Local MCAH Programs Policies and Procedures




This manual applies to Local Health Jurisdictions (LHJs) and contains Program Policies and Procedures for the following MCAH Programs:

- Local Maternal, Child and Adolescent Health (MCAH) Program

Additional policies are available for:

- Black Infant Health (BIH) Program
- Adolescent Family Life Program (AFLP)
- California Home Visiting Program (CHVP)
- Fiscal Administration Policies and Procedures

Overview

The California Department of Public Health (CDPH), Maternal, Child and Adolescent Health Division (MCAH) administers federal and state funds to local partners to promote the health of women of reproductive age, pregnant women, mothers, infants, children, and adolescents in California.

CDPH/MCAH administers funds to Local Health Jurisdictions (LHJs) and Community Based Organizations (CBOs) annually through contracts and/or allocation agreements. All contracts and allocation agreements are subject to federal and state funding appropriations.

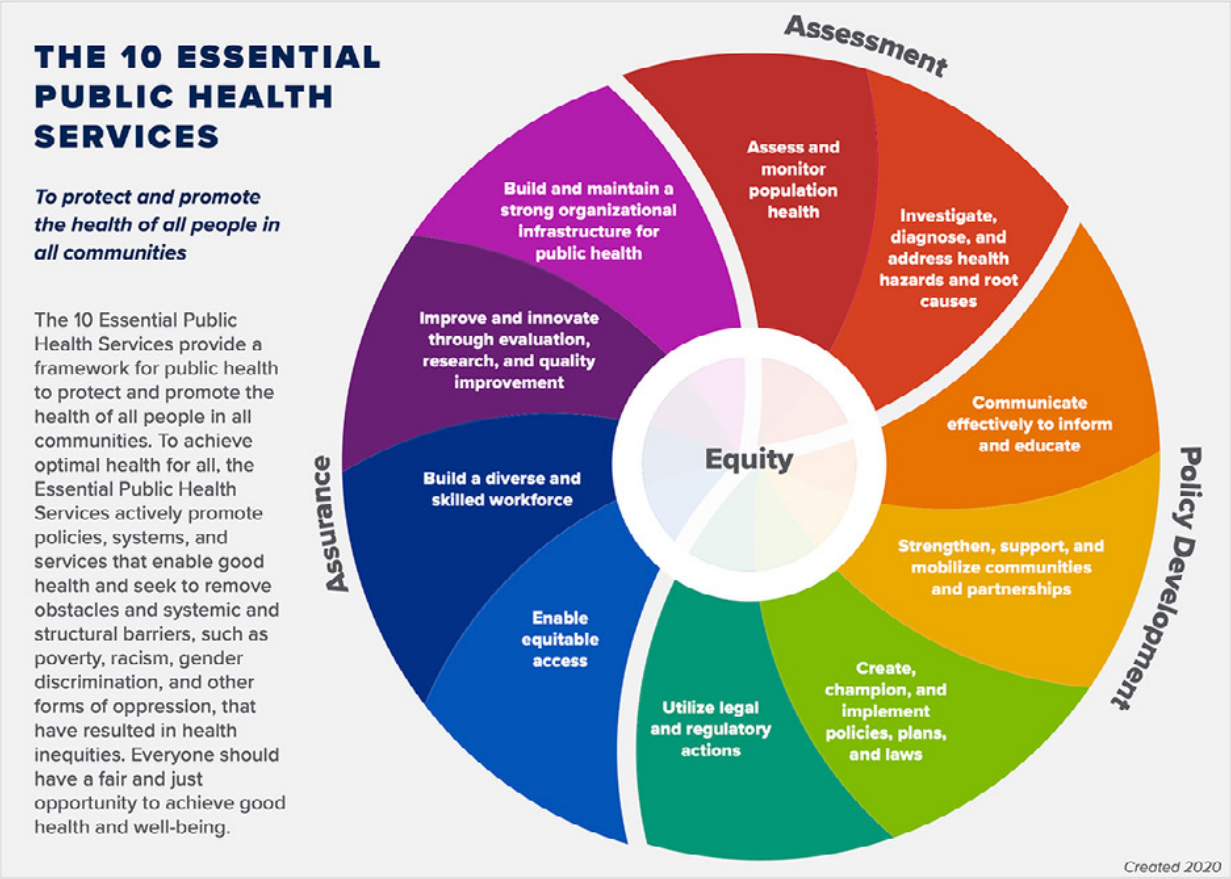
Public Health Frameworks and Strategies

The Local Health Jurisdiction (LHJ), in collaboration with the CDPH/MCAH Division, shall strive to develop systems that protect and improve the health of California's women of reproductive age, infants, children, adolescents and their families.

This is guided by several public health frameworks and strategies including the ones listed below. Please consider integrating these approaches when conceptualizing and organizing local program, policy, and evaluation efforts.

10 ESSENTIAL SERVICES OF PUBLIC HEALTH (REVISED, 2020)

The 10 Essential Public Health Services provides a framework for public health to protect the health of all people in all communities and actively promotes policy systems and overall community conditions to achieve equity, enable optimal health for all, and seek to remove systematic and structural barriers that have resulted in health inequities. CDPH/MCAH uses the framework to structure and describe activities and strategies identified by State and Local MCAH programs.



LIFE COURSE PERSPECTIVE AND SOCIAL DETERMINANTS OF HEALTH

The Life Course perspective approaches health as an integrated continuum rather than as disconnected and unrelated stages. It asserts that a "complex interplay" of social and environmental factors including governmental policies, biological, behavioral, and psychological issues help to define health outcomes across the course of a person's life. In this perspective, each life stage exerts influence on the next stage; social, economic, and physical environments also have influence throughout the life course. All these factors affect individual and community health.

Social Determinants of Health (SDOH) are conditions in the places where people are born, live, learn, work, and play that affect a wide range of health and quality-of-life outcomes and risks. SDOH can be grouped into five domains: Economic Stability, Education Access and Quality, Health Care Access and Quality, Neighborhood

and Built Environment, and Social and Community Context. SDOH impact people's health, well-being, and quality of life and contribute to wide health disparities and inequities. Just promoting health choices won't eliminate health disparities. Health organizations and their partners must take action to improve conditions in people's environment.

CDPH/MCAH recommends that LHJs integrate a life course perspective and an understanding of SDOH when developing interventions.

SPECTRUM OF PREVENTION

The Spectrum of Prevention promotes multiple levels of intervention and encourages people to move beyond the perception that prevention is merely education. The Six Levels of Intervention include influencing policy and legislation, changing organizational practices, fostering coalitions and networks, educating providers, promoting community education, and strengthening individual knowledge and skills.

CDPH/MCAH recommends that LHJs implement a multifaceted approach to prevention that includes multiple levels of intervention.

HEALTHY PEOPLE 2030

Healthy People is the nation's foundation for prevention efforts. Every 10 years, Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. These objectives identify nationwide health improvement priorities to increase public awareness and understanding, set goals for improvement, engage multiple sectors to strengthen policies and improve practices that are driven by the best available evidence, and identify critical research, evaluation, and data collection needs.

EVIDENCE-BASED PUBLIC HEALTH PRACTICE

It is essential that public health programs focus their energy on implementing strategies that have been proven effective and will maximize population impact.

LHJs should consider the following when planning and evaluating interventions:

- Population health issues are multifaceted; therefore, to be effective, interventions should take place at multiple levels.
- Interventions should focus on population effects; surveillance data is a good indicator of performance.
- Community preferences, political and logistical feasibility, and budget constraints are also important to consider.
- Measure short, medium, and long-term outcomes as many interventions take place over a long period and health outcomes may not be immediately apparent.
- Measure the magnitude of an effect as well as whether there was an effect.

Statutes

The following statute summaries paraphrase the structure and requirements for Title V funded State and Local MCAH programs.

CREATION OF CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

- In 2006, Senate Bill 162 (the California Public Health Act) added §131051 to create the California Department of Public Health, giving CDPH authority to oversee the MCAH, AFLP, BIH, and SIDS programs.
- Budget Act (Chapter 1, Statutes of 2009, Fourth Extraordinary Session) eliminated State General Funds for the MCAH Program.

MATERNAL AND CHILD HEALTH PROGRAM

- California HSC §123225-§123255: The department shall maintain a program of maternal and child health.

- In 1997, HSC (§) 123255 was added: The department may maintain a maternal and child health program in each county; shall establish minimum standards that govern the basis for allocations to counties, including, but not limited to, the services to be provided, administration, staffing, fiscal accountability, and eligibility for services. The department may recoup or withhold all or part of a county's allocation for failure to comply with those standards. Counties shall submit a plan and budget in accordance with the department's maternal and child health priorities.

