

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

About This Document

Introduction

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

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

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

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About MCAH Program

Mission

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

California MCAH Title V Priorities 2011-2015

The MCAH Division has identified the following priorities for 2011-2015:

1. Link the MCAH population to needed medical, mental, social, dental, and community services to promote equity in access to quality services.
2. Improve maternal health by optimizing the health and well-being of girls and women across the life course.
3. Reduce maternal morbidity and mortality and the increasing disparity in maternal health outcomes.
4. Reduce infant mortality and address disparities by promoting preconception health and health care and by preventing causes such as birth defects, low birth weight/prematurity, SIDS, and maternal complications in pregnancy.
5. Promote healthy nutrition and physical activity among MCAH populations throughout the lifespan beginning with exclusive breastfeeding of infants to six months of age.
6. Support the physical, socio-emotional and cognitive development of children, including the prevention of injuries, through the implementation of prevention, early identification and intervention strategies
7. Promote positive youth development strategies to support the physical, mental, sexual and reproductive health of adolescents.

Statutes and Regulations

Introduction

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

Statutes

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

Maternal and Child Health Program (MCAH)

- California H&S §123225-§123255:

The department shall maintain a program of maternal and child health; establish minimum standards that govern the basis for allocations to counties, including, but not limited to, the services to be provided, administration, staffing, fiscal accountability, and eligibility for services; and maximize use of federal funds, including Title XIX matching. The department may recoup or withhold all or part of a county's allocation for failure to comply with those standards. Counties shall submit a plan and budget in accordance with the department's maternal and child health priorities.

- California Welfare and Institutions Code (W&I) §14148.9-§14148.9: Establishes a comprehensive perinatal program and reporting mechanism to the Legislature to improve and coordinate existing programs for pregnant women and infants and remove barriers to care with an intense focus on women who are at high risk of delivering a low or high birth weight baby or a baby who will suffer from major health problems or disabilities. H&S §123505 states that the goals of the community based comprehensive perinatal health care system shall be to decrease and maintain the decreased level of perinatal, maternal and infant mortality and morbidity, and to support methods of providing comprehensive prenatal care that prevent prematurity and the incidence of low birth weight infants.

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

Comprehensive Perinatal Services Program (CPSP)

- H&S §123475-§123525: Establishes a community-based system of comprehensive perinatal care for low income women. States that prenatal care, delivery service, postpartum care, and neonatal and infant care are necessary services that have been demonstrated effective in preventing or reducing maternal, perinatal, and infant mortality and morbidity, including prematurity and low birth weight. Comprehensive perinatal care includes initial and ongoing physical assessment, psychosocial, nutrition, and health educational assessments, interventions, counseling and referral, food supplement programs, vitamins, and breast-feeding and other services as appropriate. Requires all contracted providers to make these services available directly or by subcontract, and to use an appropriate multidisciplinary team.
- W&I §14132(u): Establishes Comprehensive Perinatal Services as defined in §14134.5 as a Medi-Cal benefit.
- W&I §14134.5(a): Defines CPSP providers to include any general practice physician, family practice physician, obstetrician-gynecologist, pediatrician, certified nurse midwife, a group, any of whose members is one of the above-named physicians, or any preferred provider organization or clinic enrolled in the Medi-Cal program and certified pursuant to the standards of this section.
- W&I §14134.5(b): States that perinatal means the period from the establishment of pregnancy to one month following delivery.
- W&I §14134.5(c): States that CPSP services shall include but not be limited to the services delivered through the DHS Obstetrical Access Pilot Program.
- W&I §14134.5(d): Requires the CPSP provider to schedule visits with appropriate providers and track the patient to make sure services have been received. Requires that the patient receive psychosocial assessment and referrals; nutrition assessment, referrals to counseling for food supplement programs, vitamins, and breastfeeding; health, childbirth and parenting education.
- W&I §14134.5(e): Allows providers to contract with medical and other practitioners for the purpose of delivering CPSP services.
- W&I §14134.5(f): States that the Department and the California Conference of Local Health Officers will establish standards for services pursuant to this section.
- W&I §14134.5(g): States that the Department shall assist local health departments to establish a community perinatal program whose responsibilities may include certifying and monitoring providers of comprehensive perinatal services, shall provide technical assistance, shall utilize local health departments in the administration of the program.
- W&I §14134.5(h): States that the Department shall establish a method for reimbursement of comprehensive perinatal providers which shall include a fee for coordinating services and shall be sufficient to cover reasonable costs for the provision of comprehensive perinatal services. The department may utilize fees for service, capitated fees, or global fees to reimburse providers, however if capitated or global fees are used, the department shall set minimum standards for the provision of services including, but not limited to, the number of prenatal visits and the amount and type of psychosocial, nutrition, and education services patients shall receive. States that providers shall not be at risk for inpatient services.
- W&I §14134.5(i): States that the department shall develop systems for monitoring and oversight of comprehensive perinatal services.

- W&I §14134.5(j): States that client participation shall be voluntary.
- H&S §104560-§104569: Comprehensive Perinatal Patient/Client Education and Community Awareness Program. Establishes a comprehensive perinatal outreach program. A county or city may contract with the state department to provide perinatal program coordination, patient advocacy, and expanded access services for low-income pregnant and postpartum women and women of childbearing age who are likely to become pregnant integrated with the county's perinatal program.

Regional Perinatal Program of California (RPPC)

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

Fetal and Infant Mortality Review (FIMR)

- H&S §123650-§123655: Instructs the Department to develop a plan to identify causes of infant mortality and morbidity and to study recommendations on the reduction of infant mortality in CA.
- H&S §100325-§100330: Instructs the Department to conduct special investigations of the sources of morbidity and mortality and the effects of localities, employments, conditions, and circumstances on the public health. Under these provisions, the local health officer may obtain access to various records and information for the purpose of public health investigation of fetal and infant mortality.

Sudden Infant Death Syndrome (SIDS)

- H&S §123725-§123745, Sudden Infant Death Syndrome
 - §123725: The department shall establish a Sudden Infant Death Syndrome (SIDS) Advisory Council. The description of the Advisory Council and its duties are contained in this section. Requires an annual statewide SIDS conference.
 - §123730: The department shall keep each county health officer advised of the most current knowledge relating to the nature and causes of SIDS.
 - §123735: The department shall contract with a person to provide regular and ongoing SIDS education and training and produce, update and distribute literature on SIDS for those who interact with parents and caregivers following a death from SIDS.
 - §123740: Upon being informed by the coroner of a presumed SIDS death, the local health officer or appropriately trained public health professional, after consultation with the infant's physician of record, when possible; and then within three working days of receiving notice from the coroner of a presumed SIDS death, shall contact persons having custody and control of the infant (e.g., family, caregivers, and/or foster parents) to provide information, support, referral and follow-up services.

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

- §123745: The department shall monitor, or contract with a person to monitor compliance by county health officers with H&S §123740.
- H&S §462 and §10253:
 - The coroner shall notify the county health officer within 24 hours when there is a provisional diagnosis of SIDS.
 - Upon being informed by the coroner of a presumed SIDS death, the county health officer or his or her designated agent, after consultation with the infant's physician of record, shall immediately contact the person or persons having custody and control of the infant and explain to such persons the nature and causes of SIDS.

Adolescent Family Life Program (AFLP)

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

Black Infant Health Program (BIH)

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

Sexual Health Accountability Act

- H&S §151000-§151003 The Sexual Health Education Accountability Act of 2007: Requires sexual health education programs that are funded or administered, directly or indirectly, by the State, to be comprehensive and not abstinence-only. Information must be medically accurate, current and objective; age, culturally and linguistically appropriate for targeted audiences. Cannot promote or teach religious doctrine, nor promote or reflect bias. May be required to explain the effectiveness of one or more FDA-approved drugs and/or devices that prevent pregnancy or sexually transmitted diseases. Programs directed at minors are also required to state that abstinence is the only certain way to prevent pregnancy or sexually transmitted diseases.

Creation of Department of Public Health:

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

Regulations

The following regulations apply to Local MCAH Programs:

- U.S. Code of Regulations Title 42, The Public Health and Welfare, Chapter 7, Social Security, Subchapter V-Maternal and Child Health Services Block Grant
- California Code of Regulations, Title 22, Medical Assistance Program, Division 3, §51179-§51179.10 and §51504 (CPSP, September 1987)
- California Code of Regulations, Title 22. Social Security, Division 3. Health Care Services, Subdivision 1. California Medical Assistance Program, Chapter 3. Health Care Services, Article 3. Standards for Participation, §51249. Application Process for Comprehensive Perinatal Providers.
- California Code of Regulations, Title 17, Public Health, Division 1. State Department of Health Services, Chapter 3. Local Health Service, Subchapter 1. Standards for State Aid for Local Health
- Article Organization, §1253. Public Health Nursing Staff
- Office of Management and Budget (OMB) Circular A-87 Revised. *5J10/04-Cost Principles for State, Local and Indian Tribal Governments*
http://www.whitehouse.gov/omb/circulars_a087_2004
- Discrimination Prohibitions, Social Security Act, Section 508; Title V prohibits exclusion from participation, denial of benefits, or discrimination in any program or activity funded in whole or in part with Title V monies on the basis of race, color or national origin, sex, age, religion or handicapping condition.

Understanding Title V of the Social Security Act

About Title V

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

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

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

Title V Focus

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

The Title V Block Grants allow each state to:

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

Title V Requirements

- Provide and promote preventive services for children 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 pregnancy care, injury and violence prevention and healthy lifestyle programs to reduce the incidence of personal risk and health problems
- Every five years the MCAH Division must conduct a comprehensive statewide Needs Assessment
- Each fiscal year, the MCAH Division is required to submit a plan for meeting the needs identified by the statewide Needs Assessment
- Each fiscal year, the MCAH Division is required to submit a report of its activities under the Title V Grant to the federal government. This includes reporting on national and state performance measures, setting annual targets and reporting on progress toward meeting the identified goals and objectives
- Provide and maintain a state toll-free number (and other appropriate methods) to make available to parents information about health care providers and practitioners who provide services under Title V and Title XIX as well as other relevant information. To fulfill this requirement, MCAH Division requires all LHJs to provide and maintain a local toll-free number.
- Provide outreach services to identify pregnant women and infants who are eligible under the State's Medicaid program and assist them in applying for Medicaid assistance

MCAH Division Title V Requirements

About MCAH Division

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

Needs Assessment

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

Public Health Frameworks

Ten Essential Public Health Services

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

10 Essential Maternal, Child, and Adolescent Health Services:

Assessment

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

Policy Development

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

Assurance

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

For more information, please refer to the CDC website:

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

Healthy People 2020

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

The goals of Healthy People 2020 are to:

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

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

National Prevention Strategy (NPS)

On June 6, 2011 the Office of the Surgeon General published the National Prevention Strategy, which is a comprehensive plan to increase the number of Americans who are healthy at every stage of life. You may download the report at:

<http://www.surgeongeneral.gov/initiatives/prevention/strategy/report.html>

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

The Priorities in the NPS are:

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

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

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

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

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

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

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

Evidence-Based Public Health Practice

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

The Committee defined evidence-based public health practice as “the development, implementation, and evaluation of effective programs and policies in public health through application of principles of scientific reasoning, including systematic uses of data and information systems and appropriate use of behavioral science theory and program planning models”.

