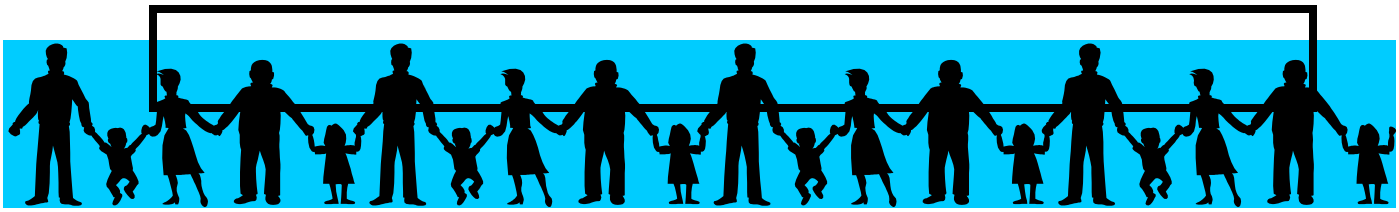

Colorado

Fiscal Year 2013

Maternal and Child Health Program

Guidelines

Colorado Department
of Public Health
and Environment

Prevention Services Division
4300 Cherry Creek Drive South
Denver, CO 80246

Colorado Maternal Child Health Program Guidelines

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Overview and Purpose of Guidelines

Welcome to the Colorado Maternal Child Health (MCH) Guidelines. These Guidelines serve as a one-stop source of information for Colorado's MCH Program and are organized into two parts:

- **Part I: MCH Background**

Part I provides background information about Maternal and Child Health and the Maternal and Child Health Services Block Grant (Title V) including anticipated FY13 federal and state funding levels, and national and state performance measures.

- **Part II: Colorado's MCH Local Planning, Implementation, Evaluation, and Reporting Processes**

Part II serves as a guide to Local Public Health Agencies (LPHAs) for participating in the Colorado Department of Public Health and Environment's (CDPHE) MCH Program planning, implementation, evaluation and reporting processes for federal fiscal year 2013 (FY13). **These Guidelines delineate the requirements and expectations of LPHAs' MCH scope of work in relationship to their FY13 MCH contracts with CDPHE.** LPHAs are therefore responsible for implementing all MCH program components as outlined in these Guidelines, per their FY13 MCH contract with the CDPHE.

The MCH Guidelines are posted online at www.mchcolorado.org. Per contract specification, any revision to these guidelines will be communicated in a timely manner to LPHA partners and will also be updated online. The hyperlinks in the MCH Guidelines link to companion documents (such as forms, instructions, and guides) posted on the MCH website.

LPHAs are also responsible for adhering to the Health Care Program for Children and Youth with Special Health Care Needs (HCP) Policies and Guidelines that are posted on the HCP web site at http://www.cdphe.state.co.us/ps/hcp/hcpPoliciesandGuidelines.htm.

PART I: MCH BACKGROUND

A. Maternal and Child Health

Maternal and Child Health (MCH) is "the professional and academic field that focuses on the determinants, mechanisms and systems that promote and maintain the health, safety, well-being and appropriate development of children and their families in communities and societies in order to enhance the future health and welfare of society and subsequent generations" (Alexander, 2004).

1. MCH Title V Funding

The Maternal and Child Health Bureau (MCHB) administers the Maternal and Child Health Services Block Grant (Title V). Since 1935, Title V has been the primary, continuous mechanism that supports national efforts to improve maternal and child health including children with special health care needs. Maternal and Child Health Services Block Grant funds are used for: State Formula Block Grants; Special Projects of Regional and National Significance (SPRANS) grants; and Community Integrated Service Systems (CISS) grants.

The purpose of the Title V MCH Block Grant Program is to create federal-state partnerships in development and enhancements of service systems that:

- Significantly reduce infant mortality
- Provide comprehensive care for women before, during, and after pregnancy
- Provide prevention and early intervention services for infants, children, and adolescents
- Provide comprehensive care and build a comprehensive system of supports for children and youth with special health care needs (CYSHCN)
- Immunize all children
- Reduce adolescent pregnancy
- Prevent injury and violence
- Implement national standards and guidelines for prenatal care, for healthy and safe child care, and for the health supervision of infants, children, and adolescents
- Assure access to care for all mothers and children
- Meet the nutritional and developmental needs of mothers, children and families.

In FY12, U.S. Congress appropriated $645 million for the Title V MCH Block Grant. The President's proposed budget for FY13 allocates $640 million to Title V. It is important to note that the President's budget is the first step in the annual funding process and is an indication of the Administration's funding priorities. This proposal does not get signed into law. Congress will decide on final funding levels during the upcoming year as they develop their annual appropriations bills. State funding levels are determined by the funding formula MCH population x poverty of the MCH population.

2. Colorado MCH

The CDPHE MCH Program's vision is healthy people, healthy families, and thriving communities. The mission of the program is to optimize the health and well-being of the MCH population through primary prevention and early intervention public health strategies. The MCH population is defined as women of reproductive age (15 – 44), children and youth (0-18), and children and youth with special health care needs (0-21).

The state MCH and HCP Programs partner with local public health agencies and other state and community partners to achieve the mission. MCH and HCP state and local partnerships are critical to our collective success in effectively serving Colorado's MCH population. These guidelines support and delineate the contractual aspects of the MCH/HCP state and local public health partnership.

As part of Title V Block Grant requirements, Colorado completes an in-depth, state-level needs assessment every five years to identify priority areas among the MCH population that need to be addressed by MCH state and local partners. The most recent state-level needs assessment was conducted in 2010. The needs assessment identified nine new state priorities with accompanying state performance measures.

The state MCH program aims to demonstrate a measurable impact on these priorities and state performance measures from 2011-2015 through a coordinated state and local effort. To this end, in the fall of 2010, the MCH Steering Team developed a new infrastructure at the state level to translate needs assessment results into effective strategies. The infrastructure developed:

- promoted a coordinated approach between state and local MCH efforts;
- provided support and capacity-building among state MCH staff;
- and provided oversight and accountability to MCH work at the state and local levels.

In addition, state MCH Implementation Teams (MITs) were formed for each MCH priority and were charged with developing, implementing and evaluating evidence-based strategies to impact their priority area. From December 2010 through March 2012, the MITs systematically applied Brownson's Evidenced-Based Public Health framework in order to ultimately develop state logic models and action plans, and local level logic models and action plans that contained strategies focused on impacting the priority issues. For more information on Brownson's Evidence-Based Public Health framework: http://prcstl.wustl.edu/EBPH/Pages/Evidence-BasedPublicHealthCourse.aspx

The MIT-developed local action plans provide guidance for LPHAs on goals, objectives, and key activities to address selected priorities. Local agencies will work with their MCH Generalist Consultant to customize these action plans through the planning process.

In order to assure that outcomes result from future state and local MCH/HCP efforts with block grant/HCP funds, alignment between state and local efforts is critical. Therefore, local public health agencies, particularly in the planning process, will be required to focus a percentage of their efforts/dollars on the MCH priorities and accompanying action plans.

In Colorado, a majority of Title V funds are distributed to the larger local public health agencies. The amount allocated to each LPHA is dictated by a funding formula based on the number of women, children, and adolescents living in a county and the number of women, children and adolescents living in poverty (at or below the 150% poverty level) in that same county. The population and poverty funding formula is applied to all 55 local public health agencies.

Additionally, all LPHAs receive combined funding to support local MCH and HCP efforts. Agencies receiving more than $50,000 annually participate in the MCH planning, implementation and reporting process supported by a MCH Generalist Consultant. Agencies will develop one-year plans (with longer term goals) for the next three years as agencies' MCH/HCP funding levels transition and as LPHAs align their program efforts with MCH funding expectations, LPHA community health assessment results, and public health improvement plans.

For FY2013, it is anticipated that Colorado's Title V funding level will remain level with previous years at approximately $7.2 million, or the funding level will decrease slightly. Overall, approximately 40% of these funds are used to support state-level MCH services and activities, while approximately 60% of the funds are allocated to local partners to provide MCH services and activities.

To assist agencies in the planning process, the state provides comprehensive support and technical assistance in public health planning, implementation and evaluation processes.

B. MCH Accountability and Performance

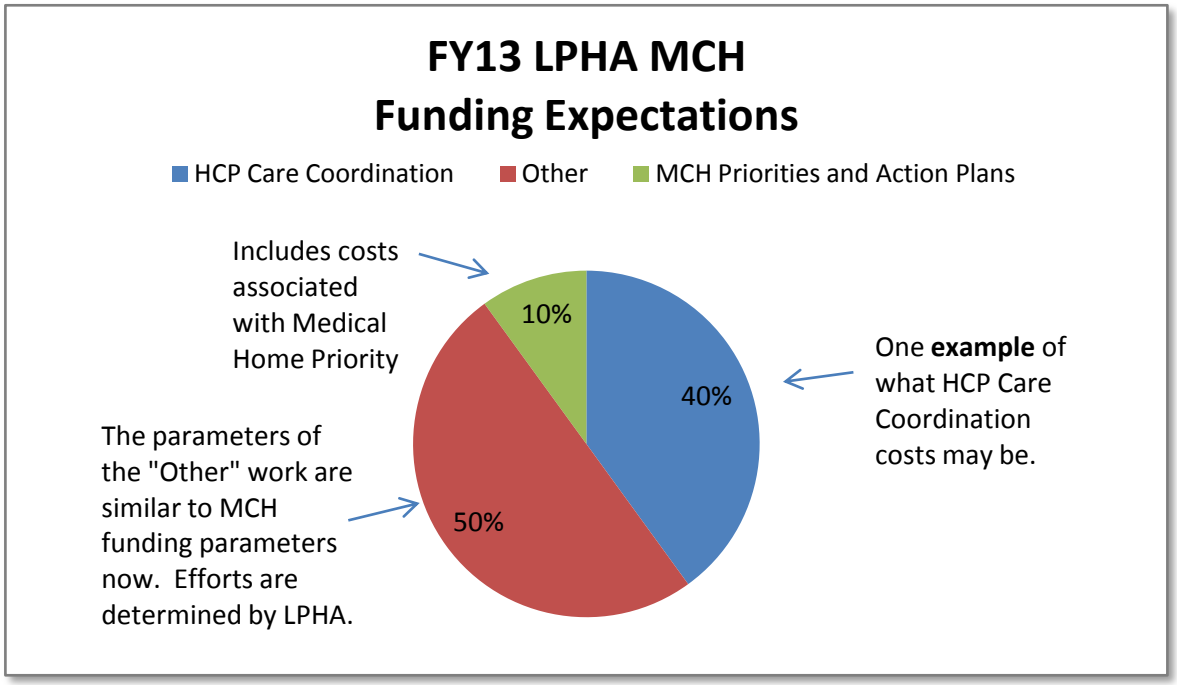
MCH public health professionals are accountable to the public and to policymakers to assure that public dollars are spent in alignment with identified priorities and in a way that effectively impacts priority areas. MCH programs can effectively impact priority areas by implementing the core functions of public health: continually assessing needs, assuring that services are provided to the MCH population, and developing policies consistent with needs. State and local MCH can also effectively impact priority areas by implementing the 10 Essential Services of Public Health (**Appendix A**) and positively impacting the MCH state and national performance measures.

