

MATERNAL, CHILD AND ADOLESCENT HEALTH DIVISION MCAH PROGRAM POLICIES AND PROCEDURES FOR LOCAL HEALTH JURISDICTIONS

Introduction

These Policies and Procedures are to be followed for all issues pertaining to the Allocation Agreement between the Maternal, Child and Adolescent Health (MCAH) Division of the California Department of Public Health (CDPH) and the local health jurisdictions (LHJs). These Policies and Procedures may be amended. The Policies and Procedures Manual is available on the MCAH Division Web site (www.cdph.ca.gov/MCAH) under Local Health Jurisdiction MCAH Program, Program Documents for Local Business Partners.

These Policies and Procedures apply to LHJ Programs funded through the CDPH MCAH Division, and include the local MCAH Program, Adolescent Family Life Program* (AFLP), Comprehensive Perinatal Services Program* (CPSP), Black Infant Health* (BIH) Program, Fetal Infant Mortality Review* (FIMR) Program and Sudden Infant Death Syndrome (SIDS) Program.

(*These Programs also have program-specific Policies and Procedures.)

Table of Contents

This document contains the following:

Topic	See Page
About MCAH Program	2
Statutes and Regulations.....	3
Understanding Title V of the Social Security Act	8
MCAH Division Title V Requirements.....	10
Public Health Frameworks and Strategies	11
Worksite Wellness Policy.....	20
Specialized MCAH Programs.....	22
Children and Youth with Special Health Care Needs (CYSHCN)	24
Guidelines for Protocols for Developmental Screening for Children in MCAH Programs.....	29
Local Health Jurisdiction Requirements	33
Key Personnel	34
Client Triage and Co-Enrollment.....	40
Guidelines for Protocols to link MCAH clients to Health Insurance and Preventive Visit(s)	41
Guidelines for Collaboration.....	42
Collective Impact	43
Agreement Funding Application (AFA).....	44
MCAH Annual Report Requirements	52
Documentation Retention Requirements	53
Client Confidentiality and HIPPA Requirements.....	54
Product/Publication Approval and Credit.....	55
Comprehensive Perinatal Services Program (CPSP) Perinatal Services Coordinators' (PSC) Policies and Procedures.....	57
Fetal Infant Mortality Review (FIMR) Program Policies and Procedures	102
Glossary of Common Acronyms	112

About MCAH Program

Mission

The mission of the CDPH MCAH Program is to develop systems that promote, protect and improve the health of California's women of reproductive age, infants, children, adolescents, and their families.

California MCAH Title V Priorities 2016-2020

The MCAH Division and the Systems of Care Division/California Children's Services (SCD/CCS) have identified the following priorities for 2016-2020:

1. Improve preconception health by decreasing risk factors for adverse life course events among women of reproductive age.
2. Reduce infant morbidity and mortality.
3. Improve the cognitive, physical, and emotional development of all children...
4. To provide high quality care to all Children and Youth with Special Health Care Needs (CYSHCN) within an organized care delivery system (SCD/CCS)
5. To increase access to CCS paneled providers such that each child has timely access to a qualified provider of medically necessary care (SCD/CCS)
6. Increase conditions in adolescents that lead to improved adolescent health.
7. Increase access and utilization of health and social services
8. Increase the proportion of children, adolescents and women of reproductive age who maintain a healthy diet and physically active lifestyle

Priorities 4 and 5 are primarily focused on the activities of SCD/CCS. MCAH and CCS work together to address the needs of all CYSHCN.

Statutes and Regulations

Introduction

In 1997, Section (§) 123255 was added to the California Health and Safety Code (H&S). The statute specifies the structure and requirements for state-funded local MCAH programs. The following statutes and regulations are applicable to the state-funded local programs of the MCAH Division and the Children's Medical Services (CMS) Branch.

Statutes

The following statutes and Budget Acts apply to the MCAH Program and the programs under its jurisdiction.

Maternal and Child Health Program (MCAH)

- California H&S §123225-§123255:

The department shall maintain a program of maternal and child health; 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; and maximize use of federal funds, including Title XIX matching. 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. H&S §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.

H&S §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.

Comprehensive Perinatal Services Program (CPSP)

- H&S §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 educational 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.
- W&I §14132(u): Establishes Comprehensive Perinatal Services as defined in §14134.5 as a Medi-Cal benefit.
- W&I §14134.5(a): Defines CPSP providers to include any general practice physician, family practice physician, obstetrician-gynecologist, pediatrician, certified nurse midwife, a group, any of whose members is one of the above-named physicians, or any preferred provider organization or clinic enrolled in the Medi-Cal program and certified pursuant to the standards of this section.
- W&I §14134.5(b): States that perinatal means the period from the establishment of pregnancy to one month following delivery.
- W&I §14134.5(c): States that CPSP services shall include but not be limited to the services delivered through the DHS Obstetrical Access Pilot Program.
- W&I §14134.5(d): Requires the CPSP provider to schedule visits with appropriate providers and track the patient to make sure services have been received. Requires that the patient receive psychosocial assessment and referrals; nutrition assessment, appropriate referrals to counseling for food supplement programs, vitamins, and breastfeeding; health, childbirth and parenting education.
- W&I §14134.5(e): Allows providers to contract with medical and other practitioners for the purpose of delivering CPSP services.
- 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.
- W&I §14134.5(g): States that the Department shall assist local health departments to establish a community perinatal program whose responsibilities may include certifying and monitoring providers of comprehensive perinatal services, shall provide technical assistance, shall utilize local health departments in the administration of the program.
- W&I §14134.5(h): States that the Department shall establish a method for reimbursement of comprehensive perinatal providers which shall include a fee for coordinating services and shall be sufficient to cover reasonable costs for the provision of comprehensive perinatal services. The department may utilize fees for service, capitated fees, or global fees to reimburse providers, however if capitated or global fees are used, the department shall set minimum standards for the provision of services including, but not limited to, the number of prenatal visits and the amount and type of psychosocial, nutrition, and education services patients shall receive. States that providers shall not be at risk for inpatient services.

- W&I §14134.5(i): States that the department shall develop systems for monitoring and oversight of comprehensive perinatal services.
- W&I §14134.5(j): States that client participation shall be voluntary.
- H&S §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 Program of California (RPPC)

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

Fetal and Infant Mortality Review (FIMR)

- H&S §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 CA.
- H&S §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)

- H&S §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 H&S §123740.
- H&S §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.

Adolescent Family Life Program (AFLP)

- In 1985, AFLP commenced as an administrative initiative in the Governor's Budget directing Title V MCH Block Grant funding to 27 providers
- H&S § 124175 and 124180: provided permanent statutory authority in 1998 for the Program to assure that clients receive prenatal care, reduce the incidence of low birth weight babies born to adolescent mothers, keep or reenroll pregnant adolescents in school, and reduce the rate of repeat teen pregnancies by establishing networks and providing case management to pregnant and parenting teens.

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. H&S §131051(d)(4) states that the Black Infant Health Program is under the jurisdiction of the Deputy Director for Primary Care and Family Health. 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. W&I §14148.9(d) lists Black women as one of the target populations.

Sexual Health Accountability Act

- H&S §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. Information must be medically accurate, current and objective; age, culturally and linguistically appropriate for targeted audiences. Cannot promote or teach religious doctrine, nor promote or reflect bias. May be required to explain the effectiveness of one or more FDA-approved drugs and/or devices that prevent pregnancy or sexually transmitted diseases. Programs directed at minors are also required to state that abstinence is the only certain way to prevent pregnancy or sexually transmitted diseases.

Creation of Department of Public Health

- H&S §131051 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, CPSP, FIMR, and SIDS programs, in addition to many other programs.

- Budget Act (Chapter 1, Statutes of 2009, Fourth Extraordinary Session), eliminated State General Funds for the MCAH Program.

Regulations

The following regulations 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
- 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*
http://www.whitehouse.gov/omb/circulars_a087_2004
- 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 on the basis of race, color or national origin, sex, age, religion or handicapping condition.

Understanding Title V of the Social Security Act

About Title V

The Federal Maternal and Child Health (MCH) Services Block Grant (Title V of the Social Security Act) is a federal program that focuses on improving the health of all mothers and children. The California Department of Public Health MCAH Division receives Title V funds that support programs that improve the health and well-being of mothers and children consistent with the state and national health status goals.

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

For more information, visit <http://www.amchp.org/AboutTitleV/Documents/UnderstandingTitleV.pdf>

Title V Focus

The focus of the Title V Block Grant is to improve the health of all mothers and children in the nation consistent with the applicable health status goals and National Health Objectives of Healthy People 2020 <http://www.healthypeople.gov/>

The Title V Block Grants allow each state to:

- Provide and assure access to quality MCH services for mothers and children, especially those with low income or limited availability to services; improve access to health care services for women, children and families; increase the number of children receiving comprehensive health assessments with follow up diagnostic and treatment services
- Provide rehabilitation services for blind and disabled individuals under the age of 16 years receiving benefits under Title XVI, to the extent medical assistance for such services is not provided under Title XIX
- Provide and promote family-centered, community-based, coordinated care, including care coordination services as defined in the legislation, for Children with Special Health Care Needs (CYSHCN) and facilitate the development of community-based systems of service for such children and their families
- Reduce maternal and infant morbidity/mortality and the incidence of preventable diseases and handicapping conditions among children; promote the health of mothers and infants by improving the quality and availability of prenatal, delivery, and postpartum services; reduce the need for inpatient or long term health care services
- Promote preventive services for women, children and families through public education; collaborate with federal, state and local agencies to provide preventive services for families; implement safety measures to reduce safety hazards for children; increase public awareness of potential safety hazards; improve utilization of preventive measures to reduce the incidence of injuries to women and children; promote healthy lifestyle modalities and assist families to incorporate beneficial physical and mental health practices into their everyday lives

Title V Requirements

- Maintain a partnership with the State Maternal and Child Health and CYSHCN programs, reaching across economic lines to support such core public health functions as resource development, capacity and systems building, population-based functions such as public information and education, knowledge development, outreach and program linkage, technical assistance to communities, and provider trainings.
 - Make a special effort to 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 and SCHIP medical assistance programs.
 - Support programs for CYSHCN to facilitate the development of family-centered, community-based, coordinated systems of care.
 - Provision of 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.
1. Every five years the MCAH Division must conduct a comprehensive statewide Needs Assessment.
 2. Each fiscal year, the MCAH Division is required to submit a plan for meeting the needs identified by the statewide Needs Assessment.
 3. Each fiscal year, the MCAH Division is required to submit a report of its activities under the Title V Grant 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.
 4. Provide and maintain a state toll-free number (and other appropriate methods) to make available to parents information about health care providers and practitioners who provide services under Title V and Title XIX as well as other relevant information. To fulfill this requirement, MCAH Division requires all LHJs to provide and maintain a local toll-free number.
 5. Provide outreach services to identify pregnant women and infants who are eligible under the State's Medicaid program and assist them in applying for Medicaid assistance.
 6. Use at least 30 percent of the Federal MCH Block Grant funds received for preventive and primary care services for children and at least 30 percent of the Federal MCH Block Grant funds received for CYSHCN.

MCAH Division Title V Requirements

About MCAH Division

The MCAH Division, as a recipient of the Federal Title V MCH Block Grant, is required to complete a statewide Needs Assessment every five years. This is the first step in a cycle for continuous quality improvement of maternal, child, and adolescent health. CDPH MCAH Division utilizes a collaborative process with the LHJs and other MCAH stakeholders to identify needs and meet its annual reporting requirements for the Title V Grant.

Needs Assessment

The 61 LHJs each complete and submit a local Needs Assessment, which the State compiles along with statewide data to develop a report that encompasses all the variations across this large and diverse State. The MCAH Division requires each LHJ to perform a local Needs Assessment and address identified problems in their annual Scope of Work (SOW). Based upon their Needs Assessment, the local MCAH programs develop a local 5-Year MCAH Action Plan for their health jurisdiction. The Five-Year Needs Assessment enables the State and the LHJs to identify State and local Title V priority problems. The Needs Assessment should be consistent with the national and State health objectives and address preventive and primary care services for pregnant women, mothers, infants, children, adolescents and their families. Information on the Title V Block Grant Program and the most current Annual Report and Needs Assessment is located at:

<http://www.cdph.ca.gov/programs/mcah/Pages/MCAH-TitleVBlockGrantProgram.aspx>

Public Health Frameworks and Strategies

Ten Essential Public Health Services

The 10 Essential Services of Public Health serve as an organizing framework for public health practice nationwide and for CDPH, and have been incorporated into the CDPH Decision Framework for evaluating internal proposals. The MCAH Program uses the 10 MCAH Essential Services to structure and describe activities implemented by the state and local MCAH programs.

10 Essential Maternal, Child, and Adolescent Health Services:

Assessment

1. Assess and monitor maternal and child health status to identify and address problems.
2. Diagnose and investigate health problems and health hazards affecting women, children, and youth.

Policy Development

3. Inform and educate the public and families about maternal and child health issues.
4. Mobilize community partnerships between policymakers, health care providers, families, the general public, and others to identify and solve maternal and child health problems.
5. Provide leadership for priority-setting, planning and policy development to support community efforts to assure the health of women, children, youth and their families.

Assurance

6. Promote and enforce legal requirements that protect the health and safety of women, children, and youth, and ensure public accountability for their well-being.
7. Link women, children, and youth to health and other community and family services, and assure access to comprehensive, quality systems of care.
8. Assure the capacity and competency of the public health and personal health work force to effectively address maternal and child health needs.
9. Evaluate the effectiveness, accessibility, and quality of personal health and population based maternal and child health services.
10. Support research and demonstrations to gain new insights and innovative solutions to maternal and child health-related problems.

For more information, please refer to the CDC web site:

<http://www.cdc.gov/od/ocphp/nphpsp/EssentialPHServices.htm>.

Healthy People 2020

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 in order 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.

The goals of Healthy People 2020 are to:

- Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development, and healthy behaviors across all life stages.

For more information, see: <http://www.healthypeople.gov/2020/default.aspx>

National Prevention Strategy (NPS)

The National Prevention Strategy is a comprehensive plan to increase the number of Americans who are healthy at every stage of life. You may download the report at:

<http://www.surgeongeneral.gov/priorities/prevention/strategy/>

The Strategic Directions in the NPS describe the foundation for implementing strategies to achieve NPS priorities. The Strategic Directions are: Healthy and Safe Community Environments, Clinical and Community Preventive Services, Empowered People, and Elimination of Health Disparities.

The Priorities in the NPS are:

Tobacco Free Living: Tobacco use is the leading cause of premature and preventable death in the United States.

Preventing Drug Abuse and Excessive Alcohol Use: Preventing drug abuse and excessive alcohol use increases people's chances of living long, healthy, and productive lives.

Healthy Eating: Eating healthy can help reduce people's risk for heart disease, high blood pressure, diabetes, osteoporosis, and several types of cancer, as well as help them maintain a healthy body weight.

Active Living: Engaging in regular physical activity is one of the most important things that people of all ages can do to improve their health.

Injury and Violence Free Living: Reducing injury and violence improves physical and emotional health.

Reproductive and Sexual Health: Healthy reproductive and sexual practices can play a critical role in enabling people to remain healthy and actively contribute to their community.

Mental and Emotional Well-Being: Mental and emotional well-being is essential to overall health.

Evidence-Based Public Health Practice

In June of 2009, HHS asked the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives to provide guidance on criteria that could be used to select "evidence-based" or "knowledge-based" actions for inclusion in Healthy People 2020. The Committee's report is located at: <http://www.healthypeople.gov/sites/default/files/EvidenceBasedClinicalPH2010.pdf>

The Committee defined evidence-based public health practice as "the development, implementation, and evaluation of effective programs and policies in public health through application of principles of

scientific reasoning, including systematic uses of data and information systems and appropriate use of behavioral science theory and program planning models”.

In a time of limited resources, it is essential that public health programs focus their energies on implementing strategies that have been proven effective and will maximize population impact. If there is an imperative to act on a problem, due to its enormity or due to constraints on how intervention resources can be used, it may be necessary to implement unproven interventions within the context of learning about their effectiveness, while using the best available theoretical constructs and expert opinion to structure interventions. Where evidence-based interventions are not available, decisions regarding intervention must be made on the evidence at hand combined with expert judgment about what is likely to work for the majority of the targeted population.

MCAH programs 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 (individual, social/community, environmental, policy—see socio-ecological model)
- Interventions 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. Many interventions take place over a long period of time. Health outcomes may not be immediately apparent.
- Measure the magnitude of an effect as well as whether there was an effect

Sources of evidence-based community health practices include:

- The Guide to Community Preventive Services (described below)
- Cochrane Public Health Group <http://ph.cochrane.org/>
- National Association for City and County Health Officials (NACCHO) Database of Model Practices in Local Public Health Agencies <http://www.naccho.org/topics/modelpractices/database/>.
- Promising Practices Network <http://www.promisingpractices.net/criteria.asp>
- Health Impact Assessment: Information and Insight for Policy, Health Impact Assessment Clearinghouse, Learning, and Information Center <http://www.hiaguide.org/>
- The Center of Excellence for Training and Research Translation (C-TRT) <http://www.center-trt.org/>

The Guide to Community Preventive Services

The Task Force on Community Preventive Services is an independent, nonfederal, volunteer body of public health and prevention experts, whose members are appointed by the Director of CDC to develop and issue recommendations and findings to inform decision making about policy, practice, research, and research funding in a wide range of U.S. settings. The Guide to Community Preventive Services is a resource for evidence-based Task Force recommendations and findings about what works to improve public health. The Guide to Community Preventive Services contains evaluations of interventions in the following areas: adolescent health, alcohol, asthma, birth defects, cancer, diabetes, health communication, HIV/AIDS, STIs and pregnancy, mental health, motor vehicle,

nutrition, obesity, oral health, physical activity, social environment, tobacco, vaccines, violence, and worksite. All MCAH LHJs are encouraged to consult this guide when choosing community preventive services to implement to address needs in their local areas. For more information, see the website at: <http://www.thecommunityguide.org/>

Life Course 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 impact individual and community health.

Social determinants of health are economic and social conditions such as income, education, occupation, employment, housing, child care, family structure, and neighborhood characteristics, which have powerful effects on health and yet are beyond the reach of medical care. It is impossible to significantly improve the health of the population by simply addressing individual risk factors without addressing the social determinants of health. Social determinants of health also determine the extent to which a person possesses the physical, social, and personal resources to identify and achieve personal aspirations, satisfy needs, and cope with the environment (a broader definition of health). Social determinants of health also include the quantity and quality of a variety of resources that a society makes available to its members.

MCAH recommends that LHJs integrate a life course perspective and an understanding of the social determinants of health when developing interventions. For more information, see the following links:

<http://mchb.hrsa.gov/lifecourseresources.htm>

<http://www.cdc.gov/socialdeterminants/>

Spectrum of Prevention

The Spectrum of Prevention was developed by the Prevention Institute in Oakland. It identifies multiple levels of intervention and encourages people to move beyond the perception that prevention is about teaching healthy behaviors. 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. MCAH recommends that LHJs implement a multifaceted approach to prevention that includes multiple levels of intervention. For more information, see the following link:

http://www.preventioninstitute.org/index.php?option=com_jlibrary&view=article&id=105&Itemid=127

Strengthening Families

The Strengthening Families Program (SFP) is a nationally and internationally recognized parenting and family strengthening program. SFP is an evidence-based family skills training program found to significantly reduce problem behaviors, delinquency, and alcohol and drug abuse in children and to improve social competencies and school performance. Child maltreatment also decreases as parents strengthen bonds with their children and learn more effective parenting skills.

Five Protective Factors are the foundation of the Strengthening Families Approach: parental resilience, social connections, concrete support in times of need, knowledge of parenting and child development, and social and emotional competence of children. Research studies have demonstrated that when these Protective Factors are well established in a family, the likelihood of child abuse and neglect diminishes. These protective factors are also “promotive” factors that build family strengths and a family environment that promotes optimal child and youth development. For more information, see <http://www.strengtheningfamiliesprogram.org/>

Socio-ecological Model

The socio-ecological model explains that individual behavior affects and is affected by the world the individual lives in. The individual lives in a group, which resides in an organization, in a community, which is affected by public policy. Prevention strategies should include a continuum of activities that address multiple levels in the model. For more information, see the following link: <http://www.cdc.gov/ViolencePrevention/overview/social-ecologicalmodel.html>

Let’s Get Healthy California Task Force Report

On December 19, 2012, the Task Force published its report, which identifies two strategic directions; first, promoting health across the lifespan (healthy beginnings, living well and end of life), and second, practice and policy changes to improve the quality of health care and the health of communities, and decrease the cost of care. The report has an overarching emphasis on reducing health disparities. Progress in these strategic directions should achieve the “Triple Aim” of better health, better care, and lower costs. The Report is available on line at:

<http://www.chhs.ca.gov/LGHC/Let%27s%20Get%20Healthy%20California%20Task%20Force%20Final%20Report.pdf>

In addition to the strategic directions and goals above, the Report identifies 30 priorities and 39 measurable indicators. Priorities relevant to MCAH in “Healthy Beginnings” are: decreasing infant deaths, increasing vaccinations, decreasing childhood trauma, increasing early learning, decreasing childhood asthma, increasing childhood fitness and healthy diets, decreasing childhood obesity and diabetes, decreasing adolescent tobacco use, and increasing mental health and well-being. Priorities relevant to MCAH in the “Living Well” section include improving health status, increasing fitness and healthy diets, decreasing tobacco use, controlling high blood pressure and cholesterol, decreasing obesity and diabetes, and increasing mental health and well-being. Improvements in these areas will improve maternal health.

Priorities relevant to MCAH in the Redesigning the Health Care System section include increasing access to primary and specialty care, increasing culturally and linguistically appropriate services, increasing coordinated outpatient care, and increasing hospital safety and quality of care.

In Creating Healthy Communities, priorities are increasing healthy food outlets, increasing walking and biking, and increasing safe communities.

