Long
Contractor's Contact Person: Vanessa Long

<table>
<thead>
<tr>
<th>QUANTITY</th>
<th>ITEM DESCRIPTION</th>
<th>UNIT COST PER ITEM (Before Tax)</th>
<th>CDPH ASSET MGMT. USE ONLY CDPH Document (DISPOSAL) Number</th>
<th>ORIGINAL PURCHASE DATE</th>
<th>MAJOR/MINOR EQUIPMENT SERIAL NUMBER (If motor vehicle, list VIN number.)</th>
<th>OPTIONAL—PROGRAM USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>HP-EO800G1-CTO</td>
<td>$1,143.87</td>
<td></td>
<td>4/27/2015</td>
<td>MXL517233J</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HP ELITEONE 83.2GHZ 8GB DDR3 1280GB SATA SSD</td>
<td>$</td>
<td></td>
<td></td>
<td>MXL517233K</td>
<td></td>
</tr>
<tr>
<td></td>
<td>INTEL 3.2GHZ 8GB DDR3 1280GB SATA SSD INTEL</td>
<td>$</td>
<td></td>
<td></td>
<td>MXL517233L</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HD GRAPHICS 4600 WIN 7 PRO 23.5&quot; DISPLAY</td>
<td>$</td>
<td></td>
<td></td>
<td>MXL517233M</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$</td>
<td></td>
<td></td>
<td></td>
<td>MXL517233N</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$</td>
<td></td>
<td></td>
<td></td>
<td>MXL517233P</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$</td>
<td></td>
<td></td>
<td></td>
<td>MXL517233Q</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$</td>
<td></td>
<td></td>
<td></td>
<td>MXL517233R</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$</td>
<td></td>
<td></td>
<td></td>
<td>MXL517233S</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$</td>
<td></td>
<td></td>
<td></td>
<td>MXL517233T</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$</td>
<td></td>
<td></td>
<td></td>
<td>MXL517233V</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>HP Elite One 800 G2 i5-6500 Desktop Computer</td>
<td>$1,026.97</td>
<td></td>
<td>12/22/2016</td>
<td>MXL6231MCL</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Epson Powerlite 1284 LCD projector, 3200-lumen</td>
<td>$775.07</td>
<td></td>
<td>10/24/2016</td>
<td>WEVK6200093</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Sanyo Model FWZV475F DVD Player</td>
<td>$203.99</td>
<td></td>
<td>11/22/2016</td>
<td>J12658935</td>
<td></td>
</tr>
</tbody>
</table>

(THIS IS NOT A BUDGET FORM)
## INVENTORY/DISPOSITION OF CDPH-FUNDED EQUIPMENT

**Current Contract Number:** 201736  
**Date Current Contract Expires:** June 30, 2018  
**Previous Contract Number (if applicable):**  
**CDPH Program Name:** Black Infant Health  
**CDPH Program Contract Manager:** Antwan Hornes  
**CDPH Program Address:** California Department of Public Health  
1615 Capitol Ave., PO Box 997420, MS 8305, Sacramento, CA 95899-7420  
**CDPH Program Contract Manager’s Telephone Number:** 916-650-0397  
**Date of this Report:** March 24, 2017 - Page 2 of 2

