Local MCAH Programs Policies and Procedures

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

- Local Maternal, Child and Adolescent Health (MCAH) Program
- Comprehensive Perinatal Services Programs (CPSP)
- Fetal Infant Mortality Review (FIMR) Program

Additional policies are available for:

- Black Infant Health (BIH) Program
- Adolescent Family Life Program (AFLP)
- California Home Visiting Program (CHVP)
- Fiscal Policies and Procedures
Product/Publication Approval and Credit ................................................................. 25
Title V/MCAH Funding Acknowledgement ............................................................. 26
Photographs ............................................................................................................ 26
Guidelines for Protocols to link MCAH clients to Health Insurance and Preventive Visit(s) .................................................................................................................. 26
Protocol Guidelines for Developmental Screening for Children in MCAH Programs .................................................................................................................. 27
Client Triage ............................................................................................................. 29
Co-Enrollment in other MCAH Programs ............................................................. 30

LOCAL MCAH KEY PERSONNEL REQUIREMENTS AND WAIVERS .......................................................... 30
Local MCAH Director Requirements and responsibilities .................................... 31
Local MCAH Coordinator Requirements and responsibilities ......................... 33
Local MCAH Key Personnel Waivers .................................................................. 34
Perinatal Services Coordinator (PSC) Requirements .......................................... 34

AGREEMENT FUNDING APPLICATION ........................................................................ 37
Funding Sources ..................................................................................................... 37
Budgets ..................................................................................................................... 38
Travel, Training and Meetings ................................................................................ 38
LHJ Community Profile Requirements ................................................................ 39

LOCAL MCAH SCOPE OF WORK ............................................................................... 39
SOW Frameworks, Title V Priority Needs, and Focus Areas ............................... 39
General instructions for completing the local MCAH SOW template ................... 41
Submittal and Approval of Scope of Work ........................................................... 43
Changes to the SOW .............................................................................................. 43

DUTY STATEMENT REQUIREMENTS ........................................................................ 43
Duty Statement Components ................................................................................ 44

ORGANIZATIONAL CHARTS .................................................................................. 44

LOCAL MCAH ANNUAL REPORT REQUIREMENTS .................................................. 45
Year-End Survey .................................................................................................... 46

COMPREHENSIVE PERINATAL SERVICES PROGRAM (CPSP) POLICIES AND PROCEDURES .................................................. 47
CPSP Program Background ................................................................................... 48
CPSP Statutes and Regulations ............................................................................. 49
CPSP Regions ......................................................................................................... 51
CPSP Program Overview ....................................................................................... 52
PSC Role, Responsibilities and Activities Overview ............................................. 56
Medi-Cal Information for PSCs ............................................................................ 60
Rural Health Clinics (RHCs) and Federally Qualified Health Clinics (FQHCs) .... 61
Audits and Investigations ....................................................................................... 62
Provider Application Process ................................................................................ 63
Maternal, Child and Adolescent Health Division

Site-Specific CPSP Protocols ....................................................................................................................... 66
Quality Assurance (QA) and Quality Improvement (QI) Activities ................................................................. 68
Electronic Health Records .......................................................................................................................... 70
Charting Rules and Record Retention .......................................................................................................... 71
PSC Executive Committee .......................................................................................................................... 71

FETAL INFANT MORTALITY REVIEW (FIMR) PROGRAM POLICIES AND PROCEDURES ......................... 73

Introduction .............................................................................................................................................. 74
California FIMR LHJs .................................................................................................................................. 75
FIMR Key Personnel .................................................................................................................................. 79
FIMR Standardized Data Collection and Reporting ..................................................................................... 80
FIMR Annual Report Requirements ............................................................................................................ 80

GLOSSARY OF COMMON ACRONYMS ........................................................................................................... 82
Purpose

These Local MCAH Program Policies and Procedures are to be followed for all issues pertaining to the Allocation Agreement between the California Department of Health/Maternal, Child and Adolescent Health Division (CDPH/MCAH) and the Local Health Jurisdictions (LHJs). These Policies and Procedures may be amended at any time and are available on the CDPH/MCAH website at: Local Maternal, Child and Adolescent Health (MCAH) Programs.

Statutes

The following statute summaries paraphrase the structure and requirements for state-funded local MCAH programs.

MATERNAL AND CHILD HEALTH PROGRAM

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

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

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

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

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

COMPREHENSIVE PERINATAL SERVICES PROGRAM (CPSP)

- California HSC §123475-§123525: Establishes a community-based system of comprehensive perinatal care for low-income women. States that prenatal care, delivery service, postpartum care, and neonatal and infant care are necessary services that have been demonstrated effective in preventing or reducing maternal, perinatal, and infant mortality and morbidity, including prematurity and low birth weight. Comprehensive perinatal care includes initial and ongoing physical assessment, psychosocial, nutrition, and health education assessments, interventions, counseling and referral, food supplement programs, vitamins, and breastfeeding and other services as appropriate. Requires all contracted providers to make these services available directly or by subcontract, and to use an appropriate multidisciplinary team.

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

- California W&I §14134.5(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.

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

- California W&I §14134.5(c): States that CPSP services shall include but not be limited to the services delivered through the DHS Obstetrical Access Pilot Program.

- California 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.

- California W&I §14134.5(e): Allows providers to contract with medical and other practitioners for the purpose of delivering CPSP services.
• California W&I §14134.5(f): States that the Department and the California Conference of Local Health Officers will establish standards for services pursuant to this section.

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

• California 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.

• California W&I §14134.5(i): States that the department shall develop systems for monitoring and oversight of comprehensive perinatal services.

• California W&I §14134.5(j): States that client participation shall be voluntary.

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

REGIONAL PERINATAL PROGRAMS OF CALIFORNIA (RPPC)

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

FETAL AND INFANT MORTALITY REVIEW (FIMR)

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

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

SUDDEN INFANT DEATH SYNDROME (SIDS)

- California HSC §123725-§123745, Sudden Infant Death Syndrome
  - §123725: The department shall establish a Sudden Infant Death Syndrome (SIDS) Advisory Council. The description of the Advisory Council and its duties are contained in this section. Requires an annual statewide SIDS conference.
  - §123730: The department shall keep each county health officer advised of the most current knowledge relating to the nature and causes of SIDS.
  - §123735: The department shall contract with a person to provide regular and ongoing SIDS education and training and produce, update and distribute literature on SIDS for those who interact with parents and caregivers following a death from SIDS.
  - §123740: Upon being informed by the coroner of a presumed SIDS death, the local health officer or “appropriately trained public health professional”, after consultation with the infant’s physician of record, when possible; and then within three working days of receiving notice from the coroner of a presumed SIDS death, shall contact persons having custody and control of the infant (e.g., family, caregivers, and/or foster parents) to provide information, support, referral and follow-up services.
    “ Appropriately trained public health professional" means a public health nurse or a social worker who is knowledgeable about the incidence of sudden infant death syndrome and the care and support of persons who have experienced a death of this nature, and who has basic grief counseling skills.
  - §123745: The department shall monitor, or contract with a person to monitor compliance by county health officers with HSC §123740.

- California HSC §462 and §10253:
  - The coroner shall notify the county health officer within 24 hours when there is a provisional diagnosis of SIDS.
  - Upon being informed by the coroner of a presumed SIDS death, the county health officer or his or her designated agent, after consultation with the infant’s physician of record, shall immediately contact the person or persons having custody and control of the infant and explain to such persons the nature and causes of SIDS.
CALIFORNIA SIDS PROGRAM MANDATES

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

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

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

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

**ADOLESCENT FAMILY LIFE PROGRAM (AFLP)**

- AFLP was established in 1985 and authorized by legislation in 1988 (CA Adolescent Family Life Act of 1988, California HSC §124175-124200). The Title V MCH Block Grant funds 20 providers.
California HSC §124180: Allows the department to conduct AFLP to assure that pregnant adolescents receive comprehensive continuous prenatal care in order to deliver healthy babies; to establish networks within regions to provide to pregnant and parenting teens and their children necessary services including medical care, psychological and nutritional counseling, maternity counseling, adoption counseling, academic and vocational programs, and day care; to provide a continuous case manager to each family unit; and to maintain a data base to measure outcomes of adolescent pregnancies.

BLACK INFANT HEALTH PROGRAM (BIH)

Senate Bill (SB 165), Budget Act of 1989 (Alquist, Chapter 93, Statutes of 1988): Made funds available for a new and innovative project to reduce the rate of black infant mortality in California.

California HSC §131051(d)(4): States that the Black Infant Health Program is under the jurisdiction of the Deputy Director for Primary Care and Family Health.

California W&I §14148.9(c): States that programs for pregnant women and infants shall focus on women who are at high risk of delivering a low or high birth weight baby or a baby who will suffer from major health problems or disabilities.

California W&I §14148.9(d): Lists Black women as one of the target populations.

PERINATAL EQUITY INITIATIVE (PEI)

In 2018, state Legislature passed the Budget Act of 2018, which included the establishment of the California Perinatal Equity Initiative (PEI) within the Department of Public Health.

The statewide mortality rate for Black infants continues to be two to four times higher than rates for other groups. PEI aims to address the cases of persistent inequity and identify best practices to eliminate disparities in infant mortality.

PEI complements programs and services offered through the BIH Group Model.

SEXUAL HEALTH ACCOUNTABILITY ACT

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

Creation of California Department of Public Health

- In 2006, Senate Bill 162 (the California Public Health Act) added §131051 to create the California Department of Public Health, giving CDPH authority to oversee the MCAH, AFLP, BIH, CPSP, FIMR, and SIDS programs.

