Colorado Maternal and Child Health Program



MCH Guidelines

Intended for use by local public health agencies with MCH contracts administered by the Prevention Services Division of the Colorado Department of Public Health and Environment



COLORADO
Department of Public Health & Environment

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 local public health agency (LPHA) 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 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. **These Guidelines delineate the requirements and expectations of agencies that are community-level initiatives as part of a Title V contract through the Prevention Services Division.** LPHA teams are responsible for implementing the MCH program components outlined in these Guidelines, per their MCH contract with the CDPHE.

This document is posted and updated online at www.mchcolorado.org. Per contract specification, any revision to these guidelines will be communicated in a timely manner.

Each MCH contract incorporates work performed under the Health Care Program for Children with Special Health Care Needs (HCP). All funded LPHA teams are required to provide Health Care Program for Children with Special Health Care Needs (HCP) Care Coordination services. Additional provisions are outlined in the MCH contracts of LPHAs that provide HCP Specialty Clinic services. LPHAs are responsible for adhering to the HCP policies and guidelines specific to the HCP services their agency provides. The Policy & Guidelines document for HCP Care Coordination and HCP Specialty Clinics is posted on the HCP web site at www.hcpcolorado.org in the HCP partner and provider resources section.

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 Funding

Enacted in 1935 as a part of the Social Security Act, the Title V Maternal and Child Health Program is the Nation's oldest Federal-State partnership. For over 80 years, the Federal Title V Maternal and Child Health program has provided a foundation for ensuring the health of the Nation's mothers, women, children and youth, including children and youth with special health care needs, and their families. Title V converted to a Block Grant Program in 1981.

Specifically, the national Title V Maternal and Child Health program seeks to:

1. Assure access to quality care, especially for those with low-incomes or limited availability of care;
2. Reduce infant mortality;
3. Provide and ensure access to comprehensive prenatal and postnatal care to women (especially low-income and at-risk pregnant women);
4. Increase the number of children receiving health assessments and follow-up diagnostic and treatment services;
5. Provide and ensure access to preventive and child care services, as well as rehabilitative services for certain children;
6. Implement family-centered, community-based,systems of coordinated care for children with special health care needs; and
7. Provide toll-free hotlines and application assistance to pregnant women with infants and children who are eligible for Title XIX (Medicaid).

State funding levels are determined by a funding formula based on the calculation of MCH population multiplied by MCH population living in poverty. In order to receive the Title V award, states must use at least 30 percent of the Title V award for preventive and primary care services for children and at least 30 percent for services to children with special health care needs. In addition, states must provide a 4:3 match using non-federal funds.

One source of matching funds for the MCH block grant in Colorado is state general funds that have been designated in statute to support children and youth with special health care needs. These general funds are allocated to the Colorado Department of Public Health and Environment's Health Care Program for Children with Special Needs (HCP). As outlined above, children and youth with special needs are an important target population for the MCH block grant. Leveraging these state general funds with the MCH block grant allocation affords Colorado the ability to

maximize support to improve health outcomes for the population of children and youth with special health care needs.

Overall, approximately 35% of these combined funds are used to support state-level MCH services and activities, while approximately 65% of the funds are allocated to local partners to provide MCH services and activities.

2. Local Public Health Funding Formula

The amount allocated to each LPHA is determined through 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 multiplied by poverty funding formula calculation is applied to all 55 local public health agencies and aligns with the funding formula used by the Maternal and Child Health Bureau to calculate Colorado's MCH block grant award.

3. MCH in Colorado

The CDPHE MCH Program 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 (0-21), 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 this mission. MCH and HCP state and local partnerships are critical to our collective success in 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 will be addressed by MCH state and local partners. The most recent state-level needs assessment was conducted in 2014, identifying seven priorities for implementation from 2016-2020.

The state MCH program aims to demonstrate a measurable impact on these priorities and state performance measures by:

- promoting a coordinated approach between state and local MCH efforts
- fostering support and capacity-building among state MCH staff
- providing oversight and accountability for MCH work at the state and local levels

State MCH Implementation Teams (MITs) are formed for each MCH priority and are charged with developing, implementing, and evaluating evidence-based strategies to impact their priority area. These teams, and the CDPHE content specialists who

lead them, systematically apply Brownson's Evidenced-Based Public Health Framework to inform the development of state logic models and Action Plans as well as local level logic models and Action Plan templates that contain strategies focused on impacting the priority issues. Learn more about Brownson's Evidence-Based Public Health framework.

The local Action Plan templates, developed by MITs in consultation with local partners, provide guidance on goals, objectives, and key activities to address selected priorities at the community level. Local agency team members work with their MCH Generalist Consultant to customize these Action Plans throughout the planning 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 partners also impact priority areas by implementing the 10 Essential Services of Public Health (Appendix A).

The Maternal and Child Health Bureau (MCHB) uses performance measurement and 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.

The MCHB currently has 18 National Performance Measures, 6 Outcome Measures, and 10 State Performance Measures." to "Fifteen National Performance Measures (NPMs) across six population health domains were established for the Title V MCH Services Block Grant program. Based on its identified priority needs, states select eight of the 15 NPMs for programmatic focus. For each of these selected NPMs, states develop at least one related Evidence-based or –informed Strategy Measures (ESMs) to assess and demonstrate the impact of its State Title V strategies on the NPM.

4. Colorado's Seven State Priorities (2016-2020)

The seven issues below 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).

- Women's mental health, including pregnancy-related depression
- Reduction of infant mortality among African Americans

- Early childhood obesity prevention
- Developmental screening and referrals
- Bullying and youth suicide prevention
- Medical home for children and youth with special health care needs
  Substance misuse reduction (tobacco, marijuana and prescription drugs) among pregnant and postpartum women

5. National Performance Measures

Based on the results of our 5-year needs assessment and the seven priorities chosen for 2016-2020, Colorado has selected the following NPMs:

- NPM 2 - Percent of cesarean deliveries among low-risk first births
- NPM 4 - A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months
- NPM 6 - Percent of children ages 10 through 71 months receiving a developmental screening using a parent completed screening tool
- NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19
- NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day
- NPM 9 - Percent of adolescents ages 12 through 17 who are bullied or who bully others
- NPM 11 - Percent of children with and without special health care needs having a medical home
- NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

6. Colorado's Five State Performance Measures (2016-2020)

- SPM 1 - Percent of mothers that report a doctor, nurse or other health care worker talked with them about what to do if they felt depressed during pregnancy or after delivery
- SPM 2 - Infant mortality rate among African Americans in Denver and Arapahoe counties
- SPM 3 - Percent of women who report using marijuana at any time during their pregnancy
- SPM 4 - Rate of emergency department visits for women for prescription drug use poisoning per 100,000 women ages 15 through 44
- SPM 5 - Rate of hospitalizations for prescription drug poisoning per 100,000 women ages 15 thought 44

