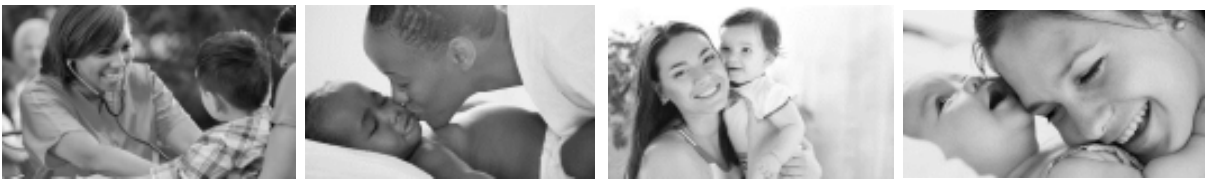




## Local MCAH Programs Policies and Procedures



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

- Local Maternal, Child and Adolescent Health (MCAH) Program
- Comprehensive Perinatal Services Programs (CPSP)

Additional policies are available for:

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

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## Overview

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

## Statutes

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

### CREATION OF CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

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

### MATERNAL AND CHILD HEALTH PROGRAM

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- California HSC §123225-§123255: The department shall maintain a program of maternal and child health.
- In 1997, HSC (§) 123255 was added: The department may maintain a maternal and child health program in each county; shall establish minimum standards that govern the basis for allocations to counties, including, but not limited to, the services to be provided, administration, staffing, fiscal accountability, and eligibility for services. The department may recoup or withhold all or part of a county's allocation for failure to comply with those standards. Counties shall submit a plan and budget in accordance with the department's maternal and child health priorities.
- California Welfare and Institutions Code (W&I) §14148.9-§14148.9: Establishes a comprehensive perinatal program and reporting mechanism to the Legislature to improve and coordinate existing programs for pregnant women and infants and remove barriers to care with an intense focus on women who are at high risk of delivering a low or high birth weight baby or a baby who will suffer from major health problems or disabilities.
- California HSC §123505: States that the goals of the community-based comprehensive perinatal health care system shall be to decrease and maintain the decreased level of perinatal, maternal, and infant mortality and morbidity, and to support methods of providing comprehensive prenatal care that prevent prematurity and the incidence of low birth weight infants.

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

## COMPREHENSIVE PERINATAL SERVICES PROGRAM (CPSP)

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- California HSC §123475-§123525: Establishes a community-based system of comprehensive perinatal care for low-income women. States that prenatal care, delivery service, postpartum care, and neonatal and infant care are necessary services that have been demonstrated effective in preventing or reducing maternal, perinatal, and infant mortality and morbidity, including prematurity and low birth weight. Comprehensive perinatal care includes initial and ongoing physical assessment, psychosocial, nutrition, and health education assessments, interventions, counseling and referral, food supplement programs, vitamins, and breast-feeding and other services as appropriate. Requires all contracted providers to make these services available directly or by subcontract, and to use an appropriate multidisciplinary team.
- California W&I §14132(u): Establishes Comprehensive Perinatal Services as defined in §14134.5 as a Medi-Cal benefit.
- California W&I §14134.5(a): Defines CPSP providers to include any general practice physician, family practice physician, obstetrician-gynecologist, pediatrician, certified nurse midwife, a group, any of whose members is one of the above-named physicians, or any preferred provider organization or clinic enrolled in the Medi-Cal program and certified pursuant to the standards of this section.
- California W&I §14134.5(b): States that perinatal means the period from the establishment of pregnancy to one month following delivery.
- California W&I §14134.5(c): States that CPSP services shall include but not be limited to the services delivered through the DHS Obstetrical Access Pilot Program.
- California W&I §14134.5(d): Requires the CPSP provider to schedule visits with appropriate providers and track the patient to make sure services have been received. Requires that the patient receive

psychosocial assessment and referrals; nutrition assessment, appropriate referrals to counseling for food supplement programs, vitamins, and breastfeeding, health, childbirth, and parenting education.

- California W&I §14134.5(e): Allows providers to contract with medical and other practitioners for the purpose of delivering CPSP services.
- California W&I §14134.5(f): States that the Department and the California Conference of Local Health Officers will establish standards for services pursuant to this section.
- California W&I §14134.5(g): States that the Department shall assist Local Health Departments to establish a community perinatal program whose responsibilities may include certifying and monitoring providers of comprehensive perinatal services, shall provide technical assistance, shall utilize Local Health Departments in the administration of the program.
- California W&I §14134.5(h): States that the Department shall establish a method for reimbursement of comprehensive perinatal providers which shall include a fee for coordinating services and shall be sufficient to cover reasonable costs for the provision of comprehensive perinatal services. The department may utilize fees for service, capitated fees, or global fees to reimburse providers, however if capitated or global fees are used, the department shall set minimum standards for the provision of services including, but not limited to, the number of prenatal visits and the amount and type of psychosocial, nutrition, and education services patients shall receive. States that providers shall not be at risk for inpatient services.
- California W&I §14134.5(i): States that the department shall develop systems for monitoring and oversight of comprehensive perinatal services.
- California W&I §14134.5(j): States that client participation shall be voluntary.
- California HSC §104560-§104569: Comprehensive Perinatal Patient/Client Education and Community Awareness Program. Establishes a comprehensive perinatal outreach program. A county or city may contract with the state department to provide perinatal program coordination, patient advocacy, and expanded access services for low-income pregnant and postpartum women and women of childbearing age who are likely to become pregnant integrated with the county's perinatal program.

## **REGIONAL PERINATAL PROGRAMS OF CALIFORNIA (RPPC)**

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

## FETAL AND INFANT MORTALITY REVIEW (FIMR)

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

## SUDDEN INFANT DEATH SYNDROME (SIDS)

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



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

## CALIFORNIA SIDS PROGRAM MANDATES

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

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

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

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

- CDPH/MCAH is required to keep each county officer advised of the most current knowledge relating to the nature and cause of SIDS.
- CDPH/MCAH provides regular and ongoing SIDS education and training programs.

### **ADOLESCENT FAMILY LIFE PROGRAM (AFLP)**

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

### **BLACK INFANT HEALTH PROGRAM (BIH)**

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

### **PERINATAL EQUITY INITIATIVE (PEI)**

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

## SEXUAL HEALTH ACCOUNTABILITY ACT

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

## Regulations

The following regulations may apply to Local MCAH Programs:

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

## Title V Maternal and Child Health (MCH) Block Grant

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

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

Title V MCH Block Grant funds help each state to:

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

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

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

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

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

Further information on Title V can be found at: [Understanding Title V of the Social Security Act](#).

## TITLE V REQUIREMENTS FOR CDPH/MCAH

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

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

## TITLE V NEEDS ASSESSMENT REQUIREMENTS

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

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

## TITLE V REQUIREMENTS FOR LHJS

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

- Provide outreach services to identify pregnant women and infants who are eligible for services under the state's Medicaid program and assist them in applying for Medicaid assistance.
- Provide and promote primary and preventive health care for children, including CYSHCN, that include violence and injury prevention and healthy lifestyle programs to reduce the incidence of personal risk and health problems.
- Provide and promote preventive services for women of reproductive age that include gap-filling prenatal health services, injury and violence prevention, and healthy lifestyle programs to reduce the incidence of personal risk and health problems.
- Provide and maintain a local toll-free number (and/or other appropriate methods of communication) to make information about health care providers and practitioners who provide services under Title V and Title XIX, as well as other relevant information, available to the community.