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

MCAH programs should consider the following when planning and evaluating interventions:

- Population health issues are multifaceted; therefore, to be effective, interventions should take place at multiple levels (individual, social/community, environmental, policy—see socio-ecological model)
- Interventions focus on population effects; surveillance data is a good indicator of performance
- Community preferences, political and logistical feasibility, and budget constraints are also important to consider
- Measure short, medium and long term outcomes. Many interventions take place over a long period of time. Health outcomes may not be immediately apparent.
- Measure the magnitude of an effect as well as whether there was an effect

Sources of evidence-based community health practices include:

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

The Guide to Community Preventive Services

The Task Force on Community Preventive Services is an independent, nonfederal, volunteer body of public health and prevention experts, whose members are appointed by the Director of CDC to develop and issue recommendations and findings to inform decision making about policy, practice, research, and research funding in a wide range of U.S. settings. The Guide to Community Preventive Services is a resource for evidence-based Task Force recommendations and findings about what works to improve public health. The Guide to Community Preventive Services contains evaluations of

interventions in the following areas: adolescent health, alcohol, asthma, birth defects, cancer, diabetes, health communication, HIV/AIDS, STIs and pregnancy, mental health, motor vehicle, nutrition, obesity, oral health, physical activity, social environment, tobacco, vaccines, violence, and worksite. All MCAH LHJs are encouraged to consult this guide when choosing community preventive services to implement to address needs in their local areas. For more information, see the Website at <http://www.thecommunityguide.org/index.html#topics>

Life Course and Social Determinants of Health

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

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

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

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

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

Spectrum of Prevention

The Spectrum of Prevention was developed by the Prevention Institute in Oakland. It identifies multiple levels of intervention and encourages people to move beyond the perception that prevention is about teaching healthy behaviors. Levels of intervention include: influencing policy and legislation, changing organizational practices, fostering coalitions and networks, educating providers, promoting community education, and strengthening individual knowledge and skills. MCAH recommends that LHJs implement a multifaceted approach to prevention that includes multiple levels of intervention. For more information, see the following link:

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

Strengthening Families

The Strengthening Families Program (SFP) is a nationally and internationally recognized parenting and family strengthening program. SFP is an evidence-based family skills training program found to significantly reduce problem behaviors, delinquency, and alcohol and drug abuse in children and to

improve social competencies and school performance. Child maltreatment also decreases as parents strengthen bonds with their children and learn more effective parenting skills.

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

MCAH endorses this approach.

Socio-ecological Model

The socio-ecological model explains that individual behavior affects and is affected by the world the individual lives in. The individual lives in a group, which resides in an organization, in a community, which is affected by public policy. Prevention strategies should include a continuum of activities that address multiple levels in the model. For more information, see the following link:

<http://www.cdc.gov/ViolencePrevention/overview/social-ecologicalmodel.html>

Let's Get Healthy California Task Force Report

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

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

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

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

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

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

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

Worksite Wellness Policy

About Policy

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

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

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

Guidelines

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

Guideline I

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

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

Guideline II

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

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

Links to worksite nutrition and physical activity resources:

Network for a Healthy California--Worksite Program:

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

Worksite Nutrition and Physical Activity Resources

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

Take Action 10-Week Health Promotion Plan:

<http://www.takeactionca.com/>

Guideline III

Support breastfeeding mothers

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

Link for lactation accommodation at the workplace resources:

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

Specialized MCAH Programs

Introduction

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

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

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

Because of specific program and budgetary mandates, the MCAH, AFLP, BIH and CHVP Programs require separate budgets, Scopes of Work (SOW), Annual Reports, and policies and procedure manuals. SIDS and FIMR programs receive separate allocations that are included in the MCAH budget.

CPSP and SIDS activities are included within the MCAH SOW. The FIMR activities are included in a separate FIMR SOW.

SIDS Program

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

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

State

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

1. Upon being notified by the coroner of a presumed SIDS death, consulting with the infant's physician, when possible; and then
2. Immediately contacting the persons having custody and control of the infant (e.g., family, caregivers, and/or foster parent) to provide information, support, referral, and follow-up services.
3. MCAH is also required by HSC §123730 to keep each county officer advised of the most current knowledge relating to the nature and cause of SIDS.

Local

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

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

Comprehensive Perinatal Services Program

See the Comprehensive Perinatal Services Program (CPSP) Perinatal Services Coordinators' (PSC) Policies and Procedures at the end of this Manual.

Black Infant Health

See the Black Infant Health Policies & Procedures

There are BIH programs in 15 Local Health Jurisdictions where over 75% of African American infant births occur: (Alameda, Berkeley, Contra Costa, Fresno; Kern, Long Beach, Los Angeles, Pasadena, Sacramento, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, and Solano).

Adolescent Family Life Program

See the Adolescent Family Life Program Policies and Procedures

There are 31 AFLP programs in California. Depending on the location, community based organizations or Local Health Jurisdictions administer AFLP programs ([AFLP Coordinator Directory](#))

Local Health Jurisdiction Requirements

LHJ Requirements

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

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

Key Personnel

Policy

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

MCAH Director Requirements

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

- A physician who is board-certified or board-eligible in specialties of Obstetrics/Gynecology, Pediatrics, Family Practice or Preventive Medicine; or
- A non-physician who must be a certified public health nurse (PHN).

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

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

The MCAH Director, in collaboration with the local health officer, has the general responsibility and authority to plan, implement, evaluate, coordinate and manage all MCAH services within the LHJ.

In LHJs participating in the California Home Visiting Program (CHVP), the MCAH Director is required to devote a minimum of 0.15 FTE to CHVP oversight, fostering partnerships and collaboration within the LHJ, and directing the local CHVP Community Advisory Board (CAB). These requirements are in addition to the Key Personnel requirements for the MCAH Director FTE as outlined in the MCAH Policies and Procedures Manual.

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

MCAH Coordinator Requirements

The MCAH Coordinator must be a Skilled Professional Medical Personnel ([SPMP](#)). Refer to the fiscal Policies and Procedures for the definition of an SPMP. The MCAH Coordinator assists the MCAH Director in fulfilling the MCAH Director's responsibilities outlined below and in the MCAH SOW.

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

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

MCAH Director Responsibilities

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

Assessment

- Participate in MCAH Division-sponsored training on data sources, data management, preparation of data for analysis, and the translation of data into information for program planning
- Monitor local health status indicators for pregnant women, infants, children, adolescents and their families using standardized data techniques for the purpose of identifying at-risk populations,

including monitoring incidence of SIDS. Utilize this data to develop an understanding of health needs within the community, and identify barriers to the provision of health and human services for the MCAH population

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

Policy Development

- Use the information gathered during assessments to develop and implement local policies and programs with measurable objectives
- Develop plans and direct resources consistent with program goals and objectives
- Facilitate access to care and appropriate use of services. This may include, but not be limited to, oversight of CPSP, recruitment of providers, patient/client outreach, education, community awareness, referral, transportation, childcare, translation services and care coordination
- Ensure the availability of a toll free or "no cost to the calling party" telephone system which provides a current list of culturally and linguistically appropriate information and referral to community health and human resources for the general public regarding access to prenatal care. The telephone number must be disseminated widely throughout the health jurisdiction by means of pamphlets, publications and media publicity. At a minimum, the toll free line must be operational during normal business hours and must be linguistically appropriate. Personnel staffing the toll free line should have cultural sensitivity training. After-hours messages must be answered by the end of the following business day
- Ensure implementation and coordination of local MCAH programs
- Ensure that SIDS activities take place, including community SIDS risk reduction education and intervention with families experiencing a presumed SIDS death.
- Coordinate all MCAH patient/client outreach, education, and community services provided by local, state and federal programs 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 indicators for women, children, adolescents and their families
- Attend MCAH Action meetings and other required trainings. Adequate funding for training and meeting expenses, including travel, must be built into the annual budget

Evaluation

- Based on activities of assessment, policy development and assurance;
 - Evaluate and modify program to ensure best practices are implemented
 - Include methods of measuring outcomes and evaluating progress toward achieving both State and local MCAH objectives in selected local priority activities
- Identify barriers/challenges to implementation activities

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

Local Health Jurisdiction Candidate Selection

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

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

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

Key Personnel Waiver

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

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

1. Submit the request for a waiver in writing on agency letterhead and signed by the agency director or designated supervisor of the proposed appointee. The request shall be submitted to the MCAH Division NC and CM.
2. Describe the reason(s) for the inability to hire an individual who meets the professional requirements for key personnel by addressing education, licensing and experience of the candidate and demonstrate how the LHJ will assure the appropriate level of clinical oversight for the program (e.g. MD oversight for counties with more than 750,000 population, and PHN oversight for counties with less than 750,000 population) if the proposed candidate does not have the required clinical license.
3. Describe the reason(s) for the inability to meet the FTE requirement for the MCAH Director.
4. Submit a description of the candidate's qualifications along with a resume. Include an assessment of expectations for successful program implementation and support for the individual within the LHJ.

5. If the LHJ is requesting a waiver for a PHN or an MPH in place of a physician, or an MPH in place of a PHN, the LHJ must describe its mechanism for oversight of medical issues.
6. Submit a duty statement that reflects the roles and responsibilities of the position.
7. Submit an organizational chart from the local MCAH program and an agency interdepartmental organizational chart.
8. Submit a copy of the approved waiver with the AFA packet annually.

The State MCAH Program will consider each waiver request individually.