7. Performance Management for Local MCH Impact

Performance management is a systematic process whereby public health staff actively use real-time data to improve their program efforts. **MCH Impact** is the Colorado MCH Program's performance improvement initiative. This initiative was launched in 2015 to improve Colorado's overall MCH performance and to improve impact on the women, infants, children and youth served. For the past year, the initiative focused on developing state-level infrastructure for integrating performance management principles and practices into state MCH priority efforts. For the next two years, the state MCH Program aims to support local public health agencies in implementing performance management principles and practices into their MCH work. The key steps in the Public Health Performance Management System Framework include:

- Identifying strategic standards or goals (such as State or National MCH Performance Measures);
- Selecting or developing meaningful measures of progress and success (such as objective or activity level data included in MCH Action Plans);
- Routinely collecting and reviewing data to understand barriers and opportunities to implementation and achieving outcomes (such as reporting quarterly on local MCH priority Action Plans and reviewing with the local team, MCH Generalists and state MIT staff);
- Conducting ongoing quality improvement efforts to ensure an agency or program achieves desired results (such as addressing identified barriers to Action Plan implementation).

Public Health Foundation

Performance management is a best practice included in national Public Health Accreditation Board standards as well as a key component of the Maternal and Child Health Bureau's MCH 3.0 public health process.

Using a performance improvement approach builds on the work that Colorado's MCH professionals already do, such as:

- Developing a work plan with objectives, strategies and activities based on evidence

- Creating a logic model with short-term, intermediate, and long-term measures
- Implementing action plans
- Collecting and reviewing data
- Addressing barriers and celebrating successes
- Making an impact

There are no contract requirements for the FY16-17 contract period to integrate performance management into local MCH work. There are new reporting requirements (see the Reporting Steps section) that will provide a foundation for performance management practices. The state MCH Performance Improvement Consultant and the MCH Generalists will support agencies in learning about and practicing performance management and quality improvement in the coming years. Future opportunities include ongoing communication, individual consultation, webinars, and voluntary learning communities.

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

A. Overview

Agencies receiving more than $50,000 annually participate in the MCH planning, implementation, and reporting process supported by a MCH Generalist Consultant. To assist agencies in the planning process, the state provides support and technical assistance in public health planning, implementation, and evaluation processes.

Please note that agencies receiving more than $15,000 in annual funding are required to implement the HCP model of care coordination. In addition to MCH contract funding, designated LPHA specialty clinic sites will receive additional funding through the MCH contract specifically to support HCP Specialty Clinics. LPHAs implementing HCP programs must complete data entry in the Children and Youth with Special Health Care Needs (CYSHCN) Data System (CDS) and comply with program requirements as outlined in the HCP Policy & Guidelines document. LPHAs will determine the specific amounts of funding to allocate to HCP Care Coordination, the MCH priorities, and "other" MCH work in order to meet these requirements. Please review the HCP Policy & Guidelines for more information.

1. Evidenced-Based Public Health Approach

The Colorado Department of Public Health and Environment 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.

Brownson's Evidence Based Public Health (EBPH) framework describes the relationship between the core functions and the ten essential services. EBPH is a guide that helps public health professionals determine the most effective application of the essential functions. For example, it is important to identify and understand the issues in one's community before selecting which intervention is appropriate. 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. Please visit Appendix B for descriptions of the basic concepts in each step of the EBPH framework in addition to those steps related to the MCH planning, implementation and evaluation process.

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

The MCH planning, implementation, and reporting process revolves around a **2-year** implementation cycle. The MCH LPHA Action Plans include longer term goals and two-year objectives, strategies, and activities. The overall steps and timelines related to this contract period are outlined in the Step-by-Step Guide in Appendix C**.**

3. Cross-cutting Fundamental Priorities

MCH at CDPHE has identified three cross-cutting, fundamental priorities to apply to our Title V funded priority work. These are:

- Health Equity: Valuing all people equally with focused and ongoing efforts to address inequalities.
- Community Engagement: Including the voice of the community whenever possible in programs, practices and policies.
- Quality Improvement/evaluation: Implementing a culture of continuous quality improvement and best practices.

The goal is to gradually integrate these principles throughout the planning, implementation and evaluation process at both the state and local level. For the FY17 contract year, local Action Plans include introductory elements of these guiding principles. LPHAs will be supported over the course of the contract year to learn more about how to effectively integrate health equity, community engagement, and quality improvement into their priority work at each stage.

Many commonalities exist between the MCH fundamentals and key components of the Colorado Health Assessment and Planning System as well as the Public Health Accreditation Bureau's standards and measures. Agencies are encouraged to align these activities - such as engaging the community voice - for greater efficiency and impact. Each of the cross-cutting priorities has a designated team lead at the state that is available to LPHAs for technical assistance.

4. MCH Consultation Model

Each agency is assigned a **MCH Generalist Consultant,** who works collaboratively throughout the contract year with LPHA staff to complete the MCH planning, implementation and reporting processes. This includes broad planning activities, assistance in completing required forms, and guidance on meeting other contract requirements. Generalists assist in identifying and promoting capacity-building opportunities. The MCH Generalist Consultant will offer expertise on the following:

- Navigation of MCH processes and how to link to resources at CDPHE
- MCH program areas, priorities and related programs
- Current public health science and practice
- Data sources and interpretation
- Planning and evaluation
- Integration of health equity, community engagement, and quality improvement into MCH work
- Budget and fiscal oversight

The **MCH Implementation Team Leads (MITs) or Program Specialists** are subject matter experts who are available through CDPHE to provide resources, technical assistance, training, and tools on specific MCH priority areas. There will continue to be an ongoing relationship between the MITs and LPHAs as the MCH priorities are implemented and evaluated. The MITs will be providing consultation, learning and networking opportunities for those agencies working on common MCH priorities and Action Plans.

The **HCP Consultants** are subject matter experts for HCP Care Coordination and Specialty Clinics. These Consultants provide LPHA HCP program, budget and invoicing oversight.