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

Regulations

The following regulations may apply to Local MCAH Programs:


- California Code of Regulations, Title 22, Medical Assistance Program, Division 3, §51179-§51179.10 and §51504 (CPSP, September 1987).


- Office of Management and Budget (OMB) Circular A-87 Revised. 5J10/04-Cost Principles for State, Local and Indian Tribal Governments.

- Discrimination Prohibitions, Social Security Act, Section 508; Title V prohibits exclusion from participation, denial of benefits, or discrimination in any program or activity funded in whole or in part with Title V monies on the basis of race, color or national origin, sex, age, religion or handicapping condition.
Title V Federal Maternal and Child Health Block Grant

The Federal Maternal and Child Health (MCH) Services Block Grant is a federal program that focuses on improving the health of all mothers and children. CDPH/MCAH 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 applies annually for Title V funds to maintain Title V Programs.

Title V MCH Block Grant enables 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.

- Reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children, to reduce the need for inpatient and long-term care services, to increase the number of children (especially preschool children) appropriately immunized against disease and the number of low income children receiving health assessments and follow-up diagnostic and treatment services, and otherwise promote the health of mothers and infants by providing prenatal, delivery, and postpartum care for low income, at-risk pregnant women, and to promote the health of children by providing preventive and primary care services for low income children.

- Provide rehabilitation services for blind and disabled individuals under the age of 16 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 and Youth with Special Health Care Needs (CYSHCN) and facilitate the development of community-based systems of service for such children and their families.

CDPH/MCAH may use its MCH Block Grant funds for the provision of health services and related activities (including planning, administration, education, and evaluation). The Title V Block Grant allocation is earmarked into four categories:

1) 30% Preventative and Primary Care for Children
2) 30% CYSHCN
3) 30% MCAH (other) activities
4) 10% Administrative costs

Further information on Title V can be found at: Understanding Title V of the Social Security Act.
TITLE V REQUIREMENTS FOR CDPH/MCAH

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

- Conduct a comprehensive statewide Needs Assessment every five (5) years.
- Submit an Application Plan for meeting the needs identified by the statewide Needs Assessment every fiscal year.
- Submit an Annual Report of activities to the federal government. This includes reporting on national and state performance measures, setting annual targets and reporting on progress toward meeting the identified goals and objectives.

TITLE V NEEDS ASSESSMENT REQUIREMENTS

Each state is required to conduct a statewide Needs Assessment once every five years. CDPH/MCAH requires each LHJ to perform a Local Needs Assessment to identify problems and priority areas to address in their local Scope of Work (SOW). Based upon their Needs Assessment, LHJs identify State and Local Title V priority problems and plans to address them and submits a deliverable packet to CDPH/MCAH.

CDPH/MCAH compiles the information from the deliverable packet and other statewide data to develop the Statewide Needs Assessment for the Title V State Action Plan.

CALIFORNIA MCAH TITLE V PRIORITY NEEDS 2021-25

CDPH/MCAH identified the following priority needs for the 2021-25 State Action Plan:

- Ensure women in California are healthy before, during and after pregnancy.
- Ensure all infants are born health and thrive in their first year of life.
- Reduce infant mortality with a focus on eliminating disparities.
- Optimize the healthy development of all children so they can flourish and reach their full potential.
- Make systems of care easier to navigate for CYSHCN and their families.
- Increase engagement and build resilience among CYSHCN and their families.
- Enhance strengths, skills and supports to promote positive development and ensure youth are healthy and thrive.

TITLE V REQUIREMENTS FOR LHJS

- Maintain a partnership with CDPH/MCAH and CYSHCN programs to support core public health functions.
• Build community capacity to deliver such enabling services as care coordination, transportation, home visiting, and nutrition counseling, which complement and help ensure the success of State Medicaid and State Children’s Health Insurance Program (SCHIP) medical assistance programs.

• Support programs for CYSHCN to facilitate the development of family-centered, community-based, coordinated systems of care.

• Provide outreach services to identify pregnant women and infants who are eligible for services under the state’s Medicaid program and assist them in applying for Medicaid assistance.

• Provide and promote primary and preventive health care for children, including CYSHCN, that include violence and injury prevention and healthy lifestyle programs to reduce the incidence of personal risk and health problems.

• Provide and promote preventive services for women of reproductive age that include gap-filling prenatal health services, injury and violence prevention, and healthy lifestyle programs to reduce the incidence of personal risk and health problems.

• Provide and maintain a local toll-free number (and/or other appropriate methods of communication) to make information about health care providers and practitioners who provide services under Title V and Title XIX, as well as other relevant information, available to the community.

• LHJs are allocated Title V MCH Block Grant Funds to provide SIDS support services and activities as outlined in the CDPH/MCAH SOW.
  
  o SIDS Coordinators are required to attend the SIDS Annual Conference, and as resources allow, attend either the Northern or Southern California SUID/SIDS training.
Public Health Frameworks and Strategies

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

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

10 ESSENTIAL SERVICES OF PUBLIC HEALTH

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

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

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

LIFE COURSE PERSPECTIVE

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

SOCIAL DETERMINANTS OF HEALTH

Social Determinants of Health (SDOH) are conditions in the places where people are born, live, learn, work and play that affect a wide range of health and quality-of-life outcomes and risks. SDOH can be grouped into five domains: Economic Stability, Education Access and Quality, Health Care Access and Quality, Neighborhood and Built Environment, and Social and Community Context. SDOH impact people’s health, well-being, and quality of life and contribute to wide health disparities and inequities. Just promoting health choices won’t eliminate health disparities. Health organizations and their partners must take action to improve conditions in people’s environment.
CDPH/MCAH recommends that LHJs integrate a life course perspective and an understanding of SDOH when developing interventions.

**SOCIAL-ECOLOGICAL MODEL: A FRAMEWORK FOR PREVENTION**

The **Social-Ecological Model** considers the complex interplay between individual, relationship, community and social factors. It allows us to understand the range of factors that put people at risk for violence or protect them from experiencing or perpetrating violence. Besides helping to clarify these factors, the model also suggests that it is necessary to act across multiple levels of the model at the same time to prevent violence. This approach is more likely to sustain prevention efforts over time than any single intervention. Prevention strategies should include a continuum of activities that address multiple levels in the model.

**STRENGTHENING FAMILIES**

**Strengthening Families** is a nationally and internationally recognized parenting and family-strengthening program for high risk and general population families. Strengthening Families 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.

The 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
- 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 build family strengths and a family environment that promotes optimal child and youth development.

**HEALTHY PEOPLE 2030**

Healthy People is the nation’s foundation for prevention efforts. Every 10 years, Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. These objectives identify nationwide health improvement priorities 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 2030 are to:

- attain healthy, thriving lives and well-being free of preventable disease, disability, injury and premature death;
- eliminate health disparities, achieve health equity and attain health literacy to improve the health and well-being of all;
- create social, physical, and economic environments that promote attaining the full potential for health and well-being for all;
- promote healthy development, healthy behaviors and well-being across all life stages; and
- engage leadership, key constituents and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

Information on Healthy People 2030 can be found at: [Healthy People](https://www.healthypeople.gov).

**EVIDENCE-BASED PUBLIC HEALTH PRACTICE**

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

LHJs should consider the following when planning and evaluating interventions:

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

**THE COMMUNITY GUIDE**

The Guide to Community Preventive Services (The Community Guide) is a collection of evidence-based findings of the [Community Preventive Services Task Force (CPSTF)](https://www.cdc.gov/healthyworkplaces/CPSTF.html). The Community Guide uses a science-based approach to determine whether an intervention approach works and is cost-effective, helps identify and select intervention approaches for behavior change, disease prevention, and environmental
change, identifies where there is insufficient evidence and more research is needed, and complements decision support tools, such as Healthy People 2030 and the Guide to Clinical Preventive Services.

The Community Guide reviews intervention approaches across a wide range of health topics and can help select interventions to improve health and prevent disease in your state, community, community organization, business, healthcare organization or school. The interventions are applicable to groups, communities and other populations and include strategies such as health care system changes, public laws, workplace and school programs and policies, and community-based programs. All interventions are intended to improve health directly, prevent or reduce risky behaviors, disease, injuries, complications, or detrimental environmental or social factors, or promote healthy behaviors and environments.

CDPH/MCAH recommends that LHJs consult this guide when choosing community preventive services to implement to address needs in their local areas.

Other Local MCAH Program Areas

BLACK INFANT HEALTH (BIH) PROGRAM

LHJs identified as having the highest Black infant births receive funds to implement a BIH Program aimed at improving Black maternal and infant health, as well as decreasing the Black-White disparities gap.

Services are provided in communities where over 90% of Black births occur currently: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Solano*, Long Beach, and Pasadena

More information and the BIH Policies and Procedures Manual can be found on the BIH Program webpage.

ADOLESCENT FAMILY LIFE PROGRAM (AFLP)

Adolescent Family Life Program (AFLP) addresses the social, health, educational and economic challenges of adolescent pregnancy by providing comprehensive case management services to expectant and parenting teens and their children.

Depending on the location, community-based organizations (CBO) or LHJs administer AFLP programs.

More information and the AFLP Policies and Procedures Manual can be found on the AFLP webpage.

* Client-centered life planning only
COMPREHENSIVE PERINATAL SERVICES PROGRAM (CPSP)

See the CPSP Perinatal Services Coordinators’ (PSC) Policies and Procedures section of this manual.

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN)

The Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB) requires states to use at least 30% of Title V funds for services for CYSHCN.

CYSHCN is defined by HRSA as:

“Children with special health care needs are those 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.

Suggested Local MCAH Program Activities for CYSHCN

To meet the HRSA/MCHB requirement to use 30% of Title V funds for services for CYSHCN, CDPH/MCAH, along with a workgroup of local MCAH Directors, identified activities that serve CYSHCN.