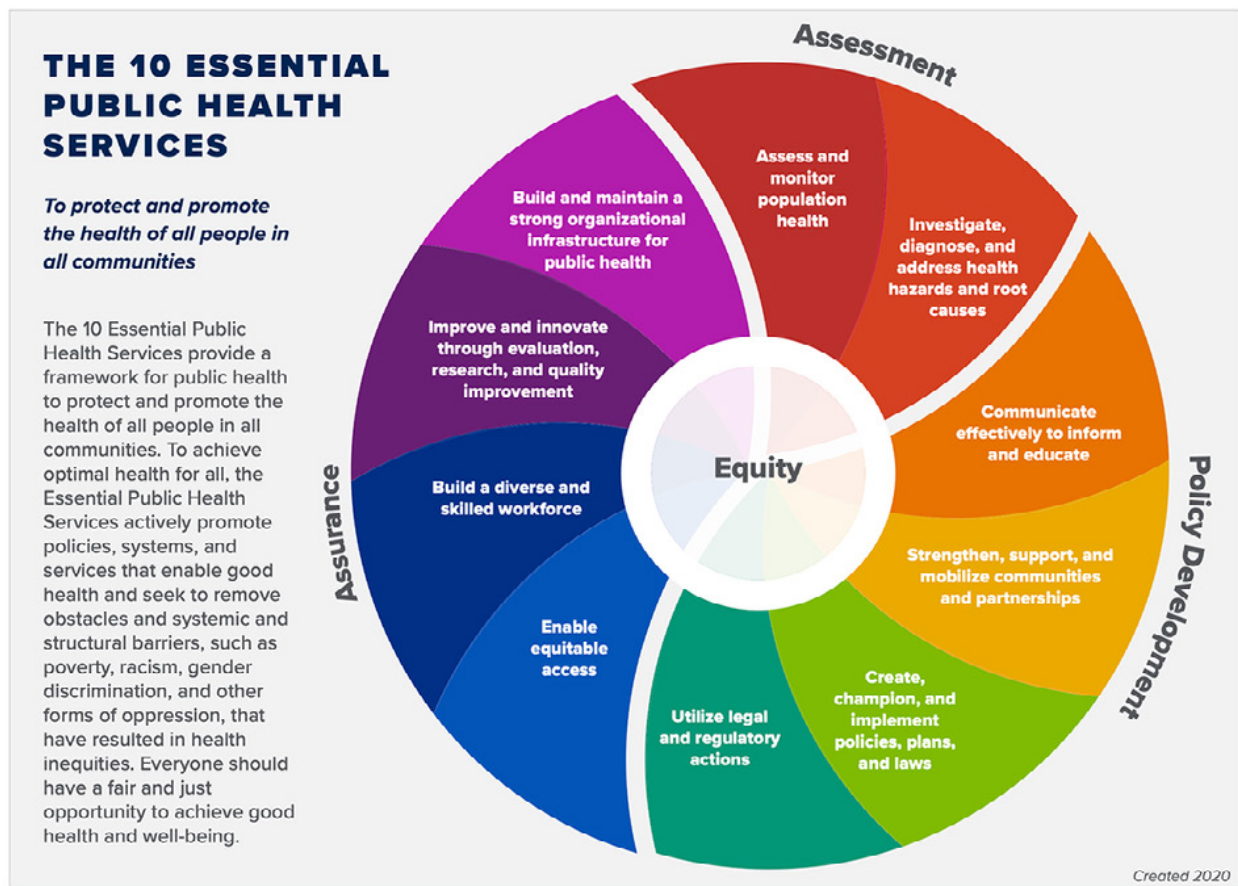
# Public Health Frameworks and Strategies

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

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

## 10 ESSENTIAL SERVICES OF PUBLIC HEALTH

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



## SPECTRUM OF PREVENTION

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

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

### Spectrum of Prevention



## LIFE COURSE PERSPECTIVE

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

## SOCIAL DETERMINANTS OF HEALTH

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



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

## SOCIAL-ECOLOGICAL MODEL: A FRAMEWORK FOR PREVENTION

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

## HEALTHY PEOPLE 2030

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

The goals of Healthy People 2030 are to:

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

Information on Healthy People 2030 can be found at: [Healthy People](#).

## EVIDENCE-BASED PUBLIC HEALTH PRACTICE

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

LHJs should consider the following when planning and evaluating interventions:

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

## Local MCAH Program Requirements

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

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

### SUDDEN INFANT DEATH SYNDROME (SIDS)

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- Provide SIDS support services and activities as outlined in the CDPH/MCAH SOW:
  - Promote and implement Infant Safe Sleep Interventions to reduce the number of SUID related deaths.
  - Provide Sudden Infant Death Syndrome/Sudden Unexpected Infant Death (SIDS/SUID) grief and bereavement services and supports through home visits and/or mail resource packets to families suffering an infant loss.
  - SIDS Coordinators are required to attend the SIDS Annual Conference, and as resources allow, attend other SUID/SIDS trainings and educational forums.

## FETAL INFANT MORTALITY REVIEW (FIMR)

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The California Department of Public Health (CDPH), Maternal, Child and Adolescent Health (MCAH) Division provides funding to a select number of local health jurisdictions (LHJs).

- LHJs that receive FIMR funding from CDPH/MCAH shall have a Community Action Team (CAT) to organize community action members to develop a plan and engage community action teams in efforts to reduce the number of sleep related deaths and implement culturally appropriate infant safe sleep strategies.
  - The CAT may include, but may not be limited to, representatives from:
    - Health professions
    - Social services agencies
    - Child health organizations
    - Community-based organizations
    - Political leadership groups
    - Faith community organizations
    - Neighborhood organizations
    - Educational organizations
    - Housing and tenants' rights organizations
    - Local businesses
    - Parents who have experienced a fetal/infant loss
- In addition to the SIDS requirements above, LHJs that receive FIMR funding from CDPH/MCAH shall conduct expanded safe sleep efforts to include one or more of the following:
  - Work with external partners to expand safe sleep training for nurses, caregivers, and childcare providers.
  - Promote and support safe sleep education and engage hospitals to support the implementation of HSC § 1254.6 regarding the requirement that hospitals provide safe sleep information upon discharge.
  - Conduct a public awareness campaign to help decrease infant mortality in the community.
- Activities should consider disparities in the local community and be reflective of the community served.

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

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

resources for the public regarding access to prenatal care. At a minimum, the toll-free line must be operational during normal business hours and must be linguistically appropriate.

## **DOCUMENTATION RETENTION REQUIREMENTS**

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

## **CLIENT CONFIDENTIALITY AND HIPPA REQUIREMENTS**

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

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

- Securing and maintaining all hard copies or other records with client information containing PHI (such as CD-ROM, diskettes, thumb drives, etc.) in a locked file cabinet inaccessible to staff other than those directly involved in either the delivery of service to the client, supervision of these direct service-delivery staff, or for data entry.
- Securing all electronic records in password-protected, encrypted files, with access only for staff directly involved in delivery of services to clients, supervision of these staff, or data entry.
- Disposing of Materials:
  - The LHJ site must have policies in place to ensure that confidential information is discarded through secure and confidential means (e.g., shredded, locked confidential destruction bins, pulverized).
  - The LHJ site must have a mechanism in place to ensure that removable media containing confidential, personal, or sensitive information is physically destroyed when no longer needed.
- Sending Confidential Information:
  - Prior to sending PHI or client-related confidential information via fax, LHJ site staff must notify the recipient of the materials faxed.
  - When sending electronic PHI to MCAH, encrypt information by writing “[secure]” on the subject line.

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

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

## **PRODUCT/PUBLICATION APPROVAL AND CREDIT**

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

The process for approval is as follows:

- Submit the product either electronically or by hard copy to the CDPH/MCAH State PC at least 60 days prior to publication or reprinting.
- Send an email or written request to the Program Consultant for approval with the following information:
  - Program or activity
  - Purpose
  - Description
  - A copy
  - Population domain (Women, Infant, Child, CYSHCN, or Adolescent)
  - Language(s) available
  - Name, email, and telephone number of contact person
- CDPH/MCAH will review the product, provide feedback, and approve/disapprove within 60 days.
- List the products developed in the Annual Report.