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

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

Interim Plan

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

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

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

Perinatal Services Coordinator (PSC) Requirements

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

PSC Activities FTE Chart	
Total Number of Births in LHJ	FTE for PSC
100,001	2.0 SPMP
50,001-100,000	1.50 SPMP
25,001-50,000	1.25 SPMP

10,001-25,000	1.0 SPMP
5,001-10,000	0.75 SPMP
1,000-5,000	0.50 SPMP
<1000	0.25 SPMP

PSC Responsibilities

The PSC, under the direction of the MCAH Director, will have the responsibility to:

- Serve as a liaison to local provider groups, managed care plans, community agencies and others to promote the coordination and accessibility of health care services for pregnant women and infants, particularly those who are Medi-Cal eligible and/or low income
- Assist in the recruitment and retention of Medi-Cal providers into the CPSP
- Assist providers to deliver CPSP services in accordance with Title 22 California Code of Regulation

Assessment

- Monitor trends in access and quality of prenatal care
- Identify geographic areas or population groups that have insufficient access to quality and timely prenatal care

Policy Development

- Report assessment findings and activities to the MCAH Director for incorporation into the LHJ's **community profile and local MCAH plan to improve services**
- Inform the perinatal community, including providers, managed care plans, and other health and human service providers about local status and trends of perinatal outcomes and their relationship to the yearly, local MCAH Plan.
- Educate the provider community, including managed care plan providers, and other health and human services providers about CPSP, the needs of the target population and sub-populations such as homeless, substance users, the migrant workers, etc.
- Collaborate with providers and other third party payers to extend comprehensive perinatal services to all pregnant women.
- Participate in local planning, work groups, advisory committees, and collaboratives to address unmet needs to provide access to prenatal care and CPSP services for all pregnant women
- Develop and implement Continuous Quality Improvement/Quality Assurance (CQI/QA) programs for CPSP providers
- Promote, develop and coordinate professional and community resources

Assurance

- Process applications for eligible providers desiring to become approved CPSP providers.
- Provide consultation and technical assistance to CPSP providers and managed care plans related to the provision of CPSP services

- At a minimum, conduct yearly QA activities to address issues related to access and quality of perinatal care delivered by CPSP providers.
- Assure 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 communications.
- Attend a new PSC orientation and a CPSP Annual meeting; and, if funds are available, a regional training, including the local Provider Overview and Steps to Take trainings.

Evaluation

- Evaluate implemented activities to determine outcome and quality of services to the target population
- Report collected data and outcomes related to implemented activities to the MCAH Director

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

Client Triage

Background: The MCAH Division is responsible for maintaining the integrity of our current MCAH programs and committed to ensuring the most effective and efficient use of limited resources. Allowing an eligible woman to participate in more than one MCAH-funded program excludes 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. Additionally, if a client is participating in more than one MCAH-funded program, evaluation of innovative and promising practices such as BIH may be compromised. The MCAH Division is looking into the possibility of conducting a pilot study in selected LHJs to assess the benefit and feasibility of client participation in more than one program.

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

Policy:

- Eligible women may enroll and participate in only one MCAH Division funded program concurrently
- It is the responsibility of the Local Health Jurisdiction MCAH Director or designated staff, in consultation with the client, to determine the program that best meets the client's needs

Procedure:

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

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

MCAH Program Descriptions, Client Profile and Client Enrollment Guidelines

The information below is provided to inform identification of the program that is the best fit for a client. The goal is to meet the client's needs by linking them to the program most likely to have the greatest health impact based on available evidence.

Black Infant Health (BIH) – Client Participant Description

The BIH Program aims to improve health among African American mothers and babies by empowering pregnant and mothering African American women to make healthy choices for themselves, their families, and their communities. Within a culturally affirming environment and honoring the unique history of African American women, the BIH Program uses a group-based approach with complementary client-centered case management to help women develop life skills, learn strategies for reducing stress, and build social support.

A group-based approach has been shown to be an effective model for health education/promotion and fostering empowerment. The potential benefits of group-based prenatal and postpartum health interventions to important maternal health-related indicators include improvements in perceived mastery, knowledge, and health-related behaviors (Klerman LV, et al., 2001), including reduced alcohol consumption (Coleman MA, et.al., 1990) and improved breastfeeding outcomes (Chapman DJ, et.al. 2012). Group activities are considered to be more conducive to an empowerment model (Rising SS. 2007) and to building connections among participants; some research suggests that

increased social support can reduce stress-related symptoms and may be linked with improved infant birthweights (Glazier RH, et.al. 2004; Norbeck JS, et.al. 1996).

Historically, the BIH Program has served a subgroup of African American women at relatively high risk of adverse maternal and infant health outcomes. Based on comparisons with African American childbearing women statewide, BIH clients are more likely to have unintended pregnancies, initiate prenatal care later in pregnancy, have Medi-Cal coverage, be unmarried, have lower educational attainment, and be younger. CDPH/MCAH anticipates that the BIH Program will continue to serve women with similar characteristics, and encourages BIH LHJs to secure matching federal funds for women who are Medi-Cal eligible.

A woman is eligible for entry into BIH if she meets the following criteria:

Is a self-identified African American woman who is pregnant or parenting (up to 3 months postpartum);

- Is 18 years of age or older;
- Resides in the target area or within the LHJ;
- Consents to actively participate in the entire BIH program including:
 - a. Group intervention;
 - b. Individual enhanced case management;
- Consent to release information from her prenatal care provider, her baby's birth certificate information, and Management Information System.

Adolescent Family Life Program (AFLP) or AFLP-Positive Youth Development (PYD) - Client Participation Description

AFLP services are available to pregnant/parenting adolescent females up to the 19th birthday. Agencies may also enroll parenting or expectant adolescent males up to the 19th birthday. The purpose of AFLP is to address the social, medical, educational, and economic consequences of adolescent pregnancy through the provision of comprehensive case management services with the following goals:

- (1) Improve the health of the pregnant and parenting teen, thus supporting the health of the baby
- (2) Improve graduation rates for pregnant and parenting teens
- (3) Reduce repeat pregnancies for pregnant and parenting teens, and
- (4) Improve linkages and create networks for pregnant and parenting teens

To positively impact the goals of the AFLP program, MCAH is developing an evidence-informed case management intervention with integrated life planning for AFLP pregnant and parenting teen clients through a pilot project called Positive Youth Development (PYD). PYD is based on a resiliency framework and incorporates the science behind preconception health promotion and life planning in order to promote adolescent sexual and reproductive health. The resiliency framework helps identify protective factors in the family, school, and the community to meet basic youth needs through the promotion of resiliency, strengths, and healthy relationships that result in positive outcomes. This program initiative, known as AFLP PYD, is being piloted in 11 of the 33 AFLP sites.

A client is eligible for entry into AFLP if she/he meets the following criteria:

- Is a pregnant or parenting adolescent female
- Is an expectant or parenting adolescent male
- Is less than 19 years of age
- If parenting, must have custody of the index child or be co-parenting with the custodial parent.

AFLP targets pregnant and parenting adolescents with risk factors such as poor health and nutrition, poor school attendance/achievement, domestic violence, unstable living environment, lack of family and social supports, mental health issues, substance use, abuse history, legal involvement, etc. AFLP benefits clients who are working toward school completion, improving their own health and the health of their own child, preventing secondary pregnancies.

Agencies must establish weighted risk factors to determine acuity and prioritize clients for entry into AFLP. Risk factors must be weighted and prioritized based on local needs and must include, but are not limited to, the following:

- Age (15 years or younger)
- African American
- Chronic health conditions (diabetes, asthma, eating disorders, etc.)
- Currently parenting
- Pregnancy
- Sexually active
- Lack of parental involvement
- Unsafe/unstable home environment
- Inadequate housing
- Substance abuse/use
- Mental health issues
- Physical risk/harm to self or others
- Problem behavior
- Academic failure
- No prenatal care or late entry into prenatal care
- Juvenile justice involvement
- Gang involvement
- Court ordered participation
- Lack of support system
- Language Barrier
- Lack of other community resources to meet client needs

To enroll a client age 19 or older, the AFLP agency must submit a waiver request. AFLP is a voluntary program that requires the client's informed consent to participate.

California Home Visiting Program (CHVP) - Client Participant Description

CDPH/MCAH established the CHVP to implement evidence-based home visiting programs in unique communities spread throughout LHJs that represent diversity in geography, including both rural and

urban areas. Home visiting is defined as an evidence-based program that includes home visiting as a primary service delivery strategy (excluding programs with infrequent or supplemental home visiting).

Funds and resources for the CHVP are provided through the U.S. Department of Health and Human Services' Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV). There are three key legislative mandates for the program:

- Strengthen and improve the programs and activities carried out under Title V
- Improve coordination of services for at-risk communities
- Identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities

There is a large body of evidence showing the positive impact that home visiting programs have on clients. Studies have shown that mothers enrolled in home visiting were more likely to become aware of more community services, attend childbirth classes more frequently, make more extensive use of nutritional supplementation program, and make greater dietary improvements. In addition, children visited by nurses had lower rates of injuries and ingestions, fewer behavioral and parental coping problems, and fewer visits to the emergency room. Research also suggests long-term benefits associated with home visiting, such as lower rates of parental abuse, drug and alcohol abuse, and arrests.

While there are many models for home visiting, CHVP utilizes two evidence-based models: Nurse Family Partnership (NFP) and Healthy Families America (HFA). Both models have specific eligibility requirements for program participation.

- NFP is designed for first-time, low-income mothers and their children. NFP requires a client to be enrolled in the program early in pregnancy and to receive a first home visit no later than the end of the 28th week of pregnancy. Services are voluntary and are available until the child is 2 years old.
- HFA services begin prenatally or within 3 months of baby's birth and are offered voluntarily over the long-term (3 to 5 years) after the birth of the baby. HFA requires the use of a "level system" for managing the intensity of home visiting services. A well-thought out level system is sensitive to the needs of each family, the changes in family needs over time, and the responsibilities of the home visitor.