The Maternal and Child Health Bureau (MCHB) uses performance measurement and other program evaluation to assess progress in attaining goals and addressing priorities. Evaluation and performance measurement is critical to MCH policy and program development, program management, and funding. A number of tools and measures have been developed to assess national, state, and local performance.

Currently the MCH Program has 18 National Performance Measures, 6 Outcome Measures, and 10 State Performance Measures. Federal MCH Program staff, states, and other grantees jointly developed these consensus measures. In addition to the national performance measures, states develop and report annually on state priority needs and performance measures.

Alignment between state and local efforts is critical to assure that outcomes with MCH/HCP funds. To this end, local public health agencies will be expected to focus a percentage of their efforts/dollars on the MCH priorities and action plans. In FY13, agencies will be required to focus at least 10% of total MCH/HCP funds on MCH-priority action plans, including the medical home priority.

Additionally, for the FY13 planning process, agencies will be required to implement the HCP model of care coordination and complete data entry in the CYSHCN data system. As already stated, agencies will also be required to implement the local action plan related to the medical home priority. The measure for the medical home priority is national performance measure #3. See below. LPHAs will determine how much funding they will allocate to HCP Care Coordination and the medical home priority in order to meet these requirements.



1. 18 National Performance Measures (2006)

The data source appears in parentheses following measurement when applicable.

1. The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their state-sponsored newborn screening programs.
2. The percent of children with special health care needs (CSHCN) age 0 to 18 whose families partner in decision-making at all levels and are satisfied with the services they receive. (CSHCN Survey)
3. The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

4. The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)
5. The percent of children with special health care needs age 0 to 18 whose families report community-based service systems are organized so they can use them easily. (CSHCN Survey)
6. The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence. (CSHCN Survey)
7. Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.
8. The rate of birth (per 1,000) for teenagers aged 15 through 17 years.
9. Percent of third grade children who have received protective sealants on at least one permanent molar tooth.
10. The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.
11. The percent of mothers who breastfeed their infants at 6 months of age.
12. Percent of newborns who have been screened for hearing before hospital discharge.
13. Percent of children without health insurance.
14. Percent of children, ages 2 to 5 years, receiving WIC services that have a Body Mass Index (BMI) at or above the 85th percentile.
15. Percent of women who smoke in the last three months of pregnancy.
16. The rate (per 100,000) of suicide deaths among youths 15-19.
17. Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
18. Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

2. 6 MCH Outcome Measures

1. The infant mortality rate per 1,000 live births.
2. The ratio of the black infant mortality rate to the white infant mortality rate.
3. The neonatal mortality rate per 1,000 live births.
4. The postneonatal mortality rate per 1,000 live births.
5. The perinatal mortality rate per 1,000 live births plus fetal deaths.
6. The child death rate per 100,000 children aged 1 through 14.

3. Colorado MCH State Priorities and Measures

In addition to the national performance measures, states identify their own state-specific measures. State-specific measures reflect local concerns that arise from a state needs assessment, required every five years. The following performance measures were derived from a needs assessment process that occurred in 2010 resulting in 9 new MCH state priorities.

Colorado's 9 State Priorities (2011-2015)

The following nine (9) issues have been identified as priorities for the Maternal and Child Health Block grant for the following target populations: early childhood (birth-8 years), including children with special health care needs; children and youth (9-21 years), including children and youth with special health care needs; and women of reproductive age (15-44 years).

- Promote preconception health among women and men of reproductive age with a focus on intended pregnancy and healthy weight.
- Promote screening, referral and support for perinatal depression.
- Improve developmental and social emotional screening and referral rates for all children ages birth to 5.
- Prevent obesity among all children ages birth to 5.
- Prevent development of dental caries in all children ages birth to 5.
- Reduce barriers to a medical home approach by facilitating collaboration between systems and families.
- Promote sexual health among all youth ages 15-19.
- Improve motor vehicle safety among all youth ages 15-19.
- Build a system of coordinated and integrated services, opportunities and supports for all youth ages 9-24.

Colorado's 10 State Performance Measures (2011-2015) – The data source appears in parentheses following measure where applicable.

1. Percentage of sexually active women and men ages 18-44 using an effective method of birth control to prevent pregnancy. (Colorado Behavioral Risk Factor Surveillance System-BRFSS)
2. Percentage of live births to mothers who were overweight or obese based on BMI before pregnancy. (Colorado Vital Statistics-Birth certificate)
3. Percent of mothers reporting that a doctor, nurse, or other health care worker talked with them about what to do if they felt depressed during pregnancy or after delivery. (Colorado Pregnancy Risk Assessment and Monitoring System- PRAMS)
4. Percent of parents asked by a health care provider to fill out a questionnaire about development, communication, or social behavior of their child ages 1 through 5. (Colorado Child Health Survey - CH169)
5. Percentage of Early Intervention Colorado referrals coming from targeted screening sources. (Early Intervention Colorado)
6. Percentage of live births where mothers gained an appropriate amount of weight during pregnancy according to pre-pregnancy BMI. (Birth certificate)
7. Percent of parents reporting that their child (age 1 through 5) first went to the dentist by 12 months of age. (Child Health Survey - CH63a)
8. Percentage of sexually active high school students using an effective method of birth control to prevent pregnancy. (Colorado Youth Risk Behavioral Survey-YRBS)
9. Motor vehicle death rate for teens ages 15-19 yrs old.
10. The percentage of group members that invest the right amount of time in the collaborative effort to build a youth system of services & supports. (Wilder Collaborative Factor Inventory)

PART II: COLORADO'S MCH PLANNING, IMPLEMENTATION, AND REPORTING PROCESS

A. Overview

1. Evidenced-Based Public Health Approach

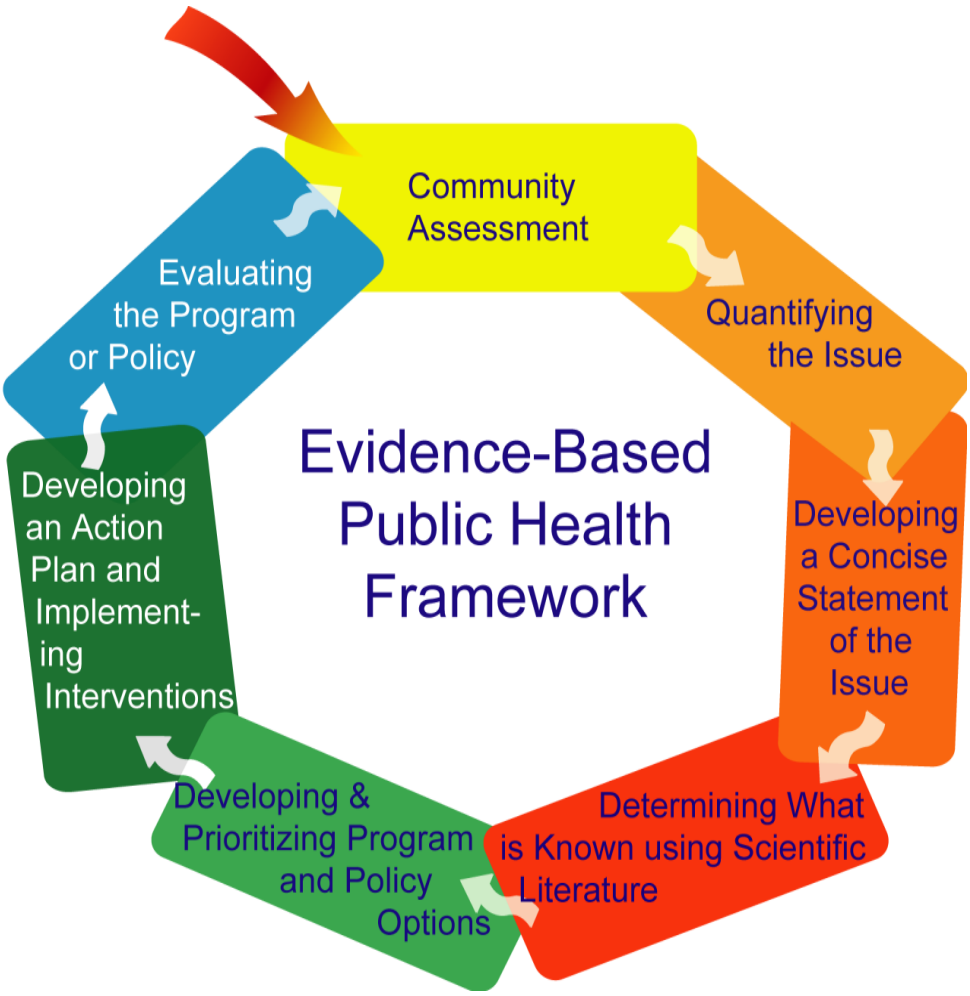
Colorado MCH partners with LPHAs to achieve the mission of Colorado MCH to optimize the health of women, children, and adolescents including children and youth with special health care needs in Colorado. It is expected that both state and LPHA professionals positively impact MCH national and state performance measures by applying the public health approach to their work.

Whereas the core functions of public health (assessment, assurance, and policy development) and the 10 Essential Services of Public Health outline the functions and duties of public health professionals and programs, Brownson's Evidence Based Public Health (EBPH) framework describes the relationship between the core functions and the ten essential services. In other words, EBPH is a guide that helps public health professionals to determine the most effective application of the essential functions. For example, it is important to identify and understand what the issue is in one's community before selecting which intervention is appropriate to address the issue. Additionally, EBPH directs public health professionals to systematically use data and information systems in order to develop, implement, and evaluate effective programs and policies.

The EBPH framework involves seven steps that allow professionals to **continually:**

- assess the community;
- quantify the issue;
- develop a concise statement of the issue;
- determine what is known through scientific literature;
- develop/identify and prioritize program and policy options;
- develop an action plan and implement interventions;
- and evaluate the program or policy.