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

CONSULTANT ROLES	MCH Generalist	PROGRAM SPECIALISTS:	
		MIT/ Priority Lead	HCP Consultant
Primary contact for agency planning meetings.	x		
Primary contact for HCP planning meetings.			x
Assists when priority issues are identified, assists in developing local MCH plan on identified issue(s).		x	
Primary point of contact at CDPHE for MCH contract. Liaison between local staff and program specialists.	x		
Assists in identifying and promoting capacity-building opportunities.	x		x
Guides agencies through MCH Planning and Reporting processes.	x		
Guides agencies through HCP Planning and Reporting processes.			x
Offers specialized consultation specific to MCH priorities.		x	x
Coordinates learning circles and/or training specific to MCH priorities.		x	x
Assists local agency team members in identification of data and technical assistance needs.	x	x	x
Links with CDPHE technical assistance providers in data analysis, performance management, evaluation, community engagement, and health equity strategies.	x		
Provides guidance and feedback on specific program budgets, plans and reports.	x	x	x
Leads development and implementation of state and local logic models and Action Plans for specific priority area, and serves as content expert for issue.		x	x
Supports local staff during implementation of plan and provides assistance for any needed revisions.	x		x
Reviews invoices and monitors progress of	x		x

plan implementation.			
Assigns contract management rating.	x		

B. Assessment

1. 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.

This process may be achieved by engaging in Colorado's Health Assessment and Planning System (CHAPS). CHAPS provides a standard mechanism for assisting local public health agencies and CDPHE in meeting assessment and planning requirements of the Public Health Act of 2008 (C.R.S. 25-1-501 et seq.) and also in preparing for public health accreditation. The components of the EBPH framework (assessing, prioritizing, planning and evaluating) are described in CHAPS as "phases," and include engaging stakeholders throughout the process. 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 priority issues are identified, teams explore the causes of each issue by conducting a literature review or looking more in-depth at county-level data. It is important to understand if there are social determinants affecting the issue (economic, social, environmental, or political) and which behavioral or genetic issues affect the issue. Consider which populations in the community are experiencing the issue most often or most severely. Once causal factors are identified, team members select the most appropriate strategies to address the issue.

Supporting tools and resources are described below.

2. MCH County Data

(State and county trend analyses, Colorado Health Indicators website, Colorado Health Information Dataset)

- Trend Analyses – MCH county trend analyses are generated by CDPHE approximately every three years for LPHAs receiving over $50,000. The trend analyses reports are shared with local agency teams and posted at www.mchcolorado.org. They include a one-page table illustrating the county or region's proximity or distance from the corresponding 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 other research purposes. The web address is www.chd.dphe.state.co.us/HealthIndicators.

  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 Dataset: www.chd.dphe.state.co.us/cohid

- HCP Annual Data Report: www.hcpcolorado.org under the data and reports section of the HCP partner and provider resources page.

  This report consists of the following data sets related to the CYSHCN population in Colorado and nationally:
  - CYSHCN Data Sets
  - HCP Supplemental Data
  - Estimating Percent of Population of CYSHCN
  - CYSHCN Outcome Measures
  - Medicaid and CHP+ Enrolled Children by County
  - CYSHCN Estimates by County

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 a local agency's MCH plan, state and local MCH staff plan, facilitate and participate in planning meetings. The overall purpose of the planning meetings is to build relationships among state and local public health agency 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 occur in April and/or May and take place either in person or via phone. The focus of the meetings is on assessment, including data review and interpretation, MCH issue prioritization and readiness tool review, plan development, and review of goals, objectives, activities, and evaluation methodology as well as budgets.

The MCH Generalist Consultant works 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 Readiness Tool

The MCH Readiness Tool is required and is meant to assist LPHAs in evaluating agency capacity and resources when considering selection of one of the seven MCH priorities. The tool may be found on the MCH website (www.mchcolorado.org).

Analyzing Strengths and Gaps

In reviewing the above mentioned MCH 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.

Consider completing a health equity assessment.

A health equity assessment can assist in identifying health disparities within a given priority area, as well as identify gaps and opportunities in addressing the disparity both within the LPHA and in the community.

C. Plan Development

1. 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 narratives that are aligned with the proposed scope of work and that are clear, descriptive and detailed.

It is expected that local public health agency plans will:

- **Align with MCH priorities and federal requirements**: In alignment with federal requirements, each agency will aim to budget 60 percent of the overall direct costs to strategies serving the CYSHCN population and 40 percent to strategies serving children, adolescents, and women of reproductive age.
- **Implement the HCP Care Coordination model** and complete data entry in the CDS data system. LPHAs will determine how much funding they will allocate to HCP Care Coordination.
- **Follow all relevant HCP policies** and guidelines available in the HCP partner and provider resources section at www.hcpcolorado.org.
- **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 Appendix F for definitions and examples of the different levels of the MCH pyramid and for specific population-based and infrastructure-building approaches. 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 described in the Action Plan.
    - LPHAs must use evidence-based strategies/programs to address issues 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 that aligns with the MCH vision, mission, and scope of work.
    - LPHAs should consider aligning efforts with the CDPHE Winnable Battles. The CDPHE Winnable Battles can be found on the home page of CDPHE's website.
- **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.

2. Action Plan

The MCH Action Plan is the LPHA's MCH scope of work for the funding period and includes the LPHA's goals, needs statements, target populations, objectives, activities and evaluation plans. LPHAs enter this information into the MCH Action Plan template and then email the plans to: cdphe.psmchreports@state.co.us or to their Generalist Consultant.

Goal statements included in local Action Plans may cover a longer term period and objectives and activities may span a 2-year period. One Action Plan must be on file for each local MCH program area.
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 on www.mchcolorado.org under the Priorities and Action Plans section.

3. HCP Planning Forms

HCP Care Coordination and HCP Specialty Clinics (when applicable) will be included in the statement of work in the LPHA's MCH contract.

While agencies are not required to submit an MCH Action Plan for any HCP services, agencies are required to submit the **Care Coordination planning form** and the **Specialty Clinic planning form** when applicable. The planning forms can be found on the MCH website at www.mchcolorado.org and should be submitted along with the relevant the budget form.

Draft HCP planning forms and associated budgets are due via email to your MCH Generalist Consultant and HCP Consultant by **May 20.**

Final HCP planning forms and associated budgets are due via email to your MCH Generalist Consultant and HCP Consultant by **June 13**.

4. MCH Planning Budget and Narrative Form

As in years past, the MCH planning budget form continues to be based on population groups. The budget form gathers specific data on the projected cost of services provided to the CYSHCN population, as well as captures program planning information such as MCH core services estimates, HCP Care Coordination estimates, and agencies' choice whether to receive CRCSN notifications.

CDPHE's 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 HCP Program understand the costs of HCP Care Coordination and Specialty Clinics, given the standardization of quality service delivery and to assure we are providing the most efficient and cost-effective services to the children and families whom we serve.

The LPHA Planning Budget form should directly reflect the personnel and resources needed to complete the Action Plans for each population group. This form is a

combined budget and narrative form. For each population group or program, LPHAs will enter their budget and narrative information on one Excel document**.** Visit the MCH website at www.mchcolorado.org to access the sample budget, instructions, and budget template.