In addition to the eligibility requirements defined by both models, CHVP defined eligible clients as being from high risk populations with one or more of the following risk factors:

- Inadequate nutrition and food insecurity
- Unsafe housing
- Homelessness
- Exposure to alcohol, drugs, abuse, neglect and violence in the home or community
- Inadequate access to community resources such as perinatal programs
- Inadequate prenatal care
- Unemployment

- High crime rate in the community
- Pre-term birth
- School drop-out
- Mental health issues

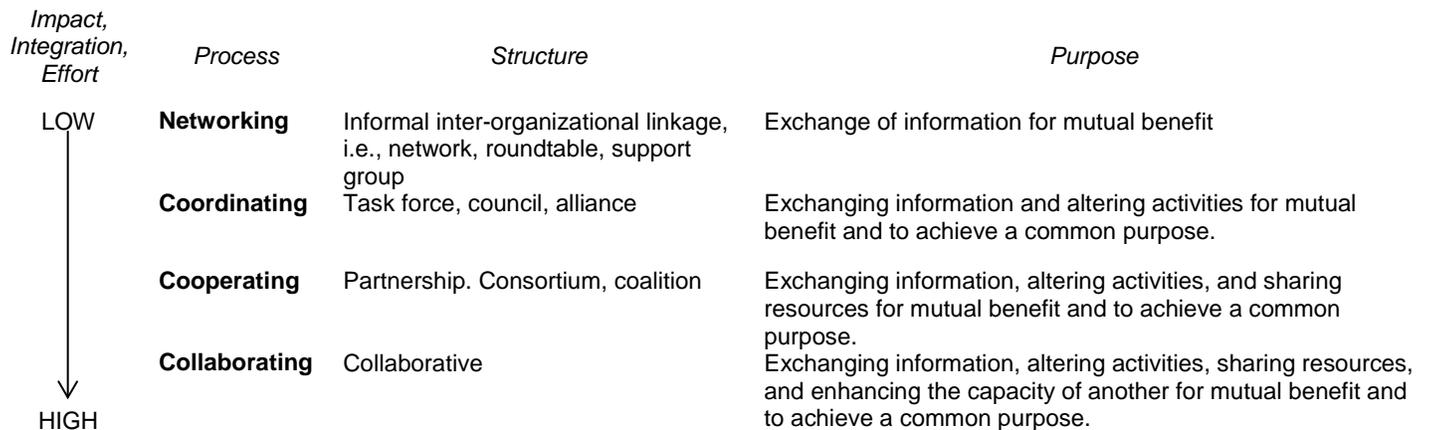
Collaboration

Collaboration is a process in which two or more people or organizations work together to develop a common shared vision and purpose and implement activities that are designed to achieve mutually identified goal(s) and objective(s). Some potential benefits of collaboration include increasing community awareness, developing new services, reducing duplication, and increasing internal capacity and leveraging resources. Collaborative efforts are dynamic and flexible and change as they grow and develop.

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

We recognize the importance of MCAH staff participation in collaborative efforts. Much of local MCAH work is accomplished through collaborative efforts. The tools and information provided below will assist you to evaluate and determine the impact of your collaborative efforts.

Collaborative efforts operate at several levels. The impact a collaborative effort has is influenced by its structure and levels of relationships as illustrated in the diagram below.



Networking is the most informal of the inter-organizational linkages and often reflects an initial level of trust, limited time availability, and a reluctance to share turf.

Coordinating requires more organizational involvement than networking and is a very crucial change strategy. Coordinated services are "user-friendly" and eliminate or reduce barriers for those seeking access to them. Compared to networking, coordinating involves more time, higher levels of trust yet little or no access to each other's turf.

Cooperating requires greater organizational commitments than networking or coordinating and may involve written agreements. Shared resources can encompass a variety of human, financial, and technical contributions, including knowledge, staffing, physical property, access to people, money, and others. Cooperating can require a substantial amount of time, high levels of trust, and significant access to each other's turf.

Collaborating requires the willingness of organizations or individuals to enhance each other's capacity for mutual benefit and a common purpose. Collaborative organizations share risks, responsibilities, and rewards. Collaborating is usually characterized by substantial time commitments, very high levels of trust, and extensive areas of common turf.

Guidelines for evaluating the effectiveness of collaborative efforts

A logic model is an essential tool to help the collaborative effort develop logically linked steps to achieve desired outcomes. A logic model will give your collaborative effort direction and a way to check progress.

Because of the unique nature of collaborative efforts, there may be no standard outcomes or indicators of success. Collaborative efforts impact one or more of the following broad goal areas:

- Service creation or modification
- Resource maximization
- Policy development
- Systems development or change
- Social or community development

These broad goals translate into tangible improvements in outcomes for individuals, families, groups, organizations, or communities.

Issues to think about as you prioritize your work and evaluate the effectiveness and impact of collaborative efforts.

Evaluation is a shared process of inquiry among collaborative members that helps inform and guide decision making, improve communication and support continuous progress. Evaluation questions focus on feasibility, process and outcomes at two levels, individual members and the organization they represent and the collaborative as a whole.

Feasibility evaluations should be a collective effort and collaborators should meet to discuss the results of the evaluations. The focus on feasibility evaluation is on the collaborative effort as a whole, its ability to function effectively and produce desired results.

Questions to ask during a feasibility evaluation are:

- Is a collaborative effort needed?
- What is likely to be the most appropriate approach and composition?
- What opportunities or barriers to collaboration exist?
- Are adequate resources and capacities available?

- What are the implications of the new initiative for the existing structure and process of the collaborative effort?
What are the consequences of dropping a particular project or ending the collaborative effort as a whole?

Process evaluation information is used by the collaborative effort to ensure that planned activities are occurring, resources are used efficiently, and to assist members in making decisions about change or improvements.

Questions to ask during a process evaluation are:

- Are the right people participating? What is the level of involvement?
- Are we working well as a group?
- Are programs or activities being implemented as planned?
- Are resources being used wisely?
- How do we sustain involvement and interest?

Outcomes are the desired results or impact that the collaborative effort is trying to achieve. Outcomes should substantiate the collaborative effort's value, use of resources and the commitment of its members and community.

Questions to ask during an outcome evaluation are:

- What has improved as a result of our work? How and for whom?
- To what extent are we achieving desired outcomes?
- What difference has resulted from our work in this collaborative effort?
- Was the collaborative effort worth the time and costs to achieve its results?

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

Collective Impact

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

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

most of our serious and complex social problems if nonprofits, government, businesses and the public worked together around a common agenda.

Collective impact requires a systematic approach that focuses on the relationships among organizations and progress toward shared objectives. The five conditions that make collective impact possible are: a common agenda, shared measurement systems, mutually reinforcing activities, continuous communication, and backbone support organizations. For more information on collective impact, see the article, "Collective Impact", by John Kania and Mark Kramer, in the winter 2011 Stanford Social Innovation Review at http://www.ssireview.org/articles/entry/collective_impact.

Agreement Funding Application (AFA)

Introduction

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

Purpose

The purpose of the MCAH allocation is to:

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

Funding Sources

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

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

Budgets

Forecasting Annual Budget

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

Travel, Training and Meetings

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

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

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

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

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

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

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

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

LHJ Community Profile Requirements

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

Scope of Work

SOW Requirements

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

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

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

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

- The SOW consists of 6 goals, which are consistent with State priorities and fulfill Title V, SIDS and CPSP requirements
- Each FY the LHJ is required to develop an objective(s) to address one problem identified in the Local Needs Assessment in each of Goals 1, 2, and 3. One Infant Health objective under Goal 3 must address SIDS prevention. If resources allow, LHJs should also develop additional objectives and place them under Goals 1-6 as appropriate.
- LHJs will be held accountable for completing activities described in their individualized SOW.
- LHJs will be responsible for monitoring and reporting on performance measures.

Structure of SOW

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

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

- Goals 1, 2 and 3 - Each LHJ is required to develop one short and/or intermediate outcome objective and corresponding intervention activities and evaluation/performance measures for Goals 1, 2, and 3.
- If resources allow, LHJs should also develop additional objectives, which they may place under any of the Goals 1-6.
- All LHJs must perform the activities in the shaded areas in Goals 1-3.
- Goals 4-6 are optional.

SOW Goals

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

- **Goal 1**– (required) Improve Outreach and Access to Quality Health and Human Services - Incorporates the MCAH priority and the Title V requirement to conduct outreach and link the MCAH population to needed medical, mental, social, dental, and community services. LHJs are required to facilitate access and referrals to Medi-Cal, Covered CA, Access for Infants and Mothers (AIM), Child Health and Disability Prevention Program (CHDP), Women, Infants, and Children (WIC), Family Planning, Access, Care, and Treatment (Family PACT), and health, and developmental disability programs. This goal also fulfills the Title V requirement for the toll-free or “no cost to the calling party” number (and other appropriate methods) to provide information about health and human services to parents and providers (LHJs must track and report the annual number of toll-free calls and web hits). Emphasis is on maintaining required foundational structure, community collaboration and public health activities that improve coordination and access to family-centered, culturally competent, health and human services.
- **Goal 2**–(required) Improve Maternal and Women’s Health - Incorporates the MCAH priorities to improve maternal and women’s health by optimizing the health and well-being of girls and women across the life course, reducing maternal morbidity and mortality and disparities in maternal health outcomes, and assuring that all pregnant women have access to early, adequate and high quality perinatal care. This goal also includes the requirement to promote access to and quality of the local CPSP.
- **Goal 3**– (required) Improve Infant Health - Incorporates the MCAH priority to reduce infant mortality and address disparities by promoting preconception health and health care and preventing causes such as birth defects, low birth weight/prematurity, SIDS, and maternal complications during pregnancy. This goal includes the requirement to contact parents/caregivers of infants with a presumed SIDS death and offer grief and bereavement support services, and attend annual SIDS conferences/trainings. Each LHJ must develop a local objective to promote SIDS risk reduction and community health education activities.
- **Goal 4**– (optional) Improve Nutrition and Physical Activity - Incorporates the MCAH priority to promote healthy nutrition and physical activity among MCAH populations throughout the lifespan beginning with exclusive breastfeeding to six months of age.
- **Goal 5**– (optional) Improve Child Health - Incorporates the MCAH priority to support the physical, socio-emotional, and cognitive development of children, including the prevention of injuries, through the implementation of prevention, early identification and intervention strategies.

- **Goal 6**– (optional) Improve Adolescent Health - Incorporates the MCAH priority to promote positive youth development strategies to support the physical, mental, sexual and reproductive health of adolescents.

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

The LHJ should use the following directions and guidelines to develop and write at least one specific SIDS objective and activities for their agency.

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

- Monitor the number and trends in presumed SIDS deaths. An appropriately trained public health professional, defined as a public health nurse or a social worker who is knowledgeable about the incidence of sudden infant death syndrome and the care and support of persons who have experienced a death of this nature, and who has basic grief counseling skills must contact all parents/caregivers who experience a presumed SIDS death to provide grief and bereavement support services.
- At least one public health professional to attend the State Annual SIDS Conference and/or other SIDS training(s).

In addition, each LHJ must also develop an additional SIDS objective to increase knowledge and implementation of infant safe sleep and SIDS risk reduction in the community. The Local SIDS Objective intervention activities may include but are not limited to:

- Producing/reproducing SIDS educational materials
- Distributing infant safe sleep and SIDS risk reduction educational materials within the community, especially to high risk populations
- Providing trainings and materials for those who interact with parents and caregivers following a presumed SIDS death, including:
 - Hospital staff
 - Child care providers
 - Foster care providers
 - First responders
 - Coroner
- Attending local health fairs, conferences and other related events to provide infant safe sleep and SIDS risk reduction materials

Developing the LHJ's Local Objective(s)

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

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

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

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

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

Changes to the SOW

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

Duty Statements

Duty Statement Requirements

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

Duty statements for personnel identified in the budget shall be used as supporting documentation for the percent of time assigned to MCAH program activities and the level of FFP matching.