To lower the cost of care, priorities relevant to MCAH include decreasing people without insurance, increasing affordable care and coverage, increasing people receiving care in an integrated system, increasing transparent information on cost and quality of care, and increasing payment policies that reward value.

For each of the priorities except the last two in lowering the cost of care, the Report includes dashboards with indicators that MCAH programs may find helpful.

CDPH California Wellness Plan

The California Wellness Plan (Plan) is the result of a statewide process led by CDPH to develop a roadmap with partners to create communities in which people can be healthy, improve the quality of clinical and community care, increase access to usable health information, assure continued public health capacity to achieve health equity, and empower communities to create healthier environments. The Plan is available online at: [http://www.cdph.ca.gov/programs/cdcb/Documents/CDPH-CAWellnessPlan2014%20\(Agency%20Approved\).FINAL.2-27-14\(Protected\).pdf](http://www.cdph.ca.gov/programs/cdcb/Documents/CDPH-CAWellnessPlan2014%20(Agency%20Approved).FINAL.2-27-14(Protected).pdf)

The overarching goal of the Plan is **Equity in Health and Wellbeing**, with an emphasis on the elimination of preventable chronic disease. To attain this, the following four goals were determined by partners through a collaborative statewide process. Statewide partners have proposed focus areas around which to align efforts for the next two years, as a means of achieving synergy and greater impact.

1. Healthy Communities

- a. Create healthy, safe, built environments that promote active transport, regular daily physical activity, healthy eating, and other healthy behaviors, such as by adoption of health considerations into General Plans

2. Optimal Health Systems Linked with Community Prevention

- a. Build on strategic opportunities, current investments and innovations in the Patient Protection and Affordable Care Act, prevention and expanded managed care, to create a systems approach to improving patient and community health

3. Accessible and Usable Health Information

- a. Expand access to comprehensive statewide data with flexible reporting capacity to meet state and local needs

4. Prevention Sustainability and Capacity

- a. Collaborate with health care systems, providers and payers to show the value of greater investment in community-based prevention approaches that address underlying determinants of poor health and chronic disease
- b. Explore dedicated funding streams for community-based prevention
- c. Align newly secured and existing public health and cross-sectoral funding sources to support broad community-based prevention

The Plan includes 26 Priorities and Performance Measures determined by the Let's Get Healthy California Taskforce, evidence-based strategies, and identifies CDPH and partner chronic disease prevention objectives, including performance measures and targets.

Text4baby

As of January 2014, the California Department of Public Health (CDPH) Maternal, Child and Adolescent Health (MCAH) Division established an official partnership with the National Healthy Mothers, Healthy Babies Coalition (HMHB) to fully participate in the evidence-informed program, Text4baby. Text4baby is a free cell phone text messaging service for pregnant women and mothers with infants under age one. Text messages are sent to pregnant women and new moms with up-to-date maternal and infant health messaging. The messages cover a broad range of topics, including pregnancy warning signs, the benefits of full-term delivery, developmental milestones, breastfeeding, and oral health, and are timed to a mom's due date or baby's birthdate. All text messages are free to

the woman. As of May 2014, Text4baby is customized with California-specific resources, including Medi-Cal, Covered California, CDPH/ MCAH programs and WIC.

The goal of this partnership is to engage and involve MCAH's local health jurisdictions (LHJs) and perinatal programs in the Text4baby project. We will accomplish this in two ways:

1. Text4baby will integrate and share California specific resources for pregnant women and parents with infants under age one via text messages
2. MCAH will encourage their eligible population to enroll in the Text4baby Project to receive evidence-based health information on their mobile devices.

With this in mind, MCAH Division recommends MCAH's LHJs adopt and integrate the Text4Baby Project into existing activities. Please contact your Nurse Consultant for further information.

Text4baby Content:

The messages cover a broad range of topics critical to maternal and child health including pregnancy warning signs, benefits of full-term delivery, developmental milestones, breastfeeding, smoking cessation, oral health, and more. The Text4baby messages were developed in collaboration with federal agencies, health care providers, major medical associations and national non-profit organizations, including the Centers for Disease Control and Prevention, American Congress of Obstetrics and Gynecologists, American Academy of Pediatrics, March of Dimes, Centers for Medicare and Medicaid, and Association of Women's Health, Obstetric, and Neonatal Nurses. A Content Development Council reviews every message quarterly and ensures its medical accuracy.

Location-Specific: Based on mother's zip code at enrollment, California mothers receive California-specific resource information (e.g., WIC services, Covered California) and relevant hotline numbers (e.g., 1-800-NO-BUTTS). The California specific resources in the service are reviewed and approved by the Department of Health Care Services and CDPH MCAH.

Interactive Features: Text4baby also includes interactive features that encourage mothers to interact with the service and access more health information. Mothers can text back and forth with the service to set up appointment and immunization reminders, review mobile web pages and videos. Text4baby also connects women to free and low-cost health coverage through the health insurance marketplace and provides timely messages on Medi-Cal eligibility, enrollment and renewal.

Signing Mothers Up:

Clients/participants sign up for Text4baby by texting the word BABY to 511411 (BEBE for Spanish) to receive at least 3 personalized text messages per week, timed to mom's due date or baby's birthday. Since May 2014, Text4baby has reached 717,000 moms nationally and over 63,000 in California. As of May 2014, Text4baby had over 32,700 active users in California. To learn more, visit:

<https://www.Text4baby.org>

Text4baby Impact and Program Evaluation:

Independent research demonstrates that Text4baby increases women's health knowledge, facilitates interaction with doctors, and improves appointment and immunization adherence. Also, research indicates that mothers who use Text4baby are **three** times more likely to feel prepared for motherhood than non-Text4baby mothers. Analyses of Text4baby data and external evaluations of the service have demonstrated significant positive results. To learn more about how Text4baby

continually encourages and utilizes data and evaluation, please visit Text4baby at: <https://www.Text4baby.org/index.php/about/data-and-evaluation>.

Getting Started:

Here are suggested methods for getting started:

System Level Changes for Organization Leadership to Implement:

1. *Identify a local contact for Text4baby efforts:*
 - a. Each LHJ should identify a person as the “Local Text4baby Coordinator.”
 - b. Sign up for an overview of the national Text4baby training (approximately one hour) here: <https://www.text4baby.org/index.php/get-involved-pg/partners/training-center> or contact Martha Dominguez (see email below).
 - c. Share the name of your Text4baby coordinator with your Nurse Consultant and/or Martha Dominguez at Martha.dominguez@cdph.ca.gov
2. *Sign your Organization up to become an Official Text4baby Outreach Partner:*
 - a. Text4baby Outreach Sign-up Form: <http://my.text4baby.org/page/s/formal-partner-sign-up>.

Implementation Strategies for Staff that Provide Direct Service to Clients

1. Identify one or two touch points in your program’s processes to promote the Text4baby Project. For example, during:
 - Enrollment
 - Group sessions
 - Case management
 - Distribution of resources
2. Encourage all staff interacting and scheduling with pregnant moms and parents with infants under age one to assist clients to enroll in Text4baby and use the appointment “REMIND” service to help them keep their appointments.
 - a. To set up the appointment reminder have them text the word “REMIND” (or “CITA” for Spanish) to 511411.
 - b. When prompted, enter the appointment date (e.g., 100214) and a short description for their appointment (e.g., “with WIC at Front St. office/bring proof of address/get lab results for Jose”)
 - c. The participant will receive the following automated text message: “Your reminder is set for your appointment on 10/02/14. Text4baby will send you a reminder three days before your appointment.”

Implementation Strategies for Staff that Coordinate Material Outreach to Clients and Families

1. Distribute materials through your existing communications to moms, new parents, and partner organizations/programs that work directly with pregnant women and moms with infants under one age one.
 - a. For example: New enrollee packets, resource packets, welcome letters, etc.
2. Post Text4baby promotional materials in visible venues (i.e., flyers in your programs’ applications, waiting areas, clipboards, exam rooms, check-in desks and bulletin boards).

3. Distribute promotional materials at health or resource fairs, community festivals, and community events.

Implementation Strategies for Staff that Oversee Web-based and Social Media Engagement of Clients and Families

1. *Text4baby Web Enrollment Button:* Put the [Text4baby enrollment button](#) (available in English and Spanish) on your organization's website to encourage pregnant women and moms to sign-up for Text4baby right from your page! This enrollment button can be used to help track enrollment to see how many individuals are signing up as a result of your promotion.
2. *Use Digital Media:* Use your existing social media channels to promote Text4baby:
 - a. If [Facebook](#) and/or [Twitter](#) (or other social media channels) are part of your outreach, follow Text4baby to stay connected to our innovative campaign and spread the word to your followers.
 - b. For example, you can post the following message on Facebook each Friday: "Text BABY to 511411 and get support through your pregnancy and baby's first year. You'll get free messages on topics like prenatal care, labor signs and symptoms, nutrition, breastfeeding, safety, baby's development, and more. Also visit www.Text4baby.org." Make sure to encourage pregnant women and moms to follow and like us.

Tools Available for Enrollment:

- Use this script when talking with patients/clients about Text4baby during identified enrollment touch points:
http://www.text4baby.org/templates/bee_20/images/HMHB/t4b_script.docx
- Print and share this quick cheat sheet with staff to be used during enrollment touch points to remind schedulers, educators, and nurses about Text4baby:
[Text4baby "Bench Card"](http://www.text4baby.org/templates/bee_20/images/HMHB/t4b_bench_card.pdf)
(http://www.text4baby.org/templates/bee_20/images/HMHB/t4b_bench_card.pdf)
- Order free Text4baby promotional materials from Text4baby online store:
<http://graphtech.myprintdesk.net/DSF/Companies/text4baby/storefront.aspx?SITEGUID=09afe492-29a2-4b8e-a05e-bdf29836f5cd>

Highlight your Work

Text4Baby wants to celebrate your successes and share your story with other partners!

- Email Martha Dominguez at Martha.dominguez@cdph.ca.gov

Worksite Wellness Policy

About Policy

MCAH supports the local, state and national focus on the value of primary prevention. We encourage our local partners to set up policies that will promote a workplace culture where it will be easier for employees and clients to adopt healthy lifestyle choices.

The goal is for each agency to firmly establish a culture of prevention where wellness is integral to daily work routines. By promoting healthy habits, such as exercise breaks, nutritious lunches and snacks, stress reduction, and other supports, we will build capacity at the local level and encourage employees and the people we serve to adopt principles and practices of healthy living that will provide lifelong benefits.

In an effort to make progress toward this goal, each agency should consider developing its own policies and mechanisms to make wellness an integral part of its worksite culture. This may mean time for lunchtime talks, meditation, walks, rewards for healthy recipes, or whatever staff members deem important. We encourage engagement of staff to help determine the make-up of the worksite wellness program. While there will be similarities from site to site, not every program will be exactly the same. Each staff member can set individual wellness goals as well.

Guidelines

The following Guidelines may be helpful to those developing worksite wellness policies and strategies:

Guideline I

Promote and support physical activities in the workplace and in interactions with clients

Examples include promoting the use of stairs, with identification of stairwells and signs in front of the elevators and escalators encouraging the use of stairs; the availability of on-site or contracted workout or exercise centers; employee walking programs, including walking meetings; and availability

Guideline II

Promote consumption of healthy food and beverages in the workplace and in interactions with clients

Examples include using “healthy choice” food and beverages at meetings and functions, and in dining rooms, cafeterias and vending machines; making educational materials available about healthy eating, including portion control and nutrients; and assuring that drinking water is available for staff and visitors throughout the facilities.

Links to worksite nutrition and physical activity resources:

Network for a Healthy California--Worksite Program:

<http://www.cdph.ca.gov/programs/CPNS/Pages/WorksiteProgram.aspx>

Worksite Nutrition and Physical Activity Resources

<http://www.cdph.ca.gov/HealthInfo/healthyliving/nutrition/Pages/WorksiteNutritionandPhysicalActivity.aspx>

Take Action:

http://www.takeactionca.cdph.ca.gov/docs/take-action/Take-Action-Program-Overview_FINAL_08_01_08.pdf

Guideline III

Support breastfeeding mothers

Develop a worksite policy that ensures there is a lactation room or a private area to pump and refrigerate breast milk and times for employees to breastfeed.

Link for lactation accommodation at the workplace resources:

<http://www.cdph.ca.gov/HealthInfo/healthyliving/childfamily/Pages/GoingBacktoWorkorSchool.aspx>

Specialized MCAH Programs

Introduction

There are six specialized CDPH MCAH programs under the local MCAH system:

- Adolescent Family Life Program (AFLP)
- Black Infant Health Program (BIH)
- Comprehensive Perinatal Services Program (CPSP)
- Fetal Infant Mortality Review (FIMR)
- Sudden Infant Death Syndrome (SIDS)
- California Home Visiting Program (CHVP)

Budgets, Policies and Procedures, and Scopes of Work for MCAH Programs

Local MCAH, AFLP, and BIH programs have their own SOWs. The FIMR SOW is incorporated into the MCAH SOW. Only those LHJs with FIMR Program funding are accountable for FIMR objectives, located in the MCAH SOW. LHJs receiving funding for AFLP and BIH are responsible for their respective SOWs. Please see the Fiscal Policies and Procedures Manual for more information.

The CHVP Program has a separate budget, SOW, Annual Report, and Policies and Procedures Manual.

SIDS Program

Beginning with Fiscal Year 2003-2004, State Mandates related to the SIDS program as listed below have been suspended by the Legislature in the Budget Act, and as a result, LHJs are no longer required to provide the services and/or duties listed within those State Mandates.

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

State

While local SIDS State Mandates have been suspended, state level SIDS Mandates are still in effect. State MCAH is required by HSC §123745 to monitor compliance by county health officers with HSC §123740, even though MCAH is only monitoring their voluntary compliance. Local duties, currently voluntary, noted under HSC §123740 include:

1. Upon being notified by the coroner of a presumed SIDS death, consulting with the infant's physician, when possible; and then
2. 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.
3. MCAH is also required by HSC §123730 to keep each county officer advised of the most current knowledge relating to the nature and cause of SIDS.

Local

The LHJs are allocated Title V MCH Block Grant Funds to provide SIDS support services and activities as outlined in the MCAH SOW.

The MCAH Division, through the California SIDS Program contractor, provides two SIDS trainings yearly for public health professionals at no cost, except for travel expenses. The CA SIDS Program Contractor also provides free consultation and technical assistance to LHJs as well as free SIDS specific literature, resources, and materials. LHJs can use part of their SIDS allocation to support costs for staff to attend SIDS training(s) and/or the Annual SIDS Conference each year.

Children and Youth with Special Health Care Needs (CYSHCN)

Background and Purpose:

Enacted in 1935 as part of the Social Security Act, Title V is a partnership with State Maternal and Child Health and Children and Youth with Special Health Care Needs (CYSHCN) programs, reaching across economic lines to support such core public health functions as resource development, capacity and systems building, population-based functions such as public information and education, knowledge development, outreach and program linkage, technical assistance to communities, and provider training.

States are required to use at least 30 percent of Federal Title V funds for preventive and primary care services for children and at least 30 percent for services for children with special health care needs.

In California, CDPH MCAH allocates a portion of the 30 percent requirement to serve CYSHCN to the Department of Health Care Services/Systems of Care Division (SCD) through the California Children's Services Program (CCS). The SCD/CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with a CCS- eligible medical condition. The explicit legislative intent of the CCS program is to provide necessary medical services for children with CCS medically eligible conditions whose parents are unable to pay for these services wholly or in part. The other portion of the 30 percent is used by CDPH MCAH to support non-CCS CYSHCN and their families or children enrolled in CCS in need of services not covered by CCS such as developing systems of care, interagency collaboration, especially with SCD/CCS, assisting LHJs to develop programs that identify and serve all CYSHCN, including non-CCS CYSHCN, case management, and outreach, screening and linking to appropriate services.

In order to meet the Department of Health and Human Services, Health Resources and Services (HRSA) Administration, Maternal and Child Health Bureau (MCHB) requirement to use 30 percent of Title V funds for services for CYSHCN, CDPH MCAH, along with a workgroup of MCAH Directors, has identified activities that may serve CYSHCN.

Federal Definitions¹

CYSHCN are defined by HRSA/MCHB as follows:

Children with Special Health Care Needs are defined as infants and children from birth through 21st year who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

This definition is broad and inclusive, and it emphasizes the characteristics held in common by children with a wide range of diagnoses which may include conditions such as, depression, attention deficit disorder, behavioral problems, asthma, diabetes, migraines or frequent headaches, head injury or traumatic brain injury, arthritis, joint problems, allergies, heart problems, autism, and intellectual disability or mental retardation.

¹ Health Resources and Services Administration, The National Survey of Children with Special Health Care Needs, Chart book 2005-2006, Retrieved from: <http://mchb.hrsa.gov/cshcn05/ on March 17, 2016>.

Please see the National Survey of Children with Special Health Care Needs (2009/10) for a list of some of the functional difficulties and health conditions that children may experience <http://www.childhealthdata.org/docs/cshcn/2009-cshcn-conds-func-diff.pdf?sfvrsn=4>

The MCHB, together with its partners, has identified six core outcomes to promote the community-based system of services mandated for all children with special health care needs. These outcomes give us a concrete way to measure our progress in making family-centered care a reality and in putting in place the kind of systems all children with special health care needs deserve. Progress toward the overall goal can be measured using these six critical outcomes:

1. Families of children and youth with special health care needs partner in decision making at all levels and are satisfied with the services they receive
2. Children and youth with special health care needs receive coordinated ongoing comprehensive care within a medical home
3. Families of CYSHCN have adequate private and/or public insurance to pay for the services they need
4. Children are screened early and continuously for special health care needs
5. Community-based services for children and youth with special health care needs are organized so families can use them easily
6. Youth with special health care needs receive the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

CYSHCN Constructs of a Service System²

1. **State Program Collaboration with other State Agencies and Private Organizations**
States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of Services for CYSHCN, State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CYSHCN and their families.
2. **State Support for Communities**
State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CYSHCN are met.
3. **Coordination of Health Components of Community-Based Systems**
A mechanism exists in communities across the state for coordination of health services with one another. This includes coordination among providers of primary care, facilitative and rehabilitative services, and other specialty medical treatment services, mental health services and home health care.
4. **Coordination of Health Services with other Services at the Community Level**

² Health Resources and Services Administration, Maternal and Child Health. Title V Information Glossary. Retrieved from: <https://mchdata.hrsa.gov/tvisreports/Glossary.html> on March 17, 2016

A mechanism exists in communities across the State for coordination and service integration among programs serving CYSHCN, including early intervention and special education, social services, and family support services.

Suggested activities for CYSHCN:

Community-Based Services:

1. Work with CCS and/or collaboratives to:
 - a) Improve care coordination for CYSHCN, especially non-CCS eligible children or children enrolled in CCS in need of services not covered by CCS
 - b) Link children with positive screens to needed services
 - c) Disseminate standard messaging regarding developmental screening to increase community awareness of the need for early identification and intervention of CYSHCN
2. Outreach activities to enroll children into public and private insurance coverage
3. Facilitate continuity of care during periods of enrollment or changes in insurance coverage to ensure that a mechanism is in place for identifying and referring CYSHCN to appropriate enhanced care
4. Enhance collaboration at the local level by including CCS in the dissemination of health communications, statistical reports, and local MCAH and home visiting advisory group meetings
5. Inform providers of existing services for CYSHCN
6. Develop mechanisms for providers to refer clients to appropriate programs, such as the California Home Visiting Program and to refer clients from home visiting and health screening programs to CCS
7. Partner with local organizations that provide services to CYSHCN to improve systems of identification, referral, and linkage of CYSHCN to needed services
8. Build systems to link CYSHCN and their families to needed services
9. Identify barriers and opportunities to improve services for CYSHCN
10. Work with school districts to identify and refer children with specialized health and developmental needs
11. Develop resource information about services available for CYSHCN

Identifying CYSHCN – Screening, Assessment, and Referral

1. Promote health and developmental monitoring, screening, identification, and referral, including social-emotional (mental health) for infants and children using a validated screening tool. providers to institute policies/protocols to perform routine screening on all children
2. Promote routine screening for physical health, oral health, mental health, developmental and psychosocial needs, and culturally and linguistic needs, as part of a well-child visit or other preventive visit and in response to triggering events (trauma, new symptoms, hospitalization) in order to identify non-CCS CYSHCN or children at risk
3. Facilitate communication of health and developmental screening results and any identified referral needs to the child's medical home and family and, as feasible, coordinate among screening entities
4. Develop and ensure protocols are in place for promotion of preventive medical visits or well-child visits, routine screening, referral, and follow-up to ensure care is received and barriers are addressed for all children.