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 Action Plans, and HCP Specialty Clinics.

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

- Medical home
- Early childhood obesity prevention
- Bullying and suicide prevention
- Pregnancy-related depression
- HCP Care Coordination (No Action Plan, included in statement of work)

Sanger County will have 3 budgets 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
   - Bullying and 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

► Draft planning budgets are due via email in Excel format to your MCH Generalist Consultant by **May 20**.
► Final planning budgets are due in Excel format via email to your MCH Generalist Consultant by **June 13.**

5. Core Services Planning Estimate (on the MCH Planning Budget Form)

The bottom section of the MCH Planning Budget form includes the MCH Core Services Planning Estimate information. The MCH Core Services Planning Estimate is used 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:
Enabling Services
Public health services and systems

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

6. FY 16 Review and Feedback of Budgets and Planning Forms

After the draft budgets are submitted, the state MCH and HCP teams, including fiscal and contracting staff, will review and provide feedback. The MCH Generalist Consultants are responsible for summarizing the feedback and sharing it with the LPHA in a timely manner.

Below is an outline of the budget review process:

1. By May 20, LPHA sends budget drafts to MCH Generalist Consultant.
2. MCH Generalist Consultant, MCH Unit Manager, MCH Implementation Team lead, and/or HCP Unit staff review and provide related comments.
3. MCH Fiscal Officer reviews and provides feedback on the budgets.
4. MCH Generalist Consultant emails and/or calls LPHA with a summary of the feedback.
5. By June 13, the LPHA revises the budget, as needed, and sends the final documents to their MCH Generalist Consultant.
6. MCH Generalist Consultant and MCH Fiscal Officer review final budgets.
7. By Sept. 1, CDPHE MCH program emails final budget approval to LPHA.

D. Action Plan Implementation

1. 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. LPHAs will carry out their MCH Action Plans by implementing the activities in the plan according to the agreed upon timeline 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

As described in the MCH contract, both state and local staff members have a responsibility to communicate regarding their MCH contract, Action Plan and budget. MCH Generalist Consultants and HCP Consultants are responsible for timely communication and revisions in the MCH Guidelines, HCP Policy and Guidelines, administrative procedures, and overall program expectations and 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 Consultant 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 to personnel including vacancies
- Possible changes in Action Plan activities
- Agency changes or developments that may impact MCH Action Plan(s)
- Community developments that may impact MCH Action Plan(s)

3. Invoicing Procedures

Local health agencies invoice CDPHE monthly for services rendered. Each Agency will receive a customized invoice form in October, the first month of the current budget period. The MCH Generalist Consultants, the HCP Consultants and the MCH Fiscal Officer will review each invoice for accuracy and alignment with the approved MCH activities and 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 receive payment until the invoice is approved by the CDPHE.

Invoices must be submitted by email (cdphe.psmchreports@state.co.us) or fax (303-753-9249) no later than 45 calendar days after the end of the billing period for which services were rendered. Invoices should be signed by the authorizing agent of the agency and include a concise explanation of expenditures.

The final invoice is due on or before **November 15**, 45 days from the expiration date of the current budget period.

4. Action Plan Revision and Adding/Deleting of Action Plans

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 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** MCH Action Plans is as follows (also see the Reporting Steps Section):

- Revising an Action Plan includes updating objectives, activities, or timelines.
- The LPHA emails a request to their MCH Generalist Consultant describing the proposed revisions and the justification or rationale for the proposed revisions.
- The MCH Generalist Consultant responds via email either in support of the request or with follow-up questions.
- Once the MCH Generalist Consultant communicates support of the request, the LPHA revises the Action Plan.
- The LPHA submits the revised plan by updating their Action Plan and emailing it to their MCH Generalist Consultant.

The process for **deleting or adding** MCH Action Plans is as follows:

The deadline to delete or add an Action Plan is May 31.
Agencies cannot bill for a new plan until it is approved by the CDPHE MCH Program, the PSD Division Contract Administrator and the Department's Contract Administrator.
Please note: It will take approximately 6-8 weeks for the new Action Plan to become effective after the agency completes the MCH program approval process below:

- The LPHA e-mails a request to their MCH Generalist Consultant describing the proposed MCH Action Plan changes and justification or rationale for the changes.
- To **delete** an Action Plan: the LPHA completes a **MCH Priority Transition Plan Worksheet** (provided by the MCH Generalist Consultant) in consultation with the MCH Generalist Consultant, MCH Program Specialist and key community stakeholders.
- To **add** an Action Plan: the LPHA completes a **MCH Priority Readiness form** (provided by the MCH Generalist Consultant). After the form is completed it is submitted to the MCH Generalist Consultant for Program Approval.
- After a CDPHE MCH Program internal review, the MCH Generalist Consultant responds via e-mail in support of the request or will follow-up with questions.
- After the MCH Action Plan change is approved by the CDPHE MCH Program, the contract does need to be amended by the CDPHE Division and Department Contract Administrators; the MCH Generalist Consultant will coordinate the necessary steps in this process with the LPHA and the CDPHE contracts office.
- The MCH Generalist Consultant will oversee follow-up and communication with the LPHA MCH Program Manager when the approval process is final.
- At this point, the revised Action Plan replaces the original Action 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.
- LPHA's are allowed to invoice for the new Action Plan, **after** CDPHE MCH Program, Division and Department approval.

5. Budget Revision Process

All budget revisions need to be submitted by June 30.

Please note: All budget expenditures must be invoiced by the end of the contract year. LPHAs may not carry over funds from one contract year to the subsequent contract year.

Program and fiscal staff in the Prevention Services Division (PSD) at CDPHE are committed to supporting contractors/grantees in fully utilizing their contract awards to implement their scope of work. The PSD grantee monitoring process has been updated and the changes have been integrated into current PSD contractor/grantee monitoring processes to assure that each contractor is able to optimally utilize the maximum amount of their award.

In this updated process, program and fiscal staff will systematically review contractor/grantee spending data throughout the contract period. If a contractor/grantee has significantly under-spent or overspent at the time of review, program staff will notify contractor/grantee to discuss circumstances surrounding the spending status, as well as options for proposed reallocation of funds that are supportive of Action Plan objectives.

A final assessment will be conducted by the PSD program and fiscal staff at the end of each contract period. If a contractor/grantee is underspent by 10% or $15,000, whichever is less, and this represents a year-to-year trend, subsequent awards may be reduced.

Budget Revision Criteria

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

- There are new items to add to a closed budget category on the current planning budget, such as opening the contractual or travel category that previously did not have any line items listed.
- There is a **cumulative** transfer of funds from one budget category to another greater than 25% of the total ***direct*** cost of the entire budget for the contract or $250,000, whichever is less.
- There is a **cumulative** transfer of funds from one budget to another greater than 25% of the total ***direct*** cost of the entire budget (example: care coordination to child/adolescent) for the contract or $250,000, whichever is less.