Community-Based Services:

- Work with CCS and/or collaboratives to:
  - Improve care coordination for CYSHCN, especially non-CCS eligible children or children enrolled in CCS in need of services not covered by CCS.
  - Link children with positive screens to needed services.
  - Disseminate standard messaging regarding developmental screening to increase community awareness of the need for early identification and intervention of CYSHCN.

- Conduct outreach activities to enroll children into public and private insurance coverage.

- 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.
• 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.

• Inform providers of existing services for CYSHCN.

• 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.

• Partner with local organizations that provide services to CYSHCN to improve systems of identification, referral, and linkage of CYSHCN to needed services.

• Build systems to link CYSHCN and their families to needed services.

• Identify barriers and opportunities to improve services for CYSHCN.

• Work with school districts to identify and refer children with specialized health and developmental needs.

• Develop resource information about services available for CYSHCN.

_Early identification of CYSHCN – Screening, Assessment, Referral and Linkage:_

• Promote health and developmental monitoring, screening, identification and referral, including social-emotional (mental health) for infants and children using a standardized screening tool per American Academy of Pediatrics (AAP) guidelines.

• Promote routine screening for physical health, oral health, mental health, developmental and psychosocial needs, and cultural 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.

• 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.

• 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:_

• Assist parents/caregivers to access appropriate services for CYSHCN.

• Teach parents/caregivers how to care for and advocate for their CYSHCN.
• Identify and provide training regarding special equipment available for CYSHCN, such as automobile child restraint systems for physically impaired children.

• Provide home visiting services to support parents/caregivers as they care for CYSHCN, and coordinate with other service providers to ensure that the plan of care is followed.

• Develop or facilitate support groups for parents/caregivers of CYSHCN.

• Facilitate referrals and linkages to specialty health and developmental services for high-risk infants due to prematurity or other health-related conditions.

• Facilitate referrals and linkages for parents/caregivers of infants to specialty services to address bonding or attachments issues.

• Conduct activities to support CYSHCN and their families in self-management and advocacy of the child’s needs.

• Conduct activities for CYSHCN to promote quality of life, healthy development and healthy behavior across the life course, including the prevention or management of secondary conditions.

• Assist parents/caregivers to identify appropriate childcare providers for their CYSHCN as they return to work or school.

• 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.

• 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 standardized screening tool according to the AAP guidelines.

• 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:

• Ensure staff working with families and children demonstrate competency by providing and/or attending training appropriate programs.

• 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.

- Explore opportunities to fund staff positions in other agencies to facilitate interagency coordination focused on CYSHCN.
- Educate agencies and individuals regarding the rights of CYSHCN.
- Standardize data collection/reporting on care coordination services for CYSHCN.
- Involve parents/caregivers and families in care coordination for CYSHCN.
- Provide forums for families to identify ways services for CYSHCN can be better coordinated and delivered, including transportation assistance.
- Assist to develop policies, processes and resources for CYSHCN as they transition to adult care systems to ensure continuity of medical care, continued skill building and access to other community supports.
- 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.
- 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.
- Involve CYSHCN in a Youth Advisory Council providing input to programs serving children and youth.

**Local MCAH Program Requirements**

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

- use core public health functions to assure that progress is made toward meeting the MCAH Program Title V and State requirements and LHJ priorities;
- develop policies and standards to implement culturally congruent and appropriate 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 that includes a PSC whose responsibilities include providing technical assistance and recommending and monitoring providers of comprehensive perinatal services;
• establish a community-based program to improve knowledge and practice of infant safe sleep and SIDS risk reduction activities; and

• incorporate life course perspective and social determinants of health to address health disparities.

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

Ensure the availability of a toll-free or “no cost to the calling party” telephone system which provides a current list of culturally and linguistically appropriate information and referral to community health and human resources for the 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.

DOCUMENTATION RETENTION REQUIREMENTS

Documentation of AFA and SOW activities must be documented and kept on file for audit purposes for three (3) years from the date of final invoice payment or longer audits purposes (See MCAH Fiscal Policies and Procedures, Audit File Retention). While participation in the MCAH Program does not authorize access to Protected Health Information (PHI), some LHJs will have access to such information by virtue of the county/city structure or with the permission of individual clients.

CLIENT CONFIDENTIALITY AND HIPPA REQUIREMENTS

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

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

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

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

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

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

**Sending Confidential Information:**

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

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

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

**PRODUCT/PUBLICATION APPROVAL AND CREDIT**

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

The process for approval is as follows:

- Submit the product either electronically or by hard copy to the CDPH/MCAH State PC at least 60 days prior to publication or reprinting.

- Include a cover letter or email requesting approval with the following information:
  - Name of program
  - Title of the product
  - Objective(s)
  - Description
  - A copy of the publication
  - Target population
  - Language
  - Date produced
o Name and telephone number of contact person

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

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

**TITLE V/MCAH FUNDING ACKNOWLEDGEMENT**

Local agencies that develop publications, products, journal articles, public reports, videos, or publications using funds provided from CDPH/MCAH must acknowledge this support with a written statement printed on the materials. LHJs must also include this statement on any curriculum, educational materials, programs, program documentation, videotapes, and/or other audio-visual materials resulting from the use of the CDPH/MCAH funds. 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:

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"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".
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**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 a photo release was obtained and kept on file.

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

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

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

**Health Insurance and Preventive Visit(s) for MCAH Clients**

To ensure that all clients in MCAH programs have health insurance, are linked to a provider and complete a preventive visit(s).
All LHJ MCAH Programs are expected to develop and adopt local protocols to improve the rates of clients accessing a preventive visit. The protocols 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, and
- 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/Year-End Survey as follows:

- Report the number of clients referred to Medi-Cal, Covered California, or other no/low cost health insurance.
- Provide a 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.
- Provide a brief description of the successes and challenges.

PROTOCOL GUIDELINES FOR DEVELOPMENTAL SCREENING FOR CHILDREN IN MCAH PROGRAMS

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

- The standardized screening tool(s) to be used.
- The periodicity of screening. The AAP recommends that general developmental screening using a standardized tool should be administered at 9, 18, and 30 months, at a minimum, or whenever the parent/caregiver has a concern.
  - Note: In addition, AAP recommends autism-specific screening at ages 18 and 24 months and social and emotional screening at regular intervals. Ongoing developmental surveillance is also recommended.
  - 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.
  o 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:
  o Connect with their primary care provider or medical home and appropriate intervention services, such as Regional Centers, Local Educational Agencies, Family Resource Centers and parent support groups.
  o Receive parent education on developmental milestones and what to do if they are concerned about their child’s development.
  o Demonstrate positive parenting skills and have the tools and guidance to optimize their child’s growth and development.
  o 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.

**Child Development Outcome Reporting**

LHJs are required to report on the outcomes of these efforts in the MCAH Annual Report as follows:

• Number of children receiving developmental screening using a standardized tool 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 CYSHCN 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.

Child Development Resources

• American Academy of Pediatrics, Bright Futures Materials and Tools
• AAP Screening and Technical Assistance Resource (STAR) Center
• Birth to 5: Watch Me Thrive
• Learn the Signs. Act Early.
• Early Start
• Help Me Grow
• Association of Maternal & Child Health Programs: CYSHCN
• Lucille Packard Foundation for Children’s Health

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.

CLIENT TRIAGE

CDPH/MCAH is responsible for maintaining the integrity of our MCAH programs and committed to ensuring the most effective and efficient use of limited resources. CDPH/MCAH 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.

It is the responsibility of the MCAH director or designated staff, in consultation with the client, to determine the program(s) that best meets the client’s needs.

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:
  o 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).
  o 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

Black Infant Health (BIH)

CDPH/MCAH 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, such as the California Home Visiting Program (CHVP).

Adolescent Family Life Program (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, such as 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.

California Home Visiting Program (CHVP)

CHVP should coordinate enrollment policies with other local programs, for example, the BIH program.

Local MCAH Key Personnel Requirements and Waivers

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

Key personnel leadership consists of the MCAH Director and the MCAH Coordinator, if the LHJ has one.
LOCAL MCAH DIRECTOR REQUIREMENTS AND RESPONSIBILITIES

Each LHJ must have an MCAH Director who meets the qualifications and Full Time Equivalent (FTE) as outlined below. 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, 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.

Local 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).
- Other professional credentials may be accepted but must be approved by the CDPH/MCAH.

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

<table>
<thead>
<tr>
<th>Total LHJ Population</th>
<th>FTE MCAH Director</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.5 million</td>
<td>2.0 Physicians</td>
</tr>
<tr>
<td>750,001-3.5 million</td>
<td>1.0 Physician</td>
</tr>
<tr>
<td>200,001-750,000</td>
<td>1.0 Public Health Nurse</td>
</tr>
<tr>
<td>75,001-200,000</td>
<td>0.75 Public Health Nurse</td>
</tr>
<tr>
<td>25,000-75,000</td>
<td>0.50 Public Health Nurse</td>
</tr>
<tr>
<td>&lt;25,000</td>
<td>0.25 Public Health Nurse</td>
</tr>
</tbody>
</table>

The LHJ must meet the qualification and FTE requirement(s) for the MCAH Director. If the LHJ is not able to meet this requirement, they may meet staffing requirements by adding an MCAH Coordinator. MCAH Coordinator requirements and responsibilities are described below.

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

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). If the total FTE exceeds 1.0 FTE, local MCAH programs must add an MCAH Coordinator.
Interim Local MCAH Director Plan

Each LHJ will notify the CDPH/MCAH 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. The individual designated as interim MCAH Director must, at a minimum, meet the position’s minimal professional qualifications and waiver criteria.