The following diagram depicts the EBPH framework:



Given the importance of the public health approach to the work of both state and local MCH, the LPHA MCH planning process is aligned with the EBPH framework. The following assessment and plan development sections of the guidelines describe some basic concepts in each step of the EBPH framework in addition to those steps related to the MCH planning, implementation and evaluation process.

The seven steps of the EBPH framework and the related MCH steps are as follows:

Steps of the Evidence-Based Public Health Framework	Definition of EBPH Framework Step	Steps of the MCH Planning Process
Community Assessment	• Define the health issue according to the needs and assets of the population or community of interest	• Review qualitative and quantitative data • Examine data about health status and risk factors in the local community • Conduct assets and gaps analysis • Identify key problems/issues

Steps of the Evidence-Based Public Health Framework	Definition of EBPH Framework Step	Steps of the MCH Planning Process
Quantify the issue(s)	• Measure behavior and, identify risk factors and disease frequency in a defined population and time frame	Specific to identified issue(s): • Review and interpret county-level data (trend analyses, other county-level data) • Review public health surveillance data and existing reports • Review qualitative data (from community members & other stakeholders) • Conduct research (literature reviews, more in-depth data analysis) <u>to determine what factors are causing the issue, who is most impacted by the issue, and to what extent</u>

Develop a concise statement of the issue	• Build support for the issue with an organization, policy makers, or a funding agency.
	• Includes:
	  ○ Health condition or risk factor considered
	  ○ Population affected
	  ○ Size and scope of the problem
	  ○ Prevention opportunities
	  ○ Potential stakeholders
		• Development of background section on action plan
		  ○ Include information from previous steps
		• Review MCH Priorities and CDPHE's Winnable Battles for potential areas of overlap

Determine what is known through the scientific literature	• Determine what strategies work to address the issue(s) identified in the previous steps:
	  ○ objective, systematic search and summarization of previous research
	  ○ Classify or rate the level of evidence
		• Identify evidence-based approaches to address causes of issues among population through a literature review
		• Focus of the literature search:
		  ○ Policy
		  ○ Systems-building
		  ○ Population-based services aimed at prevention or early identification

Develop/identify and prioritize program and policy options	• Rank the identified strategies in order of their measured importance
	• Develop prioritization criteria and tool. Consider:
	  ○ plausibility
	  ○ feasibility
		• Prioritize issues for MCH plan – use MCH Prioritization Tool

Steps of the Evidence-Based Public Health Framework	Definition of EBPH Framework Step	Steps of the MCH Planning Process
	○ impact ○ evidence-based ○ population-based ○ infrastructure level ○ MCH role ○ local role ○ political will ○ culturally appropriate	
Develop an action plan and implement interventions	• To guide the work and decisions about what to do next • To hold team members accountable for tasks and timelines	• Complete the MCH Action Plan template • Implement MCH Action Plan
Evaluate the program or policy	• To demonstrate effectiveness • For continuous program improvement • To garner support from stakeholders	• Develop evaluation plan sections of MCH Action Plan • Implement evaluation methods throughout the year; Complete evaluation sections during annual reporting to assess effectiveness of interventions/programs
REPEAT!		

2. Timeline of the MCH Planning, Implementation, and Reporting Process

With the many changes to local MCH/HCP funding, for the next three years the MCH Planning, Implementation, and Reporting Process will revolve around a one-year implementation cycle, with an emphasis on assessment and plan development occurring the months prior to the beginning of year one. MCH LPHA action plans will include longer term goals and objectives and one-year strategies and activities. This will provide LPHAs an opportunity to plan long-term but to re-evaluate their intended work efforts annually. The overall steps and timelines related to the FY13 contract period are outlined in the Step-by-Step Guide in **Appendix B**.

3. MCH Consultation Model

Significant consultation and technical assistance is available from state MCH staff to support each agency throughout the MCH Planning, Implementation and Reporting process. The goal of the MCH Consultation model is to provide quality consultation to LPHAs, resulting in improved planning, programming, and MCH outcomes.

Each agency is assigned a **MCH Generalist Consultant** who works collaboratively year round with LPHA staff to complete the MCH Planning, Implementation and Reporting processes. This includes broad planning activities, assistance in completing required

forms, and advice on meeting other contract requirements. Generalists may also provide or coordinate training and technical assistance on topics of interest to local MCH staff, including skill-building sessions necessary for completing MCH work. The Generalist Consultant will offer expertise on the following:

- Navigation of MCH processes and how to link to resources at CDPHE
- MCH program areas, state priorities and related programs
- Current public health science and practice
- Data sources and interpretation
- Planning and evaluation
- Systems building and policy development.

The **MCH Implementation Team Leads (MITs) or Program Specialists** are also available at CDPHE to provide resources, technical assistance, and training on specific MCH priority areas. The MIT serves as a subject matter expert (SME) or content area specialist for their program or project. There will be an ongoing relationship between the MITs and LPHAs as the MCH priorities are implemented and evaluated. The MITs will be providing learning and networking opportunities for those agencies working on common MCH priorities and action plan.

The Generalist Consultants work closely with the MITs from across the nine MCH Priorities. Please see the table below which further delineates these roles.

Generalist Consultant	MCH Implementation Team Leads / Program Specialist
Primary contact for agency planning meetings.	Steps in when priority issues are identified, assists in developing local MCH plan on identified issue(s).
Primary point of contact at CDPHE for MCH/HCP. Liaison between local staff and program specialists.	Specialized consultation
Coordinates general MCH training programs	Coordinates specialized program training
Guides agencies through MCH Planning and Reporting processes	Provides guidance and feedback on specific program plans and reports.
Participates in local Action Plan development as advocate for local partners	Leads MCH Action Plan development and implementation, and serves as content expert for issue.
Assists local agency to identify data and technical assistance needs.	EPE staff works in a Program Specialist role with Generalist and local partners, providing expertise on data analysis and evaluation.
Supports local staff during implementation of plan and provides assistance for any needed revisions.	
Reviews invoices, monitors progress of plan implementation, and assigns contract management rating.	

B. Assessment

1. Conceptual Overview and Expectations

The assessment phase of the MCH planning process is aligned with the first three steps of the EBPH framework: conduct a community assessment, quantify the issue, and develop a concise statement of the issue. LPHAs will define the MCH problem or issues in their community by reviewing and interpreting MCH county-level data in addition to other available county-level data that relates to MCH issues. LPHAs will also identify community resources and activities that currently address each MCH issue.

As a result of the activities involved with Colorado's Health Assessment and Planning System (CHAPS), LPHAs may determine the most pressing MCH issues in their community and prioritize such issues in their FY13 MCH plan. CHAPS provides a standard mechanism for assisting local public health agencies and the CDPHE in meeting assessment and planning requirements of the Public Health Act of 2008 (C.R.S. 25-1-501 et seq.). CHAPS also assists agencies interested in preparing for voluntary accreditation by the national Public Health Accreditation Board, since many of its processes meet national standards. The EBPH framework of assessing, prioritizing, planning and evaluating is laid out in CHAPS as "phases," with stakeholders being engaged in nearly every step. The CHAPS' phases are as follows: plan the process; engage stakeholders; assess community health; assess system capacity; prioritize issues; create a local health plan; implement, monitor, and communicate the plan; and inform the statewide plan.

Once LPHAs identify the priority issues on which they will work in the next year MCH cycle, it is important to better understand the causes of these issues. Public health professionals can explore and research the causes of each issue by conducting a literature review or looking more in-depth at the county-level MCH data. It is important to understand if there are social determinants affecting the issue (economic, social, environmental, or political) or whether there are behavioral or genetic issues affecting the issue. Also, one should aim to understand which populations in the community are experiencing the issue most often or most severely. Once causal factors are identified, LPHAs can begin to consider and select the most appropriate strategy or intervention to address the issue and the causal factors.

Each step of the MCH assessment process along with tools and resources helpful to this process are described below.

2. MCH County Data

(Trend Analyses, Colorado Health Indicators website, Colorado Health Information Database)

- Trend Analyses – MCH county trend analyses are generated approximately every three years for the LPHAs who are developing their MCH Plan. The trend analyses reports include a one-page table illustrating the county or region's proximity or distance from the HP2020 goal.

- The Colorado Health Indicators website provides county, regional and state level data on a variety of health, environmental and social topics. The dataset was created as part of the Colorado Health Assessment and Planning System (CHAPS) which is a standard process created to help local public health agencies meet assessment and planning requirements. The data are specifically designed to be useful for anyone who needs Colorado health data for a community health assessment or for other research purposes. The web address is http://www.chd.dphe.state.co.us/HealthIndicators/Default.aspx.

  The data are organized based on the Health Equity Model, which takes into account a wide range of societal factors to provide a comprehensive perspective on community health. This model groups the social determinants of health into four categories: life course perspective, determinants of health, health factors and population health outcomes.

  The website contains over 200 data points and includes several technical and supportive features. An interpretation guide to help make sense of the data includes questions to consider when analyzing data, a list of related indicators, and links to additional resources. Also, each data point has an accompanying document that provides details such as definitions, calculations, data source limitations, and much more. Additionally there are export features that allow users to download data as well as images of charts with confidence intervals.

- Colorado Health Information Database
  http://www.chd.dphe.state.co.us/cohid/Default.aspx

- HCP 2012 Annual Data Report: www.hcpcolorado.org under the Data section

► A review of these data, along with any relevant local data, is required as an initial step in the MCH Planning Process.

3. MCH Agency Planning Meetings

During the spring before the submission of the agency's MCH plan, state and local MCH staff plan, facilitate and participate in MCH Agency Planning Meetings. The overall purpose of the MCH Agency Planning Meetings is to build relationships among state and local health public agency (LPHA) program staff; to enhance communication, program planning and evaluation efforts; and to determine the need for resources and technical assistance during the MCH planning process. The LPHA will work in collaboration with the MCH Generalist Consultant and the appropriate MIT leads during this planning process.

The Agency Planning Meetings will occur in late-March, April, and/or May and will take place either in person or via phone. The focus of the meetings will be on assessment including data review and interpretation, MCH issue prioritization, plan development, and review of goals, objectives, activities, and evaluation methodology as well as the budget and budget narrative.

The MCH Generalist Consultant will work closely with LPHAs to coordinate these meetings.

► Participation of appropriate staff in the MCH Agency Planning Meetings is required during the assessment and plan development process.