Budget Revision Process

If any of the three criteria above is met, then the LPHA shall request and receive prior written approval from the MCH Generalist Consultant and MCH Fiscal Officer by completing and submitting a **Budget Revision Request Form** before the transfer can be made. There are two Budget Revisions Request Forms on the MCH website; there is one form for moving funds within the same budget and another form for moving funds between budgets.

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

- The LPHA will email a completed Budget Revision Request Form to the MCH Generalist Consultant requesting proposed budget revision(s) and the justification or rationale for the proposed revision(s). The Budget Revision Request Form must reflect the entire original MCH Plan Budget in addition to the corresponding revision(s). This form will serve as the revised MCH Plan Budget and re-set the budget.
- The Budget Revision Request Form is available on the MCH web site at www.mchcolorado.org.

- The MCH Fiscal Officer 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 e-mailed to the LPHA.
- At this point, the Budget Revision Request Form, along with the original budget narrative will serve as the new 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.

Budget Change Requests

The LPHA should monitor budgets throughout the contract year and consult with the MCH Generalist Consultant on proposed budget changes or modifications.

All budget change requests need to be submitted by the LPHA to the MCH Generalist Consultant by August 1.

Budget change request process:

- LPHA's should outline budget change requests, rationale and estimate of expenditure costs in an e-mail to the MCH Generalist Consultant and the HCP Consultant (if the budget changes involve HCP Care Coordination or Specialty Clinic budgets).
- The MCH Generalist Consultant will review the budget change request with the HCP Consultant, MCH Program Specialists and the PSD Fiscal Officer and will communicate back to the LPHA if there are questions or, if there are no objections to the budget changes.
- All contract funds must be invoiced in the current contract year.

6. Progress Checks

MCH Generalist Consultants conduct three progress check-in meetings with the Contractor (LPHA) during the contract period in order to monitor the LPHA's progress on the Action Plans as well as to provide technical assistance and support during plan implementation. During the progress check-in, the LPHA and MCH Generalist Consultant will review the LPHA MCH Quarterly report documents using a standardized set of questions to discuss progress and/or challenges of planning, implementing or evaluating MCH Action Plans and to review any relevant work products developed as part of the plan, such as team charters, reports, Medical Home Appendix A documents, etc. The LPHA 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 MCH Generalist Consultant will work collaboratively to celebrate successes and address Action Plan barriers. 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 Consultant during the check-in period for specific programmatic guidance.

The MCH Generalist Consultant is responsible for scheduling the check-in with the LPHA. 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 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. An end of fiscal year meeting will take place in **November**. Another check-in will occur in **January/February** and a check-in that includes discussions regarding the following year's plans will take place in the **spring**.

7. Contract Management Ratings (CMS)

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 **September** and at the end of the two-year contract cycle. The rating will reflect contractor performance. For MCH contracts with LPHAs, the MCH Generalist Consultant is responsible for assessing contractor performance and assigning the CMS rating. The MCH Generalist Consultant 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 Consultant 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 state HCP staff will assess contractor performance for HCP Care Coordination and HCP Specialty Clinics and will provide feedback to the MCH Generalist Consultant to inform the LPHA's CMS rating.

The MCH Generalist Consultant will communicate the rating to the LPHA via email. 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 two years.

Criteria have been identified below by state MCH staff in an effort to provide some further explanation and guidance to LPHAs regarding the CMS ratings for MCH contracts.

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 and timeliness of service, budget and invoice management, and customer service) 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 for an MCH contract 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 the MCH Generalist Consultant.
- Submits accurate invoices in a timely manner.
- Invoices are for the line items necessary to the completion of MCH activities.

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

An example that may produce an Above Standard rating for an MCH contract 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 and timeliness of service, budget and invoice management and customer service) 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 for an MCH contract 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, HCP Consultant, or MIT Content Specialist.
- Failure to invoice.
- Consistently invoicing for line items that are not necessary to the completion of MCH activities.

Following CDPHE contract monitoring guidelines for MCH contracts, the categories are defined as follows.

- **Quality of Service** – 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), adhere to relevant HCP policies and guidelines, complete reports with accuracy and complete information.

- **Timeliness of Service**– 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.
- **Cost/Budget Management and Invoicing** – LPHA partners effectively manage costs and their budgets. Costs reported on invoices match to open cost categories or, if necessary, the LPHA completes a budget revision to realign the budget cost categories (personnel, travel, operating, contractual).
- **Customer Service** – LPHA staff are professional, courteous, cooperative, proactive, responsible and reliable in their interaction with the state MCH, HCP and fiscal staff.
- **Contract Deliverables** – The LPHAs are required to implement all of the contract and scope of work requirements to include the MCH Action Plan and budget, implementing HCP services (HCP Care Coordination, HCP Specialty Clinics) as specified in the scope of work, developing future plans, completing and submitting quarterly and annual reports, and following all other MCH administrative procedures (invoicing, budget revision requests, communication of changes in plan, subcontracting, etc).

8. Subcontracting Procedures

If an 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 (MOU and scope of work) with the subcontractor that can be produced upon request by CDPHE. The MOU and scope of work should outline the following:

- Date of agreement
- Name and contact information of the subcontractor
- Roles and responsibilities of contracting agency and subcontracting entity
- Deliverables
- Timeframe for deliverables
- Price for deliverables (for staff costs, include hourly rate if applicable)

CDPHE has the right to monitor the LPHA and its subcontractors; the LPHA is ultimately responsible for subcontractor work.

9. Performance Improvement Plan

CDPHE has the right to implement a Performance Improvement Plan (PIP) if an unresolved compliance issue is not addressed by the LPHA, after multiple efforts to resolve the issue. The MCH Generalist Consultant will implement the PIP with the LPHA MCH Program Manager or Supervisor. Monthly LPHA reports and CDPHE monitoring will be implemented, to document the compliance issues, activities and remedies utilized to resolve the issue.

E. Reporting Steps

1. MCH Action Plan Quarterly Report(s):

Quarterly reports will consist of: Approved MCH Action Plans and HCP and MCH Four Square templates for each priority (instructions below). In addition, agencies implementing ECOP and/or Medical Home local action plans will complete tracking documents coordinated by the CDPHE ECOP and Medical Home Implementation Teams.

The quarterly report covers three months of local Action Plan implementation. The reports will be submitted **on or before the 15th of the month**, following the last month of each quarter. The final (July – September) quarterly report will be submitted **on or before October 31**, the month after the end of the contract year.