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.

Local MCAH Director Responsibilities

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

The core functions are discussed below:

Assessment:

- Participate in CDPH/MCAH 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/SUIDS. Share data annually with the Local Health Officer and/or key health department leadership. Utilize this data to develop an understanding of health needs within the community and identify barriers to the provision of health and human services for the MCAH population.

- Identify health issues and interact with local health care providers, community members, managed care plan providers, coalitions, etc., to enhance program efforts and improve outcomes.

Policy Development:

- Use the information gathered during assessments to develop and implement local policies and programs with measurable objectives.

- Develop plans and direct resources consistent with program goals and objectives.

- Facilitate access to care and appropriate use of services. This may include, but not be limited to, oversight of CPSP, patient/client outreach, services for CYSHCN, education, community awareness, referral, transportation, childcare, translation services and care coordination.

- Ensure implementation and coordination of local MCAH programs.
• Ensure that SIDS activities take place, including community infant safe sleep and SIDS risk reduction education and grief and bereavement support for families experiencing a presumed SIDS death.

• Coordinate all MCAH patient/client outreach, education, and community services provided by local, state and federal programs, including CCS, to prevent duplication of services and facilitate optimal use of resources.

• Ensure hiring and orientation of 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 CDPH/MCAH.

• Conduct a Needs Assessment within their community every five years.

_LOCAL MCAH COORDINATOR REQUIREMENTS AND RESPONSIBILITIES_

_Local MCAH Coordinator Requirements_

The MCAH Coordinator must be a Skilled Professional Medical Personnel (SPMP). Refer to the Fiscal Policies and Procedures for positions that qualify as an SPMP.

_Local MCAH Coordinator Responsibilities_

The MCAH Coordinator assists the MCAH Director in fulfilling the MCAH Director’s responsibilities. If the MCAH Director has a 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. The MCAH Director FTE and/or qualification requirements may be fulfilled by combining the FTEs and/or qualifications of both positions.
LOCAL MCAH KEY PERSONNEL WAIVERS

If the LHJ is not able to meet the key personnel requirements for the MCAH Director that meets the professional qualifications and/or FTE time requirements, they must submit a Key Personnel Waiver request letter to the Program Consultant requesting approval. CDPH/MCAH will consider each waiver request individually and if approved the LHJ will receive a waiver approval letter from CDPH/MCAH. A copy of the approval letter must be submitted annually with the Agreement Funding Application (AFA) package.

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.

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

- 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 CDPH/MCAH Program Consultant.
- Submit the MCAH Director’s resume, and the resume for the candidate for the MCAH Coordinator, if applicable.
- Submit the Duty Statement(s).
- Submit a revised Organizational Chart(s).
- Describe 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 populations, and PHN oversight for counties with less than 750,000 population) if the proposed candidate does not have the required qualifications.
- If the MCAH Director is not a Public Health Nurse (PHN), a Master’s in Public Health (MPH), or another qualification in place of a physician or PHN qualification requirement, the LHJ must describe its mechanism for oversight of medical or clinical issues.

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 and a new request must be submitted.

CDPH/MCAH may hold reimbursement if the minimal professional qualifications and FTE time requirements are not met unless a waiver is on file with the MCAH Program.

PERINATAL SERVICES COORDINATOR (PSC) REQUIREMENTS

It is strongly recommended but not required that each LHJ have a PSC to oversee the implementation of perinatal services and the Comprehensive Perinatal Services Program (CPSP).
If the LHJ does not have a PSC, the MCAH Director is responsible for the PSC duties and implementation of the CPSP program, if the LHJ has CPSP.

It is strongly recommended that each LHJ have a PSC that is an SPMP and meets the time requirements displayed in the table below. CDPH/MCAH recommends that the LHJ use a staff member with clinical licensure (PHN, RN) to carry out clinical Quality Assurance/Quality Improvement (QA/QI) functions.

<table>
<thead>
<tr>
<th>Total Number of Births in LHJ</th>
<th>Recommended FTE for PSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>100,001</td>
<td>2.0 SPMP</td>
</tr>
<tr>
<td>50,001-100,000</td>
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</tr>
<tr>
<td>25,001-50,000</td>
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<tr>
<td>5,001-10,000</td>
<td>0.75 SPMP</td>
</tr>
<tr>
<td>1,000-5,000</td>
<td>0.50 SPMP</td>
</tr>
<tr>
<td>&lt;1000</td>
<td>0.25 SPMP</td>
</tr>
</tbody>
</table>

**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 CDPH/MCAH upon request.

Additionally, the PSC works to improve birth outcomes by:

- Developing staff knowledge of the local systems of maternal and perinatal care.

- Developing a comprehensive resource and referral guide of available health and social services.
• Coordinating perinatal activities between MCAH and the Regional Perinatal Programs of California (RPPC) to improve maternal and perinatal systems of care, including coordinated post-partum referral systems for high-risk mothers and infants upon hospital discharge.

• Implementing local best or promising practice strategies to improve perinatal systems of care.

• Collaborating with partners such as Medi-Cal, Medi-Cal Managed Care, and managed care health plans, identify strategies and activities to improve access to health care services of early prenatal care and postpartum visit(s) for postpartum women.

For additional information regarding PSC responsibilities, specifically for CPSP related activities, please refer to the CPSP Policies and Procedures located in this manual.

Agreement Funding Application

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

When completing the AFA package, LHJs should:

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

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

FUNDING SOURCES

CDPH/MCAH administers federal and state funds to local partners to promote the health of women of reproductive age, pregnant women, mothers, infants, children, and adolescents in California. All contracts and allocation agreements are subject to federal and state funding appropriations.

Funding sources that support Local MCAH activities include: Federal Title V MCH Block Grant Funds, Federal Title XIX Medicaid (Medi-Cal) Funds, and local government (county/city) agency funds and are combined to support the program activities as defined in the SOW.
BUDGETS

To develop an annual budget, each LHJ must establish a Local MCAH SOW for the fiscal year using the template provided by CDPH/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 Directors, CPSP, SIDS and FIMR meetings, must be built into the annual MCAH budget.

The CDPH/MCAH Fiscal Policies and Procedures Manual allows out-of-state travel for agency leadership to travel to the following national conferences:

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

Travel to other national conferences may be approved on a case-by-case basis and requires prior written MCAH approval. All requests must be submitted in writing via email to your Contract Manager and Program Consultant with a brief description that includes the items listed below:

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

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

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 CDPH/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 or 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 CDPH/MCAH.

Local MCAH Scope of Work

The Local MCAH SOW defines the local activities in each jurisdiction that contribute to accomplishing the CDPH/MCAH mission and goals. The LHJ completes the Local MCAH SOW using the template provided by CDPH/MCAH. LHJs that are funded for additional MCAH programs such as AFLP and BIH must complete separate SOWs for those programs according to the program’s respective policies and procedures. If an LHJ receives Fetal Infant Mortality Review (FIMR) funds as part of the AFA agreement, the SOW for FIMR is located within the Local MCAH SOW. The Local MCAH SOW consists of general requirements and activities for all LHJs and has additional activities across five (5) population domain areas, which align with State Priority Needs and address Title V, CDPH/MCAH and local objectives.

The Local MCAH SOW is based on:

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

SOW FRAMEWORKS, TITLE V PRIORITY NEEDS, AND FOCUS AREAS

Frameworks

The development of the Local MCAH SOW is guided by several public health frameworks including the ones listed in these policies and procedures. Please consider integrating these approaches when conceptualizing and organizing local program, policy and evaluation efforts. Additionally, the SOW aligns with State Title V Priority Needs and Focus areas.

State Title V Priority Needs and Focus Areas

The priority needs and focus areas were identified through a synthesis of the Local MCAH needs assessments, a review of population data and key literature, engagement of MCAH programs and stakeholders through surveys, interviews, and stakeholder meetings, and an assessment of program capacity and key partnerships.
**Women/Maternal Priority Need 1:** Ensure women in California are healthy before, during and after pregnancy.

Focus Areas:

- Reduce the impact of chronic conditions related to maternal mortality
- Reduce the impact of chronic conditions related to maternal morbidity
- Improve mental health for all mothers in California
- Ensure optimal health before pregnancy and improve pregnancy planning and birth spacing
- Reduce maternal substance use

**Perinatal/Infant Priority Need 1:** Ensure all infants are born healthy and thrive in their first year of life.

Focus Area:

- Improve healthy infant development through breastfeeding and caregiver/infant bonding.

**Perinatal/Infant Priority Need 2:** Reduce infant mortality with a focus on eliminating disparities.

Focus Areas:

- Reduce infant mortality with a focus on reducing disparities
- Reduce preterm births

**Child Priority Need 1:** Optimize the healthy development of all children so they can flourish and reach their full potential.

Focus Areas:

- Expand and support developmental screening.
- Raise awareness of adverse childhood experiences (ACEs) and prevent toxic stress through building resilience.
- Support and build partnerships to improve the physical health of all children.

**Children and Youth with Special Health Care Needs Priority Need 1:** Make systems of care easier to navigate for CYSHCN and their families.
Focus Area:

- Build capacity at the state and local levels to improve systems that serve CYSHCN and their families.

Children and Youth with Special Health Care Needs Priority Need 2: Increase engagement and build resilience among CYSHCN and their families.

Focus Area:

- Empower and support CYSHCN, families, and family-serving organizations to participate in health program planning and implementation.

Adolescent Priority Need 1: Enhance strengths, skills, and supports to promote positive development and ensure youth are healthy and thrive.