Duty statements must:

- Contain position titles that match those on the organizational chart, budget, and budget justification documents
- Reflect MCAH activities accurately
- Contain only those duties performed for the MCAH program or specific program duties
- Provide information regarding:

- Targeted populations
- Targeted geographic areas
- Specific practice settings or function
- Duty statements for Skilled Professional Medical Personnel (SPMP) will note 'SPMP' at the top of the duty statement or along with the position title or contain the statement "*This position must meet the criteria for SPMP*".

Guidelines for Developing Duty Statements

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

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

The following provides general information for developing duty statements:

- Statements should be short, focused, concise and describe the activities to be performed accurately
- If a position has multiple personnel, it is not necessary to have separate or individual duty statements if the duties are the same
- Do not include personnel names on the duty statement
- SPMP duty statements should reflect the unique expertise required for these duties
- Enhanced FFP matching is only permissible for activities requiring the skill, knowledge and ability of an SPMP

- Key personnel duty statements should be consistent with requirements stated in the MCAH Policies and Procedures Manual
- Duty statements should be reviewed annually and may change when assignments for the position change
- Include date of creation or update

Organization Charts

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

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

The organization chart must:

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

Annual Report Requirements

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

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

Submit the Annual Report as follows:

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

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

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

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

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

Documentation

Documentation of AFA and SOW changes and activities must be in writing and kept on file for audit purposes for three years from the date of final payment or longer for open audits. (See MCAH Fiscal Policies and Procedures, Audit File Retention). While participation in the MCAH Program does not authorize access to Personal Health Information (PHI), some LHJs will have access to such information by virtue of the County/City structure or with the permission of individual clients. LHJs are advised that any PHI stored at their agency must adhere to Health Insurance Portability and Accountability Act (HIPAA) of 1996 regulations.

Product/Publication Approval and Credit

Product/ Publication Approval

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

The process for approval is as follows:

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

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

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

Title V/MCAH Funding Acknowledgement

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

- A statement identifying funding support on the title page of public reports or publications
- A statement identifying funding support on the first page of any journal articles

For example: “This project was supported by funds received from the California Department of Public Health, Maternal, Child and Adolescent Health Division.”

Photographs

Photographs used on all media products developed by LHJs require permission for the use intended. This permission may come from the source of the document and/or require the subject’s written consent. When an LHJ submits products for approval, the LHJ must state that photo consent was obtained and is kept on file. A sample photo consent form is posted on the MCAH web page and must be completed by LHJ. The LHJ may use the sample form to create a form for use within the LHJ.

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

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

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

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CPSP Program Overview

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

CPSP Goals: H&S §123505:

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

CPSP Objectives: H&S §123510:

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

CPSP provides a model of enhanced perinatal services for Medi-Cal eligible low-income, pregnant and postpartum women from the date of conception through 60 days after the month of delivery. CPSP is a Medi-Cal program for eligible obstetric (OB) providers to provide enhanced services for pregnant women. The CPSP model is based on evidence that pregnancy and birth outcomes improve when routine obstetric care is enhanced with nutrition, health education, and psychosocial services.¹ CPSP-approved Medi-Cal providers and Medi-Cal Managed Care (MCMC) contracted health plans are required to follow the current American Congress of Obstetrics and Gynecologists (ACOG) standards as the minimum standards for obstetrical services provided to Medi-Cal pregnant women.

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.

The enhanced services are delivered as defined by Title 22 Regulations. CPSP providers who provide patients with these enhanced services are reimbursed by Fee For Service (FFS) Medi-Cal at a higher rate than those who provide standard OB care. Managed care providers are reimbursed according to their contract with the managed care plan, but the reimbursement must be sufficient to cover reasonable costs of providing CPSP comparable services (Welfare and Institutions Code Section 14134.5(h)).

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

The Maternal, Child and Adolescent Health Division oversees the CPSP program. The MCAH Division is required to do the following:

- 1) Establish and maintain a comprehensive, community-based perinatal program.
 - a. H&S §123490—Develop and maintain a statewide comprehensive community-based perinatal services program and enter into contracts, grants, or agreements with health care providers to deliver these services in a coordinated effort to the extent permitted under federal law and regulation.
 - b. Welfare and Institutions Code (W&I) §14134.5(g)--provide local health departments with technical assistance for the purpose of implementing the community perinatal program. If sufficient resources are not available, the department shall use alternative means to implement the perinatal program.
- 2) Establish standards for providers, program services, reimbursements and patient rights safeguards.
 - a. W&I §14134.5: (e) adopt regulations which define qualifications of any practitioners who are not currently included.
 - b. W&I §14134.5(f) establish standards for health care providers and for services rendered pursuant to this subdivision
 - c. W&I §14134.5 (h) “establish a method for reimbursement of comprehensive perinatal providers which shall include a fee for coordinating services and which shall be sufficient to cover reasonable costs for the provision of comprehensive perinatal services”.
 - d. (h)“ if capitation or global fees 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, nutritional, and educational services patients shall receive.”
 - e. (j) Develop patient rights safeguards
 - f. H&S §123510: ensure to the extent possible that the same level of care is available to all pregnant women.
 - g. Title 22, §51348 states that Medi-Cal managed care plans shall deliver perinatal care consistent with CPSP requirements unless their contract approved by DPH provides

otherwise. Medi-Cal Managed Care contracts require plans to deliver CPSP comparable services to enrollees.

- 3) Utilize specific criteria when evaluating/approving applications
 - a. Title 22 §51249(b)—Utilize the following criteria in evaluating applications.....Training and ability of providers to deliver comprehensive perinatal services.
 - b. (c)—Have responsibility for the final decision and for notifying the provider of acceptance or rejection of the application (includes time frame)
 - c. W&I §14134.5(g): Local health departments may certify providers.
- 4) Provide technical assistance to LHJs regarding the community perinatal program
 - a. W&I §14134.5(g) “assist local health departments to establish a community perinatal program whose responsibilities may include certifying and monitoring providers.....”
 - b. (g) “provide the local health departments with technical assistance for the purpose of implementing the community perinatal program”
- 5) Develop a system for monitoring and oversight of comprehensive perinatal services provided.
 - a. H & S §123500 – “monitor the delivery of services under contracts, grants, and agreements provided for in this article through a uniform health data collection system that uses epidemiologic methodology”
 - b. W&I §14134.5(g): Local health departments may monitor providers.
 - c. W&I §14134.5(i): “develop systems for monitoring and oversight of the comprehensive perinatal services program...shall include but not be limited to...the perinatal data form”

All CPSP services are delivered face-to-face with the following philosophy of care:

- Health care services are client-centered. Services are delivered in consultation with the client and based on the client’s prioritized needs.
- Client strengths are assessed and factored into the client’s care.
- Comprehensive perinatal services are delivered through a multi-disciplinary approach to address the full needs of the client.
- CPSP services are individualized, culturally sensitive, and respect clients’ values, beliefs, and traditions.
- Clients’ choices and rights are valued and respected.
- Services delivered are consistent with approved protocols signed off by nutrition, health education, and psychosocial consultants.
- Program referrals are encouraged to enhance the care of the client. Referrals to five specific program services in the community are required:
 - Women, Infant and Children (WIC) nutritional services
 - Genetic Screening
 - Dental Care
 - Family Planning
 - Well Child Care – Child Health and Disability Prevention Program (CHDP)
- Client participation in CPSP is voluntary.

CPSP Regions

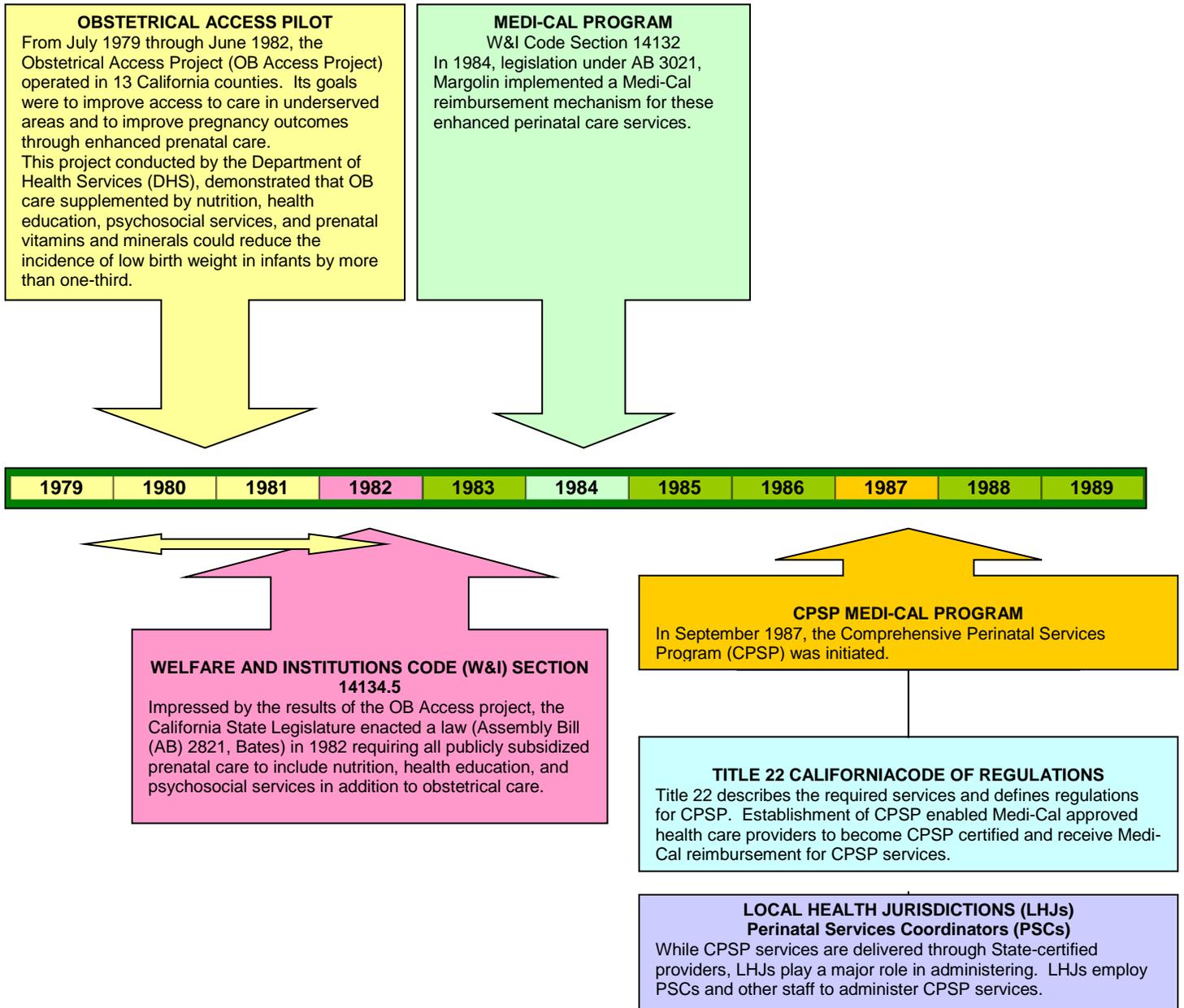
Perinatal Services by Region

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



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

California Perinatal Services Timeline



Perinatal Services Coordinator Role, Responsibilities and Activities

Overview

The PSC assists MCAH in administration of the CPSP program including monitoring and oversight of program implementation. Each LHJ will have a PSC to implement CPSP. If an LHJ does not have a PSC, the MCAH Director is responsible for PSC activities. Please refer to the CPSP Provider Handbook, and Steps to Take Manual. MCAH also provides various types of trainings for providers and PSCs to assist them in implementing CPSP.