Providing Services

1. Assist parents/caregivers to access appropriate services for CYSHCN
2. Teach parents/caregivers how to care for and advocate for their child with special health care needs.
3. Identify and provide training regarding special equipment available for children in need, such as automobile child restraint systems for physically impaired children.
4. Provide home visiting services to support parents/caregivers as they care for CYSHCN. Coordinate with other service providers to ensure that the plan of care is followed.
5. Develop or facilitate support groups for parents/caregivers of CYSHCN
6. Facilitate referrals and linkages to specialty health and developmental services for high-risk infants due to prematurity or other health-related conditions
7. Facilitate referrals and linkages for parents/caregivers of infants to specialty services to address bonding or attachments issues
8. Conduct activities to support CYSHCN and their families in self-management and advocacy of the child's needs
9. Conduct activities for CYSHCN to promote quality of life, healthy development, and healthy behavior across the life course, including the prevention of secondary conditions to prevent and avert deterioration
10. Assist parents/caregivers to identify appropriate child care providers for their CYSHCN as they return to work or school
11. Provide information to parents/caregivers of young children about the signs of healthy development and the need to act early if they feel there is a problem or are concerned
12. Develop programs using public health nurses to provide case management and/or home visiting to high risk pregnant and parenting women and their families, the uninsured, underinsured, families with complicated lives, etc. Include policies to monitor, screen and refer all children for health and developmental delays using a validated screening tool.
13. Develop relationships with providers, school administrators and other organizations that work with children to facilitate understanding of school readiness, developmental milestones, mental health issues, signs of child abuse/neglect and the process to monitor, screen, refer and link a child to appropriate services

Facilitating Care Coordination

1. Ensure staff working with families and children demonstrate competency by providing and/or attending training appropriate programs
2. Facilitate and/or participate in interagency coordination and collaboration, For example, work with CCS, Family Resource Centers, Head Start, Local Educational Agencies, Early Start, Regional Centers (Department of Developmental Services), hospitals, school nurses, Federally Qualified Health Centers, Rural Health Clinics, First 5 and other agencies serving CYSHCN to improve the system of care
3. Explore opportunities to fund staff positions in other agencies to facilitate interagency coordination focused on CYSHCN
4. Educate agencies and individuals regarding the rights of CYSHCN
5. Standardize data collection/reporting on care coordination services for CYSHCN
6. Involve parents/caregivers and families in care coordination for CYSHCN
7. Provide forums for families to identify ways services for CYSHCN can be better coordinated and delivered, including transportation assistance

8. Assist to develop policies, processes and resources for youth with special health care needs as they transition to adult care systems to ensure continuity of medical care, continued skill building, and access to other community supports
9. Work with organizations that serve adults with special health care needs to develop an effective referral system and services for youth transitioning to adult service
10. Develop relationships with organizations that work with foster or incarcerated youth to screen, refer, and link youth with positive screens for physical, mental or developmental needs to appropriate services
11. Involve CYSHCN in a Youth Advisory Council providing input to programs serving children and youth

Please see the [Children and Youth with Special Health Care Needs](#) webpage for resources for the general public, providers, including publications and statistics.

CDPH MCAH Title V Program selected two objectives to improve the health of all children, including CYSHCN. The two objectives chosen are listed in the Title V Report/Application and summarized with suggested activities in the local MCAH SOW as follows:

1. Increase the rate of developmental screening, linkage and referral according to the [American Academy of Pediatrics \(AAP\) guidelines](#)
 - Collaborate with partners, including health plans and CCS, to identify and address barriers
 - Develop protocols to screen, refer and link children in MCAH programs as needed
 - Promote the core functions of [Help Me Grow](#)
 - [Promote Birth to 5: Watch Me Thrive](#) or other materials consistent with AAP guidelines
2. All children, including CYSHCN, receive a yearly preventive medical visit
 - Promote workforce development
 - Identify and address barriers and disparities
 - Work with health plans to increase utilization of the preventive medical visit; strengthen referral systems
 - Develop protocols to promote the yearly medical visit or all well-child visits for children in MCAH Programs

The suggested activities listed in the MCAH SOW align with State Title V Action Plans. LHJs are encouraged to determine their priorities, capacity and levels of activities performed and build on or join existing efforts or collaboratives. LHJs should continue to conduct ongoing review and revisions of local Action Plans to inform their yearly MCAH SOW.

For detailed information on the State Action Plan, priorities, objectives and strategies, please see the MCAH Title V Report/Application located at:

<http://www.cdph.ca.gov/programs/mcah/Documents/Title%20V%202016%20Application%202014%20Report%20final.pdf>

Protocol Guidelines for Developmental Screening for Children in MCAH Programs

Local MCAH Programs are defined as programs or activities on the local MCAH budget.

Purpose: To ensure that all children in local MCAH Home Visiting and other MCAH Case Management Programs are being screened for developmental delays and are linked to their primary care provider or medical home for further assessment and linkages to appropriate services, as needed.

We will measure efforts to meet this goal by identifying the number of local health jurisdictions (LHJs) that adopt protocols that incorporate (a) provider outreach to support early detection and intervention; (b) community outreach to provide networking opportunities among families and service providers; (c) a centralized telephone access point for connecting children and their families to services and care coordination; (d) data collection to understand and monitor service delivery; (e) the number of children in local MCAH Programs providing case management, including CHVP, that are screened for developmental delays and linked to their primary care provider for further assessment and linkage and (f) the number of parents/caregivers of a child with special needs that receive additional supports.

For LHJs that do not provide direct services to children through their 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.

Procedure:

- All LHJ MCAH Programs are expected to develop and adopt protocols, tailored to your local needs, to ensure that children in MCAH Programs providing case management receive developmental screenings (if applicable), referrals to their primary care provider or medical home and subsequent linkages to services as needed. The MCAH Program protocols must be culturally sensitive, include ongoing developmental monitoring, developmental screening, referral and linkage and contain the following:
 - The standardized screening tool(s) to be used
 - The periodicity of screening. The American Academy of Pediatrics (AAP) recommends that developmental screening tests should be administered at 9, 18, and 30 months, at a minimum, or whenever the parent/caregiver has a concern.
 - Note - although there are specific ages that screening is recommended, screening should be done at any age if MCAH staff or the child's family are concerned about their development
 - 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, 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

LHJs will report on the outcomes of these efforts in the MCAH Annual Report as follows:

- Brief description of the components of the protocols implemented, including the process to conduct (a) provider outreach; (b) community outreach; (c) a central telephone access point; (d) data collection
- Number of children receiving developmental screening by your local MCAH Program and number of children with a positive screen
- Number of children with a positive screen that complete a follow-up visit with their primary care provider
- Number of health care providers reached to support early detection and intervention
- Number of children with a positive screen referred or linked to appropriate resources
- Number of parents/caregivers of CYSHCH that received support services such as anticipatory guidance, education about developmental milestones, insurance enrollment, transportation, translation, care coordination or other non-clinical activities that enable the families of CYSHCN to access services
- Number of calls received for referrals and linkages to appropriate services
- Identify the standardized developmental screening tool(s) adopted by your local MCAH Program
- Brief description of the successes, challenges, gaps and barriers

Resources:

American Academy of Pediatrics, Bright Futures Materials and Tools located at:

<https://brightfutures.aap.org/materials-and-tools/Pages/default.aspx>

American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care at:

https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

Birth to 5: Watch Me Thrive located at: <http://www.acf.hhs.gov/ecd/child-health-development/watch-me-thrive>

Birth to 5: Watch Me Thrive, Compendium of Screening Measures for Young Children located at:

https://www.acf.hhs.gov/sites/default/files/ecd/screening_compendium_march2014.pdf

Birth to 5: Watch Me Thrive, Developmental Screening Passport information located at:

https://www.acf.hhs.gov/sites/default/files/ecd/screening_passport.pdf

Developmental Screening Passport printable version:

https://www.acf.hhs.gov/sites/default/files/ecd/birth_to_5_watch_me_thrive_screening_passport_desktop_printing.pdf

Intimate Partner Violence (IPV) Initiative

Intimate partner violence (IPV) is a significant public health problem. In 2011 National Intimate Partner and Sexual Violence Survey (NISVS), indicated that over 10 million women and men in the United States experienced physical violence each year by a current or former intimate partner.ⁱ Nearly 1 in 2 women and 1 in 5 men experienced sexual violence victimization other than rape at some point in their lives.ⁱⁱ The most recent data in California, from the 2014 California Department of Justiceⁱⁱⁱ, indicated that there were over 155,965 domestic violence-related calls for assistance. According to the 2013-2014 Maternal and Infant Health Assessment Survey, Black women had the highest prevalence of IPV during pregnancy (physical or psychological) (11.1%) followed by Hispanic (9.1%), Asian/PI (4.5%), and White (4.2%) women.

The MCAH's Title V needs assessment ranked domestic violence 6th as a maternal/ women's health emerging issue or unmet need, and violence as the 7th most frequently reported problem. Consequently, MCAH has adopted an IPV Initiative as part of California's Title V efforts. The IPV Initiative will be developed with the understanding of the multifactorial aspects that increase the risk of IPV such as, behavioral, social, cultural, and environmental factors and the complexity of the interaction of these factors. Most importantly, the IPV Initiative will provide a framework, resources and support to MCAH programs to address IPV from their unique community needs.

To support the MCAH's IPV Initiative, we have launched an [Intimate Partner Violence \(IPV\) Webpage](#) within the California Department of Public Health, Maternal, Child and Adolescent Health Division. The page features resources, data and statistics, publications and reports for professionals and the general public. The page will continue to grow as other resources become available. Moreover, the [site](#) will have the latest information and content related to MCAH's IPV Initiative.

ⁱ Breiding MJ, Basile KC, Smith SG, Black MC, Mahendra RR. *Intimate Partner Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 2.0*. Atlanta (GA): National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2015.

ⁱⁱ Centers for Disease Control and Prevention [CDC]. Injury Prevention & Control: Division of Violence Prevention. Retrieved from <http://www.cdc.gov/violenceprevention/pdf/nisvs-infographic.pdf> on March 30, 2016.

ⁱⁱⁱ CJSC Statistics: Domestic violence-related calls for assistance. Retrieved on December 22, 2016 from the California Department of Justice Web site: <http://oag.ca.gov/crime/cjsc/stats/domestic-violence>.

Comprehensive Perinatal Services Program

See the Comprehensive Perinatal Services Program (CPSP)
Perinatal Services Coordinators' (PSC) Policies and Procedures

Black Infant Health Program

See the BIH Policies and Procedures

There are BIH programs in 15 Local Health Jurisdictions where over 90% of African American infant births occur: (Alameda, Contra Costa, Fresno, Kern, Long Beach, Los Angeles, Pasadena, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, and Solano).

Adolescent Family Life Program

See the AFLP Policies and Procedures

There are 32 AFLP agencies, serving 29 counties in California. Depending on the location, community based organizations, school districts, or Local Health Jurisdictions administer AFLP programs ([AFLP Coordinator Directory](#))

Local Health Jurisdiction Requirements

LHJ 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 and State requirements and LHJ priorities
- Develop policies and standards to implement activities designed to improve health outcomes for the MCAH population, including CYSHCN
- Develop collaborative relationships with agencies and/or community groups to support an infrastructure within their jurisdiction capable of providing family-centered, culturally competent services
- Establish a community-based perinatal program which includes a PSC whose responsibilities include providing technical assistance, and recommending and monitoring providers of comprehensive perinatal services.
- Incorporate life course perspective and social determinants of health to address health disparities

Key Personnel

Policy

Each LHJ must have an MCAH Director who is approved by the CDPH MCAH Program. Approval is required for all changes to key personnel positions including the person assigned, time allocated to the program, duties, job specifications, and organizational charts. A copy of the approval/waiver letter for the MCAH Director must be submitted annually with the Agreement Funding Application (AFA).

MCAH Director 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).

All MCAH Directors funded in whole or in part by the MCAH allocation will be the LHJ lead for the local MCAH program. The MCAH Director will dedicate a percentage of time or Full Time Equivalents (FTE) to MCAH activities that complies with the following State MCAH Program guidelines for the population.

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
25,000-75,000	0.50 Public Health Nurse
<25,000	0.25 Public Health Nurse

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.

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). These requirements are in addition to the Key Personnel requirements for the MCAH Director FTE as outlined in the MCAH Policies and Procedures Manual.

A CHVP LHJ must meet the MCAH-LHJ FTE and credentialing requirements for the MCAH Director. These CHVP LHJs may not receive waivers for the MCAH Director FTE requirements; waivers will be considered for credentialing only. If the total FTE required (CHVP plus local MCAH) exceeds 1.0 FTE, local MCAH programs may meet staffing requirements by adding an MCAH Coordinator.

MCAH Coordinator Requirements

The MCAH Coordinator must be a Skilled Professional Medical Personnel (SPMP). Refer to the Fiscal Policies and Procedures for the definition of an SPMP. The MCAH Coordinator assists the

MCAH Director in fulfilling the MCAH Director's responsibilities outlined below and in the MCAH SOW.

If the MCAH Director has reduced FTE and is providing administrative oversight only for the MCAH Program, the MCAH Coordinator will be responsible for implementing the MCAH program under the direction of the MCAH Director. In this situation, the MCAH Director FTE requirements will be fulfilled by combining the FTEs of the MCAH Director and MCAH Coordinator.

There is an SPMP questionnaire on the AFA webpage that can help you determine whether a staff member is an SPMP.

MCAH Director Responsibilities

The 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 MCAH Division-sponsored 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 for the purpose of identifying at-risk populations, including monitoring incidence of SIDS. 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 programs 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, oversight of CPSP, patient/client outreach, education, community awareness, referral, transportation, childcare, translation services and care coordination.
- 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 general public regarding access to prenatal care. The telephone number must be disseminated widely throughout the health jurisdiction by means of pamphlets, publications and media publicity. At a minimum, the toll free line must be operational during normal business hours and must be linguistically appropriate. Personnel staffing the toll free line should have cultural sensitivity training. After-hours messages must be answered by the end of the following business day.

- 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 key 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
- Include the evaluation in the Annual Report to the MCAH Division
- Conduct a Needs Assessment within their community every five years

Local Health Jurisdiction Candidate Selection

The LHJ management staff selects a candidate for the MCAH Director position who meets the professional qualifications and FTE requirements, and shall send a letter to the MCAH Division Nurse Consultant (NC) and Contract Manager (CM) requesting review and approval.

- Submit a letter within 30 days of selecting a candidate for the position
- Include in the letter the candidate's qualifications, license number, proposed FTE, and effective start date
- Submit the candidate's resume, including the resume for the candidate for the MCAH Coordinator, if applicable
- Submit the position Duty Statement
- Submit a revised organizational chart

Prior to appointment of a candidate who does not meet the professional qualifications and/or FTE requirements for the MCAH Director position, the LHJ shall request and receive an approved MCAH Program waiver to the requirements as specified in the section below.

Key Personnel Waiver

LHJs shall comply with these requirements for these key positions to maximize the potential for successful implementation strategies designed to meet the MCAH Division priorities. When the LHJ is unable to provide a candidate who meets the professional qualifications and/or FTE time requirements for the MCAH Director, a waiver shall be requested from State MCAH Program. If the LHJ has a CHVP, MCAH Director FTE waivers are not permitted.

Each LHJ requesting a waiver for the professional qualifications and/or FTE requirements for key personnel shall follow these steps:

1. Submit the request for a waiver in writing on agency letterhead and signed by the agency director or designated supervisor of the proposed appointee. The request shall be submitted to the MCAH Division NC and CM.
2. Describe the reason(s) for the inability to hire an individual who meets the professional requirements for key personnel by addressing education, licensing and experience of the candidate and demonstrate how the LHJ will assure the appropriate level of clinical oversight for the program (e.g. MD oversight for counties with more than 750,000 population, and PHN oversight for counties with less than 750,000 population) if the proposed candidate does not have the required clinical license.
3. Describe the reason(s) for the inability to meet the FTE requirement for the MCAH Director
4. Submit a description of the candidate's qualifications along with a resume. Include an assessment of expectations for successful program implementation and support for the individual within the LHJ
5. If the LHJ is requesting a waiver for a PHN or a Master's in Public Health (MPH) in place of a physician, or an MPH in place of a PHN, the LHJ must describe its mechanism for oversight of medical or clinical issues
6. Submit a duty statement that reflects the roles and responsibilities of the position
7. Submit an organizational chart from the local MCAH program and an agency interdepartmental organizational chart
8. Submit a copy of the approved waiver letter with the AFA packet annually

The State MCAH Program will consider each waiver request individually.

A waiver applies to a particular individual in a specific position. If the individual vacates the position or does not maintain the approved FTE, the waiver becomes void.

The MCAH Division will not reimburse an LHJ for the MCAH Director if the minimal professional qualifications and FTE time requirements are not met unless a waiver is on file with the MCAH Program.

Interim Plan

Each LHJ will notify the State MCAH Program of the resignation or proposed change in MCAH Director and submit a plan for the interim oversight of the program until a new director is identified and approved by the State MCAH Program. The individual designated as interim MCAH Director must, at a minimum, meet the position's minimal professional qualifications and waiver criteria.

The LHJ must submit its interim plan to the State MCAH Program within two weeks of notification of the MCAH Director's resignation. At a minimum the plan must include the title and name of the person that will assume contractual responsibility for the program, the responsibilities the individual will assume if different from the MCAH Director's duty statement, the projected time frame of the interim personnel's tenure, and the LHJ's plan for permanently filling the position.

LHJs that do not hire an MCAH Director within 90 days of the position becoming vacant must provide written explanation detailing obstacles to recruitment strategies and a plan for filling the position within the projected time frame.

Perinatal Services Coordinator (PSC) Requirements

Based upon the local birth rate, it is strongly recommended that each LHJ have a PSC that meets the professional qualifications and time requirements displayed in the table below. The PSC duties described below are mandatory. If the LHJ does not have a PSC, the implementation of the CPSP program and the duties of the PSC are the responsibility of the MCAH Director. MCAH recommends that the LHJ use a staff member with clinical licensure (PHN, RN,) to carry out clinical Quality Improvement/Quality Assurance (QI/QA) functions. PSCs employed before November 2011 are exempt from this recommendation.

Total Number of Births in LHJ	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
1,000-5,000	0.50 SPMP
<1000	0.25 SPMP

PSC Responsibilities

The PSC, under the direction of the MCAH Director, will have the responsibility to perform activities to improve systems of care for pregnant and postpartum women and assist providers to implement CPSP. Below are some general duties of the PSC. Please see the CPSP section of this manual for examples of activities to improve the perinatal system of care.

- Conduct activities with local provider networks and/or health plans, community agencies and partners to improve perinatal access, service integration and coordination to meet client needs
- Assist in the maintenance and management of a network of perinatal providers, including enrolled CPSP providers, and conduct quality assurance activities
- Assist providers to deliver CPSP services in accordance with Title 22 California Code of Regulations

Assessment

- 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

- Assure that comprehensive perinatal services are available to all Medi-Cal eligible women in both fee-for-service and capitated health systems
- Work with the perinatal community, including providers, Regional Perinatal Program Coordinators/Directors, 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
- Ensure that pregnant and postpartum women who have an undocumented resident status are aware of and linked to appropriate perinatal and applicable safety-net health and human services
- Perform CPSP mandated functions, authorized for CDPH, based on legislation (See CPSP Policies and Procedures)

Evaluation

- Evaluate implemented activities to determine outcome and quality of services
- Report collected data and outcomes related to implemented activities to the MCAH Director
- Prepare quality assurance reports for MCAH Division upon request

NOTE: FOR ADDITIONAL INFORMATION REGARDING PSC RESPONSIBILITIES SPECIFICALLY FOR CPSP RELATED ACTIVITIES, PLEASE REFER TO THE CPSP POLICIES AND PROCEDURES LOCATED IN THE CPSP/PSC POLICIES AND PROCEDURES SECTION OF THIS MANUAL.

Client Triage and Co-Enrollment

Client Triage

Background:

The MCAH Division is responsible for maintaining the integrity of our MCAH programs and committed to ensuring the most effective and efficient use of limited resources. MCAH Division recommends that MCAH Directors develop client triage policies based on the availability of local resources and knowledge of client and community needs. Local policies should consider that allowing an eligible woman to participate in more than one MCAH-funded program may exclude other potential clients from the benefits of program participation, may result in duplication of services, and could add significant data collection responsibilities to the local programs. Local policies should provide guidance on the criteria for program eligibility and participation that best meets the needs of clients and provides them the most benefit.

CPSP is not an MCAH-funded program but is a Medi-Cal program that provides comprehensive perinatal care and is highly recommended to be promoted in all MCAH funded programs. LHJs should encourage eligible clients to participate in CPSP in addition to other MCAH funded programs in which they may participate.

Policy:

- It is the responsibility of the LHJ MCAH Director or designated staff, in consultation with the client, to determine the program(s) that best meets the client's needs

Procedure:

LHJ staff will enroll clients in the program(s) that will have the greatest benefit to the individual client using a local assessment process and considering the following:

- Existing science and best practice guiding program implementation
- Individual MCAH program goals, objectives, activities, and guidelines
- Client input, needs, strengths, and goals
- Duplicate or overlapping services, programs and supports currently provided to the client by other programs
- Existing absolute contradictions to group interventions. Some clients may need an intensive home visiting program or other healthcare services to address the following situations:
 - Client medical issues that are severe enough that they logistically prohibit group involvement and/or attendance which may actually cause more harm than good (e.g. bed rest)
 - Client mental health issues that are incapacitating, uncontrolled or prevent effective participation or disruption of group activities

- The Local MCAH program should coordinate the decision making process with other local programs, for example, CHVP, BIH and AFLP programs.

Co-Enrollment in other MCAH Programs

BIH - MCAH Division recommends that BIH Coordinators develop client triage and enrollment policies based on the availability of local resources and knowledge of client and community needs. The BIH program should coordinate enrollment policies with other local programs, for example, CHVP.

AFLP -It is the responsibility of the local AFLP agency, in consultation with the client, to determine the program(s) that best meets the client's needs. AFLP agencies should coordinate the decision making process with other local programs, for example, CHVP.

Agencies participating in the Office of Adolescent Health federal evaluation must adhere to all criteria articulated in the Memorandum of Understanding established between the local AFLP agency and Mathematica Policy Research, Inc.

Guidelines for Protocols to link MCAH clients to Health Insurance and Preventive Visit(s)

Guidelines for developing or adopting protocols to ensure that MCAH clients are enrolled in health insurance, are linked to a provider and access preventive visits

Health Insurance and Preventive Visit(s) for MCAH Clients

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

Procedure:

- All LHJ MCAH Programs are expected to develop and adopt local protocols to improve the rates of clients accessing a preventive visit. The protocols must 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 outcomes of these efforts in the MCAH Annual Report as follows:

- Number of clients referred to Medi-Cal, Covered California, or other no/low cost health insurance
- Brief description of the process to track and verify health insurance status, assist clients to enroll in health insurance, link clients to a health care provider, and complete a preventive visit
- Brief description of the successes and challenges

Guidelines for Collaboration

Collaboration is a process in which agencies and individuals work together at some level, have a shared purpose or goal, and joint ownership of the work, risks, results, and rewards. Some potential benefits of collaboration include increasing community awareness, developing new services, reducing duplication, and increasing internal capacity and leveraging resources. Collaborative efforts are dynamic and flexible and change as they grow and develop.