- California Welfare and Institutions Code (W&I) §14148.9-§14148.9: Establishes a comprehensive perinatal program and reporting mechanism to the Legislature to improve and coordinate existing programs for pregnant women and infants and remove barriers to care with an intense focus on women who are at high risk of delivering a low or high birth weight baby or a baby who will suffer from major health problems or disabilities.

- California HSC §123505: States that the goals of the community-based comprehensive perinatal health care system shall be to decrease and maintain the decreased level of perinatal, maternal, and infant mortality and morbidity, and to support methods of providing comprehensive prenatal care that prevent prematurity and the incidence of low-birth-weight infants.

- California HSC §123510: States that the program objectives of the community-based comprehensive perinatal health care system shall be to ensure continuing availability and accessibility to early prenatal care throughout the state; to assure the appropriate level of maternal, newborn and pediatric care services necessary to provide the healthiest outcome for mother and infant; to ensure postpartum, family planning, and follow-up care through the first year of life and referral to an ongoing primary health care provider; to include support and ancillary services such as nutrition, health education, public health nursing, and social work that have been demonstrated to decrease maternal, perinatal, and infant mortality and morbidity as components of comprehensive perinatal care; to ensure that care shall be available regardless of the patient's financial situation; to ensure to the extent possible that the same quality of care shall be available to all pregnant women; to promote program flexibility by recognizing the needs within an area and providing for unique programs to meet those needs; to emphasize preventive care as a major component of any perinatal program; and to support outreach programs directed at low-income pregnant women to encourage early entry into and appropriate utilization of perinatal care.

PERINATAL SERVICES

- California HSC §123475-§123525: Establishes a community-based system of comprehensive perinatal care for low-income women. States that prenatal care, delivery service, postpartum care, and neonatal and infant care are necessary services that have been demonstrated effective in preventing or reducing

maternal, perinatal, and infant mortality and morbidity, including prematurity and low birth weight. Comprehensive perinatal care includes initial and ongoing physical assessment, psychosocial, nutrition, and health education assessments, interventions, counseling and referral, food supplement programs, vitamins, and breast-feeding and other services as appropriate. Requires all contracted providers to make these services available directly or by subcontract, and to use an appropriate multidisciplinary team.

- California W&I §14132(u): Establishes Comprehensive Perinatal Services as defined in §14134.5 as a Medi-Cal benefit.

- California W&I §14134.5(b): States that perinatal means the period from the establishment of pregnancy to one month following delivery.

- California W&I §14134.5(f): States that the Department and the California Conference of Local Health Officers will establish standards for services pursuant to this section.

- California W&I §14134.5(g): States that the Department shall assist Local Health Departments to establish a community perinatal program.

- California HSC §104560-§104569: Comprehensive Perinatal Patient/Client Education and Community Awareness Program. Establishes a comprehensive perinatal outreach program. A county or city may contract with the state department to provide perinatal program coordination, patient advocacy, and expanded access services for low-income pregnant and postpartum women and women of childbearing age who are likely to become pregnant integrated with the county's perinatal program.

REGIONAL PERINATAL PROGRAMS OF CALIFORNIA (RPPC)

- California HSC §123550-§123610: The department shall maintain a regionalized program that addresses the special needs of high-risk pregnant women and infants.

MATERNAL MORTALITY AND MORBIDITY

- Senate Bill (SB) 65 (Chapter 449, Statutes of 2021) requires the Department to establish the California Pregnancy-Associated Review Committee (PARC) effective August 1, 2022, to conduct in-depth reviews of all pregnancy-related deaths, analyze common causes of severe maternal morbidity (SMM) and make recommendations on strategies to prevent maternal mortality and morbidity.

INFANT MORTALITY

- California HSC §123650-§123655: Instructs the Department to develop a plan to identify causes of infant mortality and morbidity and to study recommendations on the reduction of infant mortality in California.

- California HSC §100325-§100330: Instructs the Department to conduct special investigations of the sources of morbidity and mortality and the effects of localities, employments, conditions, and circumstances on the public health. Under these provisions, the local health officer may obtain access to various records and information for the purpose of public health investigation of fetal and infant mortality.

SUDDEN INFANT DEATH SYNDROME (SIDS)

- California HSC §123725-§123745, Sudden Infant Death Syndrome

    - §123725: The department shall establish a Sudden Infant Death Syndrome (SIDS) Advisory Council. The description of the Advisory Council and its duties are contained in this section. Requires an annual statewide SIDS conference.

    - §123730: The department shall keep each county health officer advised of the most current knowledge relating to the nature and causes of SIDS.

    - §123735: The department shall contract with a person to provide regular and ongoing SIDS education and training and produce, update, and distribute literature on SIDS for those who interact with parents and caregivers following a death from SIDS.

    - §123740: Upon being informed by the coroner of a presumed SIDS death, the local health officer or "appropriately trained public health professional", after consultation with the infant's physician of record, when possible; and then within three working days of receiving notice from the coroner of a presumed SIDS death, shall contact persons having custody and control of the infant (e.g., family, caregivers, and/or foster parents) to provide information, support, referral and follow-up services.

      "Appropriately trained public health professional" means a public health nurse or a social worker who is knowledgeable about the incidence of sudden infant death syndrome and the care and support of persons who have experienced a death of this nature, and who has basic grief counseling skills.

    - §123745: The department shall monitor, or contract with a person to monitor compliance by county health officers with HSC §123740.

- California HSC §462 and §10253:

    - The coroner shall notify the county health officer within 24 hours when there is a provisional diagnosis of SIDS.

    - Upon being informed by the coroner of a presumed SIDS death, the county health officer or his or her designated agent, after consultation with the infant's physician of record, shall immediately contact the person or persons having custody and control of the infant and explain to such persons the nature and causes of SIDS.

CALIFORNIA SIDS PROGRAM MANDATES

Beginning with State Fiscal Year 2003-04, State Mandates related to the SIDS program **have been suspended** by the Legislature in the Budget Act. As a result, LHJs are no longer required to provide the following services and/or duties listed within those State Mandates:

- SIDS Training for Firefighters (Stats 1989, c.1111): California HSC §1797.193, requiring firefighters to complete a course on SIDS.
- SIDS Contacts by Local Health Officers (Stats 1991, c.268): California HSC §123740, requiring local health officers to contact persons having custody and control of the infant to provide information and support services.
- SIDS Autopsies (Stats 1989, c.955): California Government Code (GC) §27491.41, requiring coroners to follow prescribed SIDS autopsy protocols.
- SIDS Notices (Stats 1974, c.453): California HSC §102865, requiring coroners to notify the local health officers within 24 hours of a SIDS autopsy.

While some State SIDS Mandates have been suspended, other state level SIDS Mandates **are still in effect** that affect local duties and requirements.

- CDPH/MCAH is required by HSC §123745 to monitor compliance by county health officers with HSC §123740, even though CDPH/MCAH is only monitoring their voluntary compliance.
- Local duties (currently voluntary) noted under California HSC §123740 include:
    - Upon being notified by the coroner of a presumed SIDS death, consulting with the infant's physician, when possible.
    - Immediately contacting the persons having custody and control of the infant (e.g., family, caregivers, and/or foster parent) to provide information, support, referral, and follow-up services.
- CDPH/MCAH is required to keep each county officer advised of the most current knowledge relating to the nature and cause of SIDS.
- CDPH/MCAH provides regular and ongoing SIDS education and training programs.

ADOLESCENT FAMILY LIFE PROGRAM (AFLP)

- AFLP was established in 1985 and authorized by legislation in 1988 (CA Adolescent Family Life Act of 1988, California HSC §124175-124200). The Title V MCH Block Grant funds 20 providers.
- California HSC §124180: Allows the department to conduct AFLP to assure that pregnant adolescents receive comprehensive continuous prenatal care in order to deliver healthy babies; to establish

networks within regions to provide to pregnant and parenting teens and their children necessary services including medical care, psychological and nutritional counseling, maternity counseling, adoption counseling, academic and vocational programs, and day care; to provide a continuous case manager to each family unit; and to maintain a data base to measure outcomes of adolescent pregnancies.

BLACK INFANT HEALTH PROGRAM (BIH)

- Senate Bill (SB 165), Budget Act of 1989 (Alquist, Chapter 93, Statutes of 1988): Made funds available for a new and innovative project to reduce the rate of black infant mortality in California.
- California HSC §131051(d)(4): States that the Black Infant Health Program is under the jurisdiction of the Deputy Director for Primary Care and Family Health.
- California W&I §14148.9(c): States that programs for pregnant women and infants shall focus on women who are at high risk of delivering a low or high birth weight baby or a baby who will suffer from major health problems or disabilities.
- California W&I §14148.9(d): Lists Black women as one of the target populations.