Provider Handbook and Steps to Take Manuals:

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

Online Provider Training:

<http://www.cce.csus.edu/conferences/CPSP/training11/online.htm>

In-Person Training:

<http://www.cce.csus.edu/conferences/CPSP/training11/index.htm>

The local PSC assists with program administration through:

- Recruitment of Medi-Cal providers to become CPSP providers
- Making the CPSP application form available to prospective CPSP providers
- Providing consultation and technical assistance in the completion of the application process and development of site specific protocols
- Verifying professional licenses during the application process
- Verifying that providers are in good standing with Medi-Cal
- Assisting with development of antepartum/intrapartum/postpartum and dual provider agreements
- Making final recommendation on CPSP provider applications
- Forwarding the application to the State MCAH Division for processing
- Approving changes to a provider application as submitted to MCAH when appropriate
- Notifying MCAH Program when a provider is end-dated
- Providing education and training, consultation, and technical assistance for program implementation and standard of practice
- Collaborating with the MCAH Director to promote a community perinatal system of care
- Provide technical assistance to Medi-Cal Managed Care plan staff on CPSP requirements and implementation
- Coordinating and conducting provider CQI/QA site visits
- Development of CQI/QA plans for providers
- Follow up with the provider regarding their CQI/QA plan to address any program deficiencies

Meetings and Trainings

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

One Annual Meeting is convened each fall in Sacramento. It is a two-day meeting that includes a state and LHJ updates, and professional development trainings promoting best practices in maternal and infant health.

New PSCs should attend a New PSC Orientation as offered by MCAH. If a new PSC is hired and training is not available, the PSC should review these CPSP Policies and Procedures in the MCAH

Policies and Procedures Manual. New PSCs should attend a Provider Overview and Steps to Take training when it is offered in their area. PSCs should also take the Online Provider Training, which is available at no charge to PSCs.

MCAH also encourages PSCs to contact their MCAH Nurse Consultant and to participate in quarterly regional meetings or conference calls for networking, professional development, and peer support.

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

Provider Recruitment

The PSC recruits providers into CPSP by: assessing local needs for providers, identifying community providers in areas of need, visiting providers to inform them about CPSP, eliciting interest from the provider, and initiating the application process.

The goal is for providers to view the PSC as a knowledgeable partner and resource for delivering high quality perinatal care in the community who can provide up to date, unbiased information and assistance. PSCs should develop an in-depth knowledge of perinatal care and the resources in their community.

MCAH Division has provided numerous resources on the CPSP and MCAH Web sites that PSCs can use in outreach to providers. These include a sample PowerPoint presentation, and a Provider Brochure that describes CPSP and its benefits to the patient and the provider. PSCs should also take advantage of other resources on the MCAH Web site to provide information to providers in their area as an entrée into the office, for example, the CA-PAMR report, MIHA survey results, SIDS risk reduction materials, MCAH Maternal Morbidity bulletin, Perinatal Mood and Anxiety Disorder screening information, and numerous other resources. The PSC can also share information on community resources for tobacco cessation, alcohol and drug treatment, and other social assistance.

Provider Application Process

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

Requirements for Prospective Providers

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

CPSP Provider Application

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

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

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

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

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

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

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

Required CPSP Application Attachments

New CPSP applications require the seven attachments described below:

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

Recommended Referrals:

- a. Mental health
- b. Domestic Violence
- c. Access to food

7. **Agreements (See additional information below)**—These include:

- a. Antepartum/Intrapartum/Postpartum Agreements
 - b. Dual Provider Agreements
-

Provider Agreements

a. Antepartum/Intrapartum/Postpartum Agreements

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

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

1. Provision of obstetrical antenatal/postnatal services
2. Provision for referral to other appropriate providers as necessary
3. Offering all required CPSP services to the patient
4. Case coordination agreement
5. Access to and transfer of all medical and support service records and maintenance of current comprehensive patient records by all parties involved in the patient's care
6. Responsibility for signing off and explanation of the patient's rights and responsibilities document
7. Mutual billing responsibilities and methods to avoid duplicate billing to the State
8. Agreement that only itemized billing procedures will be used
9. Any of the provision deemed prudent by the parties to assure patient safety and improve the quality of perinatal care

b. Dual Provider Agreements

A Dual Provider Agreement (DPA) is needed anytime two CPSP providers are simultaneously providing CPSP services. Dual Provider Agreements are implemented when a specific documented OB access problem exists for pregnant women on Medi-Cal.

These agreements are made at the local level. The prospective provider must attach a written agreement(s) to the application. The agreement(s) must describe the relationship and specific responsibilities of the prospective provider and the OB care provider(s), including the flow of patient services, shared charting and patient information between all providers. It should include how emergency services will be provided, and billing responsibilities.

Steps for Application Review:

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

1. Notify the provider, stating the PSC has received the CPSP application. The PSC keeps a copy for their files
2. Document that the seven required attachments referenced above are included with the original application. Indicate your **recommendation** on the provider application
3. Complete the bottom section of the CDPH 4448 (for PSC use only). Indicate the retroactive billing date (if applicable); sign and date the application
4. Once the PSC has received and made a recommendation on the final application packet, send the state MCAH the original application and verification that the seven attachments were received for

state MCAH review and approval. Keep copies of the application and the seven attachments at the local level.

5. Notify the provider of the application status and keep the copy in the PSC's file

On-Line Credential and Education Verification of CPSP Providers and Practitioners

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

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

Physicians:

<http://www2.mbc.ca.gov/LicenseLookupSystem/PhysicianSurgeon/Search.aspx>

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

A comprehensive perinatal practitioner means any one of the following:

Social Worker

If the social worker is licensed, verify the license through their licensing board. If the social worker is not licensed, confirm the practitioner's eligibility by verifying that the schools attended are accredited under Title 22 California Code of Regulations.

Requirements according to Title 22:

A social worker who either:

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

or

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

or

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

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

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

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

Health Educator: Confirm the practitioner's eligibility by verifying that the schools attended are accredited as required by Title 22 California Code of Regulations.

Requirements according to Title 22:

A health educator who either has:

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

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

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

Registered Dietitians:

Requirements: Dietitians must be registered by the Commission on Dietetic Registration, the credentialing agency of the Academy of Nutrition and Dietetics (formerly, the American Dietetic Association), and must have one year of experience in the field of perinatal nutrition.

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

Scroll down to the bottom of the page and click "I Accept"

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

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

Click "Submit"

Licensed Vocational Nurses: Must be licensed and have one year of experience in the field of Maternal and Child Health. Verify the license at the Board of Vocational Nursing Website: [http://www2.dca.ca.gov/pls/wllpub/wllqryna\\$lcev2.startup?p_qte_code=VN&p_qte_pgm_code=9110](http://www2.dca.ca.gov/pls/wllpub/wllqryna$lcev2.startup?p_qte_code=VN&p_qte_pgm_code=9110), and fill in the on line form.

Suspended or Revoked License:

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

State Application Processing

The CDPH Maternal, Child, and Adolescent Division staff will track the CPSP application and notify the PSC it has been received; enter the application into our database and send a transmittal to Medi-Cal, once approved. State MCAH will scan and send an electronic copy to the PSC and a hard copy letter to the new CPSP provider indicating the effective date of the approval (i.e., the date the provider can begin to provide CPSP services for which Medi-Cal can be billed). The provider must bill under the National Provider Identifier (NPI) submitted on the CPSP application.

Provider Application Changes

CPSP providers will often update previously approved applications as needs change within the providers' practice. Application updates will be submitted by the provider to the local PSC. The PSC will review the updated provider application information and approve the changes. All provider changes will be filed at the local level and do not require submission to the state MCAH Program. However, MCAH requires the PSC to notify MCAH of the following changes for tracking purposes:

- Provider Name and/or NPI#
- Provider Address – Verify provider address change through Medi-Cal Provider Enrollment then submit documentation to MCAH
- Providers no longer providing CPSP services (End-Date Memo)

Inactivating a CPSP Provider:

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

1. The CPSP provider is no longer delivering CPSP services due to death or retirement or is no longer interested in offering CPSP services, or
2. The provider is no longer enrolled in Medi-Cal because he/she was terminated or deactivated.

The PSCs will include the following information when notifying the State of inactivating a CPSP provider:

1. Provider name,
2. Provider address, and
3. NPI number

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. A protocol describes a system for delivering CPSP services in the provider's specific setting. The protocol specifies assessment, reassessment, care planning and referral mechanisms and sets the criteria and standards to measure and monitor quality of care. A provider's protocols must reflect their current CPSP site practices, policies and procedures. CPSP staffs are required to follow their site-specific protocols when delivering CPSP services.

CPSP services are to 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 in the patient record. Comprehensive Perinatal Health Workers (CPHWs) must work under the **direct supervision** of a physician, which means the physician must be on-site and document direct supervision of the CPHW in the patient’s record (Title 22, Section 51179.7(a)(10)(B).

- Protocols must clearly describe a system of care from entry of care through postpartum. They must include a time line for each activity, including initial assessment, the individualized care plan, reassessment, postpartum assessment, use of individual and/or group interventions, case coordination, and mandated referrals.

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

Developing New Protocols

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

Protocol Development – Using Previously Approved Sample Protocols

Providers may develop their site-specific protocols using previously approved sample protocols. The PSC may provide sample protocols to the provider. When using protocols that have been previously approved, the provider must tailor them to be specific for the practice site. The PSC may assist the provider with making these changes. New providers who use previously approved protocols signed by a health educator, dietitian, and social worker do not need to have them signed again. Include a statement on the application “Based on [year] XXX LHM Protocols”.

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 (Z6412) before the initial health education assessment is completed.