Focus Areas:

- Improve sexual and reproductive health and well-being for adolescents in California.
- Improve awareness of and access to youth-friendly services for all adolescents in California.
- Improve social, emotional, and mental health and build resilience among all adolescents in California.

GENERAL INSTRUCTIONS FOR COMPLETING THE LOCAL MCAH SOW TEMPLATE

Cover Page

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

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

Section A

Outlines general requirements and activities for all LHJs.

- Nothing is entered here by the LHJ.

Section B

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

- Nothing is entered here by the LHJ.
Section C

Outlines local activities by population domain.

- The LHJ may select one or more local activities listed under any of the state strategy areas.
  - At least one activity must be selected or the LHJ must develop at least one activity of their own in the Women/Maternal Health Domain.
  - At least one activity must be selected or the LHJ must develop at least one activity of their own in the Perinatal/Infant Health Domain.
  - At least one activity must be selected or the LHJ must develop at least one activity of their own in the Child Health Domain.
  - At least one activity must be selected or the LHJ must develop at least one activity of their own in the Children with Special Health Care Needs (CYSHCN) Health Domain.
  - At least one activity must be selected or the LHJ must develop at least one activity of their own in the Adolescent Health Domain.

- For each activity selected, the LHJ answers the following information:
  - How will this activity be tracked and measured by the LHJ?
  - What is your anticipated outcome?
  - How will impacts be measured?

Developing Local Activities

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

- Prioritized needs identified during the most recent 5-Year Needs Assessment. The LHJ should develop a plan to address each activity, identify best practice strategies and methods to accomplish the activity.

- As resources allow, the LHJ should develop SOW activities to address local problems identified in the Needs Assessment.

- The LHJ should place their activity under the state strategy area that applies to their local activity.

- For each activity developed, the LHJ answers the following questions:
  - How will this activity be tracked and measured by the LHJ?
  - What is your anticipated outcome?
  - How will impacts be measured?
For reference, a list of Annual Report/Year-End Survey questions that the LHJ will be required to report on are available for planning the Local MCAH SOW. LHJs will be required to complete these during the Annual Report process. Check with your Program Consultant for this list.

Save the file as “LHJ Name MCAH SOW (insert fiscal year)” and submit during the AFA process.

**SUBMITTAL AND APPROVAL OF SCOPE OF WORK**

Each LHJ must complete and submit a Local MCAH SOW during the AFA process. The Local MCAH SOW is submitted along with the other required AFA documents to the Contract Manager.

The PC must approve the Local MCAH SOW and any changes.

**CHANGES TO THE SOW**

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

**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 Title XIX Federal Financial participation (FFP) matching.

Duty statements must:

- Duty statements for Skilled Professional Medical Personnel (SPMP) must note 'SPMP' at the top of the duty statement and contain the statement "This position meets the criteria for SPMP".
- SPMP duty statement must provide information regarding:
  - Targeted populations
  - Targeted geographic areas
  - Specific practice settings or function
- Position titles should match organizational charts and budget.
- Reflect MCAH activities accurately.
- Contain only those duties performed for the MCAH program.
DUTY STATEMENT COMPONENTS

The following information provides directions for developing duty statements:

- Name of the LHJ.
- Name of the program, such as MCAH program.
- Name of the program position, such as MCAH Director, Fiscal Officer, etc.
  - Do not include personnel names on the duty statement.
- Name of the LHJ position title and job specifications, such as Public Health Nurse or Social Worker II.
- List the personnel line item number from the budget:
  - This may be one person or multiple persons on the budget.
- If a position has multiple personnel, it is not necessary to have separate or individual duty statements if the duties are the same.
- Include a statement describing the position's supervisory relationships.
- Briefly summarize the main purpose and functions of the position. For example: The MCAH Director plans, organizes, controls, and leads the MCAH program and oversees the FIMR program.
- List by the level of importance the position responsibilities/tasks include the major responsibilities/tasks associated with the position.
- Duty statements should be reviewed annually and may change when assignments for the position change.

The following provides general guidelines for developing duty statements:

- Statements should be short, focused, concise and describe the activities to be performed.
- SPMP duty statements should reflect the unique expertise required for these duties.
  - For an SPMP position, include language that reflects his/her duties' as they relate to the FFP codes.
  - Enhanced FFP matching is only permissible for activities requiring the skill, knowledge and ability of an SPMP.
- Key personnel (MCAH Director, Coordinator and PSC) duty statements should be consistent with requirements stated under the Key Personnel section.

Organizational Charts

Each LHJ must have an organizational chart for all MCAH programs and any special programs that receive CDPH/MCAH funding.
Organizational charts serve as supporting documentation for the percentage of time assigned to Local MCAH Program activities and the level of FFP match.

The organizational chart must:

- List the name of the LHJ and date of creation or update.
- Match staff position titles with the duty statement titles and personnel 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. It is not necessary to put FTEs on the organizational chart.
- List the MCAH program and its relationship to other public services for women and children in the LHJ and the overall agency.
- Illustrate the relationship of Local MCAH positions and programs to the MCAH Director, the Local health officer, and overall agency.
- List all staff positions funded with MCAH funds or involved in MCAH activities.

Local MCAH Annual Report Requirements

All LHJs receiving CDPH/MCAH funds 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 30, are due August 15 each year. LHJs may request an extension of up to 30 days for submission of the Annual Report if needed. Please send requests in writing (email is acceptable) to your PC.

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

CDPH/MCAH 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 CDPH/MCAH Program priorities, goals and objectives.
- Demonstrate LHJ accountability and responsibility for completing activities described in their local 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 Block Grant application, which supports MCAH Program funding.
- Document the changing environment/challenges of Local MCAH Programs.
YEAR-END SURVEY

In addition to the Annual Report, each LHJ is responsible for completing a Year-End Survey. The Year-End Survey is included in the Annual Report.
CPSP Program Background

Comprehensive Perinatal Services Program (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 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. CPSP approved Medi-Cal providers are required to follow the current American College of Obstetrics and Gynecologists (ACOG) standards as the minimum standards for obstetrical services provided to Medi-Cal pregnant women. Enhanced services are delivered as defined by Title 22 Regulations. CPSP providers who provide patients enhanced services are reimbursed by Fee for Service (FFS) Medi-Cal. Managed care providers are reimbursed according to their contract with the managed care plan.

CPSP HISTORY AND CALIFORNIA PERINATAL SERVICES TIMELINE

Obstetrical Access Pilot

From July 1979 through June 1982, the Obstetrical Access Project (OB Access Project) operated in 13 California counties. Its goals were to improve access to care in underserved areas and to improve pregnancy outcomes through enhanced prenatal care.

This project conducted by the Department of Health Services (DHS), demonstrated that OB care supplemented by nutrition, health education, psychosocial services, and prenatal vitamins and minerals could reduce the incidence of low birth weight in infants by more than one-third.

1982 Welfare and Institutions Code (W&I) Section 14134.5

Impressed by the results of the OB Access project, the California State Legislature enacted a law (Assembly Bill (AB) 2821, Bates) in 1982 requiring all publicly subsidized prenatal care to include nutrition, health education, and psychosocial services in addition to obstetrical care.

Medi-Cal Program

W&I Code Section 14132

In 1984, legislation under AB 3021, implemented a Medi-Cal reimbursement mechanism for enhanced perinatal care services.

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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.
CPSP Medi-Cal Program

In September 1987, CPSP was initiated.

Title 22 California Code of Regulations

Title 22 describes the required services and defines regulations for CPSP. Establishment of CPSP enabled Medi-Cal approved health care providers to become CPSP certified and receive Medi-Cal reimbursement for CPSP services.

CPSP Statutes and Regulations

CPSP Goals: California HSC §123505:

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

CPSP Objectives: California HSC §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; and
- Support outreach programs directed at low-income pregnant women to encourage early entry into and appropriate utilization of perinatal care.
The following CPSP statutes were transferred from Department of Health Services to CDPH in 2007: HSC §123475-123525 and W&I Code §14134.5. The essential functions within those statutes are discussed below:

Provider Enrollment (reference: W&I §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.

Training and Technical Assistance (reference: W&I §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.

Monitoring and Oversight (reference: W&I §14134.5(i))

- The department shall develop systems for monitoring and oversight of the comprehensive perinatal services provided in this section and W&I §14134.5(i).
  - CDPH/MCAH Division 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.
- CPSP 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.
- CPSP 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**

There are four CPSP regions statewide: Northern Area Perinatal Advocates (NAPA), Central Area Perinatal Advocates (CAPA), Bay Area Perinatal Advocates (BAPA), and Southern Area Perinatal Advocates (SAPA).

### Northern (NAPA)

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### Southern (SAPA)

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CPSP Program Overview

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 enhanced services to pregnant women.

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

CLIENT ORIENTATION

Each client must 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 before the initial health education assessment is completed. The “Welcome to Pregnancy Care” in English and Spanish is a concise pamphlet that may be used for client orientation. It is located in the Steps to Take Manual.