PERINATAL EQUITY INITIATIVE (PEI)

- In 2018, state Legislature passed the Budget Act of 2018, which included the establishment of the California Perinatal Equity Initiative (PEI) within the Department of Public Health.
- The statewide mortality rate for Black infants continues to be two to four times higher than rates for other groups. PEI aims to address the cases of persistent inequity and identify best practices to eliminate disparities in infant mortality.
- PEI complements programs and services offered through the BIH Group Model.

SEXUAL HEALTH ACCOUNTABILITY ACT

- California HSC §151000-§151003: The Sexual Health Education Accountability Act of 2007 requires sexual health education programs that are funded or administered, directly or indirectly by the State, to be comprehensive and not abstinence-only. These statues 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 (FDA) for preventing pregnancy and sexually transmitted infections. Programs directed at minors are additionally required to specify that abstinence is the only certain way to prevent pregnancy and sexually transmitted infections.

Regulations

The following regulations may apply to Local MCAH Programs:

- U.S. Code of Regulations Title 42, The Public Health and Welfare, Chapter 7, Social Security, Subchapter V-Maternal and Child Health Services Block Grant.
- U.S. Code of Regulations Title 42, The Public Health and Welfare, Chapter 7, Social Security, Subchapter XIX-Grants to States for Medical Assistance Programs.
- California Code of Regulations, Title 22, Medical Assistance Program, Division 3, §51179-§51179.10 and §51504 (CPSP, September 1987).
- California Code of Regulations, Title 22. Social Security, Division 3. Health Care Services, Subdivision 1. California Medical Assistance Program, Chapter 3. Health Care Services, Article 3. Standards for Participation, §51249. Application Process for Comprehensive Perinatal Providers.
- California Code of Regulations, Title 17, Public Health, Division 1. State Department of Health Services, Chapter 3. Local Health Service, Subchapter 1. Standards for State Aid for Local Health.
- Article Organization, §1253. Public Health Nursing Staff.
- Office of Management and Budget (OMB) Circular A-87 Revised. 5J10/04-Cost Principles for State, Local and Indian Tribal Governments.
- Discrimination Prohibitions, Social Security Act, Section 508; Title V prohibits exclusion from participation, denial of benefits, or discrimination in any program or activity funded in whole or in part with Title V monies based on race, color or national origin, sex, age, religion, or disabling condition.

Title V Maternal and Child Health (MCH) Block Grant

The Title V Maternal and Child Health (MCH) Services Block Grant is a partnership program between the federal government and states that focuses on improving the health and well-being of all mothers, children, and families.

The Title V Block Grant is federally administered by the Health Resources and Services Administration (HRSA). Title V Block Grant funds are used to reimburse MCAH, BIH, and AFLP program expenses incurred for activities consistent with the goals and purposes of the grant.

The Title V MCH Block Grant is authorized under the Social Security Act of 1935. CDPH/MCAH applies annually for Title V funds to maintain Title V Programs.

Title V MCH Block Grant funds help each state to:

- Assure access to quality maternal and child health care services for mothers and children, especially those with low-incomes or limited availability of care.
- Reduce infant mortality.
- Provide access to prenatal, delivery, and postnatal care, especially pregnant women who are low-income and at-risk.
- Increase regular screenings and follow-up diagnostic and treatment services for children who are low-income.
- Provide access to preventive and primary care services for children who are low-income and rehabilitative services for children with special health needs.
- Implement family-centered, community-based, systems of coordinated care for children with special health care needs.
- Set up toll-free hotlines and assistance with applying for services to pregnant women with infants and children eligible for Medicaid.

CDPH/MCAH may use its MCH Block Grant funds for the provision of health services and related activities (including planning, administration, education, and evaluation) in accordance with the CDPH/MCAH application. The MCH Block Grant funds may not be used for cash payments to intended recipients of health services or for purchase of land, buildings, or major medical equipment.

CDPH/MCAH organizes its reporting on the three legislatively defined MCH populations in the context of five population health domains: 1) Women/Maternal Health; 2) Perinatal/Infant Health; 3) Child Health; 4) Adolescent Health; and 5) Children and Youth with Special Health Care Needs (CYSHCN).

The Title V Block Grant allocation is earmarked into four categories:

1) 30% Preventative and Primary Care for Children
2) 30% CYSHCN to include providing and promoting family-centered, community-based, coordinated care (including care coordination services) for CYSHCN and facilitating the development of community-based systems of services for such children and their families.
3) 30% MCAH (other) activities
4) 10% Administrative costs

Further information on Title V can be found at: Understanding Title V of the Social Security Act.

TITLE V REQUIREMENTS FOR CDPH/MCAH

As a recipient of the federal Title V MCH Block Grant, CDPH/MCAH is required to:

- Conduct a comprehensive statewide Title V Needs Assessment every five (5) years.

- Submit an Application Plan for meeting the needs identified by the statewide Title V Needs Assessment every fiscal year.
- Submit an Annual Report of activities to the federal government. This includes reporting on national and state performance measures, setting annual targets and reporting on progress toward meeting the identified goals and objectives.

TITLE V NEEDS ASSESSMENT REQUIREMENTS

Each state is required to conduct a statewide Title V Needs Assessment once every five years. CDPH/MCAH requires each LHJ to perform a Local Needs Assessment once every five years to identify problems and priority areas to address in their Local Scope of Work (SOW).

CDPH/MCAH compiles the information from the LHJ statewide Needs Assessment and collects data to develop the 5-Year Title V State Action Plan.

TITLE V REQUIREMENTS FOR LHJS

- Maintain a partnership with CDPH/MCAH and CYSHCN programs to support core public health functions.
- Build community capacity to deliver such enabling services as care coordination, transportation, home visiting, and nutrition counseling, which complement and help ensure the success of State Medicaid programs.
- Support programs for CYSHCN to facilitate the development of family-centered, community-based, coordinated systems of care.
- Provide outreach services to identify pregnant women and infants who are eligible for services under the state's Medicaid program and assist them in applying for Medicaid assistance.
- Provide and promote primary and preventive health care for children, including CYSHCN, that include violence and injury prevention and healthy lifestyle programs to reduce the incidence of personal risk and health problems.
- Provide and promote preventive services for women of reproductive age that include gap-filling prenatal health services, injury and violence prevention, and healthy lifestyle programs to reduce the incidence of personal risk and health problems.
- Provide and maintain a local toll-free number (and/or other appropriate methods of communication) to make information about health care providers and practitioners who provide services under Title V and Title XIX, as well as other relevant information, available to the community.

Agreement Funding Applications (AFA)

CDPH/MCAH allocates funds to 61 Local Health Jurisdictions (LHJs) annually through the Agreement Funding Application (AFA) process for the Local MCAH program. Each LHJ must complete and submit an AFA package for approval which includes a Local MCAH Scope of Work (SOW), budget and required forms prior to receiving funding.

When completing the AFA package, LHJs should:

- Ensure that each LHJ has the necessary key personnel to fulfill Title V requirements and carry out the core public health functions of assessment, policy development, assurance, and evaluation and implement programs using the ten essential public health services to improve the health of their MCAH population; and

- Ensure that MCAH staff within the LHJ are aware they are responsible for promotion of maternal, child, and adolescent health.

LOCAL MCAH BUDGETS

To develop the Local MCAH budget, each LHJ must establish adequate funding levels to accomplish the activities in the Local MCAH Scope of Work (SOW). The LHJ must use the template(s) provided by CDPH/MCAH. All expenses shown on the budget documents must directly relate to the accomplishment of the goals, objectives, activities, timelines, and outcomes identified under the Local MCAH Program(s) Scope of Work (SOW).

TRAVEL, TRAINING AND MEETINGS

Adequate funding for training and meeting expenses, including travel to MCAH Directors and SIDS meetings, must be built into the annual Local MCAH budget. Travel costs are listed on the budget for all staff who travel to conduct Program business and to attend conferences and training that are directly related to the objectives described in the SOW.

Prior MCAH written approval is required for travel and training costs for staff not listed on the program budget, but who contribute a portion of their time to the MCAH program. Any written approval from the Division as well as any receipts or information required for Travel Reimbursement must be retained by the Agency for audit purposes.

Training costs are listed on the budget for staff who conduct or attend conferences and training that are directly related to the objectives described in the SOW.

- Agencies may host or sponsor Program-related trainings, seminars, workshops, or conferences.

Prior written MCAH approval is required for the following:

- Training and associated travel and per diem costs for staff not listed on the budget, but who contribute a portion of their time to the Program.
- To host trainings, seminars, workshops, or conferences.