For further guidance, please refer to the CDPH/MCAH [Fiscal Administration Policy and Procedure Manual](#).

## TITLE V CDPH/MCAH FUNDING ACKNOWLEDGEMENT

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

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

## PHOTOGRAPHS

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Photographs used on all media products developed by LHJs require permission for the use intended. This permission may come from the source of the document and/or require the subject’s written consent. When an LHJ submits products for approval, the LHJ must state that a photo release was obtained and kept on file.

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

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

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

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

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

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

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

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

## PROTOCOL GUIDELINES FOR DEVELOPMENTAL SCREENING FOR CHILDREN IN MCAH PROGRAMS

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

- The standardized screening tool(s) to be used.
- The periodicity of screening. The AAP recommends that general developmental screening using a standardized tool should be administered at 9, 18, and 30 months, at a minimum, or whenever the parent/caregiver has a concern.
  - Note: In addition, AAP recommends autism-specific screening at ages 18 and 24 months and social and emotional screening at regular intervals. Ongoing developmental surveillance is also recommended.
  - Note: Although there are specific ages that screening is recommended, screening should be done at any age if MCAH staff or the child's family are concerned about their development.
- A list of referral resources, such as Early Start, Family Resource Centers, Help Me Grow program.
- A process to ensure that the child attends their well-child visits and their primary care provider is notified of the results of screenings.
  - If the child has an at-risk or positive screening result, confirm that parents/caregivers understand that the child needs to have a more comprehensive evaluation by their primary care provider and ensure that the child completes a visit with their primary care provider.
- A process to ensure that a child identified with special needs and their parents/caregivers:
  - Connect with their primary care provider or medical home and appropriate intervention services, such as Regional Centers, Local Educational Agencies, Family Resource Centers, and parent support groups.
  - Receive parent education on developmental milestones and what to do if they are concerned about their child's development.

- Demonstrate positive parenting skills and have the tools and guidance to optimize their child’s growth and development.
- Receive additional supports to address family or environmental factors that may be impeding their child’s development.
- Instructions on how to document the screening process, results, and follow-up.
- A tracking mechanism to verify that a child in need of further evaluation by a primary care provider completes a visit and is referred and linked to appropriate resources as needed.
- Quality assurance activities to ensure that protocols are implemented as intended and revised as needed.

### Child Development Outcome Reporting

LHJs are required to report on the status of these efforts in the Local MCAH Annual Report.

### Child Development Resources

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

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

### CLIENT TRIAGE

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CDPH/MCAH recommends that Local MCAH directors develop client triage policies based on the availability of local resources and knowledge of client and community needs. Local policies should consider that allowing an eligible woman to participate in more than one MCAH-funded program may exclude other potential clients from the benefits of program participation, may result in duplication of services, and could add significant data collection responsibilities to the local programs.

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



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

## **CO-ENROLLMENT IN OTHER MCAH PROGRAMS**

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### **Black Infant Health (BIH)**

CDPH/MCAH recommends that BIH Coordinators develop client triage and enrollment policies based on the availability of local resources and knowledge of client and community needs. The BIH program should coordinate enrollment policies with other local programs, such as the California Home Visiting Program (CHVP).

### **Adolescent Family Life Program (AFLP)**

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

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

### **California Home Visiting Program (CHVP)**

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

## **Other Local MCAH Program Areas**

### **BLACK INFANT HEALTH (BIH) PROGRAM**

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LHJs identified as having the highest Black infant births receive funds to implement a [BIH Program](#) aimed at improving Black maternal and infant health, as well as decreasing the Black-White disparities gap. Services are provided in communities where over 90% of Black births occur.

More information and the BIH Policies and Procedures Manual can be found on the [BIH Program](#) webpage.

### **ADOLESCENT FAMILY LIFE PROGRAM (AFLP)**

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

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

More information and the AFLP Policies and Procedures Manual can be found on the [AFLP](#) webpage.

## **COMPREHENSIVE PERINATAL SERVICES PROGRAM (CPSP)**

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See the CPSP Policies and Procedures section of this manual.

## **CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN)**

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

CYSHCN is defined by HRSA as:

- Children with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

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

### **Suggested Local MCAH Program Activities for CYSHCN**

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

#### *Community-Based Services:*

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

- Facilitate continuity of care during periods of enrollment or changes in insurance coverage to ensure that a mechanism is in place for identifying and referring CYSHCN to appropriate enhanced care.
- Enhance collaboration at the local level by including CCS in the dissemination of health communications, statistical reports, and local MCAH and home visiting advisory group meetings.
- Inform providers of existing services for CYSHCN.
- Develop mechanisms for providers to refer clients to appropriate programs, such as the California Home Visiting Program and to refer clients from home visiting and health screening programs to CCS.
- Partner with local organizations that provide services to CYSHCN to improve systems of identification, referral, and linkage of CYSHCN to needed services.
- Build systems to link CYSHCN and their families to needed services.
- Identify barriers and opportunities to improve services for CYSHCN.
- Work with school districts to identify and refer children with specialized health and developmental needs.
- Develop resource information about services available for CYSHCN.

*Early identification of CYSHCN – Screening, Assessment, Referral and Linkage:*

- Promote health and developmental monitoring, screening, identification, and referral, including social-emotional (mental health) for infants and children using a standardized screening tool per American Academy of Pediatrics (AAP) guidelines.
- Promote routine screening for physical health, oral health, mental health, developmental and psychosocial needs, and cultural and linguistic needs, as part of a well-child visit or other preventive visit and in response to triggering events (trauma, new symptoms, hospitalization) to identify non-CCS CYSHCN or children at risk.
- Facilitate communication of health and developmental screening results and any identified referral needs to the child’s medical home and family and, as feasible, coordinate among screening entities.
- Develop and ensure protocols are in place for promotion of preventive medical visits or well-child visits, routine screening, referral, and follow-up to ensure care is received and barriers are addressed for all children.

*Providing Services to CYSHCN:*

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

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

*Facilitating Care Coordination to CYSHCN:*

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

- Facilitate and/or participate in interagency coordination and collaboration, for example, work with CCS, Family Resource Centers, Head Start, Local Educational Agencies, Early Start, Regional Centers (Department of Developmental Services), hospitals, school nurses, Federally Qualified Health Centers, Rural Health Clinics, First 5 and other agencies serving CYSHCN to improve the system of care.
- Explore opportunities to fund staff positions in other agencies to facilitate interagency coordination focused on CYSHCN.
- Educate agencies and individuals regarding the rights of CYSHCN.
- Standardize data collection/reporting on care coordination services for CYSHCN.
- Involve parents/caregivers and families in care coordination for CYSHCN.
- Provide forums for families to identify ways services for CYSHCN can be better coordinated and delivered, including transportation assistance.
- Assist to develop policies, processes, and resources for CYSHCN as they transition to adult care systems to ensure continuity of medical care, continued skill building and access to other community supports.
- Work with organizations that serve adults with special health care needs to develop an effective referral system and services for youth transitioning to adult service.
- Develop relationships with organizations that work with foster or incarcerated youth to screen, refer, and link youth with positive screens for physical, mental, or developmental needs to appropriate services.
- Involve CYSHCN in a Youth Advisory Council providing input to programs serving children and youth.

## **Local MCAH Director Requirements and Key Position Responsibilities**

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

### **LOCAL MCAH DIRECTOR REQUIREMENTS AND RESPONSIBILITIES**

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The LHJ must meet the qualification and FTE requirement(s) for the MCAH Director as outlined below. All MCAH Directors funded in whole or in part by the Local MCAH allocation will be the LHJ lead for the local MCAH program. The MCAH Director, in collaboration with the Local Health Officer, has the general

responsibility and authority to plan, implement, evaluate, coordinate, and manage all MCAH services within the LHJ.