Types of CPSP Services Offered by Provider

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>What it includes:</th>
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<tr>
<td>Obstetrical Services</td>
<td>Routine obstetrical services must be provided in accordance with most current ACOG Guidelines, including:</td>
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<td>• Prenatal care</td>
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<td>• Intrapartum (delivery) care</td>
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<td>• Postpartum care</td>
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<td></td>
<td>Provided by a qualified on-staff practitioner or contracted practitioner</td>
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<tr>
<td>Type of Service</td>
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| Enhanced Services (nutrition, psychosocial, health education) | Enhanced services include:  
- Client orientation  
- Nutrition assessment, reassessments and interventions  
- Health education assessment, reassessments, and interventions  
- Psychosocial assessments, reassessments, and interventions  
- Individualized care plan, coordination of care, and referrals  
Provided by a qualified on-staff practitioner or contracted practitioner                                                                                           |
| 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, when needed, to the following services:  
- Special Supplemental Nutrition Program for WIC  
- Genetic screening  
- Dental care  
- Family planning (Family PACT)  
- Child Health and Disability Prevention Program (CHDP)  
Provided by the CPSP provider directly, or by referral to a qualified provider                                                                                                                                              |

**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.

**CPSP Assessments and Forms**

Obstetric, health education, nutrition and psychosocial are the components to be assessed. The provider should make every effort to complete an initial assessment in the four components within four weeks of the initial visit. The provider must offer health education, nutrition, and psychosocial reassessment in the second and third trimesters, as well as a postpartum assessment. The assessments will be signed by the staff person completing the assessment.
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. Additionally, the assessment process identifies the client’s strengths and risks related to her health and well-being during pregnancy.

Providers should use the CDPH/MCAH approved CPSP Initial and Trimester Assessment, Postpartum Assessment and Individualized Care Plan form, or any other state approved forms.

Individualized Care Plan (ICP)

The CPSP practitioner and client use the information gathered during the assessments to develop an ICP based on the client’s unique risk conditions, strengths and needs. The ICP is developed for each CPSP client at the time of the initial assessment and updated at least every trimester and postpartum visit, and more often if needed. 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.

Referrals

CPSP providers are required to make the following five referrals as described below:

- Women, Infants, and Children (WIC)
  - Referral forms for WIC are in the Provider Handbook and are also available online at: WIC Forms
- Supplemental Nutrition Services Program (SNAP)
- Genetics screening
  - Genetic screening information is available on the CDPH website at GeneticScreening.
  - Providers must offer Prenatal Screening. If the client screens positive, the provider should refer the client to a state approved Prenatal Diagnosis Center, where they can receive genetic counseling and other follow-up services free of charge.
  - Newborn screening is completed at the hospital. Please see the California Prenatal Screening Program materials at CA Prenatal Screening Program.
- Dental care
  - Dental Referral Form and instructions are available at Medi-Cal Dental Patient Referral Service Form.
- Childhood Health and Disability Prevention Program (CHDP)
  - The CHDP Referral Form and instructions are available at this link: Child Health and Disability Prevention Program Referral Form
• Family planning, such as Family Planning, Access, Care, and Treatment (Family PACT).
  o If a woman has full scope Medi-Cal or Medi-Cal Managed Care, family planning services are covered after the postpartum period.
  o 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.
  o For more information, see the Family PACT website

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.

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.
PSC Role, Responsibilities and Activities Overview

It is strongly recommended that each LHJ 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. CDPH/MCAH also provides various types of trainings for providers and PSCs to assist them in implementing CPSP and improving systems of perinatal care.

The PSC works to improve birth outcomes by:

- ensuring CPSP is administered according to regulations;
- developing staff knowledge of the local systems of maternal and perinatal care;
- developing a comprehensive resource and referral guide of available health and social services;
- coordinating perinatal activities between MCAH and the Regional Perinatal Programs of California (RPPC) to improve maternal and perinatal systems of care, including coordinated post-partum referral systems for high-risk mothers and infants upon hospital discharge;
- implementing local best or promising practice strategies to improve perinatal systems of care; and
- collaborating with partners such as Medi-Cal, Medi-Cal Managed Care and managed care health plans, identify strategies and activities to improve access to health care services of early prenatal care and postpartum visit(s) for postpartum women.

The PSC assists with CPSP implementation by:

- providing training, consultation, and technical assistance to CPSP providers and Medi-Cal Managed Care plan staff on program implementation;
- facilitating a process to assist providers to develop or revise protocols; and
- conducting CPSP Quality Assurance/Quality Improvement (QA/QI) activities to address:
  - barriers to perinatal care;
  - office/administrative systems to track client follow-up and completion of referrals, including postpartum care; and
  - improving care coordination and resource utilization.

- Coordinating and conducting CPSP provider QA/QI site visits and providing technical assistance to improve care.
  - Activities that may occur during site visits include:
    - chart reviews,
    - administrative reviews,
    - observation and interview of staff, and
    - follow up with the provider regarding their plan to address program deficiencies.
ADDITIONAL PSC ROLES

The PSC assists with improving the local perinatal systems of care by working at the beneficiary, provider or community level. PSCs in LHJs with no providers or opportunities to enroll new providers into the CPSP should perform locally specific activities to ensure that women, including pregnant and postpartum women, have access to appropriate preventive, reproductive and perinatal services.

Some examples of activities that can be implemented at each level are as follows:

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

Examples:

- Deliver presentations to increase understanding of CPSP and promote access to CPSP services to partner agencies such as WIC offices, schools, foster homes, care providers, CalWORKs, CBOs and nonprofit organizations.

- Outreach coordination to underserved populations and provide information and education on topics to improve health outcomes for mothers, infants and their families.

**Provider Level:** Promote CPSP in the provider community.

Examples:

- 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.

- 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.

- Implement QA/QI activities such as technical assistance regarding client follow-up for referrals and adequate interagency agreements to promote coordinated care as appropriate.

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

Examples:

- Coordinate with RPPC to implement best practices to ensure mothers and babies have access to appropriate maternal levels of care.
• Conduct activities with local provider networks and/or health plans to improve perinatal access, service integration and coordination to meet complex needs

**State Level:** Improve access to maternal and infant care.

Example:

• Develop a collaborative relationship with the Medi-Cal Managed Care liaison by sharing strategies to improve perinatal care.

**PSC PROVIDER APPLICATION AND ENROLLMENT RESPONSIBILITIES**

• Ensures the current [CPSP Provider Application](#) form is used by prospective CPSP applicants.

• Provides consultation and technical assistance to the completion of the CPSP provider application and protocol development:
  
  o Verify professional licenses during the application process.
  
  o Verify that providers are in good standing with Medi-Cal.
  
  o Verify 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.

• Provide consultation to providers in the development of antepartum/intrapartum/postpartum and dual provider agreements as needed.

• Approve changes to the CPSP provider application as submitted to CDPH/MCAH when appropriate.

• Recruit Medi-Cal providers into CPSP. Additionally, the PSC assists providers with assessing local needs for providers.

**PSC MEETING AND TRAINING RESPONSIBILITIES**

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

• PSC Statewide Meeting (either virtually or in-person)

• State directed trainings related to perinatal systems of care

• New PSCs should attend a CPSP Provider Orientation Training
  
  o Priority for CPSP Provider Orientation training will be given to providers. PSCs may attend if space is available.

• [Provider Overview Online Training](#)

• Skill-based online training modules, as needed
PSCs should be familiar with resources, such as:

- Steps to Take Manual
- Provider Handbook
- CPSP website and resources
- MCAH Program Policies and Procedures Manual
- CPSP Assessment Tools
- QA/QI tools

Information on the CPSP Provider Handbook and Steps to Take Manuals, as well as no cost online and in-person trainings can be found at: CPSP Trainings

RESOURCES FOR PSCS

CDPH/MCAH provides resources on the CPSP webpage and CDPH/MCAH webpage that PSCs can use to engage providers regarding quality perinatal care.

A list of PSCs is located at CPSP Perinatal Services Coordinators Directory
Medi-Cal Information for PSCs

If providers or Medi-Cal members have questions, need assistance or need to report a problem, PSCs should refer them to the Medi-Cal Telephone Service Center (TSC) at 1-800-541-5555.

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 TSC is the first line of communication between providers and the DHCS Fiscal Intermediary. 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

The Telephone Service Center: 1-800-541-5555

MEDI-CAL MANAGED CARE PLANS

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.

Medi-Cal Managed Care Health Plan Directory lists the health plans in each county: MMCD Health Plan Directory

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.

For more information about Medi-Cal Managed Care, go to the MCMC web site at:
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 dates, times, and locations of billing seminars. The Medi-Cal Learning Portal is an 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 resources, such as online tutorials, live and recorded webinars.

Access the Medi-Cal Learning Portal at Medi-Cal Learning Portal

Other Medi-Cal Resources

- Medi-Cal website: Medi-Cal Provider Homepage
- Claims and Billing: Medi-Cal Contact Services
- Provider Enrollment Division: Medi-Cal Provider Enrollment Division
- Fee-for-Service billing codes: Medi-Cal Provider Manuals

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:

Rural Health Clinics and Federally Qualified Health Clinics Billing

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 Treatment Authorization Request (TAR). RHCs and FQHCs, however, must maintain in the patient’s medical record the same level of documentation that would be needed in a TAR. 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:

- the expected date of delivery,
- clinical findings of high-risk factors involved in the pregnancy,
• an explanation of why basic CPSP services are not sufficient,
• a description of the services being requested,
• the length of visits and frequency with which the requested services are provided, and
• anticipated benefit(s) 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: Rural Health Clinics and Federally Qualified Health Clinics Billing

Audits and Investigations

DHCS Audits and Investigations (A&I) ensures the fiscal integrity of the health programs administered by DHCS and ensures quality of care provided.

A&I serves as 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 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 PC 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 and lack of individualization of services.

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

The A&I web site is: Audits and Investigations Homepage
The most direct line for making fraud referrals 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: Stop Medi-Cal Fraud

MEDICAL BOARD OF CALIFORNIA

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

- The quality of care and treatment provided by a physician (e.g., negligence)
- Violation of drug laws, misprescribing, 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

Provider Application Process

REQUIREMENTS FOR CPSP PROVIDER APPLICANTS

If the prospective CPSP provider is not yet a Medi-Cal provider, the PSC will refer them to DHCS Medi-Cal Provider Enrollment at Provider Enrollment Division.