Agencies requesting approval to host trainings or seminars must submit the following items:

- A description of the proposed training or seminar in the Program Budget Justification Narrative.
- A written request at least 60 days prior to the proposed training or seminar date(s) to the Contract Liaison and Program Consultant which includes:
    - The date and location of proposed training or seminar
    - Subject matter of the training or seminar
    - Draft of agenda and list of instructors
    - Draft of instructional/educational materials
    - Targeted audience and projected number of attendees
    - Draft of publicity materials
    - Total cost

Note: *Federal regulations disallow the use of any federal funds for advocacy at the local, state, or federal level. Therefore, the $1,100 allocated for the semi-annual MCAH Action training conference may only be used for training and travel related expenses to assist in meeting the educational needs of the MCAH Director. This should be shown in your budget under the travel and/or training line items, as appropriate. Any expenses related in any way to advocacy must be paid from local agency funds and are not eligible for Title XIX matching funds. For any Federal Financial Participation (FFP) reimbursement, activities must meet the FFP objectives and requirements.*

DUTY STATEMENTS

All personnel included on the Local MCAH budget are required to have duty statements comprised of activities performed for the Local MCAH SOW and are funded through the MCAH allocation.

Duty statements for personnel identified in the budget shall be used as supporting documentation for the percent of time assigned to MCAH program activities and the level of Title XIX Federal Financial participation (FFP) matching.

Duty statements must:

- Reflect Local MCAH activities accurately.
- Contain only those duties performed for the Local MCAH program.
- Duty statements should be reviewed annually and updated when duties and responsibilities change.

Skilled Professional Medical Personnel (SPMP) Duty Statements

- Duty statements for Skilled Professional Medical Personnel (SPMP) must contain the statement "This position meets the criteria for SPMP".
- SPMP duty statements must list activities that meet at least one (1) of the two (2) FFP objectives listed below to claim Title XIX funding.
    - Assisting individuals eligible for Medi-Cal to enroll in the Medi-Cal program.
    - Assisting individuals on Medi-Cal to access Medi-Cal services**.**
- SPMP duty statements should reflect the unique expertise required for these duties.
    - For an SPMP position, include language that reflects his/her duties' as they relate to the FFP codes.
    - Enhanced FFP matching is only permissible for activities requiring the skill, knowledge, and ability of an SPMP.

SIDS Coordinator Duty Statements

- Duty statements for the SIDS Coordinator must reference the following activities:
    - Upon being notified by the coroner of a presumed SIDS death, consulting with the infant's physician, when possible.
    - Immediately contacting the persons having custody and control of the infant (e.g., family, caregivers, and/or foster parent) to provide information, support, referral, and follow-up services.
    - Promote and implement Infant Safe Sleep Interventions to reduce the number of SUID related deaths.
    - Provide Sudden Infant Death Syndrome/Sudden Unexpected Infant Death (SIDS/SUID) grief and bereavement services and supports through home visits and/or mail resource packets to families suffering an infant loss.

Duty Statement Components

- Name of the LHJ.
- Name of the program, such as SIDS program.

- Position title, such as MCAH Director, Fiscal Officer, etc.
    - **Do not include personnel names on the duty statement**.
    - Position titles should match those listed on the organizational charts and positions listed on the budget.
    - List the program position from the corresponding personnel line item(s) on the budget. This may be one person or multiple persons on the budget.
    - If a program position has multiple personnel, it is not necessary to have separate or individual duty statements if the duties are the same.
- A statement describing the position's supervisory relationship(s). For example: The Administrative Analyst reports directly to the MCAH Director.
- Summary of the main duties, roles, and responsibilities of the position. For example: The MCAH Director plans, organizes, controls, and leads the MCAH program and oversees the SIDS program.
    - Summaries should be short, focused, concise and describe the activities to be performed.

ORGANIZATIONAL CHARTS

Each LHJ must have an organizational chart illustrating the interrelationship of the LHJ staff associated with all Local MCAH-funded programs.

Organizational charts must:

- Illustrate the relationship of Local MCAH positions and programs to the MCAH Director, the Local health officer, and overall agency.
- List all staff positions funded with Local MCAH funds or involved in Local MCAH activities.

Organizational Chart Components

- Name of the LHJ
- Date of creation or update.
- Name of the program(s).
- Position titles, such as MCAH Director, Fiscal Officer, etc. from the personnel line number on the budget and the budget line items on the organizational chart(s).
    - Match program position titles with the duty statement(s).
    - List budget line number on the organizational chart.
    - It is not necessary to put FTEs on the organizational chart.
    - It is not necessary to list staff names on the organizational chart.

Local MCAH Scope of Work

The Local MCAH Scope of Work (SOW) defines the local activities in each jurisdiction that contribute to accomplishing the CDPH/MCAH mission and goals. The LHJ completes the Local MCAH SOW using the template provided by CDPH/MCAH. Each LHJ must complete and submit a Local MCAH SOW during the AFA process.

LHJs that are funded for additional MCAH programs such as AFLP and BIH must complete separate SOWs for those programs according to the program's respective policies and procedures.

The Local MCAH SOW consists of general requirements and activities for all LHJs and has additional activities across five (5) population domain areas, which align with State Priority Needs and address Title V, CDPH/MCAH and local objectives.

The Local MCAH SOW is based on:

- LHJ needs and problems identified in the Five-Year Needs Assessment.
- CDPH/MCAH requirements and priorities.
- Title V, Title XIX, state and federal requirements, and initiatives.

GENERAL INSTRUCTIONS FOR COMPLETING THE LOCAL MCAH SOW TEMPLATE

Cover Page

The cover page identifies the LHJ, Agreement Number and State Fiscal Year. It also has links to frameworks for reference. The MCAH Director should sign and date the cover page prior to submittal.

- Select LHJ from the drop-down menu at the top.
- Enter the corresponding Agreement Number associated with the applicable Agreement Funding Application (AFA).
- Select the State Fiscal Year from the drop-down menu at the top.

Section A

Outlines general requirements and activities for all LHJs.

- Nothing is entered here by the LHJ.

Section B

Outlines specific requirements for certain population domains or specific MCAH programs.

- Nothing is entered here by the LHJ.

Section C

Outlines local activities by population domain.

- The LHJ may select one or more local activities listed under any of the state strategy areas.
    - At least one activity must be selected or the LHJ must develop at least one activity of their own in the Women/Maternal Health Domain.
    - At least one activity must be selected or the LHJ must develop at least one activity of their own in the Perinatal/Infant Health Domain.
    - At least one activity must be selected or the LHJ must develop at least one activity of their own in the Child Health Domain.
    - At least one activity must be selected or the LHJ must develop at least one activity of their own in the Children with Special Health Care Needs (CYSHCN) Health Domain.
    - At least one activity must be selected or the LHJ must develop at least one activity of their own in the Adolescent Health Domain.
- For each activity selected, the LHJ answers the following information:
    - What is your anticipated outcome?

Developing Local Activities

If the LHJ chooses to develop their own local activities, they should be based on:

- Prioritized needs identified during the most recent 5-Year Needs Assessment. The LHJ should develop a plan to address each activity, identify best practice strategies and methods to accomplish the activity.
- As resources allow, the LHJ should develop SOW activities to address local problems identified in the Needs Assessment.
- The LHJ should place their activity under the domain area, objective and state strategy area that applies to their local activity.
- For each activity developed, the LHJ answers the following questions:
    - What is your anticipated outcome?

SUBMITTAL AND APPROVAL OF SCOPE OF WORK

The Local MCAH SOW is submitted along with the other required AFA documents to the Contract Liaison.

During the AFA review process, the Program Consultant reviews and approves the Local MCAH SOW and the LHJ is notified of SOW approval and sent a final copy when notified of AFA approval.

REVISIONS TO THE SOW

Proposed revisions to the Local MCAH SOW must be submitted with all corresponding documents to the CDPH/MCAH Program Consultant for review and approval. If there are fiscal implications, submit the proposed changes to both the Program Consultant and Contract Liaison for approval. CDPH/MCAH staff will review and provide feedback and/or approval as appropriate.

Local MCAH Annual Report

All LHJs receiving CDPH/MCAH funds are required to complete and submit a Local MCAH Annual Report. The LHJ reports on the status of activities and outcomes for the previous State Fiscal Year ending June 30.

LHJs may request an extension for submission of the Local MCAH Annual Report. Send requests in writing (email is acceptable) to your Program Consultant.

CDPH/MCAH has the option to withhold payment on invoices for failure to submit a complete and timely report.

How Annual Report Data is Used

CDPH/MCAH aims to collect the minimum necessary information with the specific purpose of monitoring the Local MCAH SOW and/or Title V reporting.

The Local MCAH Annual Report is not a gathering mechanism and is not used in lieu of other methods for eliciting LHJ and stakeholder feedback.