MCH/HCP quarterly report due dates and reporting timeframes:

By January 15: Submit report for Oct. – Dec.

By April 15: Submit report for Jan. – March

By July 15: Submit report for April – June

By October 31: Submit report for July – Sept.

MCH Local Action Plan/reporting template: Complete the quarterly objective(s) and key activities checklist using the letters identified in the key embedded in your action plan template and described below:

c-green: complete (objective/activity is completed).

n-pink: not yet started (objective/activity is scheduled to begin/take place at a later time).

o-blue: on-track (objective/activity is in progress or is regularly occurring).

b-tan: behind schedule (due to a barrier, objective/activity is not yet started or is behind schedule).

MCH Local Impact Four Square reporting template: A customized Excel file will be sent to each LPHA. Please complete a Four Square template for each local Action Plan following this guidance. Content should be brief and is not intended to be a documentation of all activity occurring, only significant highlights.

Background Information:
In this section, please briefly document emerging issues in your agency or community that may impact this action plan such as existing or future outside funding you are using to support the priority (e.g., "Agency received SIM grant to begin 10/1") and if this priority is included in your Community Health Improvement Plan (e.g., "Community health improvement plan prioritization

process was completed; ECOP was identified as a county priority for next 5 years").

Successes:
Successes related to your objectives and strategies that occurred over the past three months or that you hope to achieve in the current month.

Barriers:
Key roadblocks to Action Plan progress over the past three months or those you anticipate in the next three months. Please share if you would like assistance and describe the kind of support you feel would be helpful (e.g., tools or resources, information, connections with others doing similar work, or other support from MIT or MCH Generalist).

Action Plan, Staffing, or Budget Changes:
Briefly document proposed changes for the next quarter.

Next Steps:
Briefly list key/significant milestones planned to occur in the next quarter.

LPHA MCH Program Manager or Supervisor:
The completed MCH-HCP Quarterly Report documents should be reviewed by the Program Manager to make sure the Action Plan (with updated, quarterly color-coding) and Four Square Template are complete. After this internal review, the Program Manager will send the report documents per the MCH Quarterly report schedule via e-mail to cdphe.psmchreports@state.co.us.

These quarterly local Action Plan reporting documents will be reviewed by the MCH Generalist Consultant and MIT Program Specialist at the LPHA progress check-in meetings. At the progress check-in the "Next Steps" section of the Four Square quarterly report will be finalized to include follow-up tasks agreed upon by the LPHA Program Manager, local Action Plan lead, MCH Generalist Consultant and Program Specialist. The LPHA Four Square quarterly report will provide a foundation for LPHA performance management and quality improvement practices designed to enhance local Action Plan implementation.

The MCH Core Services Annual Report and HCP report information and forms will be sent to all LPHAs via e-mail by September 15. The forms will also be available on the MCH web site at www.mchcolorado.org

2. HCP Reports:

A. HCP "4-Square" Quarterly Report:

Each agency will complete a 1-page reporting form on a quarterly basis. This form will be emailed to each LPHA at the beginning of the contract year as a tab within an Excel file. The HCP "4-Square" quarterly report form is designed to capture key HCP successes, barriers, next steps, and proposed changes related to the plan, staffing or budget. Please follow the instructions provided on the form and

remember that information reported may be brief and succinct. **Quarterly submission dates and instructions are listed on 28 -29.** Please submit all reports to cdphe.psmchreports@state.co.us

B. HCP Annual Report:

The FY 2016 HCP Annual Report form and instructions will be sent to LPHAs by the HCP Program team by September 20. The HCP Annual Report form mirrors the HCP planning tool and requires agency CYSHCN CDS data for the current fiscal year, which will be available after October 1. The HCP Annual Reports are due **by October 31** to cdphe.psmchreports@state.co.us

3. MCH Core Services Annual Report

The MCH Core Services Annual Report must also be submitted at year-end with actual (versus estimate) data. These data are required for federal Title V Block Grant reporting purposes.

For each budget, review the objectives and activities included in the corresponding MCH Action Plan(s), report on the percentage of total budget funds focused on the different levels of the MCH pyramid (enabling services and public health services and systems).

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

The MCH Core Services Annual Report along with final quarterly Action Plan (color-coded) reports and Four Square reports are due by **October 31.** Submit via email to cdphe.psmchreports@state.co.us.

4. Review and Feedback of Reports

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

PART III. 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

[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. Seven Steps of the EBPH Framework

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
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) to determine what factors are causing the issue, who is most impacted by the issue and to what extent
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	Identify evidence-based approaches to address causes of issues among population through a literature review Focus of the literature search: Policy Systems-building

Steps of the Evidence-Based Public Health Framework	Definition of EBPH Framework Step	Steps of the MCH Planning Process
	evidence	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 impact evidence-based population-based infrastructure level MCH role local role political will culturally appropriate	Prioritize issues for MCH plan using MCH Prioritization Tool
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		

APPENDIX C. Step-by-Step Guide: MCH Planning & Implementation Process

TIMELINE	LOCAL ACTION ITEM
Monthly	Submit invoices to: cdphe.psmchreports@state.co.us Customized invoice templates are provided to each agency. Agencies have **45 days** after the end of the monthly invoicing period to submit an invoice.
October 1	Begin implementation of Year 2 MCH Action Plans and budget.
November	LPHA staff participate in progress check-in with MCH Generalist Consultant.
January/February	LPHA staff participate in progress check-in with MCH Generalist Consultant.
March	Participate in webinar outlining the MCH Guidelines and planning process.
March	LPHAs and the MCH Generalist Consultant coordinate Spring planning/check-in meetings.
March/April	Consult with MCH Implementation Team leads for technical assistance on MCH Priorities.
April/May	LPHA staff participate in planning meeting/progress check-in with MCH Generalist Consultant.
April/May	LPHAs develop updated budgets and HCP planning forms.
May 20	Submit draft Action Plans, budgets and HCP planning forms via email to your MCH Generalist Consultant.
May 31	Deadline to add or delete an entire Action Plan.
June 13	Final planning budget/narrative forms and HCP planning forms due via email to MCH Generalist Consultant.