### Local MCAH Director Requirements

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

- A physician who is board-certified or board-eligible in specialties of Obstetrics/Gynecology, Pediatrics, Family Practice or Preventive Medicine; or
- A non-physician who must be a certified public health nurse (PHN).
- Other professional credentials may be accepted but must be verified by CDPH/MCAH.

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

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

The LHJ must meet the qualification and FTE requirement(s) for the MCAH Director. If the LHJ is not able to meet requirements, CDPH/MCAH recommends the LHJ add an MCAH Coordinator position and/or other positions to meet the MCAH Director requirements and assist with the responsibilities of the MCAH Director.

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

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

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

If the LHJ does not have a Perinatal Services Coordinator (PSC), the MCAH Director is responsible for the PSC duties and implementation of the Comprehensive Perinatal Services Program (CPSP) program, if the LHJ has CPSP.

## Local MCAH Director Responsibilities

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

The core functions are discussed below:

### *Assessment:*

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

### *Policy Development:*

- Use the information gathered during assessments to develop and implement local policies and programs with measurable objectives.
- Develop plans and direct resources consistent with program goals and objectives.
- Facilitate access to care and appropriate use of services. This may include, but not be limited to, oversight of CPSP, patient/client outreach, services for CYSHCN, education, community awareness, referral, transportation, childcare, translation services and care coordination.
- Ensure implementation and coordination of Local MCAH programs.
- Ensure that SIDS activities take place, including community infant safe sleep and SIDS risk reduction education and grief and bereavement support for families experiencing a presumed SIDS death.
- Coordinate all MCAH patient/client outreach, education, and community services provided by local, state, and federal programs, including CCS, to prevent duplication of services and facilitate optimal use of resources.
- Ensure hiring and orientation of Local MCAH personnel, adhering to MCAH program policies for personnel requirements.
- Participate in quality assurance activities designed to improve community health outcomes for women, children, adolescents, and their families.

- Attend MCAH Action meetings and other required trainings. Adequate funding for training and meeting expenses, including travel, must be built into the annual budget.

*Evaluation:*

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

**Local MCAH Director Changes**

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

A Local MCAH Director Verification of Requirements Form is required to be submitted for any changes to the Local MCAH Director position such as budget revisions and/or change in Local MCAH Director.

**LOCAL MCAH COORDINATOR REQUIREMENTS AND RESPONSIBILITIES**

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**Local MCAH Coordinator Requirements**

The MCAH Coordinator is a recommended position.

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

**Local MCAH Coordinator Responsibilities**

The MCAH Coordinator assists the MCAH Director in fulfilling the MCAH Director’s responsibilities.

**LOCAL MCAH DIRECTOR VERIFICATION OF REQUIREMENTS FORM**

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Documentation of MCAH Director requirements is tracked on the Local MCAH budget and verified during the AFA process and any subsequent budget revisions or changes to the MCAH Director position.

**Information and requirements for completing the form**

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



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

### Submittal Requirements

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

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

### PERINATAL SERVICES COORDINATOR (PSC) REQUIREMENTS

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It is **strongly recommended but not required** that each LHJ have a PSC to oversee the implementation of perinatal services and the Comprehensive Perinatal Services Program (CPSP).

**If the LHJ does not have a PSC, the MCAH Director is responsible for the PSC duties and implementation of the CPSP program for the LHJ.**

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

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

**PSC Responsibilities**

The PSC, under the direction of the MCAH Director, will have the responsibility to perform activities that improve systems of care for pregnant and postpartum women. The PSC will assist providers in implementing perinatal systems of care, including CPSP. Please see the CPSP section of this manual for examples of activities to improve perinatal systems of care.

Below are some general duties of the PSC:

- Conduct activities with local provider networks and/or health plans, community agencies and partners to improve perinatal access, service integration and coordination to meet client needs.
- Assist in the maintenance and management of a network of perinatal providers and conduct quality assurance/quality improvement activities.

*Assessment:*

- Identify at-risk maternal and infant populations and develop strategies to address barriers and improve access to early and comprehensive quality perinatal care.
- Use local maternal and infant data to develop safety-net strategies with providers and community partners to ensure at-risk women receive appropriate perinatal care and relevant services.
- Assess disparities, strengths, and needs of pregnant women, families, and populations and apply appropriate interventions.

*Policy Development:*

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

*Assurance:*

- Assure that comprehensive perinatal services are available to all Medi-Cal eligible women in both fee-for-service and capitated health systems.
- Work with the perinatal community including providers, Regional Perinatal Program Coordinators/Directors, managed care plans and other health and human service providers to reduce barriers to care, avoid duplication of services and improve quality of perinatal care.
- Ensure that pregnant and postpartum women who have an undocumented resident status are aware of and linked to appropriate perinatal and applicable safety net health and human services.

*Evaluation:*

- Evaluate activities to determine outcome and quality of services.
- Report data and outcomes related to perinatal activities to the MCAH Director.
- Prepare quality assurance reports for CDPH/MCAH upon request.

Additionally, the PSC works to improve birth outcomes by:

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

For additional information regarding CPSP activities, please refer to the CPSP Policies and Procedures located in this manual.

## Agreement Funding Application

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

When completing the AFA package, LHJs should:

- Ensure that each LHJ has the necessary key personnel leadership to fulfill Title V requirements and carry out the core public health functions of assessment, policy development, and assurance and implement programs using the ten essential public health services to improve the health of their MCAH population; and
- Ensure that MCAH staff within the LHJ are aware they are responsible for promotion of maternal, child, and adolescent health.

### LOCAL MCAH BUDGETS

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

### TRAVEL, TRAINING AND MEETINGS

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

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

- Annual meetings of the National Association of Maternal, Child and Adolescent Health Programs.
- Centers for Disease Control and Prevention (CDC) MCAH Epidemiology Conference.
- Annual CityMatCH Conference.

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

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

Out-of-State travel must be identified in the training area the budget and under the appropriate goal and objective in the SOW.

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

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

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

Prior written MCAH approval is required for the following:

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

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

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

- Targeted audience and projected number of attendees
- Draft of publicity materials
- Total cost

Note: Federal regulations disallow the use of any federal funds for advocacy at the local, state, or federal level.

For any Federal Financial Participation (FFP) reimbursement, activities must meet the FFP objectives and requirements.

## Local MCAH Scope of Work

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

LHJs that are funded for additional MCAH programs such as AFLP and BIH must complete separate SOWs for those programs according to the program's respective policies and procedures. If an LHJ receives Fetal Infant Mortality Review (FIMR) funds as part of the AFA agreement, the SOW activities for FIMR are in the Local MCAH Program requirements section of this manual.

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

The Local MCAH SOW is based on:

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

## GENERAL INSTRUCTIONS FOR COMPLETING THE LOCAL MCAH SOW TEMPLATE

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### Cover Page

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

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

### Section A

Outlines general requirements and activities for all LHJs.

- Nothing is entered here by the LHJ.

### Section B

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

- Nothing is entered here by the LHJ.

### Section C

Outlines local activities by population domain.

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

### Developing Local Activities

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

- Prioritized needs identified during the most recent 5-Year Needs Assessment. The LHJ should develop a plan to address each activity, identify best practice strategies and methods to accomplish the activity.
- As resources allow, the LHJ should develop SOW activities to address local problems identified in the Needs Assessment.

- The LHJ should place their activity under the domain area, objective and state strategy area that applies to their local activity.
- For each activity developed, the LHJ answers the following questions:
  - What is your anticipated outcome?

## SUBMITTAL AND APPROVAL OF SCOPE OF WORK

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

The Program Consultant reviews and approves the Local MCAH SOW and the LHJ is notified of SOW approval when notified of AFA approval.