Collaboration is a part of broader interventions that help LHJs achieve improved health status and health systems change. The MCAH Director's participation in collaborative efforts can offer significant impacts to MCAH programs and activities. MCAH Directors bring public health knowledge and expertise to collaborative efforts, influence program planning, provide information and increase awareness of the needs of the MCAH population.

We recognize the importance of MCAH staff participation in collaborative efforts. Much of local MCAH work is accomplished through collaborative efforts. The collaborative efforts that the MCAH Director or designated staff member participate in should be in alignment with the goals of the MCAH SOW. We encourage MCAH Directors to prioritize and limit the number of collaborative efforts they participate in, their role or contribution and the value of each collaborative effort as it relates to fulfilling your MCAH SOW goals, objectives and activities.

Please see the information in the following links to help guide and evaluate your collaborative efforts:

Community Health Partnerships, Tools and Information for Development and Support:

http://www.nbch.org/nbch/files/cclibraryfiles/filename/00000000353/community_health_partnerships_tools.pdf

United We Serve – The White House Council for Community Solutions: <http://www.serve.gov/site-page/council-resources>

- Community Collaborative Toolbox:
http://www.serve.gov/sites/default/files/ctools/CommunityCollaborativeToolkit_all%20materials_1.pdf

Collective Impact

Collective Impact results from the highest levels of collaboration. Collective Impact is improvement that occurs when a large group of community leaders from different sectors join together to implement a common agenda to solve a complex social problem that no group can address alone. Collective impact initiatives involve a centralized infrastructure, a dedicated staff, and a structured process that leads to a common agenda, shared measurement, continuous communication, and mutually reinforcing activities among all participants. Members from each sector work together to address the elements of the problem that are relevant in their sector, and at which they excel, in a way that is supportive of others, which results in meaningful change.

There have been successful collective impact initiatives to address education reform, childhood obesity, restoring wetland environments, and poverty. These are complex, adaptive problems where the answer is not clear, and no single organization has the capacity to effect change. Large scale social change comes from better cross-sector coordination rather than isolated efforts of individual organizations. Evidence suggests that we could make substantially greater progress in addressing most of our serious and complex social problems if nonprofits, government, businesses and the public worked together around a common agenda.

Collective impact requires a systematic approach that focuses on the relationships among organizations and progress toward shared objectives. The five conditions that make collective impact possible are: a common agenda, shared measurement systems, mutually reinforcing activities, continuous communication, and backbone support organizations. Please see the following for more information on collective impact:

- Article, “Collective Impact”, by John Kania and Mark Kramer, winter 2011 Stanford Social Innovation Review: http://www.ssireview.org/articles/entry/collective_impact.

Collective Impact Forum: <http://collectiveimpactforum.org/resources/collective-impact-webinar>

Agreement Funding Application (AFA)

Introduction

The CDPH MCAH Division allocates funds annually through a three year contract to support local MCAH Programs that are developed, operated, and managed by LHJs throughout California. There are 61 LHJs funded to accomplish the MCAH Program mission and goals.

Purpose

The purpose of the MCAH allocation is to:

- Ensure that each LHJ has the necessary leadership to fulfill Title V requirements and carry out the core public health functions of assessment, policy development, and assurance; implementing programs using the ten essential public health services to improve the health of their MCAH population.
- Assist the LHJs in providing leadership in planning, developing, and supporting comprehensive systems of preventive and primary care services for pregnant women, mothers, infants, children, adolescents and their families. This includes assessment of needs, coordination of effort at both state and local levels, and planning to assure that systems of care achieve the health objectives set by the state. In conjunction with the national health objectives, identify and incorporate best practices into MCAH activities.
- Ensure that MCAH staff within the LHJ is aware they are responsible for promotion of maternal, child, and adolescent health.

Funding Sources

Federal Title V MCH Block Grant Funds, Federal Title XIX Medicaid (Medi-Cal) Funds, and local government (county/city) funds are combined to support the program activities as defined in the SOW.

In determining allowable administrative costs, the basic principle is that duplicate payments are **not** allowable ([OMB Circular A-87](#)). Payments for allowable Medi-Cal administrative activities under Title XIX must not duplicate payments that the Centers for Medicare and Medicaid Services believes have been, or should have been, included and paid as part of outpatient clinic rates, targeted case management services, part of a capitation rate, or through some other state or federal program. In no case should a program or claiming unit in a local jurisdiction be reimbursed more than the actual cost.

Budgets

Forecasting an Annual Budget

To forecast an annual budget, each LHJ must establish a SOW for the fiscal year using the framework provided by MCAH and based on the needs and problems of the jurisdiction identified through their most recent Five-Year Needs Assessment.

Travel, Training and Meetings

Adequate funding for training and meeting expenses, including travel to MCAH Action meetings, must be built into the annual MCAH budget

The MCAH Fiscal Policies and Procedures Manual, Operating Expenses, Budget Documents Section-Travel Policy, allows specified local agency personnel to be reimbursed for travel expenditures to the following selected MCAH national conferences.

- Annual meeting of the National Association of MCAH Programs
- Centers for Disease Control and Prevention (CDC) MCAH Epidemiology Conference
- Annual City MatCH Conference

Travel to any of the above listed MCAH national conferences must be identified in the training explanation area of the J-Operation justification tab of the budget and under the appropriate goal and objective in the SOW. Out-of-state travel is reimbursable if necessitated by the SOW and approved in advance by the program with which the contract is held.

Consistent with the MCAH Policies and Procedures Manual, requests to travel to other national conferences, trainings and meetings may be submitted to the NC for consideration on a case by case basis. Submit requests in writing with a brief description, including the items listed below:

- Name and date of the conference, training, meeting, etc.
- Name and title of the individual(s) traveling.
- Necessity of the trip and how it relates to the goals, objectives, and outcomes of the SOW and improves the skills of the attendee.
- Travel location and dates.
- Breakdown of the proposed costs of the trip.

Adequate funding must be identified in the budget and budget justification to accommodate any out-of-state travel expenditures. Reimbursement of salary only (excluding travel costs) on out of state travel must still be approved by MCAH and follow the out-of-state travel policy. All costs claimed under the MCAH budget must be in accordance with the rates and terms established under the revised Travel Reimbursement Information guidelines. For any Federal Financial Participation (FFP) reimbursement, activities must meet the FFP objectives and requirements.

LHJ Community Profile Requirements

The purpose of the Community Profile is to provide a snapshot of the health status of your local community. You may use the Community Profile to share information with stakeholders/community partners and to educate your population. The Community Profile should provide a description of the community, including major employers, health systems, health status of the MCAH population and disparities. Update the Community Profile annually and submit it with the AFA package. To complete the LHJ Community Profile, use the template provided by MCAH.

Scope of Work

SOW Requirements

The SOW defines the local activities in each jurisdiction that contribute to accomplishing the statewide MCAH mission and goals. The LHJ completes the SOW using the template provided by the MCAH Division. The SOW is based on:

- LHJ needs and problems identified in the Five-Year Needs Assessment
- State MCAH Program requirements and priorities
- Title V, Title XIX, State and Federal requirements and initiatives
- Locally developed 5-year Action Plans to address local problems

The LHJ should first consult with the NC assigned to the agency before contacting the Family Health Outcomes Project ([FHOP](#)) for assistance in completing the MCAH SOW. The MCAH Division NC must approve the MCAH SOW and any changes to the MCAH SOW.

Each LHJ must complete and submit with their AFA the current Fiscal Year (FY) SOW that is posted on the MCAH Program website.

The MCAH SOW consists of 6 goals, which are consistent with State priorities and fulfill Title V, SIDS and CPSP requirements.

- LHJs will be held accountable for completing activities described in their individualized MCAH SOW.
- LHJs will be responsible for monitoring and reporting on performance measures.

Structure of SOW

The development of the SOW was guided by several public health frameworks including the 10 Essential Services of Public Health and the three core functions of assessment, policy development and assurance; the Spectrum of Prevention; the Life Course Perspective; the Socio-ecological Model, and the Social Determinants of Health, which were described previously. Integrate these approaches when conceptualizing and organizing objectives, activities and evaluation measures, as applicable.

LHJs are encouraged to develop an ongoing process to review and revise their Action Plans based on priorities, resources, and local capacity and build on or join existing efforts or collaboratives. LHJs Action Plans should inform the yearly SOW.

The 6 goals in the SOW reflect the priorities of the MCAH Division as identified by the federally required Title V 5-Year Need Assessment, which incorporates local problems:

- Goals 1 and 2 - Each LHJ is required to develop at least one short and/or intermediate outcome objective(s) and corresponding intervention activities and evaluation/performance measures for Goals 1 and 2
- Goal 3 – Each LHJ is required to develop 2 objectives for Goal 3, a local infant health promotion objective and a SIDS objective
- As resources allow, LHJs may develop additional objectives, which they may place under any of the Goals 1-6.

- All LHJs must perform the activities in the shaded areas in Goals 1-3.
- Goals 4-6 are optional.

General instructions for developing the MCAH SOW

- To complete the MCAH SOW, download and save the appropriate FY MCAH SOW template from the AFA website at: <http://www.cdph.ca.gov/services/funding/mcah/Pages/FiscalDocuments.aspx> to your computer. Name the file “LHJ Name MCAH SOW 2016-17”
- Nothing is entered in the shaded areas

SOW Goals

The following is a more detailed description of the MCAH Goals:

- **Goal 1**– (required) Increase access and utilization of health and social services (cross-cutting) - Incorporates the MCAH priority and the Title V requirement to conduct outreach and link the MCAH population, including CYSHCN, to needed preventive, medical, mental, substance use, social, dental, and available support services. LHJs are required to facilitate access and referrals to Medi-Cal, Medi-Cal Access Program, Covered CA, Child Health and Disability Prevention Program (CHDP), Women, Infants, and Children (WIC), Family Planning, Access, Care, and Treatment (Family PACT), and health, and developmental disability programs. This goal also fulfills the Title V requirement for the toll-free or “no cost to the calling party” number (and other appropriate methods) to provide information about health and human services to parents and providers (LHJs must track and report the annual number of toll-free calls and web hits). Emphasis is on maintaining required foundational structure, community collaboration and public health activities that improve coordination and access to family-centered, culturally competent, health and human services.
- **Goal 2**–(required) Improve preconception health by decreasing risk factors for adverse life course events among women of reproductive age - Incorporates the MCAH priorities to improve maternal and women’s health by optimizing the health and well-being of girls and women across the life course, decrease unintended pregnancy, the burden of chronic disease, intimate partner violence and disparities in maternal health outcomes, and assuring that all pregnant women have access to early, adequate and high quality perinatal care. This goal also includes the requirement to promote access to and quality of the local perinatal services, including CPSP.
- **Goal 3**– (required) Reduce infant morbidity and mortality - Incorporates the MCAH priority to reduce pre-term births, increase infant safe sleep practices and SIDS risk reduction, improve access to enhanced perinatal (neonatal) services (NICU, CPets) and address disparities by promoting preconception health and preventing causes such as birth defects, low birth weight/prematurity, perinatal substance use, SIDS, and maternal complications during pregnancy. This goal includes the requirement to contact and offer grief and bereavement support services to parents/caregivers of infants with a presumed SIDS death, attend annual SIDS conferences/trainings and conduct and promote infant safe sleep and SIDS risk reduction education activities. **This is the only goal with two required local objectives, one for SIDS and one to reduce infant morbidity and mortality.**
- **Goal 4**– (optional) Increase the proportion of children, adolescents and women of reproductive age who maintain a healthy weight - Incorporates the MCAH priority to promote healthy nutrition

and physical activity among MCAH populations throughout the lifespan beginning with exclusive breastfeeding to at least six months of age.

- **Goal 5**– (optional) Improve the cognitive, physical, and emotional development of all children, including CYSHCN - Incorporates the MCAH priority to support the physical, socio-emotional, and cognitive development of children, including the prevention of injuries, and child abuse and neglect, and early identification, referral and linkage of CYSHCN, through the implementation of prevention, early identification and intervention strategies.
- **Goal 6**– (optional) Increase conditions in adolescents that lead to the improved adolescent health - Incorporates the MCAH priority to reduce teen pregnancies, teen dating violence, bullying and harassment and promote positive youth development strategies to support the physical, mental, sexual and reproductive health of adolescents.

Developing the SIDS Objective (incorporated into Goal 3 of the SOW)

The LHJ should use the following directions and guidelines to develop and write at least one SIDS objective.

The SIDS allocation monies that LHJs receive are from the Title V MCH Block Grant funds and are to be used to support SIDS services and activities. All LHJs are required to conduct the following activities:

- Monitor the number and trends in presumed SIDS deaths. An appropriately trained public health professional, defined as 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 must contact all parents/caregivers who experience a presumed SIDS death to provide grief and bereavement support services.
- At least one public health professional to attend the State Annual SIDS Conference and/or other SIDS training(s).

In addition, each LHJ must also develop an additional SIDS objective to increase knowledge and implementation of infant safe sleep and SIDS risk reduction practices in the community. This objective may address SIDS risk reduction directly or indirectly for example, by addressing perinatal substance use prevention, and promotion of exclusive breastfeeding. The Local SIDS Objective intervention activities may include but are not limited to:

- Providing infant safe sleep and SIDS risk reduction education within the community, especially to high risk populations
- Providing trainings and materials for those who interact with parents and caregivers following a presumed SIDS death, including:
 - Hospital staff
 - Child care providers
 - Foster care providers
 - First responders
 - Coroner

- Attending local health fairs, conferences and other related events to promote infant safe sleep and SIDS risk reduction education.

Developing the LHJ's Local Objective(s)

The LHJ should develop Specific, Measurable, Achievable, Realistic and Time-framed (SMART) local objective(s) based on the problems it identifies from the results of its most recent 5-Year Needs Assessment and 5-Year Action Plans, State Title V priorities and national initiatives. The LHJ monitors and reports local trends for the MCAH population and any population changes that impact the implementation of MCAH programs. The LHJ plans and modifies local plans and program implementation to improve maternal, child, adolescent, and family health.

Objectives should be specific statements of desired achievements that are expected to occur as a result of an intervention or program. As resources allow, the LHJ should develop SOW objectives to address local problems identified in the Needs Assessment.

The LHJ should develop a plan to address each objective, identify best practice strategies and activities designed to accomplish the objective, include a time frame for implementation, and a process for evaluation and continuous quality improvement.

Each LHJ will develop and write their specific SMART local short and/or intermediate outcome objectives, implementation activities and define the process or outcome measures that the LHJ will use to determine progress toward achieving the objectives during the fiscal year. The LHJ should develop process, short and/or intermediate performance measures to evaluate progress toward long term goals that may encompass one or more fiscal years.

- Each objective must have a method of measuring or evaluating the outcome as it relates to meeting the objective
- All objectives should be specific and measurable
- Timelines should conform to the fiscal year for which the allocation applies, though LHJs may conceptualize and plan longer term strategies with intermediate measures that span more than one year in their 5-Year Action Plans. The time frame for a particular objective or activity may be shorter than the fiscal year.

Changes to the SOW

Proposed changes to the SOW must be submitted both in writing and electronically with all corresponding documents to the MCAH Division NC for review and approval. If there are fiscal implications, discuss the proposed changes with the NC and CM prior to submitting them for approval. The MCAH Division staff will respond in writing within 30 days after receiving all required documents and information.

Duty Statements

Duty Statement Requirements

All personnel funded through the local MCAH budget are required to have duty statements that describe those activities funded through the MCAH allocation or that relate directly to the MCAH program.

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 FFP matching.

Duty statements must:

- Contain position titles that match those on the organizational chart, budget, and budget justification documents
- Reflect MCAH activities accurately
- Contain only those duties performed for the MCAH program or specific program duties
- Provide information regarding:
 - Targeted populations
 - Targeted geographic areas
 - Specific practice settings or function
- Duty statements for Skilled Professional Medical Personnel (SPMP) will note 'SPMP' at the top of the duty statement or along with the position title or contain the statement *"This position must meet the criteria for SPMP"*.

Guidelines for Developing Duty Statements

The following information provides guidelines for developing the structure of duty statements:

- Budget Line
 - This may be one person or multiple persons on the budget
 - List each budget line number filling this position
- Name of the LHJ
- Name of the program, such as MCAH program
- Name of the program position, such as MCAH Director, Fiscal Officer
- Name of the LHJ position title and job specifications, such as Public Health Nurse or Social Worker II
- There should be a statement describing the position's supervisory relationships
- Briefly summarize the main purpose and functions of the above identified position. For example: *The MCAH Director plans, organizes, controls, and leads the MCAH program and oversees the FIMR program.*
- If the position is a SPMP the following statement should be added *"This position must meet the criteria for SPMP"*
- List by the level of importance the position responsibilities/tasks include the major responsibilities/tasks associated with the position. For an SPMP position, include language that reflects his/her duties' as they relate to the FFP codes but **should not be the exact language verbatim**

The following provides general information for developing duty statements:

- Statements should be short, focused, concise and describe the activities to be performed accurately
- If a position has multiple personnel, it is not necessary to have separate or individual duty statements if the duties are the same
- Do not include personnel names on the duty statement
- SPMP duty statements should reflect the unique expertise required for these duties
- Enhanced FFP matching is only permissible for activities requiring the skill, knowledge and ability of an SPMP
- Key personnel duty statements should be consistent with requirements stated in the MCAH Policies and Procedures Manual
- Duty statements should be reviewed annually and may change when assignments for the position change
- Include date of creation or update

Organization Charts

Each LHJ must have an organization chart for all MCAH programs and any special programs that receive MCAH Division funding.

Organization charts and current Duty Statements for personnel identified on the local MCAH budget serve as supporting documentation for the percent of time assigned to local MCAH Program activities and the level of FFP match.

The organization chart must:

- Identify the LHJ, MCAH Program and its relation to other public services for women and children, local health officers and overall agency
- Illustrate the relationship of local MCAH positions and programs to the MCAH Director, the local health officer, and overall agency
- Identify all staff positions funded with MCAH funds or involved in MCAH activities
- Match staff position titles with the duty statement titles and budget line number and title
- List the budget line number and position title on the organizational chart for ease of identification with the positions in the budget and budget justification documents
- Include the name of the LHJ and date of creation or update

MCAH Annual Report Requirements

All LHJs receiving State MCAH Division allocations are required to complete and submit an Annual Report for their Local MCAH Programs. Annual Reports, which describe activities and outcomes for the fiscal year ending June 30th, are due August 15th each year. LHJs may request an extension for submission of the Annual Report if needed. Please send requests in writing (email is acceptable) to your NC.

State MCAH Division has the option to withhold payment on current invoices for failure to submit a complete and timely report.

Submit the Annual Report as follows:

- Email all components of the Annual Report to MCAHAR@cdph.ca.gov
 - a. Submit documents requiring an original signature by email in PDF format
 - b. Submit all other documents by email in Word format
- All Annual Report forms are available on the State MCAH Division website.

The MCAH Division uses the information and data in the Annual Report to:

- Monitor implementation of the SOW and the LHJ's performance in meeting the Title V Block Grant and the State MCAH Program priorities, goals, and objectives
- Demonstrate LHJ accountability and responsibility for completing activities described in their individualized SOW and monitor progress towards state and local objectives
- Monitor health status and program outcomes for the MCAH population
- Provide data for legislative drills and the Title V Grant application, which supports MCAH Program funding
- Document the changing environment /challenges of local MCAH Programs

These are some of the questions that the Annual Report will answer:

- Has the SOW been met?
- What and how are services provided?
- If the SOW has not been met, what are the barriers?
- What is unique about the LHJ that impacts the MCAH Programs?
- What strategies and activities were effective in meeting the goals and objectives?
- How is the LHJ addressing local priority health issues?
- Has progress been made on addressing LHJ local priorities?

Documentation Retention Requirements

Documentation of AFA and SOW changes and activities must be in writing and kept on file for audit purposes for three years from the date of final payment or longer for open audits. (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. LHJs are advised that any PHI stored at their agency must adhere to Health Insurance Portability and Accountability Act (HIPAA) of 1996 regulations.

Client Confidentiality and HIPPA Requirements

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:

- a. 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; and
- b. 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.
- c. Disposal of Materials:
 - a. 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);
 - b. 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.
- d. Sending Confidential Information:
 - a. Prior to sending PHI or client-related confidential information via fax, LHJ site staff must notify the recipient of the materials being faxed.
 - b. When sending electronic PHI to MCAH, encrypt information by writing “[secure]” on the subject line;
 - c. 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.

Product/Publication Approval and Credit

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

The process for approval is as follows:

1. Submit the product either electronically or by hard copy to the CDPH MCAH State NC at least 60 days prior to publication or reprinting.
2. Include a cover letter or email requesting approval with the following information:
 - Identify the program
 - Title of the product
 - Objectives
 - Description
 - A copy of the publication
 - Target population
 - Language
 - Date produced
 - Name and telephone number of contact person
3. The NC will review the product; provide feedback and approval/disapproval within 60 days.
4. List the products developed in the annual report

For further guidance, please refer to the MCAH Fiscal Administration Policy and Procedures Manual.

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

Title V/MCAH Funding Acknowledgement

Local agencies that develop publications, products, journal articles, public reports, videos/DVDs, or publications using funds provided from CDPH MCAH Division 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, and/or other audio-visual materials resulting from the use of the MCAH allocation. 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. This permission may come from the source of the document and/or require the subject's written consent. When an LHJ submits products for approval, the LHJ must state that photo release was obtained and is kept on file. A sample photo release form is posted on the MCAH web page and must be completed by LHJ. The LHJ may use the sample form to create a form for use within the LHJ.

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

Photographs used from software clip art sites require the permission of the software company authorizing use of the photograph. The LHJ or Community Based Organization (CBO) will need to contact the software company/webmaster to request permission to use the photograph.