Assessments, Reassessments and Referrals

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

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

Assessments

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

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

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

There are three assessment and reassessment forms that providers may use as an example and are located on the CPSP website (link below): a Separate Assessment and Care Plan, a Combined Assessment and Care Plan and the CDPH 4455 assessment forms. Providers may use other assessment forms, if they contain all the elements in the State recommended assessment, reassessment, and postpartum forms.

Individualized Care Plan (ICP)

The CPSP practitioner and client use the information gathered during the assessments to develop an ICP. The ICP is developed for each CPSP client after the initial assessment and updated after each prenatal visit and at least every trimester as well as at the postpartum visit. The ICP will be signed by the staff person completing the ICP.

All recommended forms are located here:

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

Referrals

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

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

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

There are two mechanisms by which the PSC monitors CQI/QA within CPSP. The first is through ongoing provider education about CPSP implementation through on-site trainings and technical assistance visits, provider meetings and local roundtables.

The second mechanism is to conduct, at a minimum annually, QA visits to CPSP provider offices to assess, maintain, or improve the quality of CPSP services and assure appropriate care.

- The QA site visit requires a chart review to determine that the provider is implementing CPSP according to their protocols and in accordance with Title 22 Regulations.
- QA findings provide the PSC with an opportunity to offer technical assistance to the provider and develop a CQI/QA plan to support appropriate implementation of the Program.
- The PSC provides technical assistance regarding CQI activities to address deficiencies identified during the QA site visit.
- The PSC assists the providers with following approved program protocols to ensure the provider is offering patients the proper level of prenatal care.
- The PSC provides the provider with a written report and corrective action plan (CAP) as needed. A timeline for completing the CAP will be given to the provider.

PSCs receive Medi-Cal Paid Claims Reports that can assist them in identifying providers for QA visits. If the PSC finds that a provider is not delivering CPSP services appropriately the PSC should notify their Program Consultant and consult with the Medical Consultant at Audits and Investigations to discuss the need for an audit. Please request the current CPSP Resources and Contacts List from your Nurse Consultant.

Electronic Health Records (EHR)

Overview

This is an overview of Federal and State efforts to implement Electronic Health Records (EHRs). This information is provided only as a PSC reference. PSCs are not expected to be experts in EHR development, only in assisting providers to ensure inclusion of 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 chart or electronic. The PSC can provide their programmatic expertise to help guide the provider in this process, but it is the provider's responsibility to make sure the system will be functional.

The Office of the National Coordinator is leading Federal efforts to implement Electronic Health Records. The Web site is:

http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov_home/1204

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

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

The Center for Medicare and Medicaid Services (CMS) is working to encourage providers to adopt EHRs by providing incentives and support to providers and supporting health IT workforce training. The goal is to achieve widespread adoption of EHRs by 2015. CMS adopted the EHR Incentive Rule in July 2010. This rule makes EHR incentives available to Medicare and Medicaid providers, but providers are not required to apply. Information on the EHR incentive program is available at: <http://www.cms.gov/EHRIncentivePrograms>

Registration for the EHR incentive program began January 3, 2011. Providers may register before they have a system installed. Medicare providers may receive up to \$44,000, and Medicaid providers may receive up to \$63,750 over 6 years for implementing eligible systems. Providers may receive incentives under only one of the options and may switch programs only one time after they receive the first payment. Eligible professionals may qualify for incentive payments if they adopt, implement, upgrade (AIU) or demonstrate meaningful use (MU) in their first year of participation. They must successfully demonstrate meaningful use in subsequent participation years to receive additional payments. **The Medicaid incentive program is dependent on individual States.** Medi-Cal is developing a system to manage incentive payments for California's eligible providers. **The most current information specific to California** is available at: <http://medi-cal.ehr.ca.gov/> .

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

Meaningful Use

Eligible systems must enable "Meaningful Use" (MU), which includes:

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

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

For more information on Meaningful Use, review the following Web site:

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

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

Stage 1 of MU (2011-13) includes both a core set and a menu set of objectives that are specific to eligible professionals.

Stage 2 (expected to be implemented in 2014) and Stage 3 (expected to be implemented in 2015 or later) will continue to expand on this baseline and be developed through future rule making. Providers must successfully implement Stage 1 MU before moving to Stage 2.

Stage 1 Meaningful Use Requirements:

For eligible professionals, there are a total of 25 meaningful use objectives. To qualify for an incentive payment, 20 of these 25 objectives must be met.

There are 15 required core objectives.

•The remaining 5 objectives may be chosen from the list of 10 menu set objectives. The core objectives are available at <http://www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf>

Quality Measures

In addition, providers must report six quality measures; three core quality measures and three additional measures that they choose from 38 measures. Information on the Quality Incentive Program is available at:

<http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/ClinicalQualityMeasures.html>

Specifications for the quality measures are available at the following link:

http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp

Core measures are:

1. Blood pressure measurement
2. Tobacco use and intervention
3. Adult weight screening and follow up.

An alternative core measure set is:

1. Weight assessment and counseling for children and adolescents
2. Flu shot for people over 50
3. Childhood immunizations

There are two prenatal care measures that providers may choose from the 38 optional measures:

NQF 0012 Prenatal Care: HIV Screening

Title: Prenatal Care: Screening for Human Immunodeficiency Virus (HIV) Description: Percentage of patients, regardless of age, who gave birth during a 12-month period who were screened for HIV infection during the first or second prenatal care visit.

QF 0014 Prenatal Care: Anti-D immune Globulin

Title: Prenatal Care: Anti-D Immune Globulin Description: Percentage of D (Rh) negative, unsensitized patients, regardless of age, who gave birth during a 12-month period who received anti-D immune globulin at 26-30 weeks gestation.

The following measures are under consideration for 2014 reporting:

NQF 0608: Pregnant women that had HBsAg testing: This measure identifies pregnant women who had an HBsAg (hepatitis B) test during their pregnancy.

NQF 1401: Maternal depression screening: The percentage of children who turned 6 months of age during the measurement year who had documentation of a maternal depression screening for the mother between 0 and 6 months of life.

In addition, several of the general quality measures are applicable to CPSP patients. For a list of quality measures for 2014, see the following link:

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/Eligible-Providers-2014-Proposed-EHR-Incentive-Program-CQM.pdf>

EHR Functionality Basics

This section provides information that (PSCs and their CPSP providers may want to consider when evaluating EHR functionality in CPSP practices.

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

Each PSC and Provider should evaluate the content and functionality of the EHR system. The PSC should review the EHR content using an approved set of CPSP forms as a guide. It is only necessary to forward the content to the MCAH Program Consultant if there is a change in the content.

If a CPSP provider implements a CPSP EHR that is not functional, it may be difficult to conduct QA to assure implementation of CPSP in accordance with Title 22. Forms that are scanned into an EHR will not allow sufficient functionality to meet Meaningful Use requirements, and may make it difficult to access the information to conduct CPSP QA activities. Please see the "EHR Overview" section above for information on Meaningful Use, and Title 22 and MCAH CPSP Policies and Procedures and Scope of Work for CPSP QA requirements.

The following questions can assist PSCs and 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.

1. Does the EHR document CPSP client orientation, initial assessments, 2nd and 3rd trimester reassessments, postpartum assessments, and ICPs in all four domains (obstetric, psychosocial, nutrition, and health education) as required by Title 22?
2. Does the EHR generate reports that will enable the provider and PSC to conduct QA to monitor delivery of services and outcomes?
3. Does the system recognize risk conditions from the assessments, reassessments, and postpartum assessments?
4. Will the system automatically populate the ICP with information from the assessment results/risks/problems and link to appropriate:
 - Site specific CPSP protocols

- CPSP Steps to Take Guidelines
- STT Patient handouts
- Resources/Referrals

5. Will the system automatically populate applicable lab results in the CPSP assessments as well as other appropriate locations in the EHR?
6. When the height and weight are entered into the system, will the system automatically select and plot the correct weight gain grid (a generic weight grid is not acceptable)?

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?

7. Does the system recognize CPSP services, including time spent, to enable correct billing and can it easily implement coding changes?
8. Is the vendor able to make regular system upgrades at a reasonable price to incorporate CPSP program enhancements?

Medi-Cal

Medi-Cal Fee for Service

The Fiscal Intermediary (FI) Telephone Service Center (TSC) is one of Medi-Cal’s main sources in assisting providers with information, technical support, and billing inquiries. PSCs can also be a resource to CPSP providers regarding basic billing and reimbursement inquiries. However, 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.

The TSC can be accessed at **1-800-541-5555** Monday through Friday 8:00 am to 5:00 pm except holidays.

General billing questions:

- Eligibility verification
- Ordering forms
- General billing assistance
- Follow-up procedures
- Contact a Fiscal Intermediary Regional Representative for one-to-one assistance

- To leave a message for a Regional Representative, contact the TSC at 1-800-541-5555 then follow the prompts 11, 15, 14

Other Resources:

Medi-Cal web site: <http://www.dhcs.ca.gov/Pages/default.aspx>

Medi-Cal Training Seminars: <http://files.medi-cal.ca.gov/pubsdoco/eo/training.asp>

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

Medi-Cal Learning Portal: This Web page provides information from the Medi-Cal Fiscal Intermediary including billing, regional representatives, and provider training. <https://learn.medi-cal.ca.gov/>

Medi-Cal Managed Care

Medi-Cal Managed Care (MCMC) plans exist in 33 LHJs, with an expansion to 28 rural counties planned for September 2013. The PSC must be aware of the type of MCMC plan that exists in their respective Local Health Jurisdiction. The types of plans include County Organized Health Systems, Geographic Managed Care and Two-Plan Model.

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

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

In most Two-Plan model counties, there is a “Local Initiative” (LI) and a “commercial plan” (CP). The Department of Health Care Services (DHCS) contracts with both plans.

Local government, community groups and health care providers are able to give input when the LI is created. The LI is designed to meet the needs and concerns of the community. The CP is a private insurance plan that also provides care for Medi-Cal beneficiaries.

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

Two-Plan Model (17)	GMC (2)	COHS (14)
Alameda, Berkeley,	Sacramento,	Marin, Mendocino,
Contra Costa, Fresno,	San Diego	Merced, Monterey,
Kern, Kings, Long		Napa, Orange, San
Beach, Los Angeles,		Mateo, San Luis
Madera, Pasadena,		Obispo, Santa Barbara,
Riverside, San		Santa Cruz, Solano,
Bernardino, San		Sonoma, Ventura, Yolo
Francisco, San		
Joaquin, Santa Clara,		
Stanislaus, Tulare		

In addition, there is a Managed Care Rural Expansion planned in 28 rural counties planned to begin on September 1, 2013. The following plans will serve the following counties:

Partnership Health Plan (8 counties) (COHS): Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties beginning September 1, 2013.