## REVISIONS TO THE SOW

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

# Duty Statement Requirements

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

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

Duty statements must:

- Reflect Local MCAH activities accurately.
- Contain only those duties performed for the Local MCAH program.
- Key personnel duty statements should be consistent with requirements stated under the Key Personnel section.
- Duty statements should be reviewed annually and updated when duties and responsibilities change.

Skilled Professional Medical Personnel (SPMP) Duty Statements:

- Duty statements for Skilled Professional Medical Personnel (SPMP) must note 'SPMP' at the top of the duty statement and contain the statement "This position meets the criteria for SPMP".



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

## DUTY STATEMENT COMPONENTS

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

## Organizational Charts

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

Organizational charts must:

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

## **ORGANIZATIONAL CHART COMPONENTS**

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

## **Local MCAH Annual Report Requirements**

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

LHJs may request an extension of up to 30 days for submission of the Local MCAH Annual Report. Send requests in writing (email is acceptable) to your Program Consultant.

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

CDPH/MCAH uses the information and data in the Local MCAH Annual Report to:

- Monitor implementation of the Local MCAH SOW and performance in meeting the Title V Block Grant and the CDPH/MCAH Program priorities, goals, and objectives.
- Demonstrate LHJ accountability and responsibility for completing activities described in their local SOW and monitors progress towards state and local objectives.
- Monitors program outcomes and health status of the MCAH population.
- Provides data for legislative drills and the Title V Block Grant application, which supports Local MCAH Program funding.



# Comprehensive Perinatal Services Program (CPSP) Policies and Procedures



## CPSP Program Background

The Comprehensive Perinatal Services Program (CPSP) provides a model of enhanced perinatal services for participating clients from entry into care through postpartum. The CPSP model is based on evidence that pregnancy and birth outcomes improve when routine obstetric care is enhanced with psychosocial (PSY), health education (HE) and nutrition (NUT) services.<sup>1</sup>

### CPSP History and California Perinatal Services Timeline

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

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

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

In 1984, legislation under AB 3021 implemented a Medi-Cal reimbursement mechanism for enhanced perinatal care services. In September 1987, CPSP was initiated, enabling Medi-Cal providers to apply for CPSP approval and receive reimbursement for covered services provided to eligible clients.

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

## CPSP Statutes and Regulations

CPSP Goals: [HSC §123505](#):

- decrease and maintain the decreased level of perinatal, maternal, and infant mortality and morbidity; and
- support methods of providing comprehensive prenatal care that prevents prematurity and the incidence of low birthweight infants.

CPSP Objectives: [HSC §123510](#):

- Ensure continuing availability and accessibility to early prenatal care throughout the state.
- Assure the appropriate level of maternal, newborn, and pediatric care services necessary to provide the healthiest outcome for mother and infant.
- Ensure postpartum, family planning, and follow-up care through the first year of life including referrals to an ongoing primary health care provider.
- As components of comprehensive perinatal care, include support and ancillary services such as nutrition, health education, public health nursing and social work that have demonstrated to decrease maternal, perinatal, and infant mortality and morbidity.
- Ensure perinatal care 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 individuals.
- 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 individuals to encourage early entry into and appropriate utilization of perinatal care.

The following CPSP statutes were transferred from Department of Health Services to CDPH in 2007: [HSC §123475-123525](#) and [WIC §14134.5](#). The essential functions within those statutes are discussed below:

### Provider Enrollment

- CDPH is authorized to review and evaluate a provider's CPSP application based on the established criteria defined by [22 CCR § 51249](#). The Perinatal Services Coordinator (PSC) in each local health jurisdiction (LHJ) assists CDPH in this process. CDPH approves the application of Fee-for-Service (FFS)

Medi-Cal providers and providers from Rural Health Centers (RHCs) and Federally Qualified Health Centers (FQHCs).

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

Training and Technical Assistance [reference: [W&I § 14135.5 \(g\)](#)]

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

Monitoring and Oversight [reference: [W&I § 14134.5 \(i\)](#)]

- The department shall develop systems for monitoring and oversight of the comprehensive perinatal services provided in this section and [W&I §14134.5 \(i\)](#).
  - CDPH/MCAH Division defines “monitoring” by requiring each LHJ to implement individualized activities, based on local capacity and needs, to improve access to early and quality perinatal services. CDPH/MCAH will utilize MCAH’s data and reports to monitor specific perinatal outcomes and provide technical assistance to the LHJs as appropriate.

CPSP services are delivered 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.
- CPSP services are delivered through a multi-disciplinary approach to address the full needs of the client.
- CPSP services are individualized, culturally sensitive, and respect clients’ values, beliefs, and traditions.
- CPSP services delivered are consistent with approved protocols signed off by nutrition, health education and psychosocial consultants.
- The CPSP provider shall refer clients, as appropriate, to services not specifically made part of comprehensive perinatal services, which shall include and not be limited to, those provided by the following programs:
  - Women, Infants and Children (WIC) nutritional services
  - Genetic Screening
  - Dental Care
  - Family Planning

- Well Child Care – Child Health and Disability Prevention Program (CHDP), Immunization program
- Other local resources (i.e., home visiting programs, mental health support, local infectious disease programs, etc.)

Client participation in CPSP is voluntary.

## CPSP Regions

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

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

## CPSP Program Overview

CPSP provides a model of enhanced perinatal services for Medi-Cal eligible pregnant and postpartum individuals from entry to care through postpartum. These enhanced services are delivered by qualified Medi-Cal providers.

CPSP services must be provided in conformance with current American College of Obstetrics and Gynecologists (ACOG) recommendations, [17 CCR § 6501 Newborn Screening Regulations](#) and [17 CCR § 2500 Hemolytic Disease of the Newborn Regulations](#) as the minimum standards for obstetrical services. Enhanced services are delivered as defined by Title 22 Regulations. CPSP providers are reimbursed by Fee-for-Service (FFS) Medi-Cal. Managed care providers are reimbursed according to their contract with the managed care plan.

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

### CLIENT ORIENTATION

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

### Types of CPSP Services Offered by Provider

Type of Service	What it includes:
Obstetrical Services	<p>Routine obstetrical services must be provided in accordance with most current ACOG Guidelines, including:</p> <ul style="list-style-type: none"><li>• Prenatal care</li><li>• Intrapartum (delivery) care</li><li>• Postpartum care</li></ul> <p>Provided by a qualified on-staff practitioner or contracted practitioner</p>



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

**ASSESSMENTS, REASSESSMENTS, REFERRALS, AND INDIVIDUALIZED CARE PLANS**

Per [22 CCR § 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 Assessments and Reassessments, Individualized Care Plans and Referrals.

**CPSP Assessments and Forms**

Obstetric, health education, nutrition and psychosocial are the components to be assessed. The provider should make every effort to complete an initial assessment in the four components within four weeks of the initial visit. The provider must offer health education, nutrition, and psychosocial reassessment in the second and third trimesters, as well as postpartum assessments. The assessments will be signed by the staff person completing the assessment(s).

Each assessment is completed by a CPSP practitioner during an 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, the client's readiness to take action and resources needed to address the issues identified. Additionally, the assessment process identifies the client's strengths and risks related to health and well-being during pregnancy.

Providers may use the CDPH/MCAH approved CPSP templates for [Initial and Trimester Assessment](#), [Postpartum Assessment and Individualized Care Plan and](#) Protocols.

The Nutrition, Psychosocial and Health Education Initial Assessment Form, 2<sup>nd</sup> and 3<sup>rd</sup> Trimester Reassessment Form, Postpartum Assessment Form, Individual Care Plan and CPSP Protocol Template provided on the CPSP website are considered resources and does not define the standard of care in California. Potential new and current CPSP Providers can use or adapt these resources based on their local facility's level of care and patient populations served while still meeting the requirements outlined in Title 22 of the California Code of Regulations.