Comprehensive Perinatal Services Program (CPSP) Perinatal Services Coordinators' (PSC) Policies and Procedures

Table of Contents

Topic	See Page
CPSP Program overview	58
CPSP Regions.....	61
California Perinatal Services Timeline.....	62
Perinatal Services Coordinator Role, Responsibilities and Activities	63
Provider Application Process	68
Provider Agreements	70
Steps for Application Review:	72
State Application Processing	75
Provider Application Changes.....	76
Inactivating a CPSP Provider (End-Date Memo).....	77
Site-Specific CPSP Protocols	78
Client Orientation	80
Assessments, Reassessments, Referrals and Individualized Care Plans	81
Quality Improvement (QI) and Quality Assurance (QA) Activities:.....	83
Electronic Health Records (EHR).....	85
Record Retention.....	88
Medi-Cal	89
Rural Health Clinics (RHCs) and Federally Qualified Health Clinics (FQHCs).....	93
Audits and Investigations.....	94
Medical Board of California.....	95
Perinatal Services Coordinators' (PSC) Executive Committee (EC).....	96
Additional Program Information on Perinatal Services	99
CPSP Staff Contacts:.....	100
Types of CPSP Services offered by provider	101

CPSP Program overview

The purpose of this CPSP/PSC Policies and Procedures Manual is to compile all current program policies into a single, up-to-date PSC resource. It contains links to information and resources that are available to the local PSC and further details on the roles and responsibilities of the PSC in supporting the CPSP (see Key Personnel above).

CPSP Goals: H&S §123505:

- Decrease and maintain the decreased level of perinatal, maternal and infant mortality and morbidity,
- Support methods of providing comprehensive prenatal care that prevent prematurity and the incidence of low birth weight infants.

CPSP Objectives: H&S §123510:

- Ensure continuing availability and accessibility to early prenatal care throughout the state,
- Assure the appropriate level of maternal, newborn and pediatric care services necessary to provide the healthiest outcome for mother and infant,
- Ensure postpartum, family planning, and follow-up care through the first year of life and referral to an ongoing primary health care provider,
- 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,
- Ensure that care shall be available regardless of the patient's financial situation,
- Ensure to the extent possible that the same quality of care shall be available to all pregnant women,
- Promote program flexibility by recognizing the needs within an area and providing for unique programs to meet those needs,
- Emphasize preventive care as a major component of any perinatal program,
- Support outreach programs directed at low-income pregnant women to encourage early entry into and appropriate utilization of perinatal care.

CPSP provides a model of enhanced perinatal services for Medi-Cal eligible low-income, pregnant and postpartum women from the date of pregnancy through the last day of the second month after delivery. Through CPSP, eligible Medi-Cal providers deliver these enhanced services to pregnant women. The CPSP model is based on evidence that pregnancy and birth outcomes improve when routine obstetric care is enhanced with nutrition, health education, and psychosocial services.¹ CPSP-approved Medi-Cal providers and Medi-Cal Managed Care (MCMC) contracted health plans are required to follow the current American Congress of Obstetrics and Gynecologists (ACOG) standards as the minimum standards for obstetrical services provided to Medi-Cal pregnant women. The enhanced services are delivered as defined by Title 22 Regulations. CPSP providers who provide

¹ Final Evaluation of the Obstetrical Access Pilot Project July 1979-June 1982, State of California, Health and Welfare Agency, Department of Health Services, Community Health Services Division, Maternal and Child Health Branch, December 1984, supported by Grant No. 11-P-97578/9-03, Department of Health and Human Services, Health Care Financing Administration, Baltimore, Maryland.

patients with these enhanced services are reimbursed by Fee for Service (FFS) Medi-Cal at a higher rate than those who provide standard OB care. Managed care providers are reimbursed according to their contract with the managed care plan, but the reimbursement must be sufficient to cover reasonable costs of providing CPSP comparable services (Welfare and Institutions Code Section 14134.5(h)).

The CPSP client receives a program orientation, initial nutrition, psychosocial and health education assessments, second and third trimester, and postpartum assessments. The practitioner develops an Individualized Care Plan (ICP) to address needs identified in the assessment; conducts case coordination, and assures that the client receives appropriate nutrition, health education, and psychosocial interventions and referrals from a multi-disciplinary team. CPSP services are not intended to be provided to inpatients. CPSP services are in addition to, not a replacement for, the services that are part of the ACOG visit standards.

When the Department of Health Care Services split in 2007, the California Department of Public Health (CDPH) received partial duties, functions, jurisdiction, and responsibilities specific to CPSP. The following CPSP statutes were transferred to CDPH: Health and Safety Code (HSC) sections 123475-123525 and Welfare and Institutions (WI) Code section 14134.5. The essential functions within those statutes are discussed below:

1. Provider Enrollment (reference: WI section 14134.5(f), 22 CCR § 51249 (b) (c), (d) & (e))

CDPH is authorized to continue the process of reviewing or evaluating a provider's application to be a Certified Perinatal Service Provider based on the established criteria defined by 22 CCR § 51249. The PSCs in each LHJ assist CDPH in this process. In order to provide CPSP services, CDPH has to approve the application of FFS Medi-Cal providers, and providers from Rural Health Centers and Federally Qualified Health Centers.

CDPH is responsible for assuring that providers meet the criteria defined by CPSP applicable statutes prior to enrollment.

2. Training and Technical Assistance (reference: W&I section 14135.5(g))

CDPH will continue to provide technical assistance to LHJs for the purpose of implementing the community perinatal program. Technical assistance includes, but is not limited to, CPSP training, provision of services, and quality of care.

3. Monitoring and Oversight (reference: WI section 14134.5(i))

"The department shall develop systems for monitoring and oversight of the comprehensive perinatal services provided in this section and WI section 14134.5(i)".

CDPH MCAH defines "monitoring" by requiring each LHJ to implement individualized activities, based on local capacity and needs, to improve access to early and quality perinatal services. CDPH MCAH will utilize MCAH's data and reports to monitor specific perinatal outcomes and provide technical assistance to the LHJs as appropriate.

All CPSP services are delivered face-to-face with the following philosophy of care (Reference: CCR §51179 ((Register 87, No. 38-9-19-87) (P.1262.14))

- Health care services are client-centered. Services are delivered in consultation with the client and based on the client's prioritized needs.
- Client strengths are assessed and factored into the client's care.

- Comprehensive perinatal services are delivered through a multi-disciplinary approach to address the full needs of the client.
- CPSP services are individualized, culturally sensitive, and respect clients' values, beliefs, and traditions.
- Services delivered are consistent with approved protocols signed off by nutrition, health education, and psychosocial consultants.
- The CPSP Provider shall refer patients, as appropriate, to services not specifically made part of comprehensive perinatal services, which shall include and not be limited to, those provided by the following programs:
 - Women, Infants and Children (WIC) nutritional services
 - Genetic Screening
 - Dental Care
 - Family Planning
 - Well Child Care – Child Health and Disability Prevention Program (CHDP), Immunization program
 - Other local resources (i.e. home visiting programs, mental health support, local infectious disease programs, etc.)
- Client participation in CPSP is voluntary.

CPSP Regions

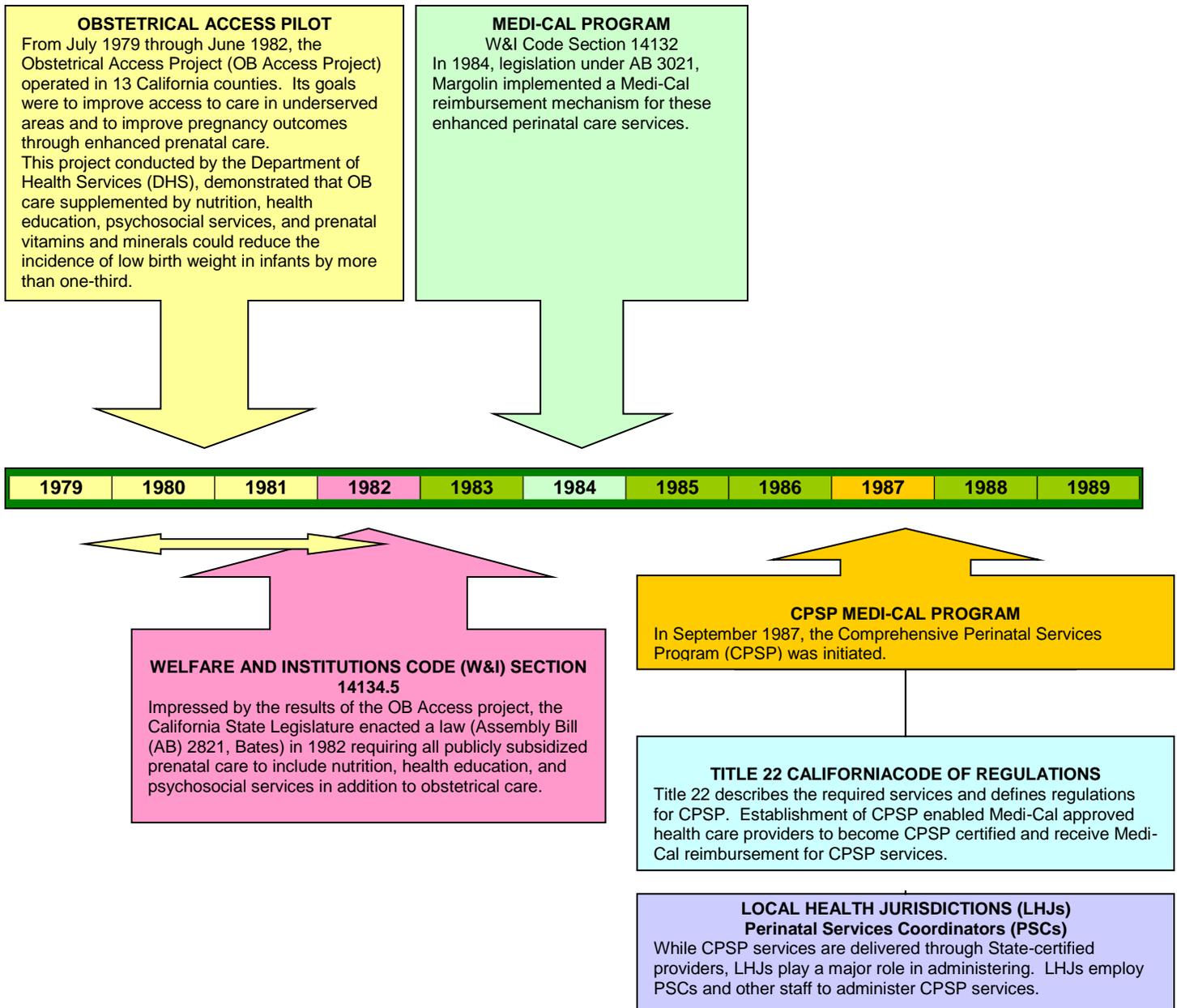
Perinatal Services by Region

There are four regions statewide: Northern Area Perinatal Advocates (NAPA), Central Area Perinatal Advocates (CAPA), Bay Area Perinatal Advocates (BAPA), and Southern Area Perinatal Advocates (SAPA). See the map below outlining the designated counties in each region.



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

California Perinatal Services Timeline



Perinatal Services Coordinator Role, Responsibilities and Activities

Overview

The PSC, under the direction of and in collaboration with the MCAH Director, works to improve birth outcomes by: 1) ensuring CPSP is administered according to regulations; and 2) implementing local best or promising practice strategies to improve perinatal systems of care. Each LHJ will have a PSC to oversee the implementation of CPSP. If an LHJ does not have a PSC, the MCAH Director is responsible for PSC activities. Please refer to the CPSP Provider Handbook, and Steps to Take Manual. MCAH also provides various types of trainings for providers and PSCs to assist them in implementing CPSP and improving systems of perinatal care.

Provider Handbook and Steps to Take Manuals:

<http://www.cdph.ca.gov/programs/CPSP/Pages/ProviderTrainingManuals.aspx>

Online Provider Training:

<http://www.cce.csus.edu/conferences/cpsp/training13/index.cfm?pid=227>

In-Person Training:

Through its contract with California State University, Sacramento, MCAH provides CPSP Provider and Practitioner Orientations at designated locations throughout the State. Information on upcoming trainings is available at: <http://www.cce.csus.edu/conferences/cpsp/training13/index.cfm?pid=226>. MCAH highly recommends that PSCs attend Provider Orientation trainings at least once a year.

The PSC assists with CPSP implementation by:

Administration

1. Providing training, consultation, and technical assistance to CPSP providers and Medi-Cal Managed Care plan staff on program implementation
2. Facilitating a process to assist providers to develop or revise protocols and train staff
3. Coordinating and facilitating a process to monitor the local CPSP program by conducting CPSP QI/QA activities that will address the following:
 - Barriers to perinatal care
 - Office/administrative systems to track client follow-up and completion of referrals, including postpartum care
 - Improving care coordination and resource utilization
 - Coordinating and conducting CPSP provider QI/QA site visits and providing technical assistance to improve care
 - Activities that may occur during site visits are:
 - i. Chart Reviews
 - ii. Administrative Review
 - iii. Observation and interview of staff
 - iv. Follow-up with the provider regarding their plan to address program deficiencies

Note: PSCs will defer questions to the Department of Health Care Services (DHCS) for the following:

- claim denials or reimbursement

- Interpretation of the Medi-Cal policy manual
- Non-CPSP related OB services

Note: PSCs will defer questions to the local Medi-Cal Managed Care Health Plans for the following:

- Coverage policies
- Eligibility requirements
- Service delivery
- Access to services

Medi-Cal Contact for Issues related to access to care or service delivery:

- PSCs should refer providers or Medi-Cal members who have questions, need assistance or need to report a problem to the Medi-Cal Telephone Service Center (TSC) with the following contact information: 1-800-541-5555
- The TSC can help with:
 - Learning how to apply for Medi-Cal
 - Learning about Medi-Cal services
 - Finding a health care provider
 - Filing a complaint
 - If a member wishes to report issues related to care access, they can e-mail Medi-Cal here
 - The following links can be accessed by either providers or Medi-Cal members for care-related information or concerns:
 - Medi-Cal Eligibility Frequently Asked Questions
 - If specific questions are not answered, they may contact If you do not find an answer to your question, please contact us at Medi-CalNow, or contact the local county office from Medi-Cal’s County Listings page.
 - For questions specific to Medi-Cal Managed Care, visit the Office of the Ombudsman webpage.
 - For questions specific to Mental Health Services, providers or Medi-Cal members can contact the Mental Health Ombudsman or the DHCS County Support Office. The phone contact information is 1-800-896-4042.

CPSP Provider Application and Enrollment

1. Ensuring the CPSP application form is available to prospective CPSP Medi-Cal providers
2. Providing consultation and technical assistance in the completion of the application process and development of site specific protocols
 - Verifying professional licenses during the application process
 - Verifying that providers are in good standing with Medi-Cal
 - Verifying that providers are eligible to enroll as CPSP providers, defined in Code of California (CCR) Regulations 51179.1 and Welfare and Institutions (W&I) Code 14134.5

3. Providing consultation to providers in the development of antepartum/intrapartum/postpartum and dual provider agreements as needed
4. Submitting and making final recommendation to state MCAH regarding provider application based on the following:
 - Completion of the application form including the signed checklist
 - Ability to provide CPSP services based on CCR 51249
 - Approve changes to a provider application as submitted to MCAH when appropriate

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 level are as follows:

1. Beneficiary level

- a. Perform activities that promote a strong safety-net support for pregnant and postpartum women (e.g. food security, shelter, housing, school placement)

Examples:

1. Deliver presentations about available perinatal services and resources to partner agencies such as WIC offices, schools, foster homes, care providers, CalWorks, community-based organizations and non-profit organizations such as faith based, Planned Parenthood, etc.
2. Identify underserved populations in need and provide information on topics to improve health outcomes for mothers, infants and their families, such as signs and symptoms of preterm labor and what to do if suspected, nutrition during pregnancy, infant and child development, breastfeeding and infant/child nutrition and physical activity
3. Collaborate with neighboring LHJs to address gaps in services and promote continuous care for clients who move or require specialized care
4. Develop a process, in collaboration with the Regional Perinatal Programs of California Coordinator, to coordinate continuity in the plan of care for high risk pregnant women
5. Implement activities to facilitate and increase access and linkage of eligible individuals to Medi-Cal or Medi-Cal related services, and other health or needed community services.
 - Participate in community events such as health fairs, health-related community presentations, MCAH meetings or presentations about local MCAH programs
 - Participate in the improvement of local triaging or referral system to streamline services and avoid duplication
 - Participate in internal MCAH meetings or presentations

2. Provider level

Examples:

1. Develop processes to raise awareness, such as round table discussions and workforce development trainings. Offer information on emerging issues affecting maternal and infant health to the community and providers. Topics may include local data findings, evidence-based practices to reduce maternal and infant mortality and morbidity, specialty care, and comprehensive perinatal services.
2. 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, etc.
3. Implement QI/QA activities such as technical assistance regarding client follow-up for referrals and adequate interagency agreements to promote coordinated care as appropriate
4. Facilitate the promotion of Text4baby and promote effective ways of communicating with clients

3. Community level

- a. Promote community partner formal or informal agreements to improve maternal and infant care coordination and collaboration

Examples:

1. Network and develop relationships with relevant partners to improve perinatal service delivery in any of the following areas:
 - Access to appropriate care
 - Share, expand, streamline and coordinate resources
 - Assessment, screening and referral practices
2. Conduct activities with local provider networks and/or health plans to improve perinatal access, service integration and coordination to meet complex needs

Examples:

1. Participate in trainings to promote professional development relevant to the Affordable Care Act, healthcare access and reduction of infant and maternal morbidity and mortality, such as life course, preconception health, and trauma-informed care.
2. Review, facilitate and implement a formal agreement with the local Medi-Cal Managed Care Plan.
3. Develop a collaborative relationship with the Medi-Cal Managed Care liaison by sharing strategies to improve perinatal care.

Meetings and Trainings

Attendance at state-sponsored PSC meetings is required as well as additional trainings.

PSCs are required to attend the following meetings or trainings to acquire the necessary skills to be successful in their job:

1. Annual state-sponsored PSC Meeting
2. State directed mandatory trainings related to perinatal systems of care
3. State sponsored Provider Orientation offered at a location near the LHJ at a minimum of once a year.
4. PSC orientations for new PSCs within 6 months of hire, if available. PSCs are encouraged to become familiar with MCAH Policies and Procedures, perinatal tools and resources, such as
 - Steps to Take Manual
 - Provider Handbook
 - CPSP website and resources
 - MCAH program Policies and Procedures Manual

Adequate funding for training and meeting expenses, including travel, must be built into the annual MCAH budget (refer to MCAH Fiscal Policies and Procedures Manual).

Provider Recruitment

The PSC maintains and manages a network of perinatal providers, including certified CPSP providers by: assessing local needs for providers, visiting Medi-Cal providers to inform them about CPSP, and assisting with the CPSP application process.

The goal is for providers to view the PSC as a knowledgeable partner and resource for delivering high quality perinatal care in the community who can provide up to date, unbiased information and assistance. MCAH Division has provided numerous resources on the CPSP and MCAH web sites that PSCs can use to engage providers regarding quality perinatal care. PSCs should take advantage of other resources on the MCAH web site to provide information to providers in their area as an entrée into the office, for example, the California Pregnancy Associated Mortality Review (CA-PAMR) report, Maternal and Infant Health Assessment (MIHA) survey results, SIDS risk reduction materials, MCAH Maternal Morbidity bulletin, Perinatal Mood and Anxiety Disorder screening information, March of Dimes resources and information and numerous other resources. The PSC can also share information on community resources for tobacco cessation, alcohol and drug treatment, and other social assistance.

Provider Application Process

The Title 22 California Code of Regulations §51249 specifies the application process for CPSP providers

Requirements for Prospective Providers

Prospective CPSP providers must be Medi-Cal providers in good standing before a CPSP application is submitted to the state. If the prospective provider is not yet a Medi-Cal provider, the PSC will refer them to Medi-Cal Provider Enrollment at: <http://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx>

CPSP Provider Application

The CPSP Provider Application and instructions (CDPH 4448/CDPH 4448a) for completing the application are located on the CPSP web page at:

<http://www.cdph.ca.gov/programs/CPSP/Pages/ApplicationforCertificationasaCPSPProvider.aspx>

NOTE: Refer to the CPSP Provider Application Instructions, found at the end of the application, for detailed step-by-step instructions for prospective providers completing the application.

The local **PSC** will consult with the prospective provider on program requirements and provide technical assistance in completing the application. A list of PSCs is located at:

<http://www.cdph.ca.gov/programs/CPSP/Pages/CPSPPerinatalServicesCoordinators.aspx>

The PSC may review the Provider Handbook with the prospective provider located at:

<http://www.cdph.ca.gov/programs/CPSP/Pages/ProviderTrainingManuals.aspx>

If a CPSP provider delivers services at another site on a part-time basis, employing the same staff, and using the same protocols, it is not necessary to submit a new application. In this case, they would bill for services using the NPI Number from the CPSP site on file with Medi-Cal.

If a CPSP provider opens a new CPSP site, they are required to submit a new application for that site. The provider may bill using the same NPI for multiple sites, but each site must have an application on file to ensure that adequate staffing and systems are in place.

If a CPSP provider purchases another CPSP practice and wishes to continue CPSP services, this provider must submit a new application for the new site. The PSC will then send the application to MCAH and also send notice to end–date the former provider after obtaining verification of ownership transfer.