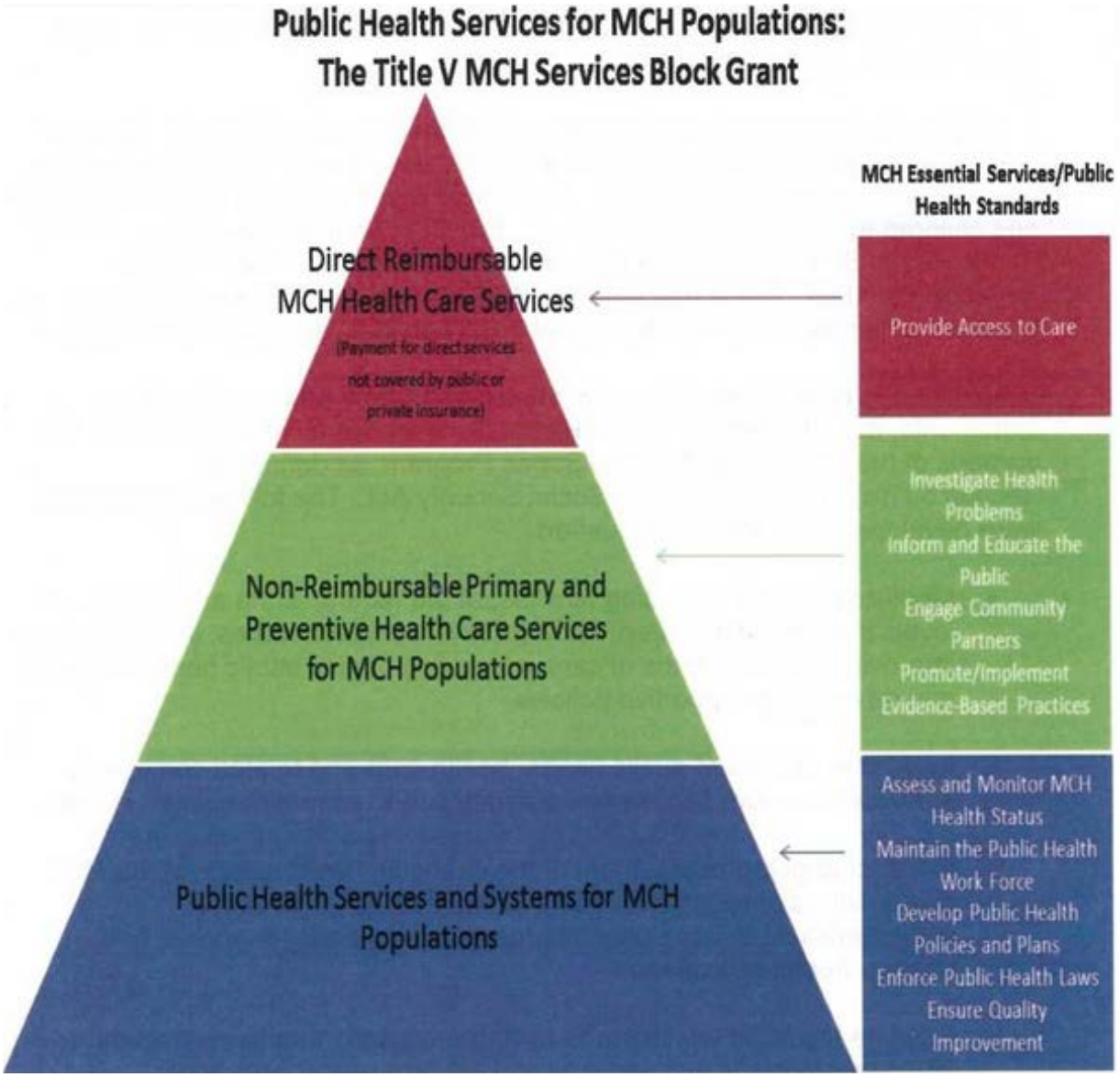
TIMELINE	LOCAL ACTION ITEM
June 30	Deadline to submit budget revisions for the current contract year.
September 1	Receive notification of budget approval via email.
September	Receive contract performance rating via email from MCH Generalist Consultant.
September 30	End of the MCH Contract year.

APPENDIX D. Step-by-Step Guide: MCH Reporting Timeline

TIMELINE	LOCAL ACTION ITEM
QUARTERLY	• Complete and submit MCH local Action Plan reporting template for each local Action Plan in your contract. • Complete and submit MCH Local Impact Four Square template for each local Action Plan in your contract. • Complete and submit HCP Four Square template MCH Program Manager/Supervisor send MCH report documents to: cdphe.psmchreports@state.co.us **See quarterly reporting guidance on pages 28 – 30**.
By January 15	The first MCH/HCP quarterly reports (see above) **are due by January 15** covering October – December activities.
By April 15	The second quarter MCH/HCP quarterly reports (see above) **are due by April 15** covering January – March activities.
By July 15	The third quarter MCH/HCP quarterly reports (see above) **are due by July 15** covering April – June activities.
By October 31	The final quarter MCH/HCP quarterly reports (see above) **are due by October 31** covering July – September activities.
ANNUALLY By October 31	Submit HCP and MCH Core Services Annual Report to cdphe.psmchreports@state.co.us **by October 31.** See Annual Report guidance in the MCH Guidelines.

APPENDIX E. 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 three 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, public health services and systems. Public health programs are encouraged to provide more of the community-based services associated with the lowest-level of the pyramid and to engage in the direct care services only as a provider of last resort.

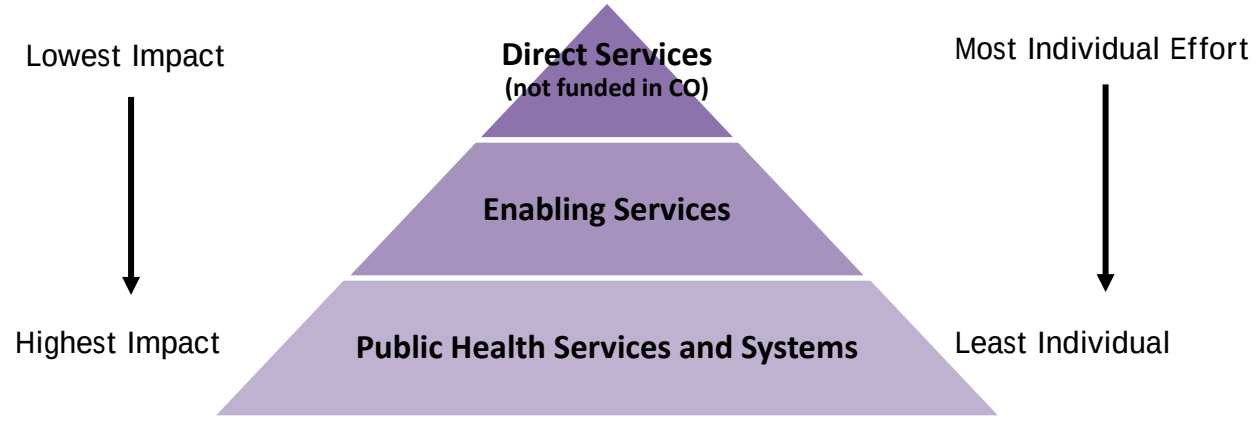


APPENDIX F. Population-Based and Infrastructure-Building Approaches to Maternal and Child Health

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 public health services and systems approaches in order to maximize health outcomes for women, children, youth, and children and youth with special health care needs (CYSCHN). Focusing on public health services and system 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 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 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 public health services and systems 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 level 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 three different approaches that can be employed to improve and impact MCH. The pyramid can be used to guide which programs and strategies will be selected, to 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 bottom level of the pyramid: public health services and systems. 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 public health services and systems.