Medi-Cal Providers wishing to become CPSP providers are required to submit a CPSP Provider Application through the PSC.

Completing the CPSP Provider Application

The PSC will provide technical assistance in completing the application and consult with the CPSP applicant on program requirements.

The CPSP Provider Application (CDPH 4448), Additional Practitioner Form (CDPH 4448a), CPSP Application Review Checklist and instructions for completing the application are located on the CPSP web page.
Provider Agreements

Agreements are to be kept on file at the provider’s office and with the LHJ.

Antepartum/Intrapartum/Postpartum Agreements and dual provider agreements are required if the CPSP provider does not provide some CPSP services themselves to ensure continuous, safe, quality, comprehensive perinatal care. The CPSP provider must have an agreement with a provider who will provide services 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, or CPSP enhanced services, this must be addressed in the appropriate Agreement. PSCs should provide samples of agreements to provider, as needed.

Dual Provider Agreements

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. These agreements are made at the local level by the CPSP providers involved with guidance from the PSC.

PSC Steps for Application Review

During the PSC application review of the application, the PSC will:

- Confirm with the provider that the CPSP application was received.
- Ensure the seven required attachments are included with the application.
- Complete the bottom section of the CDPH 4448 (for local health jurisdiction use only).
- Inform the provider in writing that the application is complete and acceptable or return the application to the provider for additional information.
- The PSC recommends an approval effective date. If the PSC recommends a provider CPSP effective date before the application is deemed completed, the PSC must submit justification for the provider’s retroactive effective date.
- The PSC may review the Provider Handbook with the applicant as needed.

SUBMITTING THE CPSP PROVIDER APPLICATION

The PSC submits the complete and signed CPSP Provider Application (CDPH 4448), Additional Practitioner Form (CDPH 4448a) if needed, and the CPSP Application Review Checklist by email to CPSP Provider Enrollment.

- Keep copies of all documents for audit purposes.
- The PSC does not need to submit additional attachments but should keep them on file.
STATE APPLICATION PROCESSING

CDPH/MCAH staff will review and process the CPSP provider application. If approved, CDPH/MCAH will send an approval letter to the PSC and a letter to the new CPSP provider indicating their effective date. If the provider is not approved, CDPH/MCAH will contact the PSC for more information and provide a denial letter for those not approved. If the application is denied, the written notification of the denial will contain the basis for the denial.

CDPH/MCAH has 60 calendar days from receipt of a completed application to review and send written notification to the applicant regarding the decision to approve or deny the application for participation as a comprehensive perinatal provider.

The PSC must inform the new CPSP provider to contact the Provider Enrollment Division (PED) before CPSP related services are billed to ensure that the CPSP category of service (COS) is applied to the provider’s National Provider Identifier (NPI). Providers should contact PED to confirm the CPSP category of service (COS 092) has been added to their PMF profile, except for FQHCs, RHCs, and Indian Health Services (IHS). PED is available to assist with any enrollment issues the provider may have. They can be reached at (916) 323-1945 or PEDCorr@dhcs.ca.gov.

PED is unable to verify CPSP enrollment for FQHC, RHC and IHS providers because their CPSP approval is not reflected in the PMF database. FQHCs, RHCs and IHS providers must submit a CPSP provider application to CDPH/MCAH and may begin billing the CPSP program immediately upon notification from CDPH/MCAH for services rendered on or after their CPSP approval date.

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 reapply to become a CPSP provider after their probation period ends.

PROVIDER APPLICATION CHANGES

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

CPSP providers will often update previously approved applications. 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.

The following application changes must be sent to CDPH/MCAH:

- Provider name
- Address
- Ownership
INACTIVATING A CPSP PROVIDER (END-DATE MEMO)

Inactivating a CPSP provider terminates their ability to bill for CPSP services.

PSCs will notify CDPH/MCAH of the following:

- The CPSP provider is no longer delivering CPSP services due to death or retirement.
- The CPSP provider has ceased offering and providing CPSP services.
- 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:

- Provider name,
- Provider address, and
- NPI number.

CDPH/MCAH staff will inactivate the provider in the CPSP database and send an electronic copy of an End Date Memo to the DHCS Provider Enrollment Division (PED) to inactivate the Category of Service. CDPH/MCAH staff will also send a copy to the PSC.

Note: Some providers use the same NPI for multiple sites. If only one site is closing, PSC must notify CDPH/MCAH of the list address being inactivated. Otherwise, when the Category of Service 092 is removed from the NPI, none of the remaining sites will be able to bill for CPSP.

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 Memo to the provider using a return receipt service. The PSC must keep documentation that the provider received the End Date Memo.

Note: Providers are subject to disenrollment for failure to adhere to program policies and administrative practices. On-site visits and attempts at corrective action may be made prior to disenrollment. If a provider is suspended from the Medi-Cal program, enrollment in CPSP is terminated effective the date of the Medi-Cal suspension and CPSP services are no longer reimbursable.

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 (Title 22, Section 51117.9). CDPH/MCAH recommends yearly (or more often if needed) review and update of the protocols.

Protocols must clearly describe a system of care from entry of care through postpartum, coordinated in the provider’s specific setting. The protocol specifies initial assessment and reassessment every trimester,
postpartum assessment, care planning, individual or group interventions, referral mechanisms and case coordination. 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.” Each provider’s protocols must define how personal supervision by a physician occurs and is documented. Please see the Medi-Cal manual: [CPSP Services](#)

**Comprehensive Perinatal Health Workers (CPHWs) must work under the direct supervision of a physician.** 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 learning objectives, content, methodology, and methods of evaluation, (2) a blank sign-in sheet with space for date, instructors name and signature, topic and time in minutes. The provider must keep the completed documentation for each class in a designated secure location, separate from the individual patient health record.

The PSC should provide consultation and technical assistance to the provider in developing protocols. Providers have the option of: 1) developing new protocols; 2) using previously approved template protocols that correspond to a particular assessment tool; or 3) using existing protocols that are currently being used at one CPSP-approved site for a new site(s) owned by the same provider.

**Developing New 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, Section 51179.9 requirements. Providers must list the three consultants who are signing protocols in the Practitioner section of the application (or application update). Consultant names and/or referral resources for high-risk conditions must be included in the protocols.

**Using Previously Approved Template Protocols**

If a provider chooses to use previously approved template protocols, he/she must use the assessment forms that align with the chosen protocols. The PSC may provide sample forms and protocols to the provider. The template must have been developed or updates within the past five years and the provider must tailor them to be specific for each practice site (for example, specify local referral resources and the specific staff at that site who conduct assessments and/or interventions).

**Using Existing Protocols (for Additional Sites Only)**
Currently approved CPSP providers who open other CPSP sites may use the protocols being used at the original site, as long as they were developed or updated within the past five years.

The supervising physician must sign the protocols to ensure they are current and customized for the new site. The protocols do not need to be signed again by a health educator, dietitian and social worker.

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

The PSC assists providers in developing an internal QA/QI plan to monitor the implementation of CPSP within the practice. CDPH/MCAH recommends that the LHJ use a staff member with clinical licensure (PHN, RN) to carry out clinical QA/QI functions.

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

The following are the four mechanisms by which the PSC provides QA/QI:

- Through ongoing provider education about CPSP implementation via on-site trainings and technical assistance visits, orientation of new staff, provider meetings and local roundtables. Roundtables are educational and networking opportunities for perinatal care providers and their staff for perinatal care and newborn care topics. Attendees may include health care providers, public health professionals, nurses, prenatal and pediatric clinic staff, home visiting programs, therapists and social workers.

- Conduct face-to-face QA/QI visits to CPSP provider offices to assess, maintain and improve the quality of CPSP services and assure appropriate care. The QA/QI visits may involve:
  - Chart Reviews – The local PSC, through CDPH/MCAH, has the 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 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.
    - Engage with providers to identify ways of improving documentation, case coordination, client follow-up and management.
• Conduct Administrative Reviews – The local PSC, has the legal authority to establish a community perinatal program whose responsibilities include monitoring providers of comprehensive perinatal services, Welfare and Institutions Code 14134.5.

Assist the provider to implement a quality CPSP program, including identification and provision of the following:

  o Adequacy of community resources
  o Review of policies
  o Development of protocols
  o Integration of activities that reflect evidence-based best or promising practices to improve quality perinatal care or early access to care
  o Address safety-net support for pregnant and postpartum women (e.g. food security, shelter, housing and school placement)
  o Assist provider to identify and address barriers to improve quality perinatal care including early entry into prenatal care
  o Assist providers to improve office/administrative systems to track client follow-up and completion of referrals
  o Improve care coordination and resource utilization

• Staff Interview and observation of any CPSP–related service activities (education classes, case coordination, etc.).

Follow-up to a QA/QI Visit

Involves activities that assist providers to develop strategies that support quality comprehensive delivery of perinatal services to women. Those activities may include:

• The PSC provides technical assistance regarding QA/QI activities to address deficiencies identified during the QA/QI 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 on how to handle these situations.
Electronic Health Records

PSC responsibilities regarding electronic health records (EHR):

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 workflow in each provider office.

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 program 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 PSC should evaluate the contents of the EHR using CPSP regulations and approved set of CPSP forms as a guide. PSCs are encouraged to consult with CDPH/MCAH regarding proposed changes in the content of assessments.

- 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.

- In order to be in compliance with the Health Insurance Portability and Accountability Act (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.

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

- 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?

- Does the EHR generate reports that will enable the provider and PSC to conduct QA to monitor delivery of services and outcomes?