Required CPSP Application Attachments

New CPSP applications require the seven attachments described below, which the PSC keeps in their local files. The PSC sends only the Application and the Checklist to MCAH:

1. **Prenatal Medical Record form(s)**—The prospective provider must attach a blank sample prenatal medical record form(s) used in his/her current practice.
2. **Individualized Care Plan**—The prospective provider must attach a blank Individualized Care Plan that includes obstetric, nutrition, psychosocial, and health education components.
3. **Assessment Tools**—These include:

- a. The Initial Assessment (individual or combined), trimester reassessments, and postpartum assessment examples are located on the CPSP web site:
<http://www.cdph.ca.gov/programs/CPSP/Pages/LHJPerinatalServicesCoordinatorInformation.aspx>
 - b. Weight gain grid(s), and the 24-Hour Diet Recall or Food Frequency Questionnaire, are located on the CPSP web site:
<http://www.cdph.ca.gov/pubsforms/forms/Pages/MaternalandChildHealth.aspx>
4. **General Description of Practice (DOP)**—The DOP provides details on how the prospective provider will incorporate the enhanced CPSP services into their practice, clinic, and/or organization. The entity must include a description of how the practice, clinic, and/or organization will provide CPSP services for the obstetric, health education, nutrition, and psychosocial services.
5. **Delivery Hospitals**—Include the name(s) and address(es) of the delivery hospital(s).
6. **Recommended Referrals**—Include the names and addresses of the agencies that provide Title 22 required referral services. The five required referrals are:
- a. Child Health and Disability Program (CHDP)
 - b. Family planning services (Family PACT)
 - c. Supplemental Nutrition Program for Women, Infants, and Children (WIC)
 - d. Genetic services
 - e. Dental services

Recommended Referrals as needed:

- a. Mental health
 - b. Domestic Violence
 - c. Food and Housing Assistance
7. **Agreements (See additional information below)**—These include:
- a. Antepartum /Postpartum Agreement
 - b. Intrapartum Agreement
 - c. Dual Provider Agreement

Provider Agreements

Agreements are to be kept on file with the providers involved and the LHJ.

In order to ensure continuous, safe, quality, comprehensive perinatal care for CPSP patients, Antepartum/Intrapartum/Postpartum Agreements and dual provider agreements are required to ensure that if the CPSP provider does not propose to provide these services themselves, then there is an agreement with a provider who will provide the services to the CPSP patient in accordance with the CPSP standard of care. If a provider other than the CPSP Provider will be responsible for performing and billing for Antepartum/Intrapartum/Postpartum services, this must be addressed in the Agreement.

a. An Antepartum/Postpartum Agreement should include, but is not limited to:

1. A list of the antepartum/postpartum services each provider will deliver
2. Agreement and procedures for emergency patient care
3. Name of the appropriate delivery hospital based on risks where obstetric provider has privileges
4. Provision for referrals to other specialty perinatal providers for women identified to be at risk during delivery or at risk to deliver a low birth weight infant
5. How patients will obtain all required CPSP services
6. Case coordination agreement
7. Procedures for access to and transfer of medical records between providers, including support service assessments, during ante-, intra- and postpartum periods
 - a. Responsibility for signing off and explaining the patient's rights and responsibilities document
 - b. Scope of mutual responsibility for patient care, including supervision of practitioners
8. Agreement of joint review of patient chart and care plan
9. Specification of mutual billing responsibilities to assure accurate, timely, and complete billing
10. Any other provisions deemed prudent by the providers to assure patient safety and improve the quality of perinatal care
11. Agreement is signed and dated by all providers involved

b. An Intrapartum Agreement should include, but is not limited to:

1. Name of the delivery hospital where obstetric provider has privileges
2. Antepartum transfer of care of the patient by the CPSP provider to the intrapartum care provider
3. Acceptance of the patient for care by the intrapartum provider
4. Postpartum transfer of care back to the CPSP provider
5. Antepartum transfer of medical records by the CPSP provider to the intrapartum provider
6. Postpartum transfer of medical records by the intrapartum care provider to the CPSP provider
7. Procedures for emergency patient care
8. Scope of mutual responsibility for patient care, including supervision of practitioners
9. Agreement of joint review of patient chart and care plan
10. Procedures for access to and transfer of medical records between providers, including support service assessments, during ante-, intra- and postpartum periods
11. Agreement to provide services according to provider protocols, as defined in Title 22, CCR, and Section 51179.9.

12. Any other provisions deemed prudent by the providers to assure patient safety and improve the quality of patient care
13. Specification of mutual billing responsibilities
14. Agreement is signed and dated by all providers involved

c. A Dual Provider Agreement should include, but is not limited to:

A Dual Provider Agreement (DPA) is needed anytime two CPSP providers are simultaneously providing CPSP services. For example, one provider may deliver OB services and another may deliver nutrition, psychosocial and health education assessment and intervention. Dual Provider Agreements are implemented when a specific documented OB access problem exists for pregnant women on Medi-Cal. These agreements are made at the local level by the CPSP providers involved.

A dual provider agreement should describe the following:

1. The reason for the dual provider agreement
2. The relationship and specific responsibilities of each provider ,
3. The flow of patient services
4. Process for continuity of care, management and care coordination of high risk needs, intrapartum, antepartum, delivery and postpartum.
5. How charting and patient information will be shared and communicated among all providers
6. Process for joint review of patient chart and care plan
7. Procedures for access to and transfer of medical records between providers, including support service assessments, during ante-, intra- and postpartum periods
8. Procedures for emergency patient care
9. Any other provisions deemed prudent by the providers to assure patient safety and improve the quality of patient care
10. Specification of mutual billing responsibilities
11. Agreement is signed and dated by all providers involved

Steps for Application Review:

During the provider application review, the PSC will track applications by documenting the following:

1. Notify the provider stating the PSC has received the CPSP application. The PSC keeps a copy for their files.
2. Document that the seven required attachments referenced above are included with the original application. Indicate your **recommendation** on the provider application.
3. Complete the bottom section of the CDPH 4448 (for PSC use only).
4. The date of CPSP provider enrollment should be within 30 calendar days of receipt of application; Inform the applicant in writing that the application is complete and acceptable or that the application is deficient and what specific information or clarification is necessary.
5. If the PSC recommends a provider CPSP enrollment date before the date that provider's application is deemed completed, the PSC must submit additional documentation justifying the provider's retroactive enrollment. CDPH MCAH will make the final determination whether a retroactive provider enrollment is acceptable, based on documents attached and individual circumstance. PSC signs and dates the application.
6. Once the PSC has received and made a recommendation on the final application packet, scan and email the signed application along with the checklist or send via postal mail to the MCAH CPSP analyst at:
California Department of Public Health
Maternal, Child and Adolescent Health
1615 Capitol Ave, MS 8306
P.O. Box 997420
Sacramento, CA 95899-7420
7. Keep copies of the application and the seven attachments at the local level.
8. Notify the provider of the application status and keep the copy in the PSC's file

Online Credential and Education Verification of CPSP Providers and Practitioners

Title 22, §51279 (See Provider Handbook Appendix for CPSP Title 22 regulations) provides specific criteria to use when reviewing provider applications. These include a thorough review of the providers' licensing authority for any revocations, suspensions, or restrictions. The PSC reviews the staff listed on pages two and three of the CDPH 4448 and **verifies all staff licenses**. Please use the On-Line Verification of CPSP Practitioners table available at the link below to guide verification of staff licenses.

<http://www.cdph.ca.gov/programs/CPSP/Documents/MO-CPSP-OnlineLicenseVerificationForm.pdf>

Physicians:

http://www.mbc.ca.gov/Breeze/License_Verification.aspx

Suspended and Ineligible Provider List:

<http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp>

Regulations: Title 22 CCR 51179.7, subsections (6), (7) and (9).

A comprehensive perinatal practitioner means any one of the following:

Social Worker

If the social worker is licensed, verify the license through their licensing board. If the social worker is not licensed, confirm the practitioner's eligibility by verifying that the schools attended are accredited under Title 22 California Code of Regulations. Only Master's prepared social workers defined in CCR, Title 22 51179.7 (a)(6)(A) or 51179 (a)(6)(B), along with one year of experience in the field of maternal and child health, may serve as consultants and approve protocols, along with the other required disciplines.

Requirements according to Title 22:

A social worker who either:

A. Holds a Master's Degree or higher in social work or social welfare from a college or university with a Social Work Degree program accredited by the Council on Social Work Education and who has one year of experience in the field of Maternal and Child Health,

or

B. Holds a Master's Degree in psychology or Marriage, Family and Child Counseling (or Marriage and Family Therapy [MFT]) and has one year of experience in the field of Maternal and Child Health,

or

C. Holds a Baccalaureate Degree in social work or social welfare from a college or university with a Social Work Degree program accredited by the Council on Social Work Education and who has one year experience in the field of Maternal and Child Health.

Website: The Council on Social Work Education's website is

<http://www.cswe.org/Accreditation/Accredited-Programs.aspx>

You will need to research the "Accredited Programs" link.

Health Educator: Confirm the practitioner's eligibility by verifying that the schools attended are accredited as required by Title 22 California Code of Regulations. Only Master's prepared health, Educators, defined in CCR, Title 22 51179.7(a)(7)(A) may serve as consultants and approve protocols along with the other required disciplines.

Requirements according to Title 22:

A health educator who either has:

(A) A Master's Degree (or higher) in Community or Public Health Education from a program accredited by the Council on Education for Public Health and who has one year of experience in the field of Maternal and Child Health,

or

(B) A Baccalaureate Degree with a major in Community or Public Health Education and who has one year of experience in the field of maternal and Child Health.

Website: The Council on Education for Public Health's website is <http://www.ceph.org>

You will need to research the "Accredited Schools of Public Health and the Graduate Public Health Programs" link.

Registered Dietitians:

Requirements: Dietitians must be registered by the Commission on Dietetic Registration, the credentialing agency of the Academy of Nutrition and Dietetics (formerly, the American Dietetic Association), and must have one year of experience in the field of perinatal nutrition. Registered Dieticians may approve protocols along with the other required disciplines.

Website: Commission on Dietetic Registration: <https://secure.eatright.org/CGI-BIN/LANSAWEB?PROCFUN+PRWEB18+P18FN01+PRD+ENG>

Scroll down to the bottom of the page and click “I Accept”

On the next screen click “Other” and type in your e-mail address.

On the next screen enter the RD’s 6 digit number and select the state

Click “Submit”

Licensed Vocational Nurses: Must be licensed and have one year of experience in the field of Maternal and Child Health. Verify the license at the Board of Vocational Nursing Website: <https://www.breeze.ca.gov/datamart/loginCADCA.do;jsessionid=04E54BC63B074780D5BC13400A989C12.vo1> and fill in the on line form.

Suspended or Revoked License:

CPSP providers listed on the application must not have suspensions, restrictions, or revocations placed on their license by the Medical Board of California. Any provider who has been placed on probation will have their CPSP application denied until the period of probation is satisfactorily concluded. The provider can re-apply to become a CPSP provider after their probation period ends.

State Application Processing

The CDPH Maternal, Child, and Adolescent Division staff will track the CPSP application and notify the PSC it has been received; enter the application into our database and send a transmittal to Medi-Cal, once approved. State MCAH will scan and send an electronic copy to the PSC and a hard copy letter to the new CPSP provider indicating the effective date that the provider is approved to be enrolled in CPSP. This means that the provider is able to provide CPSP-related services to eligible clients. **The PSC must inform the new CPSP provider to contact the Provider Enrollment Division before CPSP related services are billed to ensure that the CPSP, new category of service, is applied to the provider's NPI.** The provider must bill under the National Provider Identifier (NPI) submitted on the CPSP application.

CDPH MCAH has 60 calendar days from receipt of a completed application to reach a decision and send written notification to the applicant regarding the decision to approve or deny the application for participation as a comprehensive perinatal provider. If the application is denied, the written notification of the denial will contain the basis for the denial.

Provider Application Changes

CPSP providers will often update previously approved applications as needs change within the providers' practice. Application updates will be submitted by the provider to the local PSC. The PSC will review the updated provider application information and approve the changes. Most provider changes, such as changes in staffing, description of practice, protocols, assessment forms, and provider agreements, will be kept at the local level.

The following application changes must be sent to state MCAH:

- Provider name
- Address
- Ownership

These changes may be sent electronically or through the mail to the CPSP analyst. **The PSC should also verify with the provider that these changes have been made at Medi-Cal**

A change in a provider's NPI number requires a new CPSP application.

In addition, if a provider wants to end-date their status as a CPSP provider, the PSC should send an End-date memo to the CPSP analyst electronically or through e-mail. When sending through e-mail, please ensure to send this securely by using [secure] on the subject line at:

California Department of Public Health
Maternal, Child and Adolescent Health
1615 Capitol Ave, MS 8306
P.O. Box 997420
Sacramento, CA 95899-7420

Inactivating a CPSP Provider (End-Date Memo)

Inactivating a CPSP provider terminates their ability to bill for CPSP services. Notification in **hardcopy or electronic** form shall be submitted by the PSC to the state CPSP under the following circumstances:

PSCs will notify MCAH Program of the following:

1. The CPSP provider is no longer delivering CPSP services due to death or retirement
2. The CPSP Provider has ceased offering and providing CPSP services
3. The provider is no longer enrolled in Medi-Cal because he/she was terminated or deactivated

The CPSP provider must notify the PSC in writing that he/she wishes to cease providing CPSP services. The letter must include the following information:

- (a) Provider name,
- (b) Provider address, and
- (c) NPI number

MCAH staff will inactivate the provider in the CPSP database and send an electronic copy of the End Date Transmittal to the Provider Enrollment Division (PED) to inactivate the Category of Service 092, which is the code the provider uses to bill for CPSP services. MCAH staff will also send a copy of the transmittal to the PSC.

It is the responsibility of the PSC to notify the provider that they are no longer able to bill for CPSP services by sending a copy of the End Date Transmittal to the provider using a **return receipt service**. The PSC must also keep documentation that the provider received the End Date Transmittal notification in the local file.

Site-Specific CPSP Protocols

A CPSP provider must develop written protocols for each enhanced service – nutrition, health education and psychosocial – *within six months* of being approved as a CPSP provider. MCAH recommends yearly and as needed review and update of the protocols following approval.

Protocols must clearly describe a system of care from entry of care through postpartum, coordinated in the provider’s specific setting. The protocol specifies assessment, reassessment every trimester at a minimum, postpartum assessment, care planning, interventions, including the use of individual or group activity approach, referral mechanisms, case coordination, and the criteria and standards to measure and monitor quality of care. A provider’s protocols must reflect their current CPSP site practices, policies and procedures. CPSP staff members are required to follow their site-specific protocols when delivering CPSP services. Please see the Provider Handbook for more information on developing site-specific CPSP protocols.

CPSP services must be provided by or under the personal supervision of a physician.

California Code of Regulations, Title 22, Section 51179.5 **defines personal supervision** as “evaluation, in accordance with protocols, by a licensed physician, of services performed by others by direct communication, either in person or through electronic means.” Effective for dates of service on or after June 1, 2012 each provider’s protocols must define how personal supervision by a physician occurs and is documented. Please see the Medi-Cal manual: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/pregcom_m00o03.doc

Comprehensive Perinatal Health Workers (CPHWs) must work under the direct supervision of a physician, (Title 22, Section 51179.7(a)(10)(B). The protocols must define how direct supervision of CPHWs by a physician occurs and how this should be documented. Direct supervision may necessitate having an on-site physician or a physician being offsite but “available” to immediately furnish assistance and direction if needed.

If the provider offers group classes the protocols should include: (1) an outline for each class offered, including learner objectives, content, methodology, and methods of evaluation, (2) a blank sign-in sheet with space for date, instructors name and topic. The provider must keep the completed documentation for each class in a designated secure location.

Developing New Protocols

The PSC should provide consultation and technical assistance to the provider in developing protocols. Newly developed site-specific CPSP Protocols, not based on a sample protocol, must be reviewed and signed by a health educator, dietitian, and social worker consistent with CCR, Title 22, 51179.9 Protocol requirements. Providers must identify health education, nutrition and psychosocial consultants in the appropriate boxes on the application who are available for consultation for each discipline.

Using Existing Protocols

If a provider plans to use an existing protocol on a new site and contracts with new consultant/s, the new consultant/s do not need to sign off on existing protocols unless significant changes will be identified at the time of the CPSP provider application. Protocols should be developed, approved and adopted within 6 months of the effective date of provider approval as a CPSP provider (CCR 22 51179.9 Protocol).

When new consultants are employed at the time of the provider enrollment application, the names of those consultants should be reflected on the application form. When there are no changes to the consultants employed at the time of the application and existing protocols are used, the names of those consultants should still be listed on the application form.

New providers who use protocols that have been previously signed off by a health educator, dietitian, and social worker do not need to have them signed again. Include a statement on the application “Based on [year] XXX LHHJ Protocols”. The application must still list consultants for complex nutrition, psychosocial of health education needs.

Protocol Development – Using Previously Approved Sample Protocols

Providers may use protocols that have been previously signed off by nutrition, psychosocial and health education consultants to develop their site-specific protocols. If a provider chooses to do this, he/she must use the assessment forms that are aligned with the chosen protocols. The PSC may provide sample forms and protocols to the provider. When using protocols that have been previously signed off, the provider must tailor them to be specific for the practice site (for example, specify local referral resources and the specific staff in the practice that conducts assessments). The PSC may assist the provider with making these changes.

Client Orientation

It is highly recommended that each client receive a complete orientation to CPSP services before receiving any additional CPSP services. A complete orientation includes what services will be provided, who will provide the services, where to obtain the services, when the services will be delivered, procedures to follow in an emergency, patient's rights, and notification that participation is voluntary. Additional orientation may be billed throughout the pregnancy and postpartum. Clients may receive group perinatal education (Z6412) before the initial health education assessment is completed.

Assessments, Reassessments, Referrals and Individualized Care Plans

Per Title 22, Section 51348.1, obstetrical services for CPSP clients shall be provided in conformance with the most current ACOG guidelines for perinatal care.

The PSC is available to assist CPSP providers with the requirements for Assessment and Reassessment; Individualized Care Plans; and Referrals.

Assessments

Obstetric, health education, nutrition and psychosocial are the domains to be assessed. The provider must complete an initial assessment in the four components, obstetric, nutrition, health education and psychosocial within 4 weeks of the initial visit, and a postpartum reassessment; the providers must offer a reassessment in the second and third trimesters. The assessments will be signed by the staff person completing the assessment.

The purpose of these assessments is to provide a baseline of information about the client, generate an ICP, provide information in identified areas of need, provide referral(s) if the provider is unable to address the identified need. Additionally, the assessment process identifies the client's strengths, risks, and needs related to her health and well-being during pregnancy.

Each assessment is completed by a CPSP practitioner in a face-to-face interview with the client. During the initial assessments, the CPSP practitioner gathers baseline data and asks questions to obtain information concerning the client's health and pregnancy, risk conditions/problems, her readiness to take action and resources needed to address the issues identified.

There are two assessment and reassessment forms that providers may use as an example and are located on the CPSP website (link below): a Separate Assessment and Care Plan, and a Combined Assessment and Care Plan.

Providers may use other assessment forms, if they contain all the elements in the State recommended assessment, reassessment, and postpartum forms.

Individualized Care Plan (ICP)

The CPSP practitioner and client use the information gathered during the assessments to develop an individualized ICP based on the client's unique risk conditions, strengths and needs. The ICP is developed for each CPSP client after the initial assessment and updated after each prenatal visit and at least every trimester as well as at the postpartum visit. The ICP should provide documentation of the follow-up on identified risks or needs. The ICP will be signed by the staff person completing the ICP.

All recommended forms are located here:

<http://www.cdph.ca.gov/programs/CPSP/Pages/LHJPerinatalServicesCoordinatorInformation.aspx>

Referrals

CPSP providers are required to make the following five program and service referrals as needed: Women, Infants, and Children (WIC) Supplemental Nutrition Services Program; genetic screening; dental care; Childhood Health and Disability Prevention Program (CHDP); and family planning, such as Family, Planning, Access, Care, and Treatment (Family PACT). A complete referral includes clear

instructions and a completed form if required, instructions as to where to obtain the service, and follow up to assure that the client received the service.

WIC: To make an effective referral to WIC, the provider should do the following:

- Fill out the referral form completely
- Give it to the client with the address and contact information of the WIC office most convenient to the client
- Follow up in subsequent visits to confirm that the client received the services and is continuing to do so.

Referral forms for WIC are in the Provider Handbook and are also available online at:

<http://www.cdph.ca.gov/programs/wicworks/Pages/WICForms.aspx>

Genetic Screening information is available on the CDPH Web site at

<http://www.cdph.ca.gov/programs/GDSP/Pages/default.aspx>. There is extensive patient information in multiple languages. Providers must offer Prenatal Screening. If the client screens positive, the provider should refer the client to a state approved Prenatal Diagnosis Center, where the woman can receive genetic counseling and other follow-up services free of charge. Please see the California Prenatal Screening Program materials at: <http://www.cdph.ca.gov/programs/PNS/pages/default.aspx> Newborn Screening is completed at the hospital.

Dental Referrals: There is a Dental Referral form in the Provider Handbook Appendix. Providers should complete this form, give it to the client along with contact information for a dental office that provides dental care to pregnant women, and follow up at subsequent visits to assure that the client was able to obtain the services.

CHDP: The CHDP Referral Form and instructions are available at this link:

<http://www.dhcs.ca.gov/services/chdp/Pages/default.aspx>

Family Planning: If a woman has full scope Medi-Cal or Medi-Cal Managed Care, family planning services are covered after the postpartum period. If a woman is undocumented, and income eligible, refer her to a Family PACT provider for further service after the postpartum period. The provider may continue providing services under Family PACT after the postpartum period if the provider is a Family PACT provider. For more information, see the Family PACT web site: <http://www.familypact.org/>

Case Coordination:

Case Coordination is implementing a system to assure that team members work together with the client to assure that the care plan is completed and the client receives the comprehensive perinatal services she needs. A Case Coordinator communicates with the client, modifies the ICP as the client's needs change, assists the client with practical arrangements, assures that results of tests and referrals are recorded in the client's chart, tracks the client's attendance at appointments, assures that all information is in the client's chart, and ensures that the hospital receives copies of the prenatal record and that the hospital provides intrapartum records to the provider to facilitate postpartum care. Case coordination may require case conferences or other communication involving team members regarding the patient's care.