Managed care expansion will occur in the counties below on November 1, 2013:

Anthem Blue Cross and California Health and Wellness Plan (18): Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba Counties

Anthem Blue Cross (1): San Benito County

California Health and Wellness Plan (1): Imperial County

Medi-Cal Managed Care Requirements

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

Plans are required to execute a subcontract or Memorandum of Understanding (MOU) with local health departments in the area of Maternal and Child Health (MCH) delineating roles and responsibilities in the following areas: outreach, perinatal access, provider network, education, training, information sharing, and other areas of mutual agreement.

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

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

Issues regarding client care can be reported to:

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

Department of Managed Health Care 1-800-400-0815

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

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

This is a link to the MCMC Health Plan Directory that shows the health plans available in each county:

<http://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx>

FQHCs and RHCs

Rural Health Clinics (RHCs) and Federally Qualified Health Clinics (FQHCs) provide ambulatory health care services to people in rural and non-rural areas. These clinics are paid on a prospective payment system.

FQHCs and RHCs bill the contracted fiscal intermediary for their prospective rate. FQHCs and RHCs that contract with MCMC plans bill the plan for the contracted amount, then bill Medi-Cal for the difference between the contracted MCMC rate and their prospective rate.

The following rules apply to RHCs and FQHCs:

- They may bill for only one visit per day, except they may bill for two visits if a patient suffers an unrelated illness or injury in the day of a prenatal related visit and requires another visit, or if one of the visits is a dental visit.
- They may bill for only one visit by any CPSP practitioner in a day, this is considered the one visit.
- A “visit” includes a face to face encounter with a practitioner plus any incidental services.
- They may bill for services delivered by a CPHW.
- Licensed staff may provide CPSP services in the client’s home.
- They do not receive the CPSP bonuses.
- They do not have to submit TARs for additional CPSP services, but must document necessity in the medical record in the same detail as required in a TAR, including:
 - Expected date of delivery
 - Clinical findings of the high-risk factors involved in the pregnancy
 - Explanation of why basic CPSP services are not sufficient
 - Description of the services being requested
 - Length of visits and frequency with which the requested services are provided, and
 - Anticipated benefit of outcome of additional services

Audits and Investigations

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

Audits and Investigations audits serve a program integrity function, whereby they conduct enforcement on accuracy of claims, ensuring that services are accurately represented by codes billed. They review documentation to assure that the documentation supports billing. They also assure that services are medically necessary, evaluate quality of care, and educate providers. They are also available to consult with PSCs on any areas of concern. Contact your NC 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 less visits by FFS, lack of individualization of services, and lack of coordination between CPSP and obstetric provider

The PSC should become familiar with the role of A&I and should feel free to contact them to discuss any issues that arise, and make referrals when appropriate. The A&I Web site is:
<http://www.dhcs.ca.gov/individuals/Pages/AuditsInvestigations.aspx>

For making fraud referrals, the most direct line is:

Stop Medi-Cal Fraud (A&I Hotline for referral of provider fraud and abuse)
Email: stopmedicalfraud@dhcs.ca.gov

Phone: 1-800-822-6222

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

Please also discuss the matter with your Nurse Consultant.

Medical Board of California

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

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

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

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

Local: (916) 263-2382

Fax: (916) 263-2944

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

Purpose

On behalf of the PSCs, the EC collaborates with the California Department of Public Health, Maternal, Child and Adolescent Health (MCAH) Division staff to promote the perinatal health needs of California women and children and to serve as a resource to MCAH and promote collaboration among PSC in their regions.

Functions

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

- Represents the PSCs as a link to the biannual (May and October) MCAH Action meetings by providing CPSP Affiliate Report
- Informs MCAH Division staff regarding issues and recommendations concerning systemic issues such as access and barriers to care and Medi-Cal policy issues
- Promotes collaboration among regional PSCs, assists PSCs in resolving regional concerns, and ensures new PSCs are provided with mentors; or ensures new PSCs are provided with the name of several PSCs who can serve as resource persons
- Provides input and collaborates with MCAH staff on the following:
 - CPSP policies and procedures manual
 - PSC Annual Statewide Meetings
 - Provider Overview Online Training
 - Provider Handbook

- Steps to Take Handbook
- Attends Provider Overview and Steps to Take trainings, when offered in the local health jurisdiction, and identifies issues and concerns to inform MCAH Division staff

Membership

- The EC will support its local regions to identify EC members
- The Executive Committee will consist of two representatives from each of the four regions- north, bay area, central and south and one additional PSC from Los Angeles County, who is a member of the southern region.
- EC members shall serve a one to two-year term.

Committee Participation

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

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

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

- Rotation:

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

Meetings

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

Ad Hoc Work Groups

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

MCAH Action CPSP Affiliate Report Template

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

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

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

- CPSP Statewide meeting (if applicable)
- Steps to Take and Provider Overview trainings – a report on numbers attended would be helpful
- CPSP Executive Committee - decisions and pending issues
- Workgroup reports
- Highlights of CPSP (if any):
 - Successes
 - Barriers
 - Medi-Cal Managed Care 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

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

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

Additional Program Information on CPSP related Programs:

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

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

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

[County CPSP Resources](#)

[Local PSC Directory](#)

[CDPH Organization Chart](#)

[California Department of Health Care Services](#)

[California Indian Health Program](#)

[California Newborn Screening Program](#)

[California Smokers' Helpline](#)

[California State Office of AIDS](#)

[Family PACT](#)

[Healthy Families](#)

[Medi-Cal Audits & Investigations](#)

[Medi-Cal County Offices](#)

[Medi-Cal Dental Program](#)

[Medi-Cal Managed Care](#)

[Medi-Cal Presumptive Eligibility](#)

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

[Primary and Rural Health](#)

[Women, Infants and Children Program](#)

CPSP Staff Contacts

Laurel Cima-Coates
Acting Chief,
Program Standards Branch
(916) 650-0314
Laurel.Cima@cdph.ca.gov

Candice Gray, MPH, CHES
 Health Program Manager II
 Program Standards Branch
 (916) 650-0372
candice.gray@cdph.ca.gov

Lorraine Cardenas
 CPSP Provider Application Analyst
 (916) 650-0371
Lorraine.Cardenas@cdph.ca.gov

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

Imelda Hoeckelmann, RN, MSN, MBA
 Nurse Consultant III Specialist
 (916) 440-7164
Imelda.Hoeckelmann@cdph.ca.gov

Mary Wieg, PHN, MBA
 Nurse Consultant III Specialist
 (916) 650-0345
Mary.Wieg@cdph.ca.gov

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

Find out who the Nurse Consultant for your Local Health Jurisdiction is at:
<http://www.cdph.ca.gov/services/funding/mcah/Documents/MO-MCAH-CMPCAssignmentList.pdf>

Types of CPSP Services offered by provider

Type of Service	What it includes:
Obstetrical Services	Routine obstetrical services must be provided in accordance with most current ACOG Guidelines, including: <ul style="list-style-type: none"> ○ Prenatal care ○ Intrapartum (delivery) care ○ Postpartum care <i>Provided by a qualified on-staff practitioner or contracted practitioner</i>
Enhanced Services (nutrition, psychosocial, health education, parenting,	Enhanced services include: <ul style="list-style-type: none"> ○ Client orientation ○ Nutrition assessment, reassessments and interventions ○ Health education assessment, reassessments, and interventions

childbirth)	<ul style="list-style-type: none"> ○ Psychosocial assessments, reassessments, counseling, and interventions ○ Individualized care plan, coordination of care, and referrals <p><i>Provided by a qualified on-staff practitioner or contracted practitioner</i></p>
Vitamin/Mineral Supplements	A 300-day supply of vitamin/mineral supplements dispensed or prescribed as medically necessary
Referrals to Required Services	<p>In addition to assuring delivery of client orientation, obstetric, health education, psychosocial and nutrition services, the provider must make referrals to the following services:</p> <ul style="list-style-type: none"> ○ Special Supplemental Nutrition Program for Women, Infants and Children (WIC) ○ Genetic screening ○ Dental care ○ Family planning (Family PACT) ○ Child Health and Disability Prevention Program (CHDP) <p><i>Provided by the CPSP provider directly, or by referral to a qualified provider</i></p>

Glossary of Common Acronyms

Title 22CCR	Title 22 of the California Code of Regulations
A&I	Audits and Investigations, Department of Health Care Services
ACS	Affiliated Computer Systems (Medi-Cal Fiscal Intermediary)
AFLP	Adolescent Family Life Program
BIC	Benefits Identification Card
BIH	Black Infant Health
CBE	Childbirth Educator/Education
CCS	California Children's Services
CDAPP	California Diabetes and Pregnancy Program
CDPH	California Department of Public Health
CFHC	California Family Health Council
CHDP	California Health and Disability Prevention
CMS	Children's Medical Services
CNM	Certified Nurse Midwife
CPHW	Comprehensive Perinatal Health Worker
CPS	Child Protective Services
CPSP	Comprehensive Perinatal Services Program
DHCS	Department of Health Care Services

DSS	Department of Social Services
EDD	Expected Date of Delivery
EPSDT	Early Periodic Screening Diagnosis and Treatment
EW	Eligibility Worker
Family PACT	Family Planning, Access, Care, and Treatment
FASD	Fetal Alcohol Spectrum Disorder
FFS	Fee For Service
FICOD	Fiscal Intermediary and Contracts Oversight Division, Department of Health Care Services (oversees ACS)
FIMR	Fetal and Infant Mortality Review
FQHC	Federally Qualified Health Center
HIPAA	Health Insurance Portability and Accountability Act(Federal)
ICA	Initial Combined Assessment
ICP	Individualized Care Plan
LBW	Low Birth Weight
LCSW	Licensed Clinical Social Worker
LMP	Last Menstrual Period
MCAH	Maternal, Child and Adolescent Health
MFT	Marriage and Family Therapist
MCMC	Medi-Cal Managed Care Division
MPH	Master of Public Health
MSW	Master of Social Work
NICU	Neonatal Intensive Care Unit
NP	Nurse Practitioner
OB	Obstetrician/Obstetric
OFP	Office of Family Planning
PA	Physician's Assistant
PCG	Prenatal Care Guidance
PCP	Primary Care Physician
PE	Presumptive Eligibility
POS	Point of Service (billing)
PSC	Perinatal Services Coordinator
RAD	Remittance Advice Detail (billing)
RD	Registered Dietitian
RHC	Rural Health Center
SIDS	Sudden Infant Death Syndrome

STI	Sexually Transmitted Infection
STT	Steps to Take
SW	Social Worker
TANF	Temporary Assistance to Needy Families
TAR	Treatment Authorization Request (Medi-Cal)
THP	Tribal Health Program
W&I	Welfare and Institutions (code)
WIC	Women, Infant and Children –Supplemental Nutrition Program