- Does the system recognize risk conditions from the assessments, reassessments, and postpartum assessments?
• Will the system automatically populate the ICP with information from the assessment results/risks/problems and link to appropriate:
  o Site specific CPSP protocols
  o CPSP Steps to Take Manual handout
  o Steps to Take Patient handouts
  o Resources/Referrals

• Will the system automatically populate applicable lab results in the CPSP assessments as well as other appropriate locations in the EHR?

• 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)?

• 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?

• Does the system recognize CPSP services, including time spent, to enable correct billing and can it easily implement coding changes?

• Is the vendor able to make regular system upgrades at a reasonable price to incorporate CPSP program enhancements?

Charting Rules and Record Retention

California law mandates that medical records documenting Medi-Cal services for beneficiaries are to be written in English. Welfare and Institutions Code (WIC) Section 14124.1 requires Medi-Cal providers to keep and maintain records of each service rendered under the Medi-Cal program or any other health care program administered by DHCS. Medical records must be in English for program integrity and oversight purposes.

Provider applications and supporting documentation must be kept for a period of 3 years for audit purposes after the provider has been inactivated (end-dated).

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

PSC Executive Committee

The PSC Executive Committee represents the PSCs, and collaborates with the CDPH/MCAH staff to promote the perinatal health needs of California women and children, to serve as a resource to CDPH/MCAH, and to facilitate communication and support to the PSCs throughout the state.
The PSC Executive Committee develops an Affiliate Report twice a year for presentation at the MCAH Action 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 CPSP Affiliate Report should briefly describe on activities that have occurred since the last MCAH meeting, including:

- State perinatal services education and CPSP annual meeting (if applicable)
- Provider Overview trainings – a report on numbers attended would be helpful
- CPSP Executive Committee – decisions and pending issues
- Workgroup reports
- 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 CPSP Executive must develop the CPSP Action Affiliate Report and send it to the CDPH/MCAH CPSP Coordinator, MCAH Action and CalWIC.
Fetal Infant Mortality Review (FIMR)  
Program Policies and Procedures
Introduction

The California Department of Public Health (CDPH), Maternal, Child and Adolescent Health (MCAH) Division provides funding through the California Fetal Infant Mortality Review (FIMR) Program to a select number of local health jurisdictions (LHJs) to conduct FIMR Projects.

BACKGROUND

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. Twelve projects were funded initially, two of which were also demonstration sites of the National FIMR Program. California FIMR has since expanded to its current level of 15 LHJs.

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

PROGRAM PURPOSE

The California 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 for identified problems. It is a community-based, action-oriented process with the intent to improve health and social services for families. The California FIMR Program empowers local community members to take the necessary steps to improve fetal and infant mortality within their own communities through the California FIMR Program, 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.

California 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; and
• mobilize the community to implement interventions that lead to system and community changes to reduce fetal and infant deaths.

California 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.

California Local FIMR Projects

The California FIMR Program is currently funded and implemented in 15 LHJs.

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

REQUIRED PROGRAM COMPONENTS

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

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

• FIMR Coordinator and associated skilled staff
• Local case review authority from Local Health Officer
• Case Review Team (CRT)
• Community Action Team (CAT)
• Community involvement
• Recommendations based on case findings and innovative interventions
• A system for standardized data collection and reporting
• FIMR policies and procedures must include, but are not limited to, the following items:
  o Identify the roles and responsibilities of the FIMR Coordinator and associated skilled staff.
  o Identify the composition of the CRT and CAT.
  o 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.
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.

LOCAL FIMR PROJECTS

Local FIMR projects will:

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

The local FIMR project 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

LOCAL FIMR SCOPE OF WORK (SOW) ACTIVITIES

Additionally, each agency receiving funding from CDPH/MCAH must comply with the following FIMR SOW activities for fiscal year 2021-22. The FIMR SOW activities below include the minimum required activities for the implementation of a local FIMR project.

Assessment

- Complete case reviews fetal, neonatal, and post-neonatal deaths.
- Develop a process for case samples.
- Report on the number of cases with completed reviews and the percentage of all fetal, neonatal, and post-neonatal deaths in the Annual Report.
Maternal, Child and Adolescent Health Division

- Submit local summary report of findings and recommendations (periodicity to be determined by consulting with CDPH/MCAH).

Assurance

- Establish, facilitate, and maintain a Case Review Team (CRT) to review selected cases, identify contributing factors to fetal, neonatal, and post-neonatal deaths, and make recommendations to address these factors.

- Establish, facilitate, and maintain a Community Action Team (CAT) to recommend and implement community, policy, and/or systems changes that address review findings.

- Based on CRT recommendations, LHJs in collaborations with the CAT will identify and implement at least one evidence based or informed intervention involving policy, systems, or community norm changes.

- Submit FIMR Tracking Log and FIMR Committee Membership forms for CRT and CAT with the Annual Report.

Additional information on conducting a local FIMR project can be found below.

CULTURAL COMPETENCE

Diversity among members of the FIMR project, 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.

CONFIDENTIALITY

All FIMR project 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.

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, 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

FIMR Key Personnel

Each local FIMR project 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.
FIMR Standardized Data Collection and Reporting

Local FIMR projects are required to review case findings and submit an MCAH Annual Report and associated documents. Data collection tools may be required by MCAH.

The 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 project as outlined in the SOW result in data collection and reporting in two categories:

- Case reviews, including resulting community interventions.
- Periodic local summaries of the status of fetal and infant deaths and their contributing factors.

FIMR Trainings and Meetings

The CDPH/MCAH Program may provide training and technical assistance to FIMR projects. Local FIMR projects may be required to attend these trainings. Local FIMR projects’ 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.

FIMR Product/Publication Approval and Credit

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

FIMR Annual Report Requirements

All LHJs receiving FIMR project funding are required to complete and submit an Annual Report survey and submit required documentation. This report collects relevant information and data for evaluation, analysis, and monitoring of project performance and for meeting Title V Block Grant and CDPH/MCAH program objectives.
TIME FRAME

The FIMR Annual Report survey and accompanying documents are due annually, usually in August/September. CDPH/MCAH has the option to withhold funding for failure to submit a complete and timely report.

SUBMISSION

The FIMR Annual Report and FIMR components must be submitted via survey link sent to the LHJ.
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFLP</td>
<td>Adolescent Family Life Program</td>
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<tr>
<td>ACOG</td>
<td>American College of Obstetrics and Gynecologists</td>
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<td>AB</td>
<td>Assembly Bill</td>
</tr>
<tr>
<td>AFA</td>
<td>Agreement Funding Application</td>
</tr>
<tr>
<td>A&amp;I</td>
<td>Audits and Investigations</td>
</tr>
<tr>
<td>BIH</td>
<td>Black Infant Health</td>
</tr>
<tr>
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<td>Community Advisory Board</td>
</tr>
<tr>
<td>CAP</td>
<td>Corrective Action Plan</td>
</tr>
<tr>
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<td>Community Action Team</td>
</tr>
<tr>
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<td>California Code of Regulations</td>
</tr>
<tr>
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<td>California Children’s Services</td>
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<tr>
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<td>California Diabetes and Pregnancy Program</td>
</tr>
<tr>
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</tr>
<tr>
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<td>California Department of Public Health</td>
</tr>
<tr>
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</tr>
<tr>
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<td>California Home Visiting Program</td>
</tr>
<tr>
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<td>Children’s Medical Services</td>
</tr>
<tr>
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<td>Certified Nurse Midwife</td>
</tr>
<tr>
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<tr>
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<td>Comprehensive Perinatal Health Worker</td>
</tr>
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</tr>
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</tr>
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</tr>
<tr>
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</tr>
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</tr>
<tr>
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<td>Department of Health Care Services</td>
</tr>
<tr>
<td>EHR</td>
<td>Electronic Health Record</td>
</tr>
<tr>
<td>Family PACT</td>
<td>Family Planning, Access, Care, and Treatment</td>
</tr>
<tr>
<td>FQHC</td>
<td>Federally Qualified Health Center</td>
</tr>
<tr>
<td>FFP</td>
<td>Federal Financial Participation</td>
</tr>
<tr>
<td>FFS</td>
<td>Fee For Service</td>
</tr>
<tr>
<td>FIMR</td>
<td>Fetal and Infant Mortality Review</td>
</tr>
<tr>
<td>FTE</td>
<td>Full Time Equivalent</td>
</tr>
<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act</td>
</tr>
<tr>
<td>HRSA</td>
<td>Health Resources and Services Administration</td>
</tr>
<tr>
<td>ICP</td>
<td>Individualized Care Plan</td>
</tr>
<tr>
<td>OHS</td>
<td>Indian Health Services</td>
</tr>
<tr>
<td>LHJ</td>
<td>Local Health Jurisdiction</td>
</tr>
<tr>
<td>MCAH</td>
<td>Maternal, Child and Adolescent Health</td>
</tr>
<tr>
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<td>Maternal and Child Health</td>
</tr>
<tr>
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</tr>
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</tr>
<tr>
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<tr>
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<tr>
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<td>Perinatal Equity Initiative</td>
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</tr>
<tr>
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</tr>
<tr>
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</tr>
<tr>
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<td>Supplemental Nutrition Services Program</td>
</tr>
<tr>
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<td>Skilled Professional Medical Personnel</td>
</tr>
<tr>
<td>SIDS</td>
<td>Sudden Infant Death Syndrome</td>
</tr>
<tr>
<td>SUID</td>
<td>Sudden Unexpected Infant Death</td>
</tr>
<tr>
<td>STT</td>
<td>Steps to Take</td>
</tr>
<tr>
<td>TANF</td>
<td>Temporary Assistance to Needy Families</td>
</tr>
<tr>
<td>TAR</td>
<td>Treatment Authorization Request (Medi-Cal)</td>
</tr>
<tr>
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</tr>
<tr>
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</tr>
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