MCH Bureau

Pyramid Level Definitions

Direct Services

Direct services are preventive, primary or specialty clinical services where funds are used to reimburse or fund providers- similar to paying a medical billing claim.

Examples:
- *An 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 CYSHCN 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.

Public Health Services and Systems

Public Health Services and Systems are activities and infrastructure to carry out the core public health functions. These include population-based services, which are services provided to an entire population, or a defined subset of a population, and infrastructure-building services, which provide support for the development and maintenance of comprehensive health services systems, including standards/guidelines, training, data, planning and evaluation.

Examples:

School district-wide health education programs: An 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: *An 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.*
- 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: *An 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

The different levels of the pyramid are 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
- Public Health Services and Systems: 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**	**Public Health Services and Systems**
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

Essential Public Health Services	Service Level		
	Direct	Enabling	Public Health Services and Systems
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
8. Assure competent public and personal health care workforce			X
9. Evaluate effectiveness, 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 Public Health Services and Systems Approaches

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

In the fall of 2011, CDPHE staff completed in-depth qualitative interviews with staff from six LPHAs who successfully implemented public health services and systems 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

- 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 public health services and systems 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

- 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 Consultant as a resource.
- Institute policies that require newly hired staff to have certain public health and/or health education credentials and/or encourage existing staff to gain these credentials.

o Relationships and Collaboration

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

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.

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.

o 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 Public Health Services and System 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 level 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 level of the MCH Pyramid: public health services and system 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 public health services and system approaches, however, not at the enabling level.

For example, an 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 public health services and system 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.

MCH Generalist Consultant or Office of Planning and Partnerships and Improvements (OPPI) Nurse Consultant work with LPHAs 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 public health services and system approaches.

APPENDIX G. CYSHCN Population by County

Colorado uses the broad definition of Children and Youth with Special Health Care Needs (CYSHCN) as defined by the Maternal and Child Health Bureau (MCHB) as "children and youth who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally." Using this broad MCH definition, 17.1 percent of children in Colorado ages 0-17 have a special health care need based on results from the 2007 National Survey of Children's Health (NSCH).

In Colorado, there is an estimated 209,000 children and youth ages 0-17 with a special health care need. This number is only an estimate and is not an exact count of children and youth with special health care needs in the state. County population data for children and youth ages 0-17 multiplied by 17.1 percent equals the estimated number of children and youth 0-17 who have special health care needs in your county. For example: 30,000 x .171 = 5,130. Estimates are less precise in counties with small populations.

When you apply the 17.1 percent to children and youth in your county, ages 0-17, please remember the result is only an estimate based on survey data collected in 2007. It does not represent the exact number of children in your community/county.

Updated data for children and youth ages 0-17 will be available upon completion of the 2011 NSCH. Data for youth ages 18-21 with special health care needs are not available from the NSCH or the Colorado Child Health Survey (CHS).

Colorado Child Health Survey, 2010-2011 - Children ages 1-14	
Percent CSHCN by County	
County	**Estimated CSHCN 1-14**
Adams	22,697
Arapahoe	26,953
Boulder	4,598
Denver	17,738
Douglas	11,319
Elbert	925
El Paso	27,368
Jefferson	15,560
Larimer	7,057
Mesa	4,091
Pueblo	13,524
Weld	6,836

APPENDIX H. MCH Contracting Frequently Asked Questions

1. We have learned one of our staff members plans to leave. What are the next steps for my MCH contract?

   Let your Generalist or HCP Consultant know that you anticipate a staffing vacancy and describe your plan and timeline to fill it. Per the readiness tool completed during the planning process, agencies should have a plan in place to address staff turnover under each priority Action Plan. If the vacancy will create a spending shortfall, also begin considering your plan to reallocate these funds in a way that supports Action Plan outcomes.

2. At our current rate of spending, it is projected that our agency will underspend our award amount.

   Talk with your Generalist and internal staff to create a spending plan that supports your Action Plan outcomes. Monitor your rate of spending so that it is possible to identify a low rate of spending as early as possible. Keep in mind that not spending your total award will not affect future awards if the amount not spent is less than $15,000 or 10% of your total award. However, if the amount unspent exceeds $15,000 or 10% of the total award and if there is a trend of under-spending over more than one year, future awards may be reduced. Please see the Budget Revision section for more information.

3. I want to change my Action Plan.

   Changes to the statement of work may result in the need for a contract amendment. Talk through proposed changes to Action Plan activities with your Generalist and the MCH Implementation Team priority lead as early as possible. S/he is available to help tailor your plan to your agency's needs. Please see the Action Plan Revision and Adding/Deleting of Action Plans section for more information.

4. One of my Action Plan activities is not going as planned.

   The MCH Implementation Team and the Generalist Consultant are available as a resource at any time during the implementation process to assist in addressing barriers and connecting you to resources to enhance your success.

5. We want to hold a meeting and provide food and drink. Is this allowed?

   Food and non-alcoholic drink are allowable expenditures if the event includes the dissemination/exchange of technical information to *non-LPHA staff*, and if the cost is reasonable and necessary for successful completion of the Statement of Work.

6. My agency would like to send one or more staff members to a training.

   Staff training is allowable if the training is reasonable, necessary, and supports the Statement of Work.

7. My fiscal department is not invoicing on time.

   It is the responsibility of the LPHA MCH Manager to work with their fiscal department to ensure timely invoicing. Your Generalist and Fiscal Officer at CDPHE can contact your fiscal department directly at your request to support your efforts to invoice on time. Chronic late invoicing can affect final Contract Management System (CMS) ratings. Please see the Invoicing Procedures section for more information.

8. I would like to move some of my agency's funding from one budget or budget category to another.

   Grantees may move funds between open budget categories (personal services, travel, operating, and contractual) or between one budget to another (Care Coordination, Medical Home, etc.). Please let your Generalist know if you plan to transfer funds between categories or budgets. If the budget adjustment is in excess of 25% of the total budget for direct costs, or more than $250,000, grantees will need to complete a Budget Revision Request Form. Budget revisions are not retroactive and must be approved in writing before any costs are incurred. Please see the Budget Change Request section for more information.