4. MCH Prioritization Tool & Helpful Resources

The MCH Prioritization Tool is meant to assist LPHAs in prioritizing the performance measures that will be addressed in their MCH plan. The reverse side of the tool presents additional resources for use in a prioritization process. The tool may be found on the MCH website (www.mchcolorado.org) under the MCH Guidelines and Forms for LPHA Partners section.

► Completion of the MCH Prioritization Tool is optional, but recommended.

Strengths and Gaps Analysis

► Consider strengths and gaps in local community. No checklist is required.

In reviewing the MCH previous county data set(s), the trend analysis, and any relevant local data, LPHAs should consider the dedicated funding, political will, and current activities taking place within their community in relationship to each MCH indicator/issue. The purpose of considering these factors is to identify the strengths and gaps in the services or impact on MCH issues in their county and/or community. This strengths and gaps analysis is critical to informing the prioritization process for the LPHA's MCH plan.

C. Plan Development

1. Conceptual Overview and Expectations

The plan development phase of the MCH planning process addresses several steps of the EBPH framework including: conduct literature review, prioritize and select a strategy, develop an action plan, and implement and evaluate the program. It is during the plan development process that LPHAs select evidence-based approaches to address the causes identified in the assessment phase and develop evaluation plans to assess the effectiveness of interventions/programs that include goal, objective, and process evaluation measures. During the plan development phase, LPHAs are also charged with developing program budgets and budget narratives that are aligned with the proposed scope of work and that are clear, descriptive and detailed.

It is expected that LPHAs:

- Implement the **HCP Care Coordination** model and complete data entry in the CYSHCN data system. LPHAs will determine how much funding they will allocate to HCP Care Coordination. Care coordination and facilitating specialty clinics (if

appropriate) will not require an action plan, rather care coordination and clinic responsibilities will be included in the statement of work in the LPHA contract.

- Follow all appropriate HCP Program Policies and Procedures available at www.hcpcolorado.org

- **Address the MCH priorities**: LPHAs will be required to focus at least 10% of total MCH/HCP funds on MCH-priority action plans, including the medical home priority. All LPHAs must implement the medical home action plan.

  - FY13 – At least 10% of total MCH/HCP funds will focus on the MCH-priority action plans

  - FY14 – At least 20% of total MCH/HCP funds will focus on the MCH-priority action plans

  - FY15 and FY16 - At least 30% of total MCH/HCP will focus on the MCH-priority action plans

- **Address the other state and national performance measures** to the extent that these fit with community need. The following are parameters for the non-MCH priority work:

  - LPHAs must focus a majority of their effort and funding for each action plan on population-based and infrastructure-building strategies from the MCH pyramid. See **Appendices C and D** for definitions and examples of the different levels of the MCH pyramid and for specific population-based and infrastructure-building approaches to Maternal and Child Health. Enabling services are allowable if they are evidence-based and enhance the population-based and infrastructure-level work in the action plan. Enabling services should not comprise a majority of the effort, with the exception of HCP Care Coordination.

  - LPHAs must use evidence-based strategies / programs to address issue in the community. A strategy or program is considered evidence-based if:

    - It is based on a sound theoretical approach such as health behavior change theory or peer-reviewed literature;

    - And/or if there is research or program evaluation data that supports the effectiveness of the approach.

  - LPHAs should ensure that the strategies are culturally sensitive.

  - LPHAs should ensure that a clear local public health role exists within the MCH arena.

  - LPHAs should consider aligning efforts with the CDPHE Winnable Battles.

- Include work with public and private community partners to plan for the development and maintenance of resources that assure access to services for vulnerable women, children, and adolescents, such as those who are low-income, uninsured, underinsured, or who live in rural or underserved areas or who are from ethnic or cultural minority communities and may experience language or cultural barriers to services;

- Refer families participating in any and all programs in its agency such as Women, Infants and Children (WIC); Early and Periodic Screening, Diagnosis and Treatment (EPSDT); Immunization Clinics; Family Planning; HCP; etc., to appropriate enabling and direct care service programs in the community. All pregnant women in need of resources for prenatal medical care shall be provided with information about programs such as Prenatal Plus, Nurse Family Partnership, WIC, etc., as needed.

Each step of the MCH plan development process, along with helpful tools and resources, is described below.

2. Action Plan

The MCH Action Plan is the LPHA's MCH scope of work for the one-year funding period and includes the LPHA's goals, needs statements, target populations, objectives, activities and evaluation plans. LPHAs will enter this information into the MCH Action Plan template and then upload the template into the MCH Plan Database. The database can be accessed on www.mchcolorado.org under MCH Guidelines and Forms for LPHA Partners section.

LPHA's will complete one-year action plans over the next several years. The goal statement and the objectives may cover a 3-year period, but the activities will span a 1-year period. This will allow for flexibility between years with changes in funding and staff.

There will be one action plan for each MCH program area:

- One medical home action plan (required of all agencies receiving over $50,000 per fiscal year)
- "X" number MCH priority-related action plans (if applicable)
- "X" number "other" MCH action plans

For action plan examples, see the MCH-priority action plans prepared by the MCH Implementation Teams (MITs). The action plans can be found online at www.coprevent.org/search/label/mch.

NOTE: HCP Care Coordination and specialty clinics will be included in the statement of work in the LPHA contract and they do not require an action plan.

► Draft MCH Action Plans are due via email to your MCH Generalist by **June 1**.

► The final MCH Action Plans are due via submission in the MCH Plan Database by **Monday, July 2**. Notify your MCH Generalist Consultant by email when the final MCH Action Plans are uploaded into the database.

3. MCH Planning Budget Form and Planning Budget Narrative Form

As in years past, the MCH planning budget form continues to be based on population groups. However, the form has been revised to gather more specific data on the projected cost of services provided to the CYSHCN population as well as to capture program planning information such as MCH core services estimates, HCP Care Coordination estimates, and agencies' choice for receiving CRCSN notifications.

The MCH Program must continue to track costs based on population groups for Block Grant reporting per federal requirements. It is also critically important that the state MCH/HCP Program understand the costs of HCP Care Coordination and specialty clinics given the standardization of service delivery and to assure we are providing the most efficient and cost-effective services to the children and families whom we serve.

4. MCH Planning Budget Form – Part A

The LPHA Planning Budget should directly reflect the personnel and resources needed to complete the action plans for each **population group**. Agencies will include all child/adolescent and women of reproductive age efforts on the respective population group budgets (child/adolescent or women of reproductive age). Agencies are required to provide separate budgets for those services related to the CYSHCN population, specifically HCP Care Coordination, medical home work, and HCP specialty clinics. Please note that ABCD work will go on the child/adolescent budget.

For example, Sanger County Public Health agency may choose to work on the following five areas:

- Medical home using the ABCD model,
- Early childhood obesity prevention,
- Adolescent suicide prevention,
- Pregnancy-related depression
- HCP Care Coordination (No action plan, included in statement of work)

Because HCP Care Coordination is included in the statement of work, Sanger County Public Health will have 4 action plans for FY13.

Sanger County will have 3 budgets and 3 budget narratives respective to the population group.

1. The child/adolescent budget will include all personnel and resources allocated to:
    - Medical home & ABCD integration
    - Early childhood obesity prevention
    - Adolescent suicide prevention

2. The women of reproductive age budget will include all personnel and resources allocated to:
    - Pregnancy-related depression
3. The children and youth with special health care needs (CYSHCN) budget will include all personnel and resources allocated to:
    - HCP Care Coordination

Given this is the first year of LPHAs estimating the cost of CYSHCN-related work, it is anticipated that budget revisions may occur throughout the year. Instructions for modifying budgets during the fiscal year are in the Plan Implementation section of these MCH Guidelines.

Also, LPHAs' will organize and align their MCH invoices with MCH planning budgets. MCH Generalist Consultants will review and approve invoices using planning budgets for reference.

To complete this form, follow these instructions:

1. Complete the top portion of the form by providing the agency name and the date the form is completed.
2. Enter the name and contact information for the program and fiscal contacts who have **prepared, approved, and will oversee** the budget in the spaces provided.
3. Choose the applicable **population** category for the Planning Budget. Five choices exist:
    - Child/Adolescent,
    - Women of Reproductive Age
    - CYSHCN – HCP Care Coordination
    - CYSHCN – Medical Home
    - CYSHCN – Specialty Clinics
4. Select **all** the action plans that relate to the specific budget: early childhood dental caries, early childhood obesity prevention, early childhood screening, pregnancy-related depression, youth sexual health, and/or other MCH work. If you select other MCH work, please briefly provide the name of the other MCH work in the text box.
5. Use the following descriptions/examples for each Expense Category.
    a. **Personnel Services:** List the name, title, annual salary, annual fringe, and Full Time Equivalent (FTE) for each staff member who will be working on the action plan.

    b. **Operating Expenses:** Include expenses that are **not** included in the indirect rate for the agency, such as office supplies, copies, postage, telephone, computer network fees, project supplies and materials, professional development and training. Include funding for equipment, including computers and software.

c. **Travel Costs**: Include travel costs to be incurred while implementing the MCH action plans. Also, include any costs associated with attending state-requested or required meetings or trainings. It is required that the LPHA budget reflect the cost of sending two LPHA MCH staff members to attend a full-day, state MCH meeting in the Metro Denver area. Staff should represent all program areas. The budget should also include the cost of sending staff to attend the HCP Annual meetings. These costs can be distributed across budgets as determined by the agencies. Meeting attendance supports many action plan efforts.

d. **Contractual Services:** List costs for contractors (personnel not employed by the LPHA) working on the MCH action plan.

e. **Indirect Costs:** List the agency's indirect rate and type. Indirect rates are capped per CDPHE agreement as follows: 25% of total direct costs; 27% of total direct salaries and/or fringe; 30% of total direct salaries and fringe where no other direct costs are charged. If the rate exceeds the indirect rate caps, identify those indirect costs above the allowed rate as match or in-kind contributions.

f. **"Other" Funding:** List additional sources of MCH funding in this column.

6. Funding received from CDPHE and other sources must be listed under the "Source of Funds" columns.

7. In the box on the bottom left side of the form, indicate the types and amounts of "Other" funding and if non-federal funds can be used as match. In the box at the bottom right side of the form, indicate which of the following two methods listed below were used to calculate the source of funds in the "Other" column.

   a. **Method A:** Includes **ALL** anticipated revenue for those MCH activities that the agency is involved in, not just those activities specifically noted in the goals and objectives of the MCH Plan.

   b. **Method B:** Includes **ONLY** anticipated revenue for those MCH activities that the agency is involved in that relate to specifically accomplishing the goals and objectives of the MCH Plan.