- Information is used to report on required Title V measures
- To compile as "Enabling Services" counts on a Title V form which is submitted to the federal funder
- To provide narrative examples for Title V reporting
- For CDPH/MCAH program monitoring of the Local MCAH SOW
- For CDPH/MCAH monitoring of programs (i.e., SIDS, CYSHCN) or activities that are not included on the Local MCAH SOW but are included in the Local MCAH Program Policies and Procedure Manual

MCAH Director and Other Key Positions

All LHJs are required to have an MCAH Director and should have other key positions to support the leadership structure and core functions of the Local MCAH program. LHJs shall comply with these requirements for these key positions to maximize the potential for successful implementation of strategies designed to meet CDPH/MCAH priorities.

MCAH DIRECTOR

MCAH Director Requirements

The LHJ must meet the Full Time Equivalent (FTE) and qualification requirement(s) for the MCAH Director as outlined below. All MCAH Directors funded in whole or in part by the Local MCAH allocation will be the LHJ lead for the local MCAH program. The MCAH Director, in collaboration with the Local Health Officer, has the general responsibility and authority to plan, implement, evaluate, coordinate, and manage all MCAH services within the LHJ.

MCAH Director FTE Requirements

The MCAH Director will dedicate a percentage of time or Full Time Equivalent (FTE) to MCAH activities that complies with the following CDPH/MCAH guidelines for the population.

MCAH Director Full-time Equivalent (FTE) Chart	
Total LHJ Population	FTE MCAH Director
3.5 million	2.0 Physicians
750,001-3.5 million	1.0 Physician
200,001-750,000	1.0 Public Health Nurse
75,001-200,000	0.75 Public Health Nurse
25,001-75,000	0.50 Public Health Nurse
<25,000	0.25 Public Health Nurse

If the MCAH Director is not able to meet requirements, CDPH/MCAH recommends the LHJ add an MCAH Coordinator position and/or other positions to assist with the responsibilities of the MCAH Director.

MCAH Director Qualification Requirements

The MCAH Director must be a qualified health professional, which is defined as follows:

- A physician who is board-certified or board-eligible in specialties of Obstetrics/Gynecology, Pediatrics, Family Practice or Preventive Medicine; or
- A non-physician who must be a certified public health nurse (PHN).
- Other professional credentials must be indicated on the MCAH Director Verification Form.

MCAH Director Requirements for LHJs Participating in the California Home Visiting Program (CHVP)

In LHJs participating in the California Home Visiting Program (CHVP), the MCAH Director is required to devote a minimum of 0.05 FTE and a maximum of 0.15 FTE to CHVP oversight, fostering partnerships and collaboration within the LHJ, and directing the local CHVP Community Advisory Board (CAB).

MCAH Director Requirements for LHJs that do not have a Perinatal Services Coordinator (PSC)

If the LHJ does not have a Perinatal Services Coordinator (PSC), the MCAH Director is responsible for the PSC required activities to perform locally specific activities to ensure that people, including pregnant and postpartum individuals, have access to appropriate preventive, reproductive, perinatal, and postpartum services. Other PSC activities listed in the PSC roles and responsibilities are optional.

MCAH Director Roles and Responsibilities

The Local MCAH Director's role as the manager of the local MCAH program is to direct the local program and ensure the performance of the core public health functions of assessment, policy development, assurance, and evaluation.

The core functions are discussed below:

Assessment:

- Participate in CDPH/MCAH training on data sources, data management, preparation of data for analysis, and the translation of data into information for program planning.
- Monitor local health status indicators for pregnant women, infants, children, including CYSHCN, adolescents and their families using standardized data techniques. Share data annually with the Local Health Officer and/or key health department leadership. Utilize this data to develop an understanding of health needs within the community and identify barriers to the provision of health and human services for the MCAH population.
- Identify health issues and interact with local health care providers, community members, managed care plan providers, coalitions, etc., to enhance program efforts and improve outcomes.

Policy Development:

- Use the information gathered during assessments to develop and implement local policies and programs with measurable objectives.
- Develop plans and direct resources consistent with program goals and objectives.
- Facilitate access to care and appropriate use of services. This may include, but not be limited to patient/client outreach, services for CYSHCN, education, community awareness, referral, transportation, childcare, translation services and care coordination.
- Ensure implementation and coordination of Local MCAH programs.

- Ensure that SIDS activities take place, including community infant safe sleep and SIDS risk reduction education and grief and bereavement support for families experiencing a presumed SIDS death.
- Coordinate all MCAH patient/client outreach, education, and community services provided by local, state, and federal programs, including CCS, to prevent duplication of services and facilitate optimal use of resources.
- Ensure hiring and orientation of Local MCAH personnel, adhering to MCAH program policies for personnel requirements.
- Participate in quality assurance activities designed to improve community health outcomes for women, children, adolescents, and their families.
- Attend MCAH Action meetings and other required trainings. Adequate funding for training and meeting expenses, including travel, must be built into the annual budget.

Evaluation:

- Based on activities of assessment, policy development and assurance:
    - Evaluate and modify program to ensure best practices are implemented.
    - Include methods of measuring outcomes and evaluating progress toward achieving both State and Local MCAH objectives in selected local priority activities.
- Identify barriers/challenges to implementation activities.
- Submit an Annual Report to the CDPH/MCAH.
- Conduct a Needs Assessment within their community every five years.

Local MCAH Director Changes

Each LHJ will notify the CDPH/MCAH of the resignation or proposed change in MCAH Director.

A Local MCAH Director Verification Form, new duty statement, and organizational chart is required to be submitted for any changes to the Local MCAH Director position.

LOCAL MCAH DIRECTOR VERIFICATION FORM

The Local MCAH Director Verification Form is required to verify how the LHJ is meeting the MCAH Director requirements.

All LHJs complete and submit this form during the Agreement Funding Application (AFA) process, even if they meet the MCAH Director requirements.

Information and Requirements for Completing the Form

A copy of the form must be submitted annually during the Agreement Funding Application (AFA) process. The form will be verified with the submitted Local MCAH budget, Organizational Charts and Duty Statements.

Additionally, a new form is required to be submitted for any changes to the Local MCAH Director position throughout the year such as budget revisions and/or change in MCAH Director.

Submittal Requirements

- Complete and submit the form annually during the AFA process.
- The form must be signed by MCAH Director or designee.
- Submit the Duty Statement(s).
- Submit Organizational Chart(s).
- Submit a new form for any subsequent changes after the AFA process to the CDPH/MCAH Program Consultant.

CDPH/MCAH may hold reimbursement unless a current form is on file with CDPH/MCAH.

LOCAL MCAH COORDINATOR

MCAH Coordinator

The MCAH Coordinator is a recommended position.

If the LHJ is not able to meet the MCAH Director requirements, CDPH/MCAH recommends the LHJ add an MCAH Coordinator position and/or other positions to meet the MCAH Director requirements and assist with the responsibilities of the MCAH Director.

PERINATAL SERVICES COORDINATOR (PSC)

PSC Roles and Activities

It is recommended but not required that each LHJ have a PSC to oversee the implementation of perinatal services.

It is recommended that each LHJ have a PSC that is an SPMP and meets the time requirements displayed in the table below.

Recommended PSC FTE Chart	
Total Number of Births in LHJ	Recommended FTE for PSC
100,001	2.0 SPMP
50,001-100,000	1.50 SPMP
25,001-50,000	1.25 SPMP
10,001-25,000	1.0 SPMP
5,001-10,000	0.75 SPMP
1,001-5,000	0.50 SPMP
<1000	0.25 SPMP

PSC Required Activities

The PSC, under the direction of the MCAH Director, will perform locally specific activities to ensure that people, including pregnant and postpartum individuals, have access to appropriate preventive, reproductive, perinatal, and postpartum services. If an LHJ does not have a PSC, the MCAH Director is responsible for these **required** PSC activities.

Other PSC Activities

Below are examples of additional PSC activities. PSCs **may choose** to do some of these activities that meet the needs of their communities:

Assessment:

- Conduct activities with local provider networks and/or health plans, community agencies and partners to improve perinatal and postpartum access, service integration and coordination to meet client needs.
- Identify at-risk maternal and infant populations and develop strategies to address barriers and improve access to early and comprehensive quality perinatal care.
- Use local maternal and infant data to develop safety-net strategies with providers and community partners to ensure at-risk women receive appropriate perinatal care and relevant services.
- Assess disparities, strengths, and needs of pregnant women, families, and populations and apply appropriate interventions.

Policy Development:

- Review, update or implement policies that integrate evidence-based best or promising practices to improve early access to and the quality of perinatal care.
- Develop shared policies or quality initiatives with local health plans to ensure that pregnant and postpartum women receive needed comprehensive perinatal care.