Quality Improvement (QI) and Quality Assurance (QA) Activities:

The PSC assists providers in developing an internal QI/QA plan to monitor the implementation of CPSP within the practice. MCAH recommends that the LHJ use a staff member with clinical licensure (PHN, RN) to carry out clinical QI/QA functions. PSCs employed before November 2011 are exempt from this recommendation.

Local PSCs have the right to conduct QI/QA activities with their providers as part of CDPH/MCAH monitoring authority over CPSP, stipulated under the Welfare and Institutions Code 14134.5 (i).

There are four mechanisms by which the PSC monitors QI/QA within CPSP.

1. The first is through ongoing provider education about CPSP implementation through on-site trainings and technical assistance visits, orientation of new staff, provider meetings and local roundtables.
2. The second mechanism is to conduct face-to-face QI/QA visits to CPSP provider offices to assess, maintain, or improve the quality of CPSP services and assure appropriate care. The QI/QA visits may involve the following or a combination of:
 - Chart Reviews – The local PSC, through CDPH, has the requisite legal authority to review individual patient health records in the CPSP provider medical offices, based on “public health activities” and “health oversight activities” (45 C.F.R., § 164.512(b)) , (45 C.F.R., § 164.512(d)) and Civil Code, Section 56.10.

Purpose:

- Provide opportunity to evaluate, provide technical assistance and improve the provider’s process of implementing CPSP based on client needs, site protocols and CPSP mandated requirements.
 - Assist providers in assessing client barriers and opportunities to improve early access to quality and comprehensive perinatal care
 - Provide opportunity to engage with providers to identify ways of improving documentation, case coordination, client follow-up and management
3. Administrative Review – The local PSC, through CDPH, has the requisite legal authority to establish a community perinatal program whose responsibilities include monitoring providers of comprehensive perinatal services, Welfare and Institutions Code 14134.5.

Purpose:

- Assist the provider to implement a quality CPSP program, including identification and provision of technical assistance on the following :
 - Adequacy of community resources
 - Review of policies
 - Development of protocols
 - Integration of activities that reflect evidence-based best or promising practices to improve quality perinatal care or early access to care
 - Address safety-net support for pregnant and postpartum women (e.g. food security, shelter, housing and school placement)

- Assist provider to identify and address barriers to improve quality perinatal care including early entry into prenatal care
 - Assist providers to improve office/administrative systems to track client follow-up and completion of referrals
 - Improve care coordination and resource utilization
4. Staff Interview and observation of any CPSP–related service activity (education classes, case coordination, etc.)

Follow-up to a QI/QA Visit:

This visit involves activities that assist providers to develop strategies that support quality comprehensive delivery of perinatal services to women. Those activities may include but not limited to the following:

- The PSC provides technical assistance regarding QI/QA activities to address deficiencies identified during the QI/QA site visit.
- The PSC assists the providers with following approved program protocols to ensure the provider is offering patients the proper level of prenatal care.
- The PSC provides the provider with a written report and corrective action plan (CAP) as needed. A timeline for completing the CAP will be given to the provider.
- If the provider is not complying with CPSP program requirements based on regulations, provide the necessary technical assistance and document the issues and results. If follow-up visits show no improvement, the PSC should notify their assigned Nurse Consultant for further guidance.

Electronic Health Records (EHR)

Overview

This is an overview of Federal and State efforts to implement Electronic Health Records (EHRs). This information is provided only as a PSC reference. PSCs are not expected to be experts in EHR development, only in assisting providers to ensure that EHR systems include what needs to be documented in order to assess compliance with Title 22. It is the provider's responsibility to make sure they can demonstrate compliance whether in a paper or electronic chart. The PSC can provide their programmatic expertise to help guide the provider in this process, but it is the provider's responsibility to make sure the system will be functional.

The Office of the National Coordinator is leading Federal efforts to implement Electronic Health Records. The web site is: <http://www.healthit.gov/newsroom/about-onc>

The Health Resources and Services Administration has an excellent web site at <http://www.hrsa.gov/healthit/index.html> that includes helpful links to:

- EHR selection guidelines
- Webinars
- Regional Extension Centers
- Health IT and Quality
- Toolboxes

The Center for Medicare and Medicaid Services (CMS) is working to encourage providers to adopt EHRs by providing incentives and support to providers and supporting health IT workforce training. Information on the EHR incentive program is available at:

<https://ehrincentives.cms.gov/hitech/login.action>

Registration for the EHR incentive program began January 3, 2011. Providers may register before they have a system installed. Eligible professionals may qualify for incentive payments if they adopt, implement, upgrade (AIU) or demonstrate meaningful use (MU) in their first year of participation. They must successfully demonstrate meaningful use in subsequent participation years to receive additional payments. **The Medicaid incentive program is dependent on individual States.** Medi-Cal is developing a system to manage incentive payments for California's eligible providers. **The most current information specific to California** is available at: <http://medi-cal.ehr.ca.gov/>.

Eligible EHR systems are listed on the Office of the National Coordinator web site in a searchable format at: <http://onc-chpl.force.com/ehrcert>

Meaningful Use (MU)

Eligible systems must enable MU, which includes:

1. The use of a certified EHR in a meaningful manner, such as e-prescribing.
2. The use of certified EHR technology for electronic exchange of health information to improve quality of health care.
3. The use of certified EHR technology to submit clinical quality and other measures.

MU includes both a core set and a menu set of objectives that are specific to eligible professionals.

For more information on MU, review the following web site: <https://www.healthit.gov/providers-professionals/meaningful-use-definition-objectives>

Medicaid (Medi-Cal) professionals may qualify for incentive payments if they adopt, implement, upgrade or demonstrate meaningful use in their first year of participation. They must successfully demonstrate meaningful use for subsequent participation years.

Clinical Quality Measures (CQMs)

To participate in the Medicare and Medicaid EHR Incentive Programs and receive an incentive payment, providers are required to submit CQM data from certified EHR technology. Please review this website for information about CQMs. <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/ClinicalQualityMeasures.html>

Recommended Core Measures are listed at the following link:

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Recommended_Core_Set.html

The quality measures applicable to CPSP clients are:

Controlling High Blood Pressure

Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

Documentation of Current Medications in the Medical Record

Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up

Closing the referral loop: receipt of specialist report

PSC Responsibilities Regarding EHRs

This section provides information for PSCs when evaluating the CPSP components of the EHR.

The documentation and service delivery requirements for CPSP are the same whether a provider has electronic or paper records. These requirements are listed in Title 22 of the California Code of Regulations, and interpreted in the CPSP Provider Handbook, Steps to Take Guidelines, the orientation, assessment and Individualized Care Plan (ICP) forms, and each provider's protocols. It is important that the EHR facilitate the CPSP work flow in each provider office.

PSC Responsibilities:

1. The PSC should evaluate the contents of the EHR using an approved set of CPSP forms as a guide. PSCs are encouraged to consult with their Nurse Consultant regarding proposed changes in the content of assessments.
2. The PSC can only have access to information on patients who received CPSP services to ensure that services are provided and providers follow CPSP standards/statutes.
3. In order to be in compliance with the Health Insurance Portability and Accountability (HIPAA) regulations, it is highly recommended that navigation of the EHR system during a QI/QA chart review is conducted by the provider staff. If this is not possible, the PSC may ask the provider to print out needed CPSP documentation during the QI/QA review.

The provider is responsible for the full functionality of the CPSP EHR system. If a CPSP provider implements a CPSP EHR that is not functional, it may be difficult to conduct QI/QA to assure implementation of CPSP in accordance with Title 22. Forms that are scanned into an EHR will not allow sufficient functionality to meet MU requirements, and may make it difficult to access the

information to conduct CPSP QI/QA activities. Please see the “EHR Overview” section above for information on Meaningful Use, and Title 22 and MCAH CPSP Policies and Procedures and Scope of Work for CPSP QI/QA requirements.

The following questions can assist providers evaluate the functionality of CPSP EHRs. If a provider has already implemented an EHR system, these questions can be useful for planning system upgrades.

1. Does the EHR document CPSP client orientation, initial assessments, 2nd and 3rd trimester reassessments, postpartum assessments, and ICPs in all four domains (obstetric, psychosocial, nutrition, and health education) as required by Title 22?
2. Does the EHR generate reports that will enable the provider and PSC to conduct QA to monitor delivery of services and outcomes?
3. Does the system recognize risk conditions from the assessments, reassessments, and postpartum assessments?
4. Will the system automatically populate the ICP with information from the assessment results/risks/problems and link to appropriate:
 - Site specific CPSP protocols
 - CPSP Steps to Take Guidelines
 - STT Patient handouts
 - Resources/Referrals
5. Will the system automatically populate applicable lab results in the CPSP assessments as well as other appropriate locations in the EHR?
6. When the height and weight are entered into the system, will the system automatically select and plot the correct weight gain grid (a generic weight grid is not acceptable)?
7. Is the system user friendly to enable the provider to easily review previous assessment results, and the ICP before conducting a reassessment or postpartum assessment?
8. Does the system recognize CPSP services, including time spent, to enable correct billing and can it easily implement coding changes?
9. Is the vendor able to make regular system upgrades at a reasonable price to incorporate CPSP program enhancements?

Record Retention

Provider applications and supporting documentation must be kept for a period of 3 years for audit purposes.

Retention of CPSP client health information records must follow the Welfare and Institutions (W&I) Code 14124.1. Thus, each provider of health care services rendered under the Medi-Cal program must retain the records of Medi-Cal patients for 3 years after the date of last service. Health information records of minors shall be kept until they are over the age of 18.

Medi-Cal

Medi-Cal Fee for Service

The Fiscal Intermediary (FI) Telephone Service Center (TSC) is one of Medi-Cal's main sources to assist providers with information, technical support, claims and billing inquiries. PSCs are not qualified to offer complex solutions nor are they experts in solving provider billing and reimbursement issues. The PSC's primary role is the programmatic aspect of CPSP and building a comprehensive perinatal services system.

Getting Help with Medi-Cal Billing

To make Medi-Cal billing easier, the Medi-Cal fiscal intermediary processes claims and offers these services to enrolled CPSP providers.

The Telephone Service Center

1-800-541-5555

The Telephone Service Center (TSC) is the first line of communication between providers and the DHCS Fiscal Intermediary (Xerox). TSC is staffed by knowledgeable telephone agents who can assist providers with:

- Medi-Cal billing policies and procedures
- Correct completion of claim forms, Claims Inquiry Forms (CIFs),
- Appeal forms, and Resubmission Turnaround Documents (RTDs)
- Claim denials
- Status of CIF, Appeal, and Over-One-Year claims

Small Provider Billing Unit

This is a free, full-service billing assistance program for providers with low claim volumes. However, providers must apply for permission to use this line. It is available to only a limited number of providers at any one time.

To reach the Small Provider Billing Unit, dial the Telephone Service Center at 1-800-541-5555, press 0 and ask the operator to be connected with extension 1275 or call (916) 636-1275.

Research and Correspondence Unit Correspondence Specialist (CSU)

The CSU specializes in various claim types and conducts in-depth research. Providers may write directly to CSU (P.O. Box 13029, Sacramento, CA 95813) for clarification about recurring billing issues that have not been resolved through the following:

- Claims Inquiry Form (CIF)
- Appeal process that has resulted in claim denials

Outreach and Education (O&E)

The Provider Outreach and Education (O&E) Department consists of 21 Regional Representatives who live and work in cities throughout the State of California and perform the following tasks:

- Assist in resolving complex provider billing issues
- Research high-profile issues referred by DHCS
- Provide billing training to providers and their staff
- Conduct specialized billing workshops
- Conduct/attend Medi-Cal Provider Seminars
- Conduct Webinars
- Recorded WebEx Trainings
- eLearning Tutorials

Billing Seminars

There are seminars that cover Medi-Cal's obstetric and CPSP billing and reimbursement policies. Providers are encouraged to watch the monthly bulletins for date, time, and location of billing seminars. The Medi-Cal Learning Portal is the new, easy-to-use, one-stop learning center for Medi-Cal billers and providers. First-time users must complete a one-time registration to have access to the MLP's easy-to-use resources, such as online tutorials, live and recorded webinars from the convenience of your own office and register for Provider Training Seminars.

Access the Medi-Cal Learning Portal at this website: <https://learn.medi-cal.ca.gov/>

Other Resources:

Medi-Cal web site: <http://medi-cal.ca.gov/>

Claims and Billing: <https://files.medi-cal.ca.gov/pubsdoco/contact/services.asp>

Provider Enrollment Division: <http://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx>

Fee-for-Service billing codes: http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp?pg=&PgDwn=Yes&hURL=&qu=comprehensive+perinatal+services+program&Action=Go#top_search

Medi-Cal Managed Care

Medi-Cal Managed Care (MCMC) plans exist in all 58 California counties. The PSC must be aware of the type of MCMC plan that exists in their respective LHJ. The types of plans include County Organized Health Systems, Geographic Managed Care, Two-Plan Model, Imperial, San Benito and Regional Models. Please see the link to the Medi-Cal Managed Care website at:

<http://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx>

In County Organized Health System counties, DHCS contracts with a health plan created by the County Board of Supervisors. Local government, health care providers, community groups, and Medi-Cal beneficiaries are able to give input as the plan is created. The health plan is run by the county. In a COHS county, everyone is in the same managed care plan.

In Geographic Managed Care counties, DHCS contracts with several commercial plans. This provides more choices for the beneficiaries, so the health plans may want to try new ways to enhance how they deliver care to members.

In most Two-Plan model counties, there is a “Local Initiative” (LI) and a “commercial plan” (CP). The Department of Health Care Services (DHCS) contracts with both plans. Local government, community groups and health care providers are able to give input when the LI is created. The LI is designed to meet the needs and concerns of the community. The CP is a private insurance plan that also provides care for Medi-Cal beneficiaries.

In the Imperial and San Benito models, DHCS contracts with three managed care plans to provide medical services to most residents in these counties. DHCS contracts with Anthem Blue Cross in San Benito County and California Health and Wellness Plan and Molina Healthcare of California Partner Plan, Inc., in Imperial County.

Under the Regional Model, DHCS contracts with Anthem Blue Cross and California Health and Wellness Plan to deliver services to enrollees in these counties.

Medi-Cal Managed Care Health Plan Directory lists the health plans in each county:
<http://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx>

The PSC should work closely with MCMC staff in their local area to provide technical assistance and assure that CPSP services are available and accessible to all pregnant women. The map at the link below shows what model of managed care is in place in each county:

http://www.dhcs.ca.gov/services/Documents/MMCD_County_Map.pdf

Medi-Cal Managed Care Requirements

Plans are required to implement a comprehensive risk assessment tool for all pregnant beneficiaries that is comparable to ACOG and CPSP standards (California Code of Regulations, Title 22, Section 51348). Individualized care plans must be developed to include obstetrical, nutrition, psychosocial, and health education interventions when indicated by identified risk factors.

The plan’s prenatal care or obstetrical providers and non-physician medical practitioners, as defined in plan contracts, are exempt from the requirement of certification as Medi-Cal CPSP providers (Title 22, Section 51249 and 51179.7)

Plans are required to execute a subcontract or Memorandum of Understanding (MOU) with local health departments in the area of Maternal and Child Health (MCH). Local MCAH staff should develop a collaborative relationship with the local health plans to address and define roles, responsibilities, shared activities, and mutually agreed areas of collaboration.

Suggested topics to discuss and include in the MOU are the following:

- Communication strategies (frequency, activity participation)
- How gaps and barriers to perinatal services are identified and addressed collaboratively
- Resource sharing facilitation
- Perinatal access
- Education and training
- Other areas of mutual agreement

- Other elements required by State MCAH and/or Medi-Cal Managed Care Division

Both MCAH and DHCS MMC agreed that if the plans are not providing services in accordance with their policies or contract:

1. The member or LHJ can contact either the plan or the ombudsman at this link :
<http://www.dhcs.ca.gov/services/medi-cal/Pages/MMCDOOfficeoftheOmbudsman.asp>
2. If contact with the plan or ombudsman does not resolve the issue, CDPH will contact DHCS MMC.

Prior to CDPH contacting DHCS MMC, the information below is required to be provided by the LHJ to MCAH via secure, encrypted email in compliance with CDPH HIPAA (subject of e-mail has to have [secure] indicated):

1. Personal Health Information – Name/Date of Birth/Medi-Cal Beneficiary Identification
2. Issue
3. Plan's response
4. Policy you believe the plan is violating

For questions specific to Medi-Cal Managed Care, please visit the [Office of the Ombudsman](#) webpage.

Refer to Medi-Cal Managed Care Division (MMCD) POLICY LETTER 12-003

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2012/PL12-003.pdf>

Information regarding Birth Centers and Certified Nurse Midwives in Medi-Cal Managed Care:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15-017.pdf>.

The website link for all Medi-Cal Policy letters:

<http://www.dhcs.ca.gov/formsandpubs/Pages/MMCDPlanPolicyLtrs.aspx>

Issues or needed assistance regarding client care, inter-county transfers, and continuity of care can be reported to:

Office of the Ombudsman at 1-888-452-8609

Department of Managed Health Care at: 1-888-466-2219

For more information about Medi-Cal Managed Care, go to the MCMC web site at:

<http://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx>

Rural Health Clinics (RHCs) and Federally Qualified Health Clinics (FQHCs)

RHCs and FQHCs provide ambulatory health care services to people in rural and non-rural areas. These clinics are paid on a prospective payment system.

RHCs and FQHCs must be enrolled CPSP providers in order to provide services and bill for CPSP practitioner services. For more information regarding the definition of CPSP qualifying visits, refer providers to:

https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/rural_o01o03.doc

CPSP Services: Treatment Authorization Request (TAR) and Reporting Requirements

Claims for CPSP services in excess of the basic allowances will not be denied for the absence of a TAR. RHCs and FQHCs, however, must maintain in the patient's medical record the same level of documentation that was needed for authorization approval. DHCS Audits and Investigations may recover payments that do not meet the requirements under CCR, Title 22, Section 51458.1, "Cause for Recovery for Provider Overpayments" and Section 51476, "Keeping and Availability of Records."

Required documentation includes:

- Expected date of delivery
- Clinical findings of high-risk factors involved in the pregnancy
- Explanation of why basic CPSP services are not sufficient
- Description of the services being requested
- Length of visits and frequency with which the requested services are provided, and
- Anticipated benefit of outcome of additional services

Providing CPSP to Health Plan Beneficiaries

RHCs and FQHCs must bill the appropriate Health Care Plan (HCP) when rendering services to HCP recipients. The DHCS Fiscal Intermediary (FI) does not accept these claims unless the billed services are contractually excluded from the plan. Providers should contact the plan for plan-specific prior authorization and billing information.

If a Medi-Cal patient comes to the clinic for treatment and the clinic finds the patient is enrolled in a Medi-Cal Managed Care Plan, the clinic can render services and submit a claim to Medi-Cal. However, the RHC and FQHC facility is required to redirect the patient to their "in-network" managed care provider and document this referral in the patient's medical record. While Medi-Cal beneficiaries in Managed Care Plans are required to be treated by in-network providers, except in emergencies or other isolated instances, RHC and FQHC facilities that provide services in these circumstances must maintain proof of payment or risk denial from the managed care plan.

Source: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/rural_o01o03.doc

Audits and Investigations

The mission of Audits and Investigations (A&I) is to ensure the fiscal integrity of the health programs administered by the Department of Health Care Services (DHCS) and ensure quality of care provided to the beneficiaries of these programs. The overall goal of A&I is to improve the efficiency, economy, and the effectiveness of DHCS and the programs it administers.

Audits and Investigations audits serve a program integrity function, whereby they conduct enforcement on accuracy of claims, ensuring that services are accurately represented by codes billed. They review documentation to assure that the documentation supports billing. They also assure that services are medically necessary, evaluate quality of care, and educate providers. They are also available to consult with PSCs on any areas of concern. Contact your NC first if you would like to discuss a possible referral or need assistance with a referral to A&I.

The most common audit triggers are suspicious billing patterns, high dollar volumes per provider, and complaints.

Most frequent findings are poor documentation, FQHC high frequency visits for services rendered with fewer visits in FFS settings, lack of individualization of services, and lack of coordination between CPSP and obstetric provider.

The A&I web site is: <http://www.dhcs.ca.gov/individuals/Pages/AuditsInvestigations.aspx>

Before making fraud referrals, please also discuss the matter with your Nurse Consultant.

For making fraud referrals, the most direct line is:

Stop Medi-Cal Fraud (A&I Hotline for referral of provider fraud and abuse)

Email: stopmedicalfraud@dhcs.ca.gov

Phone: 1-800-822-6222

Web: <http://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx>

Medical Board of California

The Medical Board licenses and disciplines medical doctors for the following types of issues:

- the quality of care and treatment provided by a physician (e.g., negligence)
- violation of drug laws, miss-prescribing, or over prescribing
- substance abuse by a physician
- sexual misconduct by a physician
- dishonesty (including filing fraudulent insurance claims)
- practice of medicine by an unlicensed person or persons under the supervision of a physician

If the PSC encounters a situation with these issues, contact the Medical Board at its toll-free line:

California Toll-Free line: 1-800-633-2322

Local: (916) 263-2382

Fax: (916) 263-2944

Perinatal Services Coordinators' (PSC) Executive Committee (EC)

Purpose

On behalf of the PSCs, the EC collaborates with the California Department of Public Health, MCAH Division staff to address the perinatal health needs of California women and infants. They are MCAH's link to local PSCs to promote sharing of knowledge, resources, best practices, and facilitate and enhance local perinatal initiatives.

Functions

Provides recommendations to MCAH Division staff on CPSP and perinatal related policy matters, and collaborates with them to meet the goals of the CPSP.