► Draft Planning Budgets are due via email to your MCH Generalist by **June 1** unless otherwise determined by LPHA and the MCH Generalist.

► Final Planning Budgets are due by **July 2.** Submit via the MCH database accessible at www.mchcolorado.org.

5. MCH Planning Budget Form – Part B

The bottom section of the MCH Planning Budget form (Part A) includes the former MCH Core Services Planning Estimate Form (Part B). The data requested in Part B of the budget form is for Block Grant reporting purposes.

For each budget, review the objectives and key activities included in the corresponding MCH Action Plan(s). Estimate the percentage of total budget funds focused on the different levels of the MCH pyramid.

- Direct Services
- Enabling Services
- Population-based Approaches
- Infrastructure Building Approaches

Please see **Appendix D** for more information on the MCH Pyramid and the definitions of each level of service.

If the budget is for HCP Care Coordination:

1. Enter the estimated number of children and youth with special health care needs who will receive HCP Care Coordination services (with an HCP Care Coordination family action plan) in FY13. This estimated number should include all of the children and youth who will have completed the intake interview, assessment process, and have a current action plan. This estimated number of clients served can be used to guide budgeting processes.
2. Check the "opt-in" box if your agency is opting to receive CRCSN notifications for FY13. If you will not be receiving CRCSN notifications, then leave this box blank.

► The Planning Budget Part B is due **July 2**. Submit via the MCH database accessible at www.mchcolorado.org.

6. Planning Budget Narrative Form

To complete the Planning Budget Narrative, follow these steps:

1. Provide the agency name and the date the form was filled out.

2. Enter the name and contact information for the program and fiscal contact person who has **prepared, approved and will oversee** the budget in the space provided.

3. Choose the applicable **population** category for the Planning Budget Narrative. Five choices exist:

    - Child/Adolescent,
    - Women of Reproductive Age
    - CYSHCN – HCP Care Coordination
    - CYSHCN – Medical Home
    - CYSHCN – Specialty Clinics

4. Select the action plans that relate to the specific budget narrative: early childhood dental caries, early childhood obesity prevention, early childhood screening, pregnancy-related depression, youth sexual health, and/or other MCH work. If

you select other MCH work, please briefly provide the name of the other MCH work in the text box.

5. Follow the instructions that appear on the form for each expense category.

► Draft Planning Budget Narratives must be submitted via email to your MCH Generalist by **June 1** unless otherwise determined by LPHA and MCH Generalist.

► Final Planning Budget Narratives must be submitted by **July 2.** Submit via the MCH database accessible at www.mchcolorado.org.

7. Review and Feedback of Plans

Throughout the planning process and specifically after the draft plans are submitted on June 1st, state MCH Consultants and the MITs will review and provide feedback on LPHA MCH plans.

► The State MCH Consultants will provide notification of plan approval via email to LPHAs no later than **July 23, 2012**.

D. Plan Implementation

1. Conceptual Overview and Expectations

The plan implementation phase of the MCH planning process involves the implementation of strategies, activities, and the related budget, as well as the ongoing evaluation of the strategies/activities. During FY13, LPHAs will implement their MCH Action Plans by implementing the activities in the plan and invoicing for the costs incurred that are included in the Plan Budget. Throughout the year, LPHAs also collect and analyze evaluation data regarding their programs and activities; interpret findings; and apply evaluation findings to program improvement efforts. Applying evaluation findings for the purposes of program improvement may result in modifications to the original plan, objectives, and activities.

2. Overall Communication

According to your MCH contract, both state and local MCH staff members have a responsibility to communicate regarding their MCH contract and action plan, budget and budget narrative. State MCH/HCP staff members are responsible for communicating in a timely fashion about revisions in the MCH Guidelines, HCP Policy and Guidelines, administrative procedures, and overall program expectations or information. The MCH Generalist Consultants are responsible for providing communication around resources such as professional development, best practices, and emerging trends.

The LPHA is required to notify their MCH Generalist within 15 business days of any significant changes to their contract or MCH action plan, budget or budget narrative. For

example, the LPHA should email or call their MCH Generalist Consultant if one of the following events occurs:

- changes in staffing including vacancies,
- possible changes in plan activities,
- agency changes or developments that may impact MCH activities or plans, or
- community developments that may impact the MCH activities or plans.

3. Invoicing Procedures

Local health agencies invoice the CDPHE for services rendered monthly each fiscal year. The MCH Generalist Consultants and the MCH Fiscal Officer review each invoice for its accuracy and alignment with the approved planning budgets. LPHAs will be contacted by CDPHE staff in the event of discrepancies or questions and given a specified amount to time to correct the invoice. LPHAs will not be paid until the invoice is approved by the CDPHE. Invoices must be submitted by email (cdphe.psmchreports@state.co.us) or fax (303-753-9249). Invoices should be signed and include the expenditure details.

Agencies have 60 days after the end of the month in which services are rendered to submit their invoice. For example, invoices for services rendered in the month of October should be submitted by December 30th. The LPHA's final invoice is due by **November 29, 2013**. The Cost Reimbursement Request Statement, or invoice form, is available at www.mchcolorado.org.

4. Action Plan Revision Process (Updated March 2013)

During the fiscal year, LPHAs may revise their MCH action plans to reflect changes or adjustments in goals, objectives, activities, timelines or staff with approval from their MCH Generalist Consultant. If an agency would like to add or delete an action plan during the fiscal year, the LPHAs' contract must be amended to reflect this change. The LPHA will also need to revise budgets appropriately (see budget revision process below). The contract amendment process takes an estimated 6-8 weeks.

The process for **revising** the MCH action plans is as follows:

a. Revising an action plan includes updating objectives, activities, or timelines.

b. The LPHA emails a request to their MCH Generalist Consultant describing the proposed revisions and the justification or rationale for the proposed revisions.

c. The MCH Generalist Consultant responds via email either in support of the request or with follow-up questions.

d. Once the MCH Generalist Consultant communicates support of the request, the LPHA revises the action plan.

e. The LPHA submits the revised plan by updating their action plan and uploading it into the MCH Database and notifying the MCH Generalist Consultant via email of the submission.

The process for **adding or deleting** an MCH action plans is as follows:

a. The LPHA emails a request to their MCH Generalist Consultant describing the proposed revisions and the justification or rationale for the proposed revisions.

b. The MCH Generalist Consultant responds via email either in support of the request or with follow-up questions.

c. Once the MCH Generalist Consultant communicates support of the request, the LPHA adds or deletes the action plan.

d. In this case, the contract does need to be amended; the MCH Generalist Consultant will coordinate the necessary steps in this process with the LPHA and the CDPHE contracts office.

e. The MCH Generalist Consultant provides final approval for the plan revisions and if applicable, the contract amendment is executed.

f. At this point, the revised plan replaces the original plan. As a result, the LPHA and MCH Generalist Consultant will reference the revised version of the MCH action plan for all MCH work, including invoicing and reporting for the remainder of the fiscal year.

g. Deadline to add or delete an action plan: **May 31, 2013**. It will take 6 to 8 weeks for the new plan to become effective. LPHA's cannot bill for a new plan or budget until the contract amendment is final.

5. Budget Revision Process (Updated March 2013)

Budget Update Process

LPHAs are required to notify their MCH Generalist Consultant and submit a revised budget if:

- There is a new or different line item, such as a staff change or new expense, on the current planning budget;
- Upon request by your MCH Generalist Consultant when there is a significant movement of funds from one line item to another under a 25% variance in the total line of the budget category.

The LPHA may update their current Budget Planning Form and send it to the MCH Generalist Consultant via email.

All budget updates are due by August 30, 2013.

Budget Revision Process

If a transfer of funds occurs from one Budget Category to another Budget Category and the amount of funds being transferred is greater than 25% of the total budget category

then the LPHA shall request and receive prior written approval from the MCH Generalist Consultant by completing and submitting a **Budget Revision Request Form** before the transfer can be made.

The process that LPHAs should use for revising their MCH Plan Budgets and Budget Narratives are as follows:

a. The LPHA will email a completed Budget Revision Request Form to the MCH Generalist Consultant requesting proposed budget revisions and the justification or rationale for the proposed revisions. The Budget Revision Request Form must reflect the entire original FY13 MCH Plan Budget in addition to the corresponding revisions. This form will serve as the revised FY13 MCH Plan Budget.

   The Budget Revision Request Form is available on the MCH web site at www.mchcolorado.org under the MCH Guidelines and Forms for LPHA Partners section.

b. The MCH Generalist Consultant will respond via email either in support of the request or with follow-up questions. A signed copy of the approved budget revision will be sent to the LPHA.

c. At this point, the Budget Revision Request Form, along with the original budget narrative will serve as the revised FY13 MCH Plan Budget and Budget Narrative. As a result, the LPHA and MCH Generalist Consultant will reference this form for all MCH work, including invoicing and reporting for the remainder of the fiscal year.

All budget revisions need to be submitted by August 30, 2013.

6. Progress Check-in's

MCH Generalist Consultants conduct three progress check-in meetings with the Contractor during the contract period in order to monitor the Contractor's progress on the FY13 Action Plans as well as to provide technical assistance and support during plan implementation. During the progress check-in, the Contractor and MCH Generalist Consultant use a standardized set of questions to discuss the Contractor's progress and/or challenges of planning, implementing or evaluating the MCH Action Plans and to review any relevant work products developed as part of the plan, such as team charters, reports, community road maps, etc. The standardized questions are available at the MCH web site www.mchcolorado.org. It is recommended that the Contractor review the questions prior to the check-in meeting to adequately prepare for the meeting. The Contractor and MCH Generalist Consultant will strategize, if necessary, on how to modify the Action Plan and/or budget to address any challenges. The LPHA and Generalist will work collaboratively to celebrate successes and generate solutions. Any administrative or contractual issues will also be addressed during the check-in meeting. The MCH Generalist may also consult with the MCH Implementation Team Leads and the HCP Nurse Consultants during the check-in period for specific programmatic guidance.