### **Individualized Care Plan (ICP)**

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

### **Referrals**

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

- Women, Infants, and Children (WIC)
  - Referral forms for WIC are available online at: [WIC Forms](#)
- Genetic screening
  - Genetic screening information is available on the CDPH website at [Genetic Screening](#).
  - Providers must offer Prenatal Screening. If the client screens positive, the provider should refer the client to a state approved Prenatal Diagnosis Center, where they can receive genetic counseling and other follow-up services free of charge.
  - Newborn screening is completed at the hospital. Please see the California Prenatal Screening Program materials at [CA Prenatal Screening Program](#).
- Dental care
  - Dental Referral Form and instructions are available at [Medi-Cal Dental Patient Referral Service Form](#).
- Child Health and Disability Prevention Program (CHDP)

- The CHDP Referral Form and instructions are available at this link: [Child Health and Disability Prevention Program Referral Form](#)
- Family planning, such as Family, Planning, Access, Care and Treatment (Family PACT) Program
  - If a client has full scope Medi-Cal or Medi-Cal Managed Care, family planning services are covered after the postpartum period.
  - If a client is undocumented, and income eligible, refer the client to a Family PACT provider for further service after the postpartum period. The provider may continue providing services under Family PACT after the postpartum period if the provider is a Family PACT provider.
  - For more information, see the [Family PACT](#) website

A complete referral includes clear instructions and a completed form if required; instructions as to where to obtain the service; and follow up to assure that the client received the service.

### **Case Coordination**

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

## PSC Role, Responsibilities and Activities Overview

It is strongly recommended that each LHJ have a PSC to oversee the implementation of CPSP. If an LHJ does not have a PSC, the MCAH Director is responsible for PSC activities. CDPH/MCAH provides an online CPSP Overview Training for PSCs to assist them in implementing CPSP and improve systems of perinatal care.

The PSC works to improve birth outcomes by:

- ensuring CPSP is administered according to Title 22 regulations;
- developing staff knowledge of the local systems of maternal and perinatal care;
- developing a comprehensive resource and referral guide of available health and social services;
- coordinating perinatal activities between MCAH and the Regional Perinatal Programs of California (RPPC) to improve maternal and perinatal systems of care, including coordinated postpartum referral systems for high-risk parents and infants upon hospital discharge;
- implementing local best or promising practice strategies to improve perinatal systems of care; and
- collaborating with partners such as Medi-Cal, Medi-Cal Managed Care and managed care health plans to identify strategies and activities to improve access to health care services of early prenatal care and postpartum visit(s) for postpartum individuals.

The PSC assists with CPSP implementation by:

- providing training, consultation, and technical assistance to CPSP providers and Medi-Cal Managed Care plan staff on program implementation;
- facilitating a process to assist providers to develop or revise protocols; and
- conducting CPSP Quality Assurance/Quality Improvement (QA/QI) activities to address:
  - barriers to perinatal and postpartum care;
  - office/administrative systems to track client follow-up and completion of referrals, including postpartum care; and
  - improving care coordination and resource utilization.
- Coordinating and conducting CPSP provider QA/QI site visits and providing technical assistance to improve care.
  - Activities that may occur during site visits include:
    - chart reviews
    - administrative reviews
    - observation and interview of staff
    - follow up with the provider regarding their plan to address program deficiencies

## ADDITIONAL PSC ROLES

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

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

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

Examples:

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

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

Examples:

- Develop processes to raise awareness, such as round table discussions and workforce development trainings. Offer information on emerging issues affecting maternal and infant health to the community and providers.
- Assess adequacy of referral sources and assist providers to develop mechanisms to refer clients to appropriate programs and services, such as local MCAH home visiting programs, specialty providers, faith-based organizations, local community, and social services support system.
- Implement QA/QI activities such as technical assistance regarding client follow-up for referrals and adequate interagency agreements to promote coordinated care as appropriate.

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

Examples:

- Coordinate with RPPC to implement best practices to ensure parents and infants have access to appropriate maternal levels of care.

- Conduct activities with local provider networks and/or health plans to improve perinatal access, service integration and coordination to meet complex needs

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

Example:

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

## **PSC PROVIDER APPLICATION AND ENROLLMENT RESPONSIBILITIES**

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- Ensures the current [CPSP Provider Application \(CDPH 4448\)](#) form is used by prospective CPSP applicants.
- Provides consultation and technical assistance to the completion of the CPSP provider application and protocol development:
  - Verify professional licenses during the application process.
  - Verify that providers are in good standing with Medi-Cal.
  - Verify that providers are eligible to enroll as CPSP providers, defined in [22 CCR § 51179.1](#) and [WIC § 14134.5](#).
- Provide consultation to providers in the development of antepartum/intrapartum/postpartum and dual provider agreements as needed.
- Approve changes to the CPSP provider application as submitted to CDPH/MCAH when appropriate.
- Recruit Medi-Cal providers into CPSP. Additionally, the PSC assists providers with assessing local needs for providers.

## **PSC MEETING AND TRAINING RESPONSIBILITIES**

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

- PSC Statewide Meeting (either virtually or in-person)
- State directed trainings related to perinatal systems of care
- New PSCs should complete the online CPSP Overview Training
- Skill-based online training modules, as needed

PSCs should be familiar with resources, such as:

- CPSP website and resources
- MCAH Program Policies and Procedures Manual
- CPSP Assessment Tools
- QA/QI tools

## RESOURCES FOR PSCS

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

A list of PSCs is located at [CPSP Perinatal Services Coordinators Directory](#)

## Medi-Cal Information for PSCs

For billing inquiries, requests for billing assistance, or to report a billing issue, refer the provider to Medi-Cal's Telephone Service Center (TSC) at 1-800-541-5555. For inquiries regarding Provider Enrollment, refer the provider to [Medi-Cal's Provider Enrollment Division \(PED\) Message Center](#) to complete an Online Inquiry Form. PED may also be reached by phone at (916) 323-1945.

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### MEDI-CAL FEE-FOR-SERVICE

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

#### Getting Help with Medi-Cal Billing

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

The TSC is the first line of communication between providers and the Department of Health Care Services (DHCS) Fiscal Intermediary. TSC is staffed by knowledgeable telephone agents who can assist providers with:

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

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

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### MEDI-CAL MANAGED CARE PLANS

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

Medi-Cal Managed Care Health Plan Directory lists the health plans in each county: [MMCD Health Plan Directory](#)

The PSC should work closely with MCMC staff in their local area to provide technical assistance and assure that CPSP services are available and accessible to all pregnant and postpartum individuals.



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

[Medi-Cal Managed Care Homepage](#)

### **Billing Seminars**

There are seminars that cover Medi-Cal’s obstetric and CPSP billing and reimbursement policies. Providers are encouraged to watch the monthly bulletins for dates, times, and locations of billing seminars. The Medi-Cal Learning Portal is an easy-to-use, one-stop learning center for Medi-Cal billers and providers. First-time users must complete a one-time registration to have access to the MLP’s resources, such as online tutorials, live and recorded webinars.

Access the Medi-Cal Learning Portal at [Medi-Cal Learning Portal](#)

### **Other Medi-Cal Resources**

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

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

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

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

[Rural Health Clinics and Federally Qualified Health Clinics Billing](#)

### **TREATMENT AUTHORIZATION REQUEST (TAR) AND REPORTING REQUIREMENTS**

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Claims for CPSP services over the basic allowances will not be denied for the absence of a Treatment Authorization Request (TAR). RHCs and FQHCs, however, must maintain in the client’s medical record the same level of documentation that would be needed in a TAR. DHCS Audits and Investigations may recover payments that do not meet the requirements under CCR, Title 22, Section 51458.1, “Cause for Recovery for Provider Overpayments” and Section 51476, “Keeping and Availability of Records.”