### (THIS IS NOT A BUDGET FORM)

<table>
<thead>
<tr>
<th>QUANTITY</th>
<th>ITEM DESCRIPTION</th>
<th>UNIT COST PER ITEM (Before Tax)</th>
<th>CDPH ASSET MGMT. USE ONLY</th>
<th>ORIGINAL PURCHASE DATE</th>
<th>MAJOR/MINOR EQUIPMENT SERIAL NUMBER</th>
<th>OPTIONAL PROGRAM USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Printer, HP Color Laser Jet Enterprise M553, Model BOISB-1406-02</td>
<td>$626.77</td>
<td>6/10/2016</td>
<td>JPBCJ6110C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Printer, HP Laser Jet Pro 400 M401dne, Model SHNGC-1100-00</td>
<td>$239.24</td>
<td>6/10/2016</td>
<td>PHGFF51786</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Printer, HP Color Laser Jet Pro M452dn, Model BOISB-1407-00</td>
<td>$239.24</td>
<td>6/10/2016</td>
<td>VNB3B10691</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Laptop, HP EliteBook Folio 1040 G3 Notebook PC, Model 8260NGW</td>
<td>$1,050.03</td>
<td>6/10/2016</td>
<td>5CD6237MB8</td>
<td>5CD6237MDQ</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Vizio Plasma Television D60 D3</td>
<td>$600.35</td>
<td>11/22/2016</td>
<td>LFTRUPBS3301202</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CDPH 1204 (6/11)
INSTRUCTIONS FOR CDPH 1204
(Please read carefully.)

The information on this form will be used by the California Department of Public Health (CDPH) Asset Management (AM) to: (a) conduct an inventory of CDPH equipment and/or property (see definitions A, and B) in the possession of the Contractor and/or Subcontractors, and (b) dispose of these same items. Report all items, regardless of the items’ ages, per number 1 below, purchased with CDPH funds and used to conduct state business under this contract. (See Health Administrative Manual (HAM), Section 2-1060 and Section 9-2310.)

The CDPH Program Contract Manager is responsible for obtaining information from the Contractor for this form. The CDPH Program Contract Manager is responsible for the accuracy and completeness of the information and for submitting it to AM.

Inventory: List all CDPH tagged equipment and/or property on this form and submit it within 30 days prior to the three-year anniversary of the contract’s effective date, if applicable. The inventory should be based on previously submitted CDPH 1203s, “Contractor Equipment Purchased with CDPH Funds.” AM will contact the CDPH Program Contract Manager if there are any discrepancies. (See HAM, Section 2-1040.1.)

Disposal: (Definition: Trade in, sell, junk, salvage, donate, or transfer; also, items lost, stolen, or destroyed (as by fire).) The CDPH 1204 should be completed, along with a “Property Survey Report” (STD. 152) or a “Property Transfer Report” (STD. 158), whenever items need to be disposed of; (a) during the term of this contract and (b) 30 calendar days before the termination of this contract. After receipt of this form, the AM will contact the CDPH Program Contract Manager to arrange for the appropriate disposal/transfer of the items. (See HAM, Section 2-1050.3.)

1. List the state/ CDPH property tag, quantity, description, purchase date, base unit cost, and serial number (if applicable) for each item of;
   A. Major Equipment: (These items were issued green numbered state/ CDPH property tags.)
      • Tangible item having a base unit cost of $5,000 or more and a life expectancy of one (1) year or more.
      • Intangible item having a base unit cost of $5,000 or more and a life expectancy of one (1) year or more (e.g., software, video.)
   B. Minor Equipment/Property: (These items were issued green state/ CDPH property tags.)
      Specific tangible items with a life expectancy of one (1) year or more that have a base unit cost less than $5,000. The minor equipment and/or property items were issued green unnumbered “BLANK” state/ CDPH property tags with the exception of the following, which are issued numbered tags: Personal Digital Assistant (PDA), PDA/cell phone combination (Blackberries), laptops, desktop personal computers, LAN servers, routers and switches.

2. If a vehicle is being reported, provide the Vehicle Identification Number (VIN) and the vehicle license number to CDPH Vehicle Services. (See HAM, Section 2-10050.)

3. If all items being reported do not fit on one page, make copies and write the number of pages being sent in the upper right-hand corner (e.g. “Page 1 of 3.”)

4. The CDPH Program Contract Manager should retain one copy and send the original to: California Department of Public Health, Asset Management, MS1801, P.O. Box 997377, 1501 Capitol Avenue, Sacramento, CA 95899-7377.

5. Use the version on the CDPH Intranet forms site. The CDPH 1204 consists of one page for completion and one page with information and instructions.

For more information on completing this form, call AM at (916) 341-6168.