The MCH Generalist is responsible for scheduling the check-in with the Contractor. The format (via phone or in person) of the check-in is at the discretion of the MCH Generalist Consultant and will be communicated to LPHAs in advance. The MCH Generalist Consultant will send a follow-up summary of the check-in meeting and will highlight any issues that require follow-up. Three progress check-in meetings or phone calls will take place during the fiscal year. The first check-in will occur in **December/January.** Another check-in will take place in **April/May.** Finally, a meeting will occur in **September**

7. Contract Management Ratings

Colorado Revised Statutes §§ 24-102-205, 24-102-206, 24-103.5-101, and 24-105-102 require the State to develop and implement a statewide Contract Management System (CMS). The system is intended to improve government transparency as it pertains to contracts as well as increase the accountability of state contractors and state program managers alike.

A CMS rating will be assigned to each CDPHE contractor in **February, June, and October** and at the end of the five-year contract cycle. The rating will reflect contractor performance. In the MCH Program, the MCH Generalist Consultant is responsible for assessing contractor performance and assigning the CMS rating. The MCH Generalist will assess contract performance using the criteria referenced below, that are based on the requirements of the agency's MCH contract and the Colorado MCH Program. The MCH Generalist will gather this information by conducting progress check-ins, monitoring action plans, reviewing budgets and invoices, reviewing annual and final reports, and observing day-to-day professional interactions. Additionally, the HCP Nurse Consultant will assess contractor performance for HCP Care Coordination and specialty clinic facilitation and will provide feedback to the MCH Generalist Consultant to inform the LPHA's CMS rating.

The MCH Generalist will communicate the rating to the LPHA via email. The LPHA and MCH Generalist have the opportunity to address and resolve any issues that may result in a Below Standard rating. The rating can be changed once the resolution is implemented. The CMS ratings of contracts totaling $100,000 or more over the life of the contract will be made public at the end of the life of the contract per state statute. The "life" of the MCH contracts with LPHAs is five years.

Criteria have been identified below by MCH program staff in an effort to provide some further explanation and guidance to the LPHAs as it relates to the MCH Program.

For FY13, the following areas and factors will be considered when assigning a CMS contract performance rating. The criteria are not in any particular order and are not weighted in any particular way. The categories will be assessed using a three-point scale with Above Standard, Standard, or Below Standard. *It is anticipated the majority of LPHAs will receive **Standard** ratings on all criteria.* LPHAs will receive below standard or above standard ratings as a result of unique circumstances. Examples of these circumstances are identified below.

A **Standard** rating implies that the LPHA adequately addressed the applicable CMS criteria (quality, timeliness, price/budget, and business relations) for the rating period and met all of the MCH contract and scope of work requirements.

Situations or examples that may produce a Standard rating with your MCH contracts include:

- Implements all components of the MCH Action Plan by the end of the fiscal year.
- Consistently responds in a timely manner to communication or requests for information by your MCH Generalist Consultant.
- Submits accurate invoices in a timely manner.
- Invoices are for the line items that are included in approved planning budget and related to the MCH activities.

An **Above Standard** rating implies that the LPHA excelled in addressing the applicable CMS criteria (quality, timeliness, price/budget, and business relations) for the rating period and in meeting all MCH contract and scope of work requirements.

An example that may produce an Above Standard rating with your MCH contracts is:

- Achieving outcomes greater than projected or anticipated such as a marked improvement in performance measures or long-term outcomes, as demonstrated by research and evaluation data.

A **Below Standard** rating implies that the LPHA did not adequately address the applicable CMS criteria (quality, timeliness, price/budget, and business relations) for the rating period and did not meet the MCH contract and scope of work requirements.

Situations or examples that may produce a Below Standard rating with your MCH contracts include:

- Not implementing a component of the MCH Action Plan by the end of the fiscal year.
- Being chronically unresponsive to communication or requests for information by your MCH Generalist Consultant.
- Failure to invoice.
- Consistently invoicing for line items that are not included in planning budget and are not related to MCH activities.

The categories rated in the CMS include quality, timeliness, price/budget, business relations, and requirements in the scope of work. In the MCH Program, the categories are defined as follows.

a. **Quality** – LPHAs use a public health approach when developing their MCH Action Plans; maintain fidelity to their MCH Action Plan (implementing the plan as it was approved); complete invoices so that they accurately reflect the budget and work being implemented; complete invoices and reports with accuracy and complete

information; and develop budgets and budget narratives with accuracy and complete information.

b. **Timeliness** – Completes work/project in a timely fashion and in accordance with identified deadlines, such as invoicing, communication, and action plan and report submission. Action Plan activities are implemented on schedule for the fiscal year.

c. **Price / Budget** – Costs on LPHA invoices match line items in budgets; provides accurate back-up documentation or cost ledger with invoice submissions to support expenditures; or if necessary, the LPHA modifies the budget to reflect change in costs. LPHA partners manage their budgets responsibly.

d. **Business Relations** – LPHA partners are professional, responsible, proactive, and reliable in their interaction with the MCH program and fiscal staff.

e. **Requirements in Scope of Work** – The LPHA is responsible for meeting all of the contract and scope of work requirements such as implementing the MCH Action Plan and budget, developing future plans, completing and submitting annual reports, and following all other MCH administrative procedures (invoicing, budget revision requests, communication of changes in plan, subcontracting, etc).

8. Subcontracting Procedures (Updated March 2013)

If a LPHA chooses to contract with an outside entity to complete part of their MCH work, LPHAs need to create and maintain a formal, written agreement (scope of work or MOU) with the subcontractor that can be produced upon request by CDPHE. The scope of work or MOU should outline the following:

a. Date of agreement
b. Name and contact information of the subcontractor
c. Roles and responsibilities of contracting agency and subcontracting entity.
d. Deliverables.
e. Timeframe for deliverables.
f. Price for deliverables (For staff costs, include hourly rate if applicable).

E. Reporting Steps (Updated July 2013)

1. MCH Action Plan Annual Report

For MCH Action Plan annual reporting, update the following sections of the MCH priority-related action plans:

- Evaluation of Objective – provide a brief narrative on the progress of the objective, including successes and challenges. Discuss how the strategy contributed to moving the objective forward. Include assessment of "as measured by" indicators that correspond to "criteria for success" in this section.

- Activity Monitoring Plan Completion – comment if the activity was met or unmet.

For annual reporting, update the following sections of the "other" MCH action plans:

- Evaluation of Measure – provide the actual measure of progress for the measure/indicator previously selected

- Evaluation of Objective – provide a brief narrative on the progress of the objective, including successes and challenges. Discuss how the strategy contributed to moving the objective forward.

- Activity Monitoring Plan Completion – comment if the activity was met or unmet.

The FY13 MCH Action Plan Annual Report is due on October 31, 2013 for the period of October 1, 2012 to September 30, 2013. The completed MCH Annual Report should be emailed to cdphe.psmchreports@state.co.us.

2. HCP Annual Report

The HCP Annual Report has been changed for FY13. The report consists of four questions related to care coordination and family leadership/involvement. The instructions are on the form.

The FY13 HCP Annual Report will be available on the MCH web site at www.mchcolorado.org under MCH Guidelines and Forms for LPHA Partners section.

The FY13 HCP Annual Report is due on October 31, 2013 for the period of October 1, 2012 to September 30, 2013. Submit via email to cdphe.psmchreports@state.co.us.

3. MCH Core Services Annual Report

Information provided in the MCH Core Services Annual Report Form estimates the extent to which MCH programs have provided services at the different levels of the MCH Pyramid. This data will be used for Block Grant reporting purposes.

For each budget, review the objectives and activities included in the corresponding MCH Action Plan(s) or program area and report on the percentage of total budget funds focused on the different levels of the MCH pyramid.

- Direct Services
- Enabling Services
- Population-based Approaches
- Infrastructure Building Approaches

For core services estimates related to HCP Care Coordination and Specialty Clinics please allocate the percentages reflective of how your agency spent the budget. Please keep in mind that the HCP program components are not considered direct services and therefore no MCH funding should be reported in this service type.

Please see Appendices C and D of the FY13 MCH Guidelines for more information on the MCH Pyramid and the definitions of each level of service.

The FY13 MCH Core Services Annual Report will be available on the MCH web site at www.mchcolorado.org under MCH Guidelines and Forms for LPHA Partners section.

The MCH Core Services Annual Report is due October 31, 2013 for the period of October 1, 2012 to September 30, 2013. Submit via email to cdphe.psmchreports@state.co.us.

4. Review and Feedback of Reports

State MCH Consultants will review LPHA annual reports and communicate approval of reports or follow-up with any clarification questions or issues.

APPENDICES

Appendix A

MCH Essential Public Health Services[1]

Since 1988, the public health field has built consensus around the core public health functions (assessment, policy development, and assurance) and the corresponding set of ten essential public health services. These now serve as the blueprint for local and state public health agency operations. In the maternal and child health field, a corresponding discipline-specific tool was developed, the Ten Essential Public Health Services to Promote Maternal and Child Health in America. www.jhsph.edu/wchpc/publications/mchfxstapps.pdf

Ten Essential Public Health Services to Promote Maternal and Child Health in America

1.
Assess and monitor maternal and child health status to identify and address problems.

2.
Diagnose and investigate health problems and health hazards affecting women, children, and youth.

3.
Inform and educate the public and families about maternal and child health issues.

4.
Mobilize community partnerships between policymakers, health care providers, families, the general public, and others to identify and solve maternal and child health problems.

5.
Provide leadership for priority-setting, planning, and policy development to support community efforts to assure the health of women, children, youth and their families.

6.
Promote and enforce legal requirements that protect the health and safety of women, children, and youth, and ensure public accountability for their well-being.

7.
Link women, children, and youth to health and other community and family services, and assure access to comprehensive, quality systems of care.

8.
Assure the capacity and competency of the public health and personal health work force to effectively address maternal and child health needs.

9.
Evaluate the effectiveness, accessibility, and quality of personal health and population-based maternal and child health services.

10.
Support research and demonstrations to gain new insights and innovative solutions to maternal and child health-related problems.