Assurance:

- Collaborate with local managed care plans (MCP) to assure that comprehensive perinatal services are available to all Medi-Cal eligible women.
- Coordinating perinatal activities with the Regional Perinatal Programs of California (RPPC), managed care plans and other health and human service providers to reduce barriers to care, avoid duplication of services and improve quality of perinatal care, including coordinated postpartum referral systems for high-risk mothers and infants upon hospital discharge.
- Implement local best or promising practice strategies to improve perinatal systems of care.

Evaluation:

- Evaluate activities to determine outcome and quality of services.
- Report data and outcomes related to perinatal activities to the MCAH Director.

System Level Examples of PSC activities

The PSC assists with improving the local perinatal systems of care by working at the beneficiary, provider, or community level. Some examples of activities that can be implemented at each system level are as follows:

Beneficiary Level

Perform activities that increase access and utilization of services for Medi-Cal eligible individuals and promote a strong safety-net support for pregnant and postpartum people (e.g., food security, shelter, housing, school placement).

Examples:

- Deliver presentations to increase understanding of perinatal and postpartum services and promote access to services to partner agencies such as WIC offices, schools, foster homes, care providers, CalWORKs, Community Based Organizations (CBOs) and nonprofit organizations.
- Outreach coordination to underserved populations and provide information and education on topics to improve health outcomes for parents, infants, and their families (e.g., social media, resource fairs).

- Helping client review Medi-Cal related documents for medical and mental health providers that accept Medi-Cal.
- Providing information and assistance on transportation related to accessing Medi-Cal services.
- Assisting client to schedule appointments that are related to Medi-Cal health services.
- Assisting client to access Medi-Cal services or care and helping them to understand the need for treatment and follow up.
- Link clients to other MCAH programs such as BIH, AFLP, CHVP

Provider Level

Promote perinatal and postpartum services in the provider community.

Examples:

- Develop processes to raise awareness, increase competencies, and create action plans through round table discussions, learning opportunities such as webinars, and workforce development trainings. Offer information on emerging issues affecting maternal and infant health to the community and providers.
- Assess adequacy of referral sources and assist providers to develop mechanisms to refer clients to appropriate programs and services, such as local MCAH home visiting programs, specialty providers, faith-based organizations, local community, and social services support system and develop a Community Resource Guide to increase access to care.
- Contact and coordinate with dental practices in the County to develop a resource directory of services provided to Medi-Cal/Denti-Cal clients.
- Develop a collaborative relationship with the Medi-Cal Managed Care liaison by sharing strategies to improve perinatal and postpartum care.

Community Level

Promote formal or informal agreements to improve maternal and infant care coordination and collaboration in the community.

Examples:

- Coordinate with RPPC to implement best practices to ensure parents and infants have access to appropriate maternal levels of care.
- Partnering with community advisory boards to support best practices and reduce barriers to increase participation in Medi-Cal funded services. (i.e., doulas, BIH, home visiting, preconception care, fatherhood, dyadic and drop-in mental health services)

- Monitor the health status of the MCAH population including disparities and social determinants of health and work with local leadership to address identified issues.
- Collaborate with other agencies and local provider networks in planning to address unmet needs to improve access to Medi-Cal health and dental services and decrease barriers to care.
- Work with community collaboratives, Medi-Cal, and Medi-Cal Managed Care plans/providers to decrease barriers to services for Medi-Cal enrolled pregnant and parenting women and their partners.
- Collaborate with mental health, substance use and other agencies to identify resources that will facilitate client access to mental health/substance use services.
- Review of local perinatal statistics to identify gaps in services to develop strategies to address adequacy of services related to birth outcomes.
- Develop professional health related educational materials for local MCAH staff training.
- Review and modify local policies and procedures such as Medi-Cal enrollment and referral processes.
- Assess and review population needs and capacity of the agency to provide services or the need to refer to appropriate Medi-Cal services.

More examples can be found in the Fiscal Policies and Procedures.

Comprehensive Perinatal Services Program (CPSP)

While some state CPSP roles and responsibilities have shifted to the Department of Health Care Services (DHCS), other state level CPSP activities are still in effect that affect local duties and requirements.

- Retain CPSP Medi-Cal Applications and Supplemental Changes on File (Local) for a period of seven years in compliance with MCAH Fiscal Policies and Procedures. New CPSP applications should be emailed to CDPH/MCAH CPSP Provider Enrollment mailbox at CPSPProviderEnrollment@cdph.ca.gov.
- Updates to CPSP applications, such as staff changes, should be filed and kept at the CPSP provider site.
- CPSP Provider Application, Tools, and Resources will continue to be housed on the CDPH/MCAH CPSP website.
- Provider and general questions regarding CPSP and/or CPSP Provider Enrollment should be directed to the CPSP Provider Enrollment mailbox at CPSPProviderEnrollment@cdph.ca.gov.
- All general inquiries to CPSP should be emailed to CPSP General Inquiry mailbox at MCAHCPSPGeneralInquiry@cdph.ca.gov

- All CPSP Medi-Cal billing inquiry and other Medi-Cal related services will be directed to Medi-Cal Telephone Service Center at 1-800-541-5555.

Perinatal Regions

There are four perinatal regions statewide that can serve as resources to and facilitates communication and support to the PSCs throughout the state. They are the Northern Area Perinatal Advocates (NAPA), Central Area Perinatal Advocates (CAPA), Bay Area Perinatal Advocates (BAPA), and Southern Area Perinatal Advocates (SAPA).

Northern Area Perinatal Advocates (NAPA)					
Alpine Amador Butte Calaveras Colusa	Del Norte El Dorado Glenn Humboldt Inyo	Lake Lassen Mendocino Modoc Mono	Nevada Placer Plumas Shasta Sierra	Siskiyou Sutter Tehama Trinity Tuolumne	Yuba
Bay Area Perinatal Advocates (BAPA)					
Alameda Berkeley Contra Costa	Marin Monterey Napa	Sacramento San Benito San Francisco	San Joaquin San Mateo Santa Clara	Santa Cruz Solano Sonoma	Stanislaus Yolo
Central Area Perinatal Advocates (CAPA)					
Fresno Kern	Kings Madera	Mariposa Merced	San Luis Obispo	Tulare	
Southern Area Perinatal Advocates (SAPA)					
Imperial Long Beach	Los Angeles Orange	Pasadena Riverside	Santa Barbara San Bernardino	San Diego Ventura	

Perinatal Services Coordinator (PSC) Executive Committee

Purpose of Perinatal Services Executive Committee

The PSC Executive Committee (EC) represents all PSCs and collaborates with CDPH/MCAH staff to promote the perinatal health needs of California women and children. The PSC EC serves as a resource to CDPH/MCAH and facilitates communication and support to all PSCs throughout the state.

The PSC EC meets on the second Thursday quarterly in January, April, July, and October.

Each Region will collaborate, plan, and facilitate a meeting with the CDPH/MCAH Nurse Consultant as follows:

- January—CAPA
- April—NAPA
- July—SAPA
- October—BAPA

The PSC EC will record minutes as scheduled and submit to CDPH/MCAH within 30 days for distribution:

- January—NAPA
- April—SAPA
- July—BAPA
- October--CAPA

Additional meetings may be held as needed by the PSC Executive Committee and/or CDPH/MCAH, including creating ad hoc workgroups to accomplish specific tasks.

Additional Local MCAH Program Requirements

Under the direction of the MCAH Director, the LHJ will:

- Use core public health functions to assure that progress is made toward meeting the MCAH Program, Title V, State requirements and LHJ priorities.
- Develop policies and standards to implement culturally congruent and appropriate activities designed to improve health outcomes and reduce health disparities for all MCAH populations.
- Develop collaborative relationships with agencies and/or community groups within their jurisdiction capable of providing family-centered, culturally competent services.
- Establish a community-based perinatal program that includes providing technical assistance on perinatal services.

SUDDEN INFANT DEATH SYNDROME (SIDS)

- Provide SIDS support services and activities as outlined in the CDPH/MCAH SOW:
    - Promote and implement Infant Safe Sleep Interventions to reduce the number of SUID related deaths.

- Provide Sudden Infant Death Syndrome/Sudden Unexpected Infant Death (SIDS/SUID) grief and bereavement services and supports through home visits and/or mail resource packets to families suffering an infant loss.

- SIDS Coordinators are required to attend the SIDS Annual Conference, SIDS Advisory Council meetings, and as resources allow, attend other SUID/SIDS trainings and educational forums.