Required documentation includes:

- the expected date of delivery,
- clinical findings of high-risk factors involved in the pregnancy,
- an explanation of why basic CPSP services are not sufficient,
- a description of the services being requested,
- the length of visits and frequency with which the requested services are provided, and
- anticipated benefit(s) of outcome of additional services.

## PROVIDING CPSP TO HEALTH PLAN BENEFICIARIES

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

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

Source: [Rural Health Clinics and Federally Qualified Health Clinics Billing](#)

## Audits and Investigations

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

A&I serves as program integrity function, whereby they conduct enforcement on accuracy of claims to ensure that services are accurately represented by codes billed. They review documentation to assure that the documentation supports billing. They assure that services are medically necessary, evaluate quality of care and educate providers. They are also available to consult with PSCs on any areas of concern. The CPSP provider should contact their local PSC first to discuss a possible referral or needed assistance with a referral to A&I.

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

Most frequent findings are poor documentation; FQHC high frequency visits for services rendered with fewer visits in FFS settings; and lack of individualization of services.

The CPSP provider should discuss the matter with their local PSC before making fraud referrals.

The A&I web site is: [Audits and Investigations Homepage](#)

**The most direct line for making fraud referrals is:**

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

Email: [stopmedicalfraud@dhcs.ca.gov](mailto:stopmedicalfraud@dhcs.ca.gov)

Phone: 1-800-822-6222

Web: [Stop Medi-Cal Fraud](#)

## Provider Application Process

Provider applicants must work with their local PSC to complete the application process. PSCs provide technical assistance in the completion of the [CPSP Provider Application \(CDPH 4448\)](#) and [Additional CPSP Practitioners \(CDPH 4448A\)](#), including verification of practitioners' license status, education and experience. PSCs also provide guidance on program implementation and assist the applicant in preparing the required components described below.

### Provider Agreements

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

Keep agreements on file at the provider's office and with the LHJ.

### Dual Provider Agreements

A Dual Provider Agreement (DPA) is required when two CPSP providers simultaneously provide CPSP services. For example, one provider may deliver OB services, and another may deliver nutrition, psychosocial and health education assessments, and interventions. These agreements are made between the CPSP providers involved with guidance from the PSC.

### Application Components

The PSC reviews the application for completion prior to forwarding to CDPH/MCAH.

The Application Review Checklist Tool is available on the [CPSP website](#) for PSCs to use to ensure that the new CPSP provider meets the requirements of the CPSP Program. The Application Review Checklist Tool outlines the following required components that must be kept on file with the LHJ.

- I. Perinatal Data Form - Attach a blank sample Perinatal Data Form in a format prescribed by CDPH/MCAH for each client served. [[22 CCR § 51348 \(k\)](#)]
- II. Initial PSY, HE and NUT assessment, trimester reassessments and postpartum assessment template. For nutrition, a dietary intake template (e.g., Perinatal Food Group Recall) and current weight grids are also required. [[22 CCR § 51348](#)]
- III. Individualized Care Plan (ICP) template. May be a separate document or incorporated into the assessments form. [[22 CCR § 51179.8](#)]

- IV. General Description of Practice – overview of the practice, describing how obstetrical services (prenatal, delivery, and postpartum) and enhanced services (psychosocial, health education, and nutrition) will be provided. [[HSC § 123520 \(c\)](#)]
- V. Delivery Hospitals – name(s) and address(es) where deliveries are planned to take place. Delivery physician must have privileges. [[HSC § 123520 \(c\)](#)]
- VI. Mandated referral services - names and addresses of the persons/agencies to whom clients are referred for: [[22 CCR § 51348 \(j\)](#)]
  - Well-child services: Child Health and Disability Prevention (CHDP) Program
  - Family planning services: Family Planning, Access, Care and Treatment (Family PACT) Program
  - Nutrition services: Women, Infants and Children (WIC) Program
  - Genetic disease screening: Genetic Disease Screening Program
  - Dental care services: Denti-Cal Program
- VII. Antepartum/Intrapartum/Postpartum and Dual Provider Agreements – Attach sample provider agreement to be used when the approved CPSP provider contracts with another service provider for any of the antepartum, intrapartum, postpartum, and CPSP services. [[HSC § 123520 \(c\)](#)]

### Application Review and Approval

To become an approved CPSP provider, applicants must be enrolled in Medi-Cal and have an approved CPSP Provider Application on file with CDPH/MCAH. For information on Medi-Cal enrollment contact [DHCS Medi-Cal Provider Enrollment Division \(PED\)](#).

The PSC forwards the completed [CDPH 4448](#) and [CDPH 4448A](#) via email to [CPSPProviderEnrollment@cdph.ca.gov](mailto:CPSPProviderEnrollment@cdph.ca.gov). The original application and all required components are kept on file at the LHJ for quality assurance and audit purposes.

Within 60 days of receipt of the completed application from the PSC, CDPH/MCAH verifies the application information, determines the final decision to approve or deny and sends written notification of the decision to the provider and PSC. If approved, providers are allowed to bill for CPSP services rendered on or after the effective date indicated in the approval letter.

### Updating Application Information

Approved CPSP providers must notify their local PSC when application information is updated. Notification of a change of name, NPI, provider type, service address or ownership must be forwarded to CDPH/MCAH by email to [CPSPProviderEnrollment@cdph.ca.gov](mailto:CPSPProviderEnrollment@cdph.ca.gov). A new CDPH 4448 is required when a change of information generates a new Provider Master File (PMF) profile. Personnel updates are kept on file at the LHJ and are not forwarded to CDPH/MCAH.

For information related to Medi-Cal enrollment or billing, refer the CPSP provider to the Provider Enrollment Division (PED). PED may be reached at (916) 323-1945 or by completing the Online Inquiry Form available on the Medi-Cal website.

### End-dated Approval

When a provider's CPSP approval is end-dated, the provider is no longer authorized to bill Medi-Cal for CPSP services. CPSP approval may be end-dated at the request of the provider or for any of the following reasons:

- no longer providing CPSP services;
- deactivated by Medi-Cal or no longer in good standing; or
- non-compliance with program policies and administrative practices.

The PSC forwards the provider's request to end-date CPSP approval to [CPSPProviderEnrollment@cdph.ca.gov](mailto:CPSPProviderEnrollment@cdph.ca.gov). An End-Date Memo will be prepared requesting Medi-Cal update the provider's PMF profile by terminating CPSP approval. A copy of the End-Date Memo is sent to the PSC for the provider's file.

## Site-Specific CPSP Protocols

A CPSP provider must develop written protocols for each enhanced service – nutrition, health education and psychosocial – within six months of being approved as a CPSP provider. CDPH/MCAH recommends yearly (or more often if needed) review and update of the protocols.

Protocols must clearly describe a system of coordinated services for the client at the provider's specific setting from entry into care through postpartum. The protocol specifies initial assessment and reassessment every trimester, postpartum assessments, care planning, individual or group interventions, referral mechanisms and case coordination. A provider's protocols must reflect their current CPSP site practices, policies, and procedures. CPSP staff members are required to follow their site-specific protocols when delivering CPSP services.

**CPSP services must be provided by or under the personal supervision of a physician.** [22 CCR § 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 how the supervision is documented.

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

If the provider offers group classes, the protocols should include: (1) an outline for each class offered, including learning objectives, content, methodology and methods of evaluation; (2) a blank sign-in sheet with

space for date, instructors name and signature, topic, and time in minutes. The provider must keep the completed documentation for each class in a designated secure location, separate from the individual patient health record.