[1]Grason, H.A., and Guyer, B. *Public MCH Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America.* Baltimore, MD: Child and Adolescent Health Policy Center, The Johns Hopkins University, December 1995. www.jhsph.edu/wchpc/publications/mchfxstapps.pdf

Appendix B

Step-by-Step Guide
FY13 MCH Planning, Implementation, & Reporting Process

TIMELINE	LOCAL ACTION ITEM
Monthly or Quarterly	• **Submit invoices for MCH services rendered. See MCH web site under Plan Implementation at www.mchcolorado.org for invoice form.** Agencies have 60 days after the end of the month in which services are rendered to submit their invoice. For example, invoices for services rendered in the month of October should be submitted by December 30th.
March 7-9, 2012	• Program staff participate in orientation training on FY13 MCH planning process and on MCH Priority local action plans
March / April / May	• LPHAs meet with MCH Generalist for planning meetings regarding assessment, prioritization, plan development, and review for FY13 MCH plan. LPHA staff participates in progress check-in with MCH Generalist Consultant. May take place in-person or via phone.
March / April / May	• Consult with MCH Implementation Team leads for technical assistance on MCH Priorities
May	• LPHAs develop FY13 MCH action plans, budget, and budget narrative
June 1, 2012	• **Submit DRAFT FY13 MCH action plans, budget, and budget narrative**
June	• Receive second FY12 contract performance rating via email from MCH Generalist Consultant.
June	• Finalize action plans, budgets and budget narratives. Prepare all other planning documents for July 2 submission. See MCH Guidelines and the MCH website www.mchcolorado.org for instructions.
July 2, 2012	• **Final FY13 MCH action plan, budget, budget narrative forms are due via submission in the MCH Plan Database. The database can be accessed by going to www.mchplanningcolorado.com.**
July 23, 2012	• Receive notification of plan approval from MCH Generalist via email.
August 1, 2012	• **If needed, complete requested plan revisions to finalize MCH FY13 plan, budget and budget narrative and re-submit no later than August 1.**
August 13, 2012	• **Receive FY13 contract documents via email on or before August 13.**

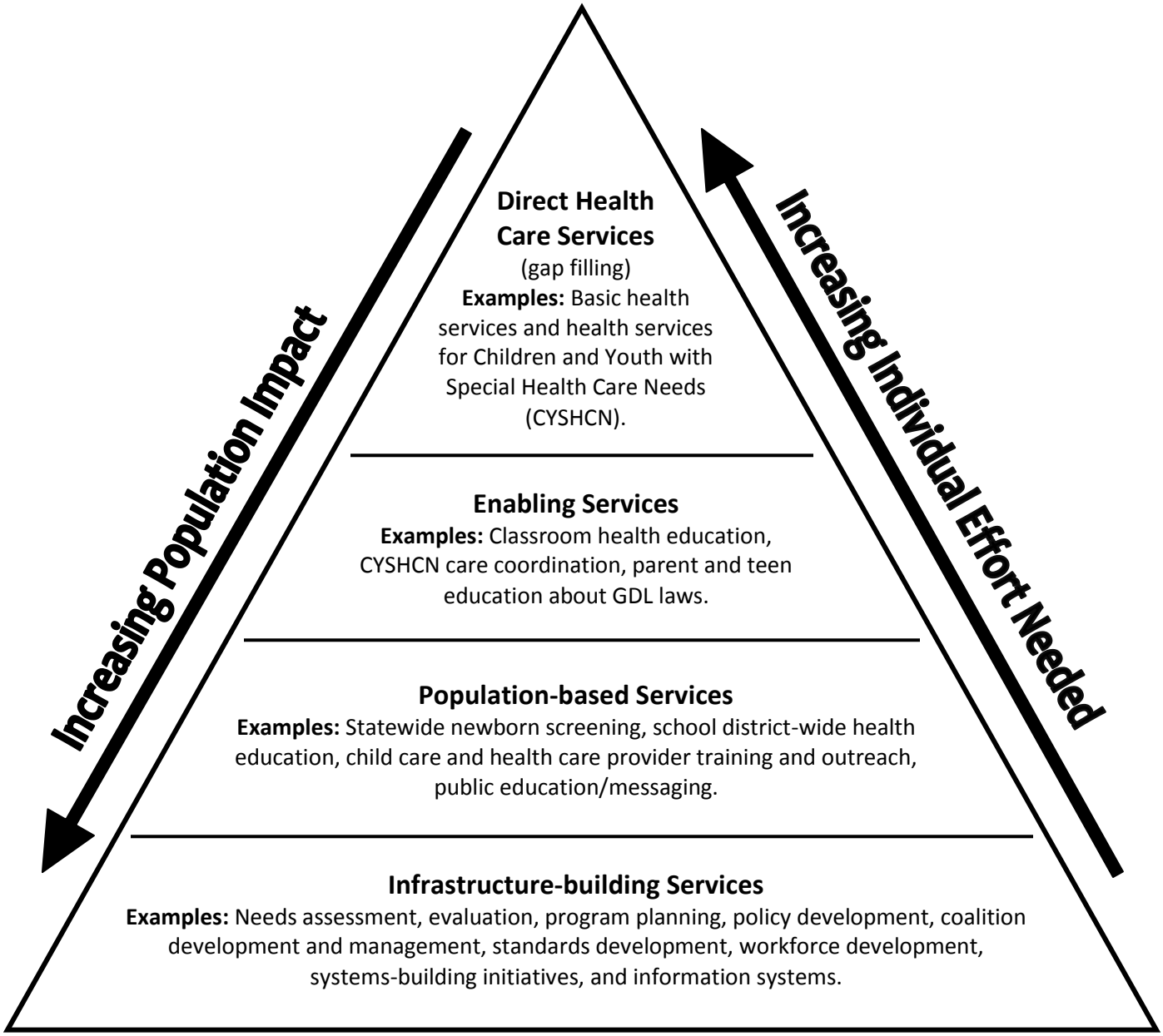
TIMELINE	LOCAL ACTION ITEM
August 31, 2012	• Deadline to submit FY12 Budget Revisions.
September 12, 2012	• **Return signed FY13 contract to CDPHE.**
September	• LPHA staff participates in progress check-in with MCH Generalist Consultant
October 1, 2012	• FY13 MCH contract becomes effective. Begin implementation of FY13 MCH plan, budget, and budget narrative
October 2012	• Receive third FY12 contract performance rating via email from MCH Generalist Consultant
November 30, 2012	• **Submit Annual Report for FY12. Reporting instructions are included in the MCH Guidelines and relevant forms are located on the MCH web site at www.mchcolorado.org.**
December/January	• LPHA staff participates in progress check-in with MCH Generalist Consultant.
February 2013	• Receive first FY13 contract performance rating via email from MCH Generalist Consultant.
April/May 2013	• LPHA staff participates in progress check-in with MCH Generalist Consultant.
May 31, 2013	• ***Deadline to add or delete an entire action plan for FY13.
June 2013	• Receive second FY13 contract performance rating via email from MCH Generalist Consultant.
August 30, 2013	• Deadline to submit FY13 Budget Revisions.

*Timelines and steps for the remainder of FY13 will be published when the FY14 planning information is released in March 2013.

Appendix C

Core Public Health Services Provided by MCH Agencies

MCH federal, state, and other professionals developed the MCH Pyramid to provide a conceptual framework of the variety of MCH services provided through the MCH Block Grant. The pyramid includes four tiers of services for MCH populations. The model illustrates the uniqueness of the MCH Block Grant, which is the only federal program that provides services at all levels of the pyramid. These services are direct health care services (gap filling), enabling services, population-based services, and infrastructure building services. Public health programs are encouraged to provide more of the community-based services associated with the lower-level of the pyramid and to engage in the direct care services only as a provider of last resort.



Appendix D

Population-Based and Infrastructure-Building Approaches to Maternal and Child Health

Over the past 10 years, the Colorado Department of Public Health and Environment (CDPHE) Maternal and Child Health (MCH) program has increased its focus on population-based and infrastructure-building approaches in order to maximize health outcomes for women, children, youth, and children and youth with special health care needs (CYSCHN). Focusing on population-based and infrastructure-building approaches will enhance Colorado's efforts to impact the MCH national performance measures (NPMs) and state performance measures (SPMs) for which the state MCH program is accountable for as part of the Title V MCH Block Grant requirements. This document is designed to serve as a resource to local public health agencies (LPHAs) receiving Title V funds to define the different levels of the pyramid and to highlight efforts used by LPHAs in Colorado to successfully transition their MCH efforts to population health.

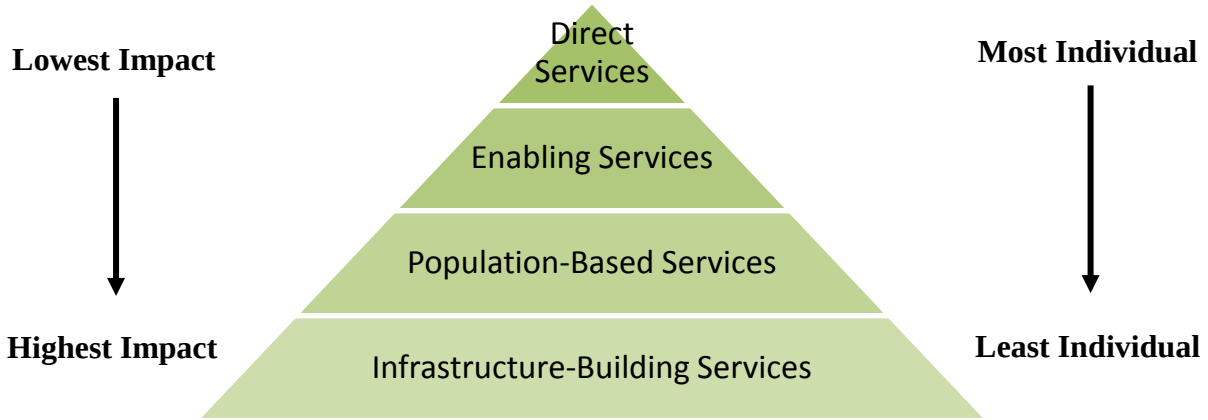
Why are we focusing on population-based and infrastructure-level approaches?

Public health is the science and practice of protecting and improving the health of a community as a whole. The MCH pyramid provides a tool for public health planning, with the bottom levels representing approaches that impact the largest number of people while requiring the least amount of individual staff effort.

What do these service levels really mean?

The MCH Pyramid

MCH professionals at the federal, state and local level developed the pyramid to represent the four different approaches which can be employed to improve and impact MCH. The pyramid can be used to guide which programs and strategies will be selected and quantify how funds will be utilized and how program efforts will be evaluated. The shape of the pyramid and placement of the different levels represent how programmatic and fiscal efforts should be focused at the national, state or local level in order to achieve the greatest impact on the MCH population at-large. The majority of efforts should focus on the two bottom levels of the pyramid: population-based and infrastructure-building approaches. Acknowledging that a variety of strategies may need to be employed at multiple levels in order to achieve an impact, enabling and direct services can be considered complementary to population-based services and infrastructure-building.



Pyramid Level Definitions

Direct Services

Direct health care services are generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room. They are intended to fill a gap in the provision of health care services by the health care delivery system.