FETAL INFANT MORTALITY REVIEW

- The purpose of Fetal Infant Mortality Review (FIMR) is to conduct comprehensive multidisciplinary review of fetal and infant deaths to understand how a wide array of local social, economic, public health, educational, environmental, and safety issues relate to the tragedy of fetal and infant loss. Additionally, FIMR teams use the findings to take action that can prevent future infant deaths and improve the systems of care and resources for women, infants, and families.

- The FIMR process provides the review and action teams with the context on the life of the parents, family, and the death of the infant. Social factors such as geography, limited access to education, experience with discrimination, trauma (including historical trauma), and limited access to physical and behavioral healthcare can contribute to poor pregnancy outcomes and fetal and infant mortality. Residential, educational, and occupational segregation impacts access to high-quality education, employment opportunities, healthy foods, and physical and behavioral health care. Combined, these structural inequities have long-lasting health impacts, including adverse birth outcomes, and fetal and infant mortality.

National Fatality Review-Case Reporting System

- The National Fatality Review-Case Reporting System (NFR-CRS) is a web-based standardized case report tool. The system allows local and state Child Death Review (CDR) and FIMR users to enter case data, summarize findings, review team recommendations, access and download data, and create standardized reports. A data use agreement must be completed to participate.

- If your LHJ wants to conduct FIMR activities and would like to utilize the NFR-CRS, please fill out the Interest In Utilizing the NFR-CRS Form distributed with the AFA package or contact your Program Consultant for a copy of the form. The State FIMR Coordinator will follow-up to discuss the NFR-CRS in more detail.

CALIFORNIA FETAL INFANT MORTALITY REVIEW PLUS (CA FIMR+)

CDPH/MCAH provides funding to a select number of LHJs for CA FIMR+.

California FIMR Plus (CA FIMR+) Program Goals

- Utilize **quantitative/qualitative fetal and infant mortality data** from LHJs experiencing the greatest Black/White disparities, to inform programmatic and community strategies.
- Offer and provide **culturally appropriate, family-centered support** to families experiencing a fetal or infant loss.
- Promote prenatal and postpartum **systems improvement**, by engaging community-based groups (e.g., serving the Black community).
- Support improvements in **respectful care delivery** and implicit bias mitigation.
- Identify the most **impactful approach** for use of these funds **and the associated costs to meet the stated goals**.

CA FIMR+ Annual Reporting Requirements

All LHJs receiving CA FIMR+ funds from CDPH/MCAH are required to report on the status of activities and outcomes for the previous State Fiscal Year ending June 30 in the Local MCAH Annual Report. Below are the components that funded LHJs will report on:

Infrastructure and Capacity Building

- What is the internal make-up of the California FIMR+ Team? List all job positions, job titles and personnel assigned for the FIMR+ Program. Describe the recruitment hiring process along with successes and/or challenges.
- What trainings have been conducted or attended to ensure staff understand role and responsibility to the work. List of trainings conducted. Describe successes and/or challenges associated with workforce development? Please explain.
- Discuss collaborative efforts with both internal and external partners in the development of both your CRT and CAT. Who were these collaborations with and what was the collaborative effort like? Challenges? Successes?

Case Selection, Interviews, and Data Collection

- Please describe your case selection process for case review. Include priority factors.
- Were maternal interviews conducted? If so, explain the benefits of the maternal interview.
- How many cases were inputted into the National Data Collection System? How many were completed?

Case Reviews and the Case Review Team

- What is the target number of reviews to be conducted annually?
- How many cases have been reviewed?
- How many maternal interviews have been conducted?
- Please provide a list of who is on your Case Review Team (CRT)

  - Please discuss the process of your CRT recruitment (successes/challenges/key issues)
  - How often is your CRT convened?
  - List the recommendations of the CRT.
- How many recommendations were provided by the CRT? Please list.

Community Engagement and CAT

- How many people comprise your CAT? What organizations are represented? Provide a list of your Community Action Team (CAT)
  - Please discuss the process of your CAT recruitment (successes/challenges/key issues)
  - How often is your CAT convened?
- List recommendations that were implemented.
  - What activities were conducted by the CAT Team?

Grief and Bereavement

- How many fetal/infant deaths occurred in your county during this fiscal year? Were all provided grief and bereavement services? If not, why?
- Explain the types of grief and bereavement services that were offered to families who experienced a fetal/infant death.

TOLL-FREE OR "NO COST TO THE CALLING PARTY" TELEPHONE SYSTEM

Ensure the availability of a toll-free or "no cost to the calling party" telephone system which provides a current list of culturally and linguistically appropriate information and referral to community health and human resources for the public regarding access to prenatal care. At a minimum, the toll-free line must be operational during normal business hours and must be linguistically appropriate.

DOCUMENTATION RETENTION REQUIREMENTS

Documentation of Agreement Funding Application (AFA) and Local MCAH Scope of Work (SOW) activities must be documented and kept on file for audit purposes for seven (7) years from the date of final invoice payment or longer audits purposes (See MCAH Fiscal Policies and Procedures, Audit File Retention). While participation in the MCAH Program does not authorize access to Protected Health Information (PHI), some LHJs will have access to such information by virtue of the county/city structure or with the permission of individual clients.

For further guidance, please refer to the CDPH/MCAH Fiscal Administration Policy and Procedure Manual.

CLIENT CONFIDENTIALITY AND HIPPA REQUIREMENTS

LHJs are advised that any PHI stored at their agency must adhere to Health Insurance Portability and Accountability Act (HIPAA) of 1996 regulations.

LHJs shall apply appropriate administrative, technical, and physical safeguards to protect the privacy of medical records and other PHI for whatever period such information is maintained, including through disposal. Appropriate safeguards include, but are not limited to:

- Securing and maintaining all hard copies or other records with client information containing PHI (such as CD-ROM, diskettes, thumb drives, etc.) in a locked file cabinet inaccessible to staff other than those directly involved in either the delivery of service to the client, supervision of these direct service-delivery staff, or for data entry.

- Securing all electronic records in password-protected, encrypted files, with access only for staff directly involved in delivery of services to clients, supervision of these staff, or data entry.

- Disposing of Materials:

    - The LHJ site must have policies in place to ensure that confidential information is discarded through secure and confidential means (e.g., shredded, locked confidential destruction bins, pulverized).

    - The LHJ site must have a mechanism in place to ensure that removable media containing confidential, personal, or sensitive information is physically destroyed when no longer needed.

- Sending Confidential Information:

    - Prior to sending PHI or client-related confidential information via fax, LHJ site staff must notify the recipient of the materials faxed.

    - When sending electronic PHI to MCAH, encrypt information by writing "[secure]" on the subject line.

    - The LHJ site shall add a confidentiality statement at the beginning or end of every fax or e-mail that contains confidential, personal, or sensitive information notifying persons receiving the fax or e-mail in error to contact the sender and destroy the document.

Under provisions of the California Health and Safety Code Section 100325 to 100335, CDPH may access records to investigate sources of mortality and shall treat such studies as confidential. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 includes provisions that allow public health monitoring, investigation and intervention, and permit health care providers and other covered entities to disclose medical information for public health purposes without authorization [45 Code of Federal Regulations 164.512(b) and California Civil Code 56.10(c)(7)].

COMMUNICATIONS AND OUTREACH

Product/Publication Approval and Credit

Local MCAH Programs are required to use materials developed by CDPH/MCAH or other credible sources when available. If appropriate materials are not available, in collaboration with their Program Consultant (PC), LHJs may develop their own materials. CDPH/MCAH policy requires that LHJs submit publications, journal articles, reports, brochures, videos, outreach materials, letters of interest or other materials (excluding interim progress reports, financial reports, and normal contractual communications) developed with MCAH allocation funds to CDPH/MCAH for approval before publication and distribution. Any products currently in use that have not been approved by the CDPH/MCAH must be approved prior to reprinting and/or further distribution.

Stuff We All Get (S.W.A.G.) is not allowed as an outreach material and should not be purchased using [program] funds. S.W.A.G. materials include promotional and marketing items such as key chains, coffee mugs, squeeze toys flashlights, ashtrays, pens, trinkets, and shirts. Reach out to your Program Consultant PC if you have questions about what is considered an allowable outreach material.

Logos

Local Program Logos: LHJs/LIAs may create a logo for their MCAH-funded local program. The design does not require MCAH program approval. Submit the logo design with the progress/annual report.

CDPH Logo: Use of the CDPH logo requires review and approval from CDPH's Office of Communications, which can be a 10-week process, sometimes longer. LHJs/LIAs can opt to use the appropriate funding tagline on their outreach materials without incorporating the CDPH logo.

If approved to use the CDPH logo, follow these guidelines when incorporating the logo into your materials: Have white space around the logo, keeping it clear from other texts and graphics; avoid logo distortion when resizing by holding down the shift key to lock the aspect ratio; no other logo should appear larger than the CDPH logo, similar sized logos are acceptable.

The process for approval is as follows:

- Submit the product to the CDPH/MCAH State PC at least 60 days prior to publication or reprinting.
- Send a request in writing to the Program Consultant for approval with the following information:
    - Program or activity
    - Purpose – why is it being developed? Is there a gap in resources? To provide data?
    - Description
    - A copy
    - Target Population (Women, Infant, Child, CYSHCN, or Adolescent)
    - Language(s) available
    - Name, email, and telephone number of contact person

- CDPH/MCAH will review the product, provide feedback, and approve/disapprove within 60 days.
- List the products developed in the Annual Report.

CDPH/MCAH will retain copyright ownership for any and all original materials produced with MCAH contract funding; refer to Exhibit D for details.

CDPH/MCAH Funding Acknowledgement

Local agencies that develop publications, products, journal articles, public reports, videos, or publications using funds provided from CDPH/MCAH must acknowledge this support with a written statement printed on the materials. LHJs must also include this statement on any curriculum, educational materials, programs, program documentation, videotapes, other audio-visual or outreach materials resulting from the use of the CDPH/MCAH funds. Outreach materials include, but are not limited to, television, radio, print advertisements, billboards, bus boards, brochures, flyers, newsletters, mailers, handouts or other items intended for public distribution. The written statement must be located on the title page of public reports or publications and on the first page of journal articles. Please use the statement below:

> "Supported by funds received from the California Department of Public Health, Maternal, Child and Adolescent Health Division" or in Spanish "Financiado por el Departamento de Salud Pública del Estado de California, División de Salud Maternal, Niños y Adolescentes".

Photographs

Photographs used on all media products developed by LHJs require permission for the use intended. Copyrighted photographs must be legally purchased or licensed for the intended use. If not copyrighted, written consent from the subject (individual in the image who is identifiable) for the intended use is required. If a minor, consent is required from a parent or guardian (e.g., subjects are youth under age 18 years and their child: written consent is required from the youth and their parent or guardian for the program participant, and the program participant may sign on behalf of their child.) When an LHJ submits products for approval, the LHJ must state that a photo release was obtained and kept on file.

Media Inquiries

If a reporter is asking about local implementation of a program, it's handled at the local level and should adhere to media policies and procedures of the Local Health Jurisdiction (LHJ) or the Local Implementing Agency (LIA). While LHJs/LIAs do not need to request permission from CDPH, it is expected that they notify their CDPH Program Consultant (PC) about their local program's media coverage. Please include a link or copy of the published media in your annual report to MCAH.

If the LHJ/LIA receives a request related to *state-implementation* of a program, refer the reporter to CDPH's Office of Communications: media@cdph.ca.gov. Additionally, send an email about the reporter inquiry to your program consultant and cc: cdph.mcahcommunications@cdph.ca.gov.

Communication Resources

Item	Location
CDPH Office of Communications (media relations, communications toolkits, newsletter)	Office of Communications
S.W.A.G. (Stuff We All Get)	Governor Brown Eliminates "S.W.A.G" | Governor Edmund G. Brown Jr. (ca.gov)
MCAH Program Outreach and Media Toolkits	*Coming soon!*
MCAH Topic-Specific Communications Toolkits (includes social media messages)	MCAH Communications Toolkits
MCAH program videos	Videos (ca.gov)

GUIDELINES FOR PROTOCOLS TO LINK MCAH CLIENTS TO HEALTH INSURANCE AND PREVENTIVE VISIT(S)

The LHJ MCAH programs are expected to develop and adopt protocols to ensure that MCAH clients, especially those in MCAH case management or home visiting programs, are enrolled in health insurance, are linked to a provider and access preventive visits.

Health Insurance and Preventive Visit(s) for MCAH Clients

To ensure that all clients in MCAH programs have health insurance, are linked to a provider, and complete a preventive visit(s).

All LHJ MCAH Programs are expected to develop and adopt local protocols to improve the rates of clients accessing a preventive visit. The protocols should contain a process to:

- Verify health insurance status.
- Assist clients to enroll in health insurance.
- Link clients to a health care provider for a preventive visit.
- Develop a tracking mechanism to verify that the client enrolled in health insurance and completed a preventive visit.

- Conduct quality assurance activities to ensure that protocols are implemented as intended and revised as needed.

LHJs will report on the status of these efforts in the Local MCAH Annual Report.

PROTOCOL GUIDELINES FOR DEVELOPMENTAL SCREENING FOR CHILDREN IN MCAH PROGRAMS

LHJs are expected to develop and adopt protocols, tailored to local needs and in accordance with AAP guidelines, to ensure that children (ages one year through 21 years) in case management programs receive developmental screenings (if applicable), referrals to their primary care provider or medical home and subsequent linkages to services as needed. CDPH/MCAH protocols must be culturally sensitive, include ongoing developmental monitoring/surveillance, developmental screening, referral, and linkage.

For LHJs that do not provide direct services to children through their Local MCAH Programs, protocols should be adopted that screen for access to insurance and primary care, and link children to a primary care provider for developmental screening.

Protocol Guidelines for Developmental Screening must contain the following:

- The standardized screening tool(s) to be used.
- The periodicity of screening.
- A list of referral resources, such as Early Start, Family Resource Centers, Help Me Grow program.
- A process to ensure that the child attends their well-child visits, and their primary care provider is notified of the results of screenings.
    - If the child has an at-risk or positive screening result, confirm that parents/caregivers understand that the child needs to have a more comprehensive evaluation by their primary care provider and ensure that the child completes a visit with their primary care provider.
- A process to ensure that a child identified with special needs and their parents/caregivers:
    - Connect with their primary care provider or medical home and appropriate intervention services, such as Regional Centers, Local Educational Agencies, Family Resource Centers, and parent support groups.
    - Receive parent education on developmental milestones and what to do if they are concerned about their child's development.
    - Demonstrate positive parenting skills and have the tools and guidance to optimize their child's growth and development.
    - Receive additional supports to address family or environmental factors that may be impeding their child's development.

- Instructions on how to document the screening process, results, and follow-up.
- A tracking mechanism to verify that a child in need of further evaluation by a primary care provider completes a visit and is referred and linked to appropriate resources as needed.
- Quality assurance activities to ensure that protocols are implemented as intended and revised as needed.

CO-ENROLLMENT IN OTHER MCAH PROGRAMS

LHJ staff will enroll clients in the program(s) that will have the greatest benefit to the individual client using a local assessment process. The Local MCAH program should coordinate the decision-making process with other local programs, such as CHVP, BIH and AFLP programs to identify duplicate or overlapping services, programs to meet goals, objectives, activities, and guidelines.

CDPH/MCAH recommends that all programs, in consultation with the client, to determine the program(s) that best meets the client's needs. CDPH/MCAH recommends Local MCAH Programs develop client triage and enrollment policies based on the availability of local resources and knowledge of client and community needs. All programs should coordinate the decision-making process with other local programs, such as the California Home Visiting Program (CHVP).

Glossary of Common Acronyms

AFLP.....Adolescent Family Life Program
AFA .....Agreement Funding Application
A&I .....Audits and Investigations
BIH .....Black Infant Health
CAB .....Community Advisory Board
CAP .....Corrective Action Plan
CAT .....Community Action Team
CCR .....California Code of Regulations
CCS .....California Children's Services
CDC.....Centers for Disease Control
CDPH .....California Department of Public Health
CHDP .....California Health and Disability Prevention
CHVP.....California Home Visiting Program
CMS .....Children's Medical Services
CPSP .....Comprehensive Perinatal Services Program
CRT .....Case Review Team
DHS.....Department of Health Services
DHCS.....Department of Health Care Services
EC .....Executive Committee
EHR .....Electronic Health Record
FFP.....Federal Financial Participation
FTE.....Full Time Equivalent
HIPAA .....Health Insurance Portability and Accountability Act
HRSA.....Health Resources and Services Administration
LHJ .....Local Health Jurisdiction
MCAH .....Maternal, Child and Adolescent Health
MCH .....Maternal and Child Health
MCHB .....Maternal and Child Health Bureau
PEI .....Perinatal Equity Initiative
PHI.....Public Health Information
PHN .....Public Health Nurse
PSC .....Perinatal Services Coordinator
QA/QI .....Quality Assurance/Quality Improvement
RN.....Registered Nurse
SOW..... Scope of Work
SCHIP .....State Children's Health Insurance Program
SPMP .....Skilled Professional Medical Personnel
SIDS .....Sudden Infant Death Syndrome
SUID.....Sudden Unexpected Infant Death
W&I .....Welfare and Institutions (code)
WIC.....Women, Infant and Children