- Represents the PSCs as a link to the biannual (May and October) MCAH Action meetings by providing CPSP Affiliate Report
- Informs MCAH Division staff regarding issues and recommendations concerning systemic issues such as access and barriers to care and Medi-Cal policy issues
- Maintains an open communication with MCAH staff regarding issues and risks affecting perinatal care within each region and provides recommendations to address those issues and risks
- Promotes collaboration among regional PSCs, assists PSCs in resolving regional concerns, and ensures new PSCs are linked with neighboring PSCs, needed resources and orientation, referral and assistance; or ensures new PSCs are provided with the name of several PSCs who can serve as resource persons
- Provides input and collaborates with MCAH staff on the following:
 - CPSP policies and procedures manual
 - PSC Annual Meetings
 - Provider Overview Online Training
 - Provider Handbook
 - Steps to Take Handbook
- Attends Provider Overview and Steps to Take trainings, when offered in the local health jurisdiction, and identifies issues and concerns to inform MCAH Division staff
- Facilitates regional meetings with frequency conducted at a minimum of twice a year. These may be held face-to-face or through conference calls, based on each LHJ's allowable budget.
- Notify the MCAH Nurse Consultants of concerns discussed during the PSC Regional Meeting
- Attend required face-to-face meetings or conference call meetings

Membership

- The EC will support its local regions to identify EC members
- The EC will consist of two representatives from each of the four regions- north, bay area, central and south and one additional PSC from Los Angeles County, who is a member of the southern region.
- EC membership is voluntary and will be evaluated by MCAH on a yearly or as needed basis.

Committee Participation

EC meetings will be held quarterly via conference call on the first Thursday of February, May and August and as needed. The November meeting will be in person the day before the annual Meeting. The assigned NC will:

- Develop agenda items and send them to the EC for input two weeks before the meeting
- Take the minutes and send them to the EC no later than two weeks after the meeting.

Meetings

- Special meetings may be called upon mutual agreement of the EC and MCAH staff.
- Each member will print materials distributed electronically by the MCAH for use during meetings.
- Additional business may be conducted electronically.

Ad Hoc Work Groups

Ad Hoc work groups may be appointed as needed to accomplish specific tasks as designated by the EC. The workgroups will provide reports to the EC during regular meetings and/or via email.

MCAH Action CPSP Affiliate Report Template

The CPSP EC develops an Affiliate Report twice a year for presentation at the MCAH Action Business meeting. The purpose of the CPSP Affiliate Report is to:

- Provide a brief written report/update on CPSP and local perinatal activities, accomplishments and emerging issues to the MCAH Action membership
- Bring to the attention of MCAH Action membership any action items related to CPSP, PSCs or perinatal services

The Affiliate Report should briefly report on activities that have occurred since the last MCAH meeting, including:

- State perinatal service education and CPSP annual meeting (if applicable)
- Steps to Take and Provider Overview trainings – a report on numbers attended would be helpful
- CPSP Executive Committee - decisions and pending issues
- Workgroup reports
- Highlights of perinatal services, including CPSP (if any):
 - Successes
 - Barriers
 - Medi-Cal Managed Care trends and issues
 - Interactions with other MCAH Programs
- Action Items – issues that PSCs have identified and wish to bring to the attention of MCAH Action for support or action:
 - Define and describe issue(s)
 - Clearly state goal(s) of requested action
 - Clearly state the steps/action(s) and time-frame for completion that the PSCs are requesting of MCAH Action

- Identify at least one PSC who will be the contact person for information, coordination and collaboration

The EC must develop the MCAH Action Affiliate Report and send it to the MCAH CPSP Coordinator, MCAH Action and CalWIC. All EC members will share outcomes of committee meetings with their regional PSCs and submit the report to the MCAH Action president two weeks before the MCAH Action meeting.

Email CPSP Affiliate Report to the MCAH Action President or designee at least 2 weeks before each Spring and Fall MCAH Action Statewide Meeting.

The EC representatives from CAPA and SAPA responsible are responsible for the Spring Affiliate Report, and the EC representatives from NAPA and BAPA are responsible for the Fall Affiliate Report.

Rotation:

May even years	CAPA
October even years	NAPA
May odd years	SAPA
October odd years	BAPA

Additional Program Information on Perinatal Services

[California Department of Public Health \(CDPH\)](#)

[Maternal, Child and Adolescent Health \(MCAH\)](#)

[Comprehensive Perinatal Services Program \(CPSP\)](#)

[Local PSC Directory](#)

[California Department of Health Care Services](#)

[California Indian Health Program](#)

[California Newborn Screening Program](#)

[California Smokers' Helpline](#)

[California State Office of AIDS](#)

[Family PACT](#)

[Medi-Cal Audits & Investigations](#)

[Medi-Cal County Offices](#)

[Medi-Cal Dental Program](#)

[Medi-Cal Managed Care](#)

[Medi-Cal Presumptive Eligibility](#)

[Medi-Cal: Child Health and Disability Prevention Program](#)

[Primary and Rural Health](#)

[Women, Infants and Children Program](#)

CPSP Staff Contacts:

Mari Taylan-Arcoleo, MPH
Section Chief
Prevention, Policy and Programs Standards Branch
(916) 650-0356
Mari.Taylan@cdph.ca.gov

Lorraine Cardenas
CPSP Provider Application Analyst
(916) 650-0377
Lorraine.Cardenas@cdph.ca.gov

Paula Curran, PHN, MHA
Nurse Consultant III, Specialist
(916) 650-6794
Paula.Curran@cdph.ca.gov

Cheryl Hunter-Marston, APRN, MSN, CNS-BC, DNPc
Nurse Consultant III, Specialist
(916) 650-0360
Cheryl.Hunter-Marston@cdph.ca.gov

Sunday Oyewole, MPH, PNP
Nurse Consultant III Specialist
(916) 650-0383
Sunday.oyewole@cdph.ca.gov

Gloria Calderon
Office Technician
(916) 650-0288
Gloria.Calderon@cdph.ca.gov

Click the link below to find your Local Health Jurisdiction Nurse Consultant:

<http://www.cdph.ca.gov/services/funding/mcah/Documents/MO-MCAHCMPCAssignmentListing.pdf>

Types of CPSP Services offered by provider

Type of Service	What it includes:
Obstetrical Services	Routine obstetrical services must be provided in accordance with most current ACOG Guidelines, including: <ul style="list-style-type: none"> ○ Prenatal care ○ Intrapartum (delivery) care ○ Postpartum care <p><i>Provided by a qualified on-staff practitioner or contracted practitioner</i></p>
Enhanced Services (nutrition, psychosocial, health education, parenting, childbirth)	Enhanced services include: <ul style="list-style-type: none"> ○ Client orientation ○ Nutrition assessment, reassessments and interventions ○ Health education assessment, reassessments, and interventions ○ Psychosocial assessments, reassessments, counseling, and interventions ○ Individualized care plan, coordination of care, and referrals <p><i>Provided by a qualified on-staff practitioner or contracted practitioner</i></p>
Vitamin/Mineral Supplements	A 300-day supply of vitamin/mineral supplements dispensed or prescribed as medically necessary
Referrals to Required Services	In addition to assuring delivery of client orientation, obstetric, health education, psychosocial and nutrition services, the provider must make referrals to the following services: <ul style="list-style-type: none"> ○ Special Supplemental Nutrition Program for WIC ○ Genetic screening ○ Dental care ○ Family planning (Family PACT) ○ Child Health and Disability Prevention Program (CHDP) <p><i>Provided by the CPSP provider directly, or by referral to a qualified provider</i></p>

Fetal Infant Mortality Review (FIMR) Program Policies and Procedures

Overview

Introduction

The Maternal, Child and Adolescent Health Program provides allocations to 16 identified local health jurisdictions (LHJs) to conduct a FIMR Program.

Table of Contents

This document contains the following:

Topic	See Page
Background	103
Local FIMR Activities	105
Key Personnel	108
Standardized Data Collection and Reporting	109
Trainings and Meetings.....	110
Product/Publication Approval and Credit.....	110
Annual Report.....	111

Background

History

The California FIMR Program is modeled after the National FIMR Program of the American College of Obstetricians and Gynecologists (ACOG). In 1991, California was the first state to establish a state-directed FIMR Program. The MCAH Program funded 12 projects, two of which were also demonstration sites of the National FIMR Program. California has since expanded the FIMR Program to its current level of 16 local projects.

The Black Infant Health (BIH)-FIMR Program was initiated in November 2004 through a Title V-funded FIMR expansion project to address the persistent disparity in African American fetal and infant deaths. The FIMR expansion funds were distributed to the eight BIH jurisdictions that accounted for the largest percentage of African American live births and infant deaths based on 2002 vital statistics data. With the completion of the three-year pilot of the Baby Abstracting System and Information NETWORK database, the BIH-FIMR Program ended on June 30, 2009.

Under provisions of the California Health and Safety Code Section 100325 to 100335, the California Department of Public Health 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)].

Program Purpose

The FIMR Program is a method for understanding the health care system and social problems that contribute to preventable fetal and infant deaths, and for identifying and implementing local interventions to rectify identified problems. The FIMR Program empowers local community members to take the necessary steps to improve fetal and infant mortality within their own communities. It is a community-based, action-oriented process with the intent to improve health and social services for families. Through FIMR, the community, in effect, becomes the expert and acquires knowledge about the entire local service delivery system and community resources for women, infants, and their families. FIMR is designed to:

- Identify and examine factors that contribute to fetal, neonatal, and post neonatal deaths by establishing ongoing case review and community action teams
- Make recommendations that address the contributing factors
- Mobilize the community to implement interventions that lead to system and community changes that reduce fetal and infant deaths

FIMR includes the following four public health program elements:

- Assessment of fetal and infant deaths in local communities via data collection and analysis
- Program planning by organizing community members to develop recommendations and a plan of action to address the identified medical, social, environmental, and other factors which lead to fetal and infant deaths

- Implementation of primary, secondary, and tertiary prevention interventions through systems change and the institutionalization of long-term policies
- Evaluation and monitoring of program outcomes

Jurisdictions

The FIMR Program is currently implemented in 16 LHJs.

Alameda	Contra Costa
Fresno	Humboldt
Kern	Los Angeles
Placer	Sacramento
San Bernardino	San Diego
San Francisco	San Joaquin
Solano	Sonoma
Ventura	Yolo

Local FIMR Activities

Policy

LHJs that receive funding from the State MCAH Program shall conduct a FIMR Program to identify local system and community problems that contribute to fetal and infant deaths and implement solutions to prevent future deaths.

Local FIMR programs will:

- Examine contributing factors to fetal, neonatal, and post neonatal deaths
- Identify and investigate disparities
- Engage the community to develop mechanisms to respond to identified needs, thus helping to prevent similar occurrences
- Distribute the findings to other programs, such as BIH, California Perinatal Services Program (CPSP), and Sudden Infant Death Syndrome (SIDS) Program, and to community groups addressing fetal/infant mortality

The local FIMR Program shall involve community members in all aspects of the program, including review of fetal/infant death cases, planning and implementation of interventions, and evaluations. Community member participation in the Case Review Team (CRT) and Community Action Team (CAT) will allow the FIMR Program to:

- Gather insight into local health determinants
- Elicit community concerns and desires
- Assure that the community will be vested in the process

Cultural Competence

Diversity among members of the CRTs and CATs, which reflect the community served, is essential to the teams' success. Diverse team composition promotes the development of findings and recommendations that accurately reflect the community's strengths as well as the need for improved services.

Diversity of professional representation in the teams is important. The broader the representation, the more relevant to the community the proposed interventions will be.

Each agency must comply with the FIMR Scope of Work (SOW). ⁴⁷This SOW includes the minimum required activities for the implementation of a FIMR program.

Confidentiality

All FIMR Program activities must be handled with adherence to strict practices of confidentiality. All written records must be kept in locked files and electronic records must be protected. Identifiers must be removed and cases adequately summarized to prevent identification of individuals. Members of

the CRT and CAT must sign a pledge of confidentiality and be reminded of these standards frequently.

Required Program Components

Each agency receiving FIMR funds is required to include the following components:

1. FIMR Coordinator and associated skilled staff
2. Local case review authority from Local Health Officer
3. FIMR Program protocols, policies and procedures
 - The policies and procedures must include, but are not limited to, the following items:
 - Identify the roles and responsibilities of the FIMR Coordinator and associated skilled staff
 - Identify the composition of the CRT and CAT
 - Identify the CRT and CAT meeting format
 - Define how many members in the CRT and CAT make up a quorum or majority
 - Define the member mix that makes up a quorum or majority for the CRT and CAT
 - Identify the methods for maintaining confidentiality, addressing confidentiality requirements for the CRT and CAT members
 - Identify the process for finding cases
 - Identify the criteria used for selecting fetal and infant death cases for review
 - Identify the process for finding and contacting mothers
 - Identify the process for conducting home interviews
 - Identify the process for medical records abstraction
 - Identify the medical record abstraction forms and home interview tool
4. Case Review Team
5. Community Action Team
6. Community involvement
7. Recommendations based on case findings and innovative interventions
8. A system for standardized data collection and reporting

Each FIMR Program has a CRT and a CAT. The FIMR Coordinator determines the method and criteria used for selecting fetal and infant death cases for review.

Case Review Team (CRT)

The CRT shall consist of medical and nonmedical representatives and have culturally diverse representation. Members of the CRT shall represent a broad range of professional organizations and public and private agencies. Such organizations and agencies may include health, social service, education, advocacy, and those that provide services and resources for women, infants, and families. Membership shall be modified as the at-risk populations and priorities for review change.

The CRT conducts the review of selected cases and makes recommendations to prevent future fetal/infant deaths.

Community Action Team (CAT)

The CAT shall reflect the needs and diversity of the community and include membership that can define and organize key community-based, public policy, and systems changes that arise from case reviews. Membership shall be modified as the at-risk populations and priorities for review change.

The CATs shall have coordination or representation from related state and local programs serving women and children, such as the SIDS Program, Women, Infants & Children (WIC), CPSP, and BIH.

The CAT may include, but may not be limited to, representatives from:

- Health professions
- Social services agencies
- Child health organizations
- Community-based organizations
- Political leadership groups
- Faith community organizations
- Neighborhood organizations
- Educational organizations
- Housing and tenants' rights organizations
- Local businesses
- Parents who have experienced a fetal/infant loss

The CAT reviews the findings and recommendations of the CRT and implements community, policy, and/or systems changes that will assist in preventing future fetal/infant deaths.

CRT and CAT Implementation

- CRTs that also serve as the CAT must be composed of a professionally and ethnically diverse membership that is representative of the community.
- CRTs may serve as the CAT if membership and activities are appropriate.
- If the CRT also serves as the CAT, the CRT recommends and implements changes that are designed to prevent future fetal/infant deaths.
- Crossover representation between CRT members and CAT members is strongly encouraged. This promotes buy-in among the CAT members who not only translate the CRT findings into recommendations and actions, but also participate in implementing interventions designed to address the identified problems.
- Communities with existing community coalitions or groups for which fetal/infant mortality issues are a priority may have these coalitions assume the role of the CAT when appropriate. These community coalitions must collaborate closely with the CRTs.

Recommendations and Interventions

The case-based recommendations and interventions shall center on local factors and/or address broad questions of systems performance and public policy. Identification of recommendations and interventions may be determined based on a combination of FIMR and Perinatal Periods of Risk (PPOR) strategies. Interventions may include, but may not be limited to, changes in:

- Public health and social policies
- Health service delivery systems, networks, and practices
- Professional training and community-based education
- Patterns of community knowledge, skills, lifestyles, and norms

Key Personnel

Policy

Each FIMR Program must have trained staff to perform functions as FIMR Coordinator, Records Abstractor, Parental Interviewer, and Data Manager. These roles may be combined or shared as staffing availability permits.

FIMR Coordinator Role

All FIMR Coordinators must ensure the following tasks are completed:

- Obtain local case review authority from the Local Health Officer or a local Committee for the Protection of Human Subjects to conduct ongoing FIMR reviews. If unable to obtain authority for review of records locally, they must obtain authorization from parents or legal guardians of the deceased.
- Develop and maintain protocols and procedures for the review of cases according to state and national FIMR guidelines.
- Provide leadership and direction to CRTs and CATs
- Abstract information from various data sources and oversee data entry and management
- Conduct parental interviews
- Submit to CRT and CAT summarized information from the parental interviews and other data sources, maintaining client confidentiality
- Distribute findings of the case reviews to the CAT with recommendations for action
- Distribute findings and make recommendations to related local programs serving women and children, such as BIH, SIDS Program, and WIC
- Collect, analyze and submit to the state MCAH Program local data pursuant to MCAH guidelines
- Attend and participate in conference calls, statewide and/or regional meetings, and trainings as scheduled and coordinated by the state MCAH Program

Standardized Data Collection and Reporting

Policy

FIMR Programs are required to review case findings and submit an Annual Report. Data collection tools may be required by MCAH. (Refer to the FIMR SOW and Annual Report requirements for details.)

The Perinatal Periods of Risk (PPOR) approach is a tool that may be used in a complementary fashion with FIMR efforts. Particularly useful for jurisdictions with more than 60 fetal and infant deaths annually, PPOR can assist in prioritizing cases for review based on identified contributing factors.

FIMR SOW Information

The objectives of the FIMR program as outlined in the SOW result in data collection and reporting in two categories:

1. case reviews, including resulting community interventions
2. periodic local summaries of the status of fetal and infant deaths and their contributing factors

Trainings and Meetings

The MCAH Program may provide training and technical assistance to FIMR Programs. Local FIMR Programs may be required to attend these trainings. Local FIMR Programs' input on desired trainings is highly encouraged.

Adequate funding for training and meeting expenses, including travel expenses, shall be built into the annual budget. Efforts will be made to provide trainings via teleconference/webcast or in conjunction with other routine meetings.

Product/Publication Approval and Credit

All products, including publications, reports, brochures, or other materials developed and produced using MCAH allocation funds, must be approved by the MCAH Program prior to printing and distribution. Any products currently in use which have not been approved by the MCAH Program must be approved prior to reprinting and further distribution. (See details in the MCAH Policies and Procedures Manual, Product/Publication Approval and Credit section, for requirements and process.)

Annual Report

Purpose

The FIMR Annual Reports collect relevant information and data for evaluation, analysis, and monitoring of program performance and for meeting Title V Block Grant and MCAH Program objectives.

Annual Report Requirements

All agencies receiving FIMR Program funding are required to complete the FIMR component of the MCAH Annual Report.

Time Frame

The Annual Report is due August 15th each year. The MCAH Program has the option to withhold payment of current invoices for failure to submit a complete and timely report.

Submission

The Annual Report must be submitted by following the directions stated in the MCAH Policies and Procedures Manual under the Annual Report Requirements section.

Glossary of Common Acronyms

Title 22 CCR	Title 22 of the California Code of Regulations
A&I	Audits and Investigations, Department of Health Care Services
ACS	Affiliated Computer Systems (Medi-Cal Fiscal Intermediary)
AFLP	Adolescent Family Life Program
BIC	Benefits Identification Card
BIH	Black Infant Health
CBE	Childbirth Educator/Education
CCS	California Children's Services
CDAPP	California Diabetes and Pregnancy Program
CDPH	California Department of Public Health
CFHC	California Family Health Council
CHDP	California Health and Disability Prevention
CMS	Children's Medical Services
CNM	Certified Nurse Midwife
CPHW	Comprehensive Perinatal Health Worker
CPS	Child Protective Services
CPSP	Comprehensive Perinatal Services Program
DHCS	Department of Health Care Services
DSS	Department of Social Services
EDD	Expected Date of Delivery
EPSDT	Early Periodic Screening Diagnosis and Treatment
EW	Eligibility Worker
Family PACT	Family Planning, Access, Care, and Treatment
FASD	Fetal Alcohol Spectrum Disorder
FFS	Fee For Service
FICOD	Fiscal Intermediary and Contracts Oversight Division, Department of Health Care Services (oversees ACS)
FIMR	Fetal and Infant Mortality Review
FQHC	Federally Qualified Health Center
HIPAA	Health Insurance Portability and Accountability Act(Federal)
ICA	Initial Combined Assessment
ICP	Individualized Care Plan
LBW	Low Birth Weight
LCSW	Licensed Clinical Social Worker
LMP	Last Menstrual Period

MCAH	Maternal, Child and Adolescent Health
MFT	Marriage and Family Therapist
MCMC	Medi-Cal Managed Care Division
MPH	Master of Public Health
MSW	Master of Social Work
NICU	Neonatal Intensive Care Unit
NP	Nurse Practitioner
OB	Obstetrician/Obstetric
OFFP	Office of Family Planning
PA	Physician's Assistant
PCG	Prenatal Care Guidance
PCP	Primary Care Physician
PE	Presumptive Eligibility
POS	Point of Service (billing)
PSC	Perinatal Services Coordinator
RAD	Remittance Advice Detail (billing)
RD	Registered Dietitian
RHC	Rural Health Center
SIDS	Sudden Infant Death Syndrome
STI	Sexually Transmitted Infection
STT	Steps to Take
SW	Social Worker
TANF	Temporary Assistance to Needy Families
TAR	Treatment Authorization Request (Medi-Cal)
THP	Tribal Health Program
W&I	Welfare and Institutions (code)
WIC	Women, Infant and Children –Supplemental Nutrition Program

ⁱ Breiding MJ, Basile KC, Smith SG, Black MC, Mahendra RR. *Intimate Partner Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 2.0*. Atlanta (GA): National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2015.

ⁱⁱ Centers for Disease Control and Prevention[CDC]. Injury Prevention & Control: Division of Violence Prevention. Retrieved from <http://www.cdc.gov/violenceprevention/pdf/nisvs-infographic.pdf> on March 30, 2016.

ⁱⁱⁱ CJSC Statistics: Domestic violence-related calls for assistance. Retrieved on December 22, 2016 from the California Department of Justice Web site: <http://oag.ca.gov/crime/cjsc/stats/domestic-violence>.