Examples:

- *A LPHA nurse provides immunizations to a young child.*
- *An HCP Specialty Clinic neurology exam is provided to a 12-year-old boy with a traumatic brain injury.*

Enabling Services - For groups of individuals who share defining characteristics

Enabling services improve access to direct health care services for individual clients. This not only includes increasing the quantity of health-related services received, but also the quality of these services.

Examples:

- Translation: *A native Spanish speaker offers translation services to patients and parents at an HCP cardiology clinic.*
- Individual health education: *A health educator at a LPHA provides one-on-one education about nutrition, smoking cessation and the importance of prenatal care to pregnant women.*
- Care Coordination: *The state Health Care Program for Children with Special Needs (HCP) Care Coordination program facilitates access to and coordination of medical and social support services for CSHCN across different providers and organizations through* a *medical home team approach. Care Coordination focuses on supporting a family's participation in health care decisions, communication with health care providers and coordinating health and community services.*

Population-Based Services

Population-based services are provided to an entire population, or a defined subset of a population, at the state or local level, rather than to individuals on a one-on-one basis.

Examples:

- Statewide screening programs: *All babies born in hospitals in Colorado receive hearing and metabolic screenings.*
- School district-wide health education programs: *A LPHA works with the local school district superintendent to provide middle and high school students and their parents with comprehensive and evidence-based sex education.*
- Promotion of the Graduated Drivers License (GDL) laws: *A LPHA works with the local police department to disseminate messaging among police officers through a variety of communication channels to improve awareness and enforcement of Colorado's Graduated Drivers Licensing laws among adolescents in the community.*
- Support of the Colorado Ten Steps to Successful Breastfeeding program: *CDPHE engages high level hospital leaders and critical change champions from each hospital to form a maternity care collaborative, and facilitate necessary support for quality improvement initiatives in-hospital.*

Infrastructure-Building Services
Infrastructure-building services are directed at improving and maintaining the health status of the entire MCH population by providing support for the development and maintenance of comprehensive health services systems, including standards/guidelines, training, data, planning and evaluation. A health services system can be defined as "all activities whose primary purpose is to promote, restore, and maintain health" (World Health Organization, 2000).

Examples:

- Community health assessments: *When completing their most recent community health assessment, one LPHA convened a stakeholder group that reviewed the data for the assessment and is working together to determine what health areas should be the focus of community-wide efforts.*
- Program planning and evaluation: *In-depth interviews are being conducted by staff from one LPHA to evaluate an early childhood program model that has been disseminated to a number of counties across Colorado.*
- Coalition leadership and collaboration: *Another LPHA expanded and convened a regional passenger safety taskforce within a county that has a significant number of teen crashes. They oversaw the development of a plan to improve teen motor vehicle safety and then transitioned the leadership responsibilities to local county stakeholders to implement the plan.*
- Policy development: *A LPHA works with the local school board to create policy around healthy eating in schools, including providing healthier options to the schools' vending machines.*

MCH Pyramid Considerations

Activities within a level of the MCH pyramid rarely occur in isolation. For example, one LPHA's infrastructure-building approach to teen motor vehicle safety includes participating on local and state teen motor vehicle task forces (coalition leadership and collaboration) and collecting baseline data regarding student seat belt use and school policies related to teen motor vehicle safety in county schools (community health assessments) prior to designing specific evidence-based prevention activities (program planning).

The different levels of the pyramid are also dynamic, and many services and programs fall into more than one category or may even change levels over time. For example, immunizations are addressed at all levels of the pyramid. Examples at each level include:

- Direct services: A nurse administers immunization shots to individual infants
- Enabling services: A hospital offers infant care classes for parents that cover the importance of immunizations
- Population-based services: A county-wide advertising campaign promotes immunizations via billboards and radio spots
- Infrastructure-building services: Medical providers enter immunization data into the state immunization registry so that rates can be tracked and used to plan and evaluate immunization-related programs

Essential Public Health Services

MCH is not alone in following a public health framework of core services. More specifically, the MCH pyramid aligns closely with the Ten Essential Public Health Services. The Essential Services were developed in 1994 by the Core Public Health Functions Steering Committee which included representatives from U.S. Public Health Service agencies and other public health organizations. The Essential Services provide a working definition of public health and a guiding framework for the responsibilities of local public health systems. The Essential Services and the MCH Pyramid are

different ways of categorizing the same core public health functions. The concepts expressed in each Essential Service correspond to a level or levels of the pyramid (see Table 1). Every Essential Service aligns with an infrastructure-building approach to some extent, while only one Essential Service corresponds to direct services.

Table 1. The Essential Public Health Services and corresponding service levels from the MCH Pyramid

	Service Level			
Essential Public Health Services	**Direct**	**Enabling**	**Population-Based**	**Infrastructure-Building**
1. Monitor health status to identify and solve community health problems				X
2. Diagnose and investigate health problems and health hazards in the community				X
3. Inform, educate and empower people about health issues		X	X	X
4. Mobilize community partnerships and action to identify and solve health problems				X
5. Develop policies and plans that support individual and community health efforts				X
6. Enforce laws and regulations that protect health and ensure safety				X
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable	X	X	X	X
8. Assure competent public and personal health care workforce			X	X
9. Evaluate effectives, accessibility, and quality of personal and populations-based health services				X
10. Research for new insights and innovative solutions to health problems				X

The LPHA Transition to Population-Based and Infrastructure-Building Approaches

"You are not abandoning the problem; you are just taking a new and different approach."

In the fall of 2011, CDPHE staff completed in-depth qualitative interviews with staff from six LPHAs who successfully implemented population-based and infrastructure-building approaches. The interviews included a discussion of strategies/factors that influenced the LPHAs' transitions. The major themes that emerged from this discussion are described below, along with quotes from the interview participants.

Strategies and Factors Influencing LPHAs Transition

1. **Leadership**

"Sometimes what is needed is for someone to take an idea and run with it."

When a staff member at a LPHA champions the transition, it can help the process move faster and more smoothly. This staff member should embrace the concept and be willing to advocate for taking a new approach to doing work. Gaining the support of a senior level

leader at an agency can be particularly helpful. LPHA interview participants listed many ways that agency leadership can assist with transitions including:

- Educate other staff members and community members about the importance of population-based and infrastructure-building approaches
- Institute policies that support the new approaches, such as changing staff requirements in order to hire employees with education or specific experience in public health
- Enforce new rules or expectations about how funding can be spent
- Find additional funding when necessary

2. Education and professional development for staff

A common barrier to transitioning services included motivating employees who did not understand or support the changes. As mentioned above, this barrier was overcome through education and policy change.

> ***"We can make a bigger difference overall by reaching a whole population rather than a finite number of clients. [State] MCH staff did an awesome job helping us understand this. At first it sounded 'dumb,' and we thought 'that is not what families want.' But we found there were lots of things to do that would have a big impact."***

Providing staff with education on public health and the MCH Pyramid can greatly increase the overall support for community-based approaches. In one case where funding for more traditional staff development was not available, a new LPHA director started a book club for all staff. Book club discussions provided participants with a background and basic knowledge on public health.

Other education-related strategies identified by LPHA staff included:

- Learn more about successful transitions from other LPHAs in Colorado and around the United States
- Help staff find and connect with public health mentors
- Use their MCH generalist as a resource
- Institute policies that newly hired staff have certain public health and/or health education credentials and/or encourage existing staff to gain these credentials

3. Relationships and Collaboration

Forming and maintaining strong partnerships, both within an agency and with other community organizations, maximize what a LPHA can achieve.

> ***"There is a culture of collaboration in this county with very few exceptions. People working here…believe in collaboration."***

The more aware LPHAs are of what other organizations in the community are doing, the better they are able to determine who should provide specific services. Coordinating service provision with local organizations can reduce duplication, allowing resources to be directed elsewhere. Relationships with other community organizations also help determine who is best positioned to assume LPHAs' direct or enabling services.

Some lessons learned about forming and/or strengthening relationships:

- Learn to listen and understand where other people are coming from
- Avoid being too demanding with requests in the beginning
- Develop clear ideas and goals before making a presentation

- Agree on key parts of an initiative or issue, but not necessarily on everything
- Convene everyone together in order to create and/or strengthen comprehensive partnerships across the entire system. Minimize meeting with organizations one-on-one

> ***"I've learned to never assume anything. Never assume that a partnership that was broken in the past cannot work again in the future. It is a second chance to start working together again."***

LPHA staff also reported that gaining the trust of key community organizations and leaders was important if they wanted to gain the support of a community overall.

4. **Community support**

   In addition to gaining support and building relationships with other local organizations, LPHAs found it important to have the support of the larger local community. Depending on the program, community support can include buy in from key local leaders and members of the general public (e.g., parents of children receiving sex education at local public schools). The same tips listed above for forming and/or strengthening relationships with other organizations can also be applied to gaining support from the community at large. LPHAs emphasized the importance of flexibility and adaptability when working with the community.

Local MCH Funding Guidance on Population-Based/Infrastructure-Building Approaches

Over the past several years, the MCH Program at CDPHE has requested that LPHAs who participate in the MCH planning process utilize MCH funds to focus on the bottom two levels of the pyramid. Now that the transition down the pyramid has begun, it is important to clarify this guidance.

The MCH Pyramid illustrates that, in order to achieve the greatest impact on the MCH population with limited funding, the majority of efforts and funds should focus on the bottom two levels of the MCH Pyramid: population-based and infrastructure-building approaches. The state MCH Program also supports enabling services that are evidence-based and that are implemented in coordination with or as a complement to evidence-based population-based and infrastructure-building approaches. A greater proportion of funds and staff time should be focused on the population-based or infrastructure building approaches, however, not at the enabling level.

For example, a LPHA might implement the infrastructure-building strategy of convening a teen driving coalition at the local level to assess and influence local policy. Teaching teens and parents about Colorado's new graduated driver's licensing (GDL) laws is a complementary, evidence-based strategy that is focused on the enabling level but supports the infrastructure-building approach to addressing teen motor vehicle crashes. A majority of the LPHA's resources supports the coalition work with fewer resources focused on teaching teens and parents about GDL laws.

LPHAs work with their MCH Generalist Consultant or Office of Planning and Partnerships (OPP) Nurse Consultant to determine how their MCH efforts can best align with the local MCH funding guidance described above. These consultants can also connect interested LPHAS with other LPHAs further along in their transitions. Staff from these more experienced LPHAs can share their stories and provide additional strategies to help ensure successful transitions to population-based and infrastructure-building approaches.