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

### **Developing New Protocols**

Newly developed site-specific CPSP protocols, not based on a sample protocol, must be reviewed and signed by a health educator, registered dietitian and social worker consistent with [22 CCR § 51179.9](#) requirements. Consultant names and/or referral resources for high-risk conditions must be included in the protocols.

### **Using Previously Approved Template Protocols**

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

### **Using Existing Protocols (for Additional Sites Only)**

Currently approved CPSP providers who open other CPSP sites may use the protocols being used at the original site if they were developed or updated within the past five years. The supervising physician must sign the protocols to ensure they are current and customized for the new site. The protocols do not need to be signed again by a health educator, registered dietitian, or social worker.

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

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

Local PSCs have the right to conduct QA/QI activities with their providers as part of CDPH/MCAH monitoring authority over CPSP, stipulated under [WIC § 14134.5 \(i\)](#).

The PSC provides QA/QI by the following:

- Through ongoing provider education about CPSP implementation via on-site or virtual trainings and technical assistance visits, orientation of new staff, provider meetings and local roundtables. Roundtables are educational and networking opportunities for perinatal care providers and their staff to discuss perinatal and newborn care topics. Attendees may include health care providers, public health professionals, nurses, prenatal and pediatric clinic staff, home visiting programs, therapists, and social workers.
- Conduct face-to-face or virtual QA/QI visits to CPSP provider offices to assess, maintain and improve the quality of CPSP services and assure appropriate care.
  - Purpose:
    - Provide technical assistance and improve the provider’s process of implementing CPSP based on client needs, site protocols and CPSP mandated requirements.
    - Assist providers in assessing client barriers and opportunities to improve early access to quality and comprehensive perinatal care.
    - Engage with providers to identify ways of improving documentation, case coordination, client follow-up and management.
  - The QA/QI visits may involve:
    - Chart Reviews – The local PSC, through CDPH/MCAH, has the legal authority to review individual patient health records in the CPSP provider medical offices, based on the Title 45 Code of Federal Regulations (CFR) standard for uses and disclosures for public health activities [[45 CFR § 164.512 \(b\)](#)] and uses and disclosures for health oversight activities [[45 CFR § 164.512 \(d\)](#)], and [Civil Code § 56.10](#) on the disclosure of medical information by providers.
    - Provider Enrollment
- Conduct Administrative Reviews – The local PSC has the legal authority to establish a community perinatal program whose responsibilities include monitoring providers of comprehensive perinatal services, pursuant to [WIC § 14134.5](#).

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

- adequacy of community resources
- review of policies
- development of protocols
- integration of activities that reflect evidence-based best or promising practices to improve quality perinatal care or early access to care



- address safety-net support for pregnant and postpartum individuals (e.g., food security, shelter, housing, and school placement)
  - assist providers to identify and address barriers to improve quality perinatal care including early entry into prenatal care
  - assist providers to improve office/administrative systems to track client follow-up and completion of referrals
  - improve care coordination and resource utilization
- Staff Interview and observation of any CPSP–related service activities (education classes, case coordination, etc.).

### Follow-up to a QA/QI Visit

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

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

## Electronic Health Records

PSC responsibilities regarding electronic health records (EHR):

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 regulations. It is important that the EHR aligns with the CPSP model in each provider office.

PSCs are not expected to be experts in EHR development, only in assisting providers to ensure that EHR systems include documentation that is compliant with Title 22. It is the provider’s responsibility to make sure they can demonstrate compliance whether in a paper or electronic chart. The PSC can provide program expertise to help guide the provider in this process, but it is the provider’s responsibility to make sure the system will be functional.

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

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

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

## Charting Rules and Record Retention

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

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

Retention of CPSP client health information records must follow [WIC § 14124.1](#). Each provider must retain the records of Medi-Cal patients for seven years after the date of last service. Health information records of minors shall be kept until they are over the age of 18.

## PSC Executive Committee

The PSC Executive Committee represents the PSCs and collaborates with the CDPH/MCAH staff to promote perinatal health needs in California. In addition, the PSC Committee serves as a resource to CDPH/MCAH and facilitates communication and support to the PSCs throughout the state.

The PSC Executive Committee consists of representatives from four regions:

- Bay Area Perinatal Advocates (BAPA)
- Central Area Perinatal Advocates (CAPA)
- Northern Area Perinatal Advocates (NAPA)
- Southern Area Perinatal Advocates (SAPA)

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

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

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

- State perinatal services education and CPSP annual meeting (if applicable)
- PSC Executive Committee – decisions and pending issues

- Workgroup reports
- Medi-Cal Managed Care trends and issues
- Interactions with other MCAH Programs
- Action items – issues that PSCs have identified and wish to bring to the attention of MCAH Action for support or action:
  - define and describe issue(s)
  - clearly state goal(s) of requested action
  - clearly state the steps/action(s) and timeframe for completion that the PSCs are requesting of MCAH Action
  - identify at least one PSC who will be the contact person for information, coordination, and collaboration

The PSC Executive Committee must develop the CPSP Action Affiliate Report and send it to the CDPH/MCAH CPSP Coordinator, MCAH Action and CalWIC.

## Glossary of Common Acronyms

AFLP.....	Adolescent Family Life Program	HIPAA .....	Health Insurance Portability and Accountability Act
ACOG .....	American College of Obstetrics and Gynecologists	HRSA.....	Health Resources and Services Administration
AB .....	Assembly Bill	ICP .....	Individualized Care Plan
AFA .....	Agreement Funding Application	IHS .....	Indian Health Services
A&I .....	Audits and Investigations	LHJ .....	Local Health Jurisdiction
BIH.....	Black Infant Health	MCAH .....	Maternal, Child and Adolescent Health
CAB .....	Community Advisory Board	MCH .....	Maternal and Child Health
CAP .....	Corrective Action Plan	MCHB .....	Maternal and Child Health Bureau
CAT .....	Community Action Team	MCMC .....	Medi-Cal Managed Care Division
CCR .....	California Code of Regulations	MPH.....	Master of Public Health
CCS .....	California Children’s Services	NPI.....	National Provider Identifier
CDAPP .....	California Diabetes and Pregnancy Program	PEI .....	Perinatal Equity Initiative
CDC.....	Centers for Disease Control	PHI .....	Public Health Information
CDPH .....	California Department of Public Health	PHN .....	Public Health Nurse
CHDP .....	California Health and Disability Prevention	PSC .....	Perinatal Services Coordinator
CHVP.....	California Home Visiting Program	QA/QI .....	Quality Assurance/Quality Improvement
CMS .....	Children’s Medical Services	RHC.....	Rural Health Center
CNM .....	Certified Nurse Midwife	RN.....	Registered Nurse
COS.....	Category of Service	SOW.....	Scope of Work
CPHW .....	Comprehensive Perinatal Health Worker	SCHIP .....	State Children’s Health Insurance Program
CPS .....	Child Protective Services	SNAP.....	Supplemental Nutrition Services Program
CPSP .....	Comprehensive Perinatal Services Program	SPMP .....	Skilled Professional Medical Personnel
CPSTF.....	Community Preventive Services Task Force	SIDS .....	Sudden Infant Death Syndrome
CRT .....	Case Review Team	SUID.....	Sudden Unexpected Infant Death
DHS.....	Department of Health Services	STT.....	Steps to Take
DHCS.....	Department of Health Care Services	TANF.....	Temporary Assistance to Needy Families
EHR .....	Electronic Health Record	TAR .....	Treatment Authorization Request (Medi-Cal)
Family PACT....	Family Planning, Access, Care, and Treatment	W&I .....	Welfare and Institutions (code)
FQHC .....	Federally Qualified Health Center	WIC.....	Women, Infant and Children
FFP.....	Federal Financial Participation		
FFS.....	Fee for Service		
FIMR .....	Fetal and Infant Mortality Review		
FTE.....	Full Time